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NEW SOMATIC SYMPTOM DISORDER IN DSM-5

Welcome to the 21st century

Twenty years ago Frances chaired the DSM (*Diagnostic and Statistical Manual of Mental Disorders*) taskforce, which emphasised “medically unexplained symptoms” as the key feature of somatoform disorders.¹ Where did that get us?

Patients feel that their problems are viewed as inauthentic, and doctors can’t agree about what is or is not medically unexplained. All of this reinforces a mind-body dualism, which is more consonant with the 17th century than the 21st. Psychiatric symptoms and general medical symptoms can coexist. We think and feel with our brains and are affected by life experience and the cellular milieu that we live in.

The DSM-5 diagnosis of somatic symptom disorder represents an attempt to correct these problems in DSM-IV. The DSM-5 diagnosis does not question the reality of patients’ suffering but emphasises that psychiatric disorders are better diagnosed on the basis of features such as disproportionate and excessive thoughts, feelings, and behaviours rather than by negative features such as “medically unexplained symptoms.”

Frances thinks the DSM-5 criteria will be “too loose.” However, the DSM-IV criteria for “undifferentiated somatoform disorder” yielded higher estimates of the population at risk than the DSM-5 criteria do.

He also suggests that doctors should use a “benign diagnosis.” We agree that DSM-IV diagnoses were highly stigmatising. We hope that the DSM-5 approach will be less so, particularly with the de-emphasis of medically unexplained symptoms. DSM is hardly “a bible.” DSM-IV wasn’t, and DSM-5 won’t be either. DSM aims to accurately describe the patient’s presentation with the intention of providing helpful treatment. When a patient is better described by one diagnosis than another, it is sensible to use the most accurate.

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Competing interests: The authors are members of the DSM somatic symptoms workgroup.

1 Frances A. The new somatic symptom disorder in DSM-5 risks mislabeling many people as mentally ill. *BMJ* 2013;346:f1580. (19 March.)

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Punishing deviancy

The new diagnosis of somatic symptom disorder seems to confirm that psychiatry will stick a diagnostic label on anything that appears in any way deviant.¹

Dimsdale argues that the new disorder will correct the patient unfriendly DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders*, third edition) notion of “medically unexplained symptoms,”² with patients relieved that their symptoms are not being treated as “inauthentic.” But how can a clinician, medical or psychiatric, decide whether a medically ill patient’s distress is beyond the bounds of what is appropriate for that patient and that illness? In addition, Dimsdale’s argument that patients will feel invalidated by “medically unexplained symptoms” applies equally to somatic symptom disorder—patients will worry about not only having a serious medical illness, but also a psychiatric one, just because they expressed their distress.

In the guidelines for changing DSM-5,³ as a new diagnosis, somatic symptom disorder would qualify as a “major change.” The guidelines state that “the empirical evidence for any change introduced in DSM-5 should be proportional to the magnitude of the change. That is, the larger and more significant the change, the stronger should be the required level of support.”³ It is not evident where the support for somatic symptom disorder comes from. The guidelines also provide a list of 10 validators for supporting a diagnosis, and none seems to strongly support the new diagnosis. In not following its own guidelines, the DSM-5 task force seems vulnerable to the criticism of diagnostic expansion.

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2 Dimsdale JE, Sharpe M, Creed F. Helping to find the most accurate diagnosis. *BMJ* 2013;346:f2228.
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A step in the wrong direction

As a physician who trained in both psychiatry and pain management and chaired the DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders*, fourth edition) and DSM-IV-TR (text revision) committees on pain disorder, I am worried about subsuming these diagnoses under the new somatic symptom disorder diagnosis in DSM-5.¹

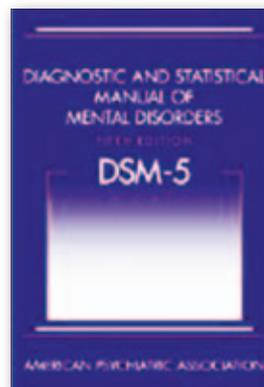
This new diagnosis, at least with regard to pain, is a step in the wrong direction, and the rationale for making the proposed changes is erroneous. How can we determine what are “excessive thoughts, feelings and behaviours” to pain in patients with cancer or disabling chronic pain, for example, when we have no idea what the normal or expected response would be? For many patients, such thoughts, feelings, and behaviours probably reflect the mismanagement of pain by caregivers rather than psychological problems.

Furthermore, the indication in DSM-5 that this

diagnosis fits on a continuum with conversion and factitious disorders strongly suggests that the pain involved isn’t “real.” Pain that is secondary to mental disorders (and pain is a common presenting symptom of depressive and anxiety disorders) is just as real to patients as that related to medical disorders, and both may share similar underlying neurophysiological mechanisms.

This diagnosis harkens back to the DSM-III requirement that psychological factors be judged to be the primary cause of the pain and its DSM-III-R replacement that the patient be preoccupied with the pain. These were replaced by DSM-IV pain disorder that required only that the pain be “associated with psychological factors” and allowed for the presence of comorbid medical conditions.²

Unlike Frances, who fears that the new diagnosis may be overused, I believe it will rarely be used.



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BOLDT: THE GREAT PRETENDER

Where are the coauthors?



The article on the German anaesthetist Joachim Boldt, whose faked works greatly influenced the field of anaesthesiology and critical care medicine, suggests that Boldt was motivated by a greedy desire for self aggrandisement.¹ But what of his many coauthors, including international partners and drug producers? Did these collaborators ever detect any faults in their investigations—including regular investigational documents, original experiment data, and statistical data—before the event was exposed to the world?

The whole thing seems like a monodrama, with Captain Boldt playing it alone and taking full responsibility so far. Before and after the event, his cooperators—in famous journals or at international conferences—kept silent, not mentioning their contribution or confessing their mistakes. Should we ask them about their motives, when they repeatedly took part in Boldt's studies without finding any errors over so long a time?

Hydroxyethyl starch has long been used in fluid resuscitation, even though we now know that it may cause organ injury. Its popularity was mainly due to the worldwide promotional strategy and "star effects" established by these famous experts.

It is therefore reasonable to question Boldt's academic and business partners, as well as regulators and publishers, about the real lesson and to ask them to reconsider their responsibility.

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CANCER OF THE PENIS

Helping men cope

Because penile cancer is rare, affected men are unlikely to meet anyone outside their clinical team who has had direct or indirect experience of their cancer. Resources about the condition and the experiences of other patients will help men learn how to adapt to the changes that they will experience. Alongside the resources highlighted by Ayra and colleagues,¹ www.healthtalkonline.org has published a module on penile cancer.

Developed as part of the Patients' Experiences of Penile Cancer (PEPC) study,² the module consists of almost 300 audio, text, and video clips of men talking about their condition. The site has 24 themes across five main categories: early signs, diagnosis, treatment, and after treatment. The fifth category includes reflections on sharing experiences and the main messages they would give to health professionals.

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MISUSE OF PRESCRIPTION DRUGS

A legal way to obtain pleasure

As a GP for more than 20 years, I was naive about the addictive potential and use of prescribed drugs; now, as a GP in Holloway prison, such misuse is obvious and shocking.

Most of Holloway's inmates are young women, who often come in on a cocktail of prescribed analgesics and mind altering drugs of many types. Some of the analgesics have been prescribed by pain clinics, and, as Spence mentions,¹ presumably justified as not being addictive because used for pain. That most women also misuse illegal drugs is passed over or not picked up, along with the dubious diagnoses

of epilepsy for which only clonazepam works.

It is interesting to talk to women about why they like certain drugs and what currently has street value. Surprisingly, current favourites are quetiapine, mirtazapine, carbamazepine, gabapentin, and pregabalin, as well as the more obvious opioid analgesics and benzodiazepines. All are used for their mind altering qualities but are (presumably) prescribed for "diagnosed" conditions. Illegal drug users recognise that moving to prescribed drugs is an easier and legal way of obtaining pleasure.

The medical profession needs to recognise this too and decide on a strategy to manage the fall out.

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HORMONAL CONTRACEPTION AND THROMBOSIS

Any review must carefully weigh the available evidence

Helmerhorst and Rosendaal's recommendation that women prescribed oral contraceptives should receive levonorgestrel and 30 µg of ethinylestradiol is based on the observation that thrombosis risk is related to ethinylestradiol amount and progestogen type.¹ Although interesting, this strategy is not adequately evidence based.

Retrospective database studies of contraception and thrombosis are often cited because they are inexpensive and can rapidly amass large datasets. Unfortunately, conclusions are weakened by crucial methodological flaws, including lack of validation of diagnosis, lack of controls for confounders (including indication), and violations of time order.^{2,3} Furthermore, in the MEGA study, a case-control study cited by the authors, the confidence intervals of odds ratios for deep vein thrombosis and pulmonary embolism for cyproterone acetate and levonorgestrel overlap.⁴

Conclusions regarding progestogen type and thrombosis risk must be based on high quality prospective data that use appropriate comparators and active surveillance. Studies meeting these criteria have consistently failed to demonstrate differences in risk of venous thromboembolism between levonorgestrel and other progestogens. Recently, the Society of Obstetricians and Gynaecologists of Canada affirmed the comparable safety of third generation, fourth generation, and cyproterone acetate/ethinylestradiol formulations.⁵

Finally, we discourage a “one pill fits all” approach to contraception. Women benefit from a range of options that allow for a balance between indication, benefit, and risk. A restrictive prescribing practice is paternalistic and would probably increase dissatisfaction and non-adherence. The consequences of unintended pregnancy and contraceptive failure are serious and should not be underestimated.

We hope the European Medicines Agency will carefully evaluate the existing data and, in doing so, reassure women that oral contraceptives are safe (not risk-free). Meanwhile, we must continue to provide patients with a range of tools to prevent pregnancy and knowledge to assist in safe contraceptive decision making.

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Authors' reply

Costescu and Waddington think that there is no reason for a European Medicines Agency review or any concern because oral contraceptives containing third generation progestogens, drospirenone, and cyproterone acetate are all equally safe.^{1 2}

Their main point is that all retrospective studies are fraught with bias. Undoubtedly, any study can be biased—we dealt with this point more than 10 years ago, when we dissected all conceivable biases that had been brought forward.³ None held true. Since then, many more studies have been published, with very different designs, and all have confirmed the increased risk of the oral contraceptives mentioned above over those containing levonorgestrel.⁴

In addition, new laboratory methods enabled us to warn about a thrombotic risk of oral contraceptives containing drospirenone even before epidemiological studies found evidence.⁵

The main difference between studies that did and did not show a higher risk is that those that did not were paid for by the manufacturers.⁶ Even the same database (general practice research database) showed an increased risk of third generation oral contraceptives when analysed with public funding, but the absence of such risk when bought by one of the manufacturers and reanalysed. This evidence led us to warn: “Competing interests and controversy about third generation oral contraceptives. *BMJ* readers should know whose words they read.”⁷ Not much has changed.

The choice is simply between a safe and an unsafe oral contraceptive. The risk of fatal pulmonary embolism due to the use of an unsafe oral contraceptive should not be minimised. There is a crucial difference between proving effectiveness and safety—effectiveness needs to be proved but harm does not. Reasonable doubt about harm is sufficient to render prescribing a drug irresponsible.

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HEALTHCARE IN IMMIGRATION REMOVAL CENTRES

Many detainees shouldn't be there in the first place

I welcome the transfer of healthcare from the UK Border Agency to the NHS in immigration removal centres.¹ I am a retired GP and have been visiting such centres as a volunteer doctor



DAVID ROSE/PANOS

for the past six years. I have been involved with more than 370 asylum seekers, 306 of them in immigration removal centres, and at least 180 of these detainees had medical problems that were not being properly dealt with by the healthcare centres.

Many of the detainees tell me that the medical staff do not believe them when they consult with serious symptoms. Examples include, headaches in someone later admitted with meningitis; haemoptysis in a patient previously diagnosed with tuberculosis; and blood pressure, asthma, and diabetes out of control. Some detainees fear that the medical staff are “in league” with the UK Border Agency and determined to pronounce them “fit to fly,” despite being very sick or in the middle of treatment.

Asylum seekers who have been tortured in their home country are so terrified of return that they seriously self harm—cutting themselves, attempting suicide, refusing food. They have limited access to psychiatric help despite such profound despair.

The medical care of these extremely vulnerable people deserves to be a speciality on its own, with healthcare providers receiving specialist training on these patients' medical and psychological needs.

However, it would be infinitely better if these people were not imprisoned in the first place, especially as many are eventually released back into the community. A study by South Bank University, London, concluded that at most 8-9% of asylum seekers who get bail (after being released from an immigration removal centre) subsequently attempted to evade the asylum system.² It seems extreme to incarcerate people who are very sick, have mental health problems, or are in wheelchairs.

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