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REVIEW ARTICLE

Medically unexplained symptoms and somatisation in ENT

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Abstract

Background: Somatisation has been described as the perception of a physiological event influenced by emotion.

Method: A review of the medical literature was carried out using the following Medical Subject Headings: somatisation (which identified 357 articles), medically unexplained symptoms (749 articles), unexplained or idiopathic dizziness (142 articles), tinnitus (360 articles), catarrh (1068 articles) and globus pharyngeus (3114 articles).

Results: Up to 40 per cent of out-patient attendances have medically unexplainable symptoms. In ENT clinics, this includes patients with dizziness, tinnitus, 'pseudo' eustachian tube dysfunction, being 'unable to hear', catarrh and postnasal drip, atypical facial pain, globus pharyngeus, and functional dysphonia. Medical explanations of these symptoms often differ from patients' perceptions. Demonstrating normal test results and providing reassurance have little effect on patients' doubts and anxieties. Consultations that recognise the symptoms and their impact, and offer a tangible and involving explanation are more likely to satisfy and empower patients.

Conclusion: The treatment of medically unexplained symptoms has changed in recent years; there is now more emphasis on psychological factors due to an association with anxiety and depression.

Key words: Somatization; Medically Unexplained Symptoms; Otorhinolaryngology; Dizziness; Tinnitus; Catarrh; Globus Pharyngeus

Introduction

The term somatisation was initially coined by Steckel in 1943 who defined it as a 'bodily disorder that arises as the expression of a deep-seated neurosis, especially of a "disease of the conscious"'.[1] However, Steckel tended to create new words for previously existing terms, in this case, Freud's idea of conversion.[1] The definition has continued to evolve over the years. Somatisation was a popular concept in the 1980s and 1990s. However, it subsequently fell out of favour, as did the previously popular diagnosis of 'hysteria' in the 1970s. Recent texts prefer the use of neutral terms such as medically unexplained symptoms or functional symptoms. The understanding and measurement of medically unexplained or functional symptoms has changed over the years, and there is now more emphasis on psychological factors. This is less stigmatising to patients and may allow them to foster a better way of managing their symptoms.[2]

The Diagnostic and Statistical Manual of Mental Disorders version four (DSM-IV) defines undifferentiated somatoform disorder according to the following characteristics. (A) The individual has one or more physical complaints (e.g. fatigue, gastrointestinal or urinary complaints). (B) (1) After appropriate investigation, the symptoms cannot be fully explained by a known general medical condition or the direct effects of a substance, or (2) when there is a related medical condition, the physical complaints, or resulting social or occupational impairment is in excess of what would be expected from the history, physical examination or laboratory findings. (C) The symptoms cause clinically significant distress or impairment in social, occupational or other areas of functioning. (D) The duration of the disturbance is at least six months. (E) The disturbance is not better accounted for by another mental disorder (e.g. a mood disorder). (F) The symptom is not intentionally produced or feigned (as in factitious disorder or malingering).

Medically unexplained symptoms are very common, with about 80 per cent of healthy individuals experiencing them in any one week.[3,4] Statistically, the experience of bodily discomfort while being physically well is normal. Multiple studies have shown that the prevalence of medically unexplained symptoms in primary care is between 20 and 27 per cent.[5–7] In secondary care, 25–40 per cent of attendees to out-patient clinics are thought to have medically unexplainable symptoms.[8]

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Patients with unexplained symptoms are invariably subjected to investigations and interventions which do not uncover organic disease, and might be regarded in retrospect as unnecessary except that they exclude recognised medical diseases. The cost of somatisation to the healthcare services is high. In addition, there is an indirect cost to the patient in terms of the impact on quality of life, which can be very severe.

The aetiology of medically unexplained symptoms is uncertain and probably multifarious. Adoption studies have shown that while some of these syndromes were associated with psychopathology in the biological parent, others were related to psychopathology in the adoptive parent.[9] It is therefore probable that these are a heterogeneous group of pathologies. The home environment in childhood appears to play a significant role. The symptoms could be 'learnt' from childhood experiences of an illness either in the patient or their relatives, which predisposes the child to functional somatic symptoms in adult life. Children who somatise seem to copy symptoms exhibited by other members of the family. Factors of home life, such as lower social class, education, culture and subculture, all affect the extent to which emotional distress is expressed as physical symptoms. There is evidence to show that somatisation in adults is associated with parental interest and attention to symptoms in the patient's childhood. Selective perception influences our experience of bodily sensations; for example, if individuals are reminded that there is a flu epidemic, this leads to an increase in reported flu symptoms.[10] Furthermore, with practice individuals can learn to enhance their perception of bodily sensations. Therefore, an individual's habitual attention to a part of their own body will increase their sensitivity to perceive sensations in that area. Hence, some sort of traumatic event either to the patient or someone close to them could cause the patient to habitually fixate on a body part, thereby increasing the likelihood of somatic complaints.

Some authors have described somatisation as the perception of a physiological event influenced by emotion. This is shown by the physiological changes that occur with some somatic symptoms, such as the contractions in the smooth muscle of the alimentary tract that are influenced by stress, often leading to somatic discomfort. Unfortunately, there is no clear distinction between somatisers and those with psychophysiological disorders such as irritable bowel syndrome or tension-type headache. Furthermore, there may be some underlying physiological factors in somatisation that have not been reported.

Many researchers have emphasised the association between somatisation and depression. While there is robust evidence for this association, it is unclear which occurs first, depression or somatisation. Some authors have suggested that the symptoms of somatisation are a feature of depression, indicating that somatisation has the same aetiology, course and response to treatment as depression.[11] There is no conclusive evidence that this is the case; however, functional somatic symptoms may occur after stressful life events. Somatic symptoms are also seen in patients with anxiety, and many authors view the symptoms as bodily manifestations of anxiety states. Again, there is consistent evidence of an association between somatisation and anxiety. It is difficult to study the relationship between somatisation and anxiety or depression alone as they tend to coexist in a large proportion of patients. Somatic symptoms have been shown to decrease in number and severity when the anxiety or depressive disorder abates. Comorbidity between somatoform disorders and mental disorders appears to be becoming more common,[7] but this may be due to better recognition.

When Steckel originally described somatisation, he suggested that it is the body physiologically manifesting the troubles of the mind.[1,12] Another explanation is that it is a defence mechanism which helps a person to deny or rationalise a stressful event. In other words, it may be a means of transferring problems into a bodily sensation. Somatisation could also be considered a form of conflict resolution, wherein the patient becomes preoccupied with the sensation rather than dealing with an intolerable conflict.

A further concept that relates to somatisation is hypochondriasis. It has been suggested that hypochondriasis and somatisation are different manifestations of the same phenomenon. The key difference is that hypochondriasis is a named illness as opposed to an array of symptoms as seen in somatisation. There is consistent evidence of the association between somatic symptoms and the fear or conviction of having a disease. Therefore, it follows that patients with sufficiently distressing somatic symptoms are likely to have hypochondriacal concerns, and the stress produced by the symptom leads them to catastrophise. Conversely, individuals with an already established fear of a disease, or conviction of having that disease, will fixate more on bodily sensations. This does not mean that all somatising patients become hypochondriacs. In fact, some patients with long-standing somatic symptoms often develop insight, allowing them to appraise the situation and realise that the symptoms are not life-threatening. Unfortunately, there seems to be a vicious cycle in which functional somatic symptoms are often maintained. A new symptom during a period of anxiety or depression can, by way of selective perception, and motivated by hypochondriacal concerns, lead to further anxiety and in turn produce more somatic symptoms.

Relevance to ENT

The first duty of a doctor is to try and make a diagnosis. If the doctor is unable to arrive at a diagnosis in spite of investigations or a trial of medical treatment, then it may be prudent to ask for a further medical opinion. This still leaves a group of patients with medically unexplained symptoms. In ENT there is a sizable

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minority of patients who, in spite of investigation and time, are not found to have a recognised organic disease (we have to recognise the possibility that these patients have an as yet unrecognised pathology). Some of these patients interpret a normal range of symptoms as disease. The challenge is to exclude organic disease, but also be helpful to those who have no disease who may be equally disabled by their symptoms. Very little has been written about somatisation and medically unexplained symptoms in ENT. This is surprising given their frequency in ENT clinics. One study of 983 consecutive ENT patients found that 90 patients had medically unexplained symptoms and 49 were depressed.[11]

We briefly discuss below the main medically unexplained symptoms of patients presenting to the ENT department.

Dizziness

Even after extensive investigations, many patients with dizziness have unexplained symptoms.[12,13] Dizzy patients with an increase in bodily pain and a tendency to hypochondriasis are less likely to have a discernible peripheral vestibular disease.[14] However, an examination of patients with chronic subjective dizziness attending a tertiary care balance centre revealed that: 60 per cent of patients had a primary or secondary anxiety disorder; 39 per cent had a central nervous condition such as migraine, mild traumatic brain injuries or dysautonomia; 10 per cent had an otogenic condition; and 2 per cent had a dysrhythmia.[15] The high prevalence of secondary anxiety should not shroud underlying pathology.[15,16] Patients with chronic subjective dizziness comprised 10.6 per cent of one series of 1552 patients who presented with vertigo, and it was twice as common in women. Anxiety was a strong predisposing factor as well as a fear of heights and a former resolved vestibular event. However, 79 per cent had poor performance on dynamic posturography, which highlights the complex interaction between supratentorial factors and the vestibular system.[17] Nevertheless, even when anxiety is not the cause of dizziness, it becomes a factor with persistence of the symptom.[18]

Selective serotonin reuptake inhibitors have been found to help patients who have chronic subjective dizziness and anxiety, as well as those with an otogenic cause who have anxiety secondary to this. However, they do not appear to help those whose neurotologic condition exacerbates a pre-existing anxiety.[19]

Cognitive behaviour therapy has been shown to help reduce functional impairment in chronic subjective dizziness.[20]

Tinnitus

It is currently hypothesised that tinnitus is due to deafferentation of tonotopically organised central auditory structures, which leads to an increase in the spontaneous firing of neurons in the auditory cortex.[21] However, patients with tinnitus have many other symptoms, such as sleep disturbance, anxiety, depression, irritation and concentration difficulties.[22] There appears to be a complex interplay between tinnitus and depression.[23] When the pathophysiological explanations for tinnitus have been excluded, it is worth addressing other psychopathological symptoms that can exacerbate tinnitus, such as sleep disturbance, hostility, anxiety and emotional lability, and treating these symptoms accordingly.[24] A meta-analysis of 15 studies showed the benefits of cognitive behaviour therapy, which were maintained over time.[25]

Many older individuals do not have tinnitus, possibly because inhibitory circuits are preserved.[21]

'Pseudo' eustachian tube dysfunction

It is not uncommon for an adult to present with a sensation of blockage or 'cotton wool in the ears' with no objective signs of disease.[26] In some patients' otoscopic examination, the ability to inflate the middle ear by Valsalva's manoeuvre is normal, as are audiometry and tympanometry findings. Tympanometry is the main diagnostic test for eustachian tube dysfunction;[27] patients with pseudo symptoms have normal middle-ear impedance. These patients are often distressed and demanding, more so than patients who have objective signs of eustachian tube dysfunction. Medical and surgical manipulations can provide some transient symptomatic benefit, but this appears to be the result of a placebo effect or cognitive dissonance,[28] and the adage 'primum non nocere' (first, do no harm) comes to mind.

'Unable to hear'

Some patients complain of poor hearing yet have a normal audiogram. The labels 'obscure auditory dysfunction', 'King–Kopetzky syndrome' or 'central auditory processing disorder' have been used to describe this condition. Obscure auditory dysfunction has been defined as difficulty understanding speech in the presence of noise, which is accompanied by clinically normal hearing thresholds and no other obvious cause. Recognition, discrimination, separation, grouping, localisation or ordering of non-speech sounds can all be affected.

The term obscure auditory dysfunction deliberately avoids particular pathophysiological connotations. Affected patients show a performance deficit on speech-in-noise tasks. Although auditory dysfunction and poor linguistic ability are contributory causes, the high level of self-rated disability and handicap cannot entirely explain the deficit. Obscure auditory dysfunction is a multifactorial syndrome affected by auditory, psychological and linguistic factors.[29] Investigations have tried to define whether patients with obscure auditory dysfunction have a central processing problem or blunt tuning curves.[30] One small study of high frequency audiometry showed significant differences at 10, 14, 16 and 20 kHz. However, there is large

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inter-subject variability in high frequency audiometry thresholds within the normal population at these frequencies.[31] The role of psychological and organic factors in patients with this condition is unclear.

Catarrh and postnasal drip

The term catarrh means different things to different patients and it is important to find out what patients mean when they report this symptom. It is interesting that only a minority of patients with allergic rhinitis or chronic bacterial rhinosinusitis complain of catarrh.[32] Many patients who complain of catarrh appear to have an aberration of normal body sensations,[33] with greater pharyngeal awareness.[34]

If the primary symptom is posterior nasal discharge, then more detective work is needed to establish whether the patient has become hyperaware of normal mucus or whether they really have an overproduction of mucus.

Several groups of patients complain of catarrh or postnasal mucus in the absence of any excessive or abnormal mucus production. One such group are the snorers whose uvula is oedematous. These patients complain of a sensation of 'something' around the soft palate, and after further enquiry may complain of a collection of thick 'wallpaper paste' like mucus that collects in their throat due to mouth breathing. They may try to hawk up the mucus. They may snort, causing further vibration of the palate; indeed this can be an isolated habit that appears to sensitise the palate to feel normal postnasal mucus. Snorers often have mucus that dries up as they mouth breathe, and their snore becomes more tenacious as the mucus collects in the nasopharynx and oropharynx during the night. Some patients believe that it is unhealthy to swallow this.

It is far more common for patients to have a hyperawareness of normal postnasal mucus. Through repeated clearing of their throat or snorting, they may have sensitised these areas to the 20–40 ml of nasal mucus and around 1000 ml of saliva we swallow each day.

There is no objective investigation to confirm postnasal drip as a diagnosis, and there is a lack of specificity and sensitivity for symptoms and/or signs that form the diagnosis. Nasal mucus is normally tenacious and it cannot drip like tap water. Postnasal drip syndrome appears to have become more of a label than a useful term to describe underlying nasal pathology. Indeed, a review on the subject describes this syndrome as a 'dustbin' label medical term.[35] The vast majority of these patients have no demonstrable nasal disease. The symptoms of catarrh and postnasal drip symptoms could imply the presence of underlying postnasal drip syndrome to the non-specialist. The term 'drip' is a misnomer and implies that mucus can drip from the soft palate or nasopharynx into the larynx or hypopharynx causing cough. This does not happen because of the rheological properties of mucus, namely its cohesional forces, spinnability and adhesiveness.[36] The label of postnasal drip syndrome should be replaced by the more accurate diagnoses of rhinitis and rhinosinusitis when this is a cause for secretions. In the remaining patients, non-specific pharyngeal symptoms on their own, which have previously been attributed to postnasal drip syndrome, are not usually an indication of intranasal disease. Such patients typically have a hyperawareness of normal mucus and saliva.

A strategy to break the cycle of repetitive throat clearing, dry swallowing and hawking is to advise the patient to strictly avoid all these for one week. They should instead be advised to swallow ice cold water, which will stimulate the back of the throat and lessen the desire to carry out these actions. Patients must be disciplined about this and rotate bottles of ice cold water from the fridge regularly, keeping some by their bedside. It also helps to explain to the patient that their secretions are healthy and can be swallowed without causing any problems. This is a form of cognitive behaviour therapy. An audit of this strategy in a large proportion of patients with these symptoms showed the effectiveness of this technique.[37]

Atypical facial pain

Atypical facial pain is very much a diagnosis of exclusion. Care must be taken in reaching this diagnosis, even when the patient has received previous opinions and no pathology has been identified. The history is often vague and inconsistent, with widespread pain extending from the face onto other areas of the head and neck. The pain may move from one part of the face to another between different consultations, and other symptoms such as 'mucus moving' in the sinuses are often reported. Pain is often described in dramatic terms in conjunction with an excess of other unpleasant life events. Many affected patients have a history of other pain syndromes and their extensive records show minimal progress despite various medications. They have often undergone previous sinus or dental surgery and may be resentful about their treatment. Many patients with atypical facial pain exhibit significant psychological disturbance or a history of depression and are unable to function normally as a result of their pain. Some project a pessimistic view of treatment, almost giving the impression they do not wish to be rid of the pain that plays such a central role in their lives.

A comprehensive examination (including nasendoscopy) is essential, and imaging such as magnetic resonance imaging is advisable to exclude pathology before the patient is labelled as having atypical pain. The management of such patients is challenging and confrontation is nearly always counterproductive. A good starting point is to reassure the patient that you recognise that they have genuine pain; an empathetic consultation should be conducted with an explanation provided. Drug treatment involves a gradual build-up

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to a higher nightly dose of the analgesic and antidepressant amitriptyline (75–100 mg).[38] Second-line treatment includes gabapentin or carbamazepine. Patients should sympathetically be made aware that psychological factors may play a role in their condition and referral to a clinical psychologist or psychiatrist may be helpful.[39] Referral to a pain clinic is often appropriate.

'My nose is dry, I can't blow anything out'

If a patient is unhappy because they are unable to blow anything out into their handkerchief, they are unlikely to have any paranasal sinus disease. Such patients may instead have a very dry lining, atrophic rhinitis, or the mucosal cilia may have been damaged by excessive surgery or disease. Under these circumstances, the mucus dries out, and as it stagnates there are usually subtle mucosal changes that account for these symptoms. Douching and keeping the lining moist with petroleum jelly will usually reverse the symptoms. These patients may also complain of nasal obstruction if they have a large airway; the receptors do not work well with a dry lining and will fail to enable a subjective sensation of airflow that is normally produced by a change in humidity and temperature.

Globus pharyngeus

Patients with globus pharyngeus may complain of a lump in the throat, catarrh or a sensation of 'something' at the level of the cricoid cartilage. It is important to exclude any upper gastrointestinal pathology. These patients often have a habit of throat clearing or dry swallowing, and this appears to help perpetuate these symptoms. There is an overlap in the subjective experience of these patients and those with catarrh and postnasal drip. Men with globus have an increased risk of being diagnosed with somatisation disorder.[40] Globus may present monosymptomatically as a somatoform disorder, or be a secondary illness and a symptom of anxiety, depression or a personality disorder.[41]

Functional dysphonia

For patients with symptoms of functional dysphonia, it is important to exclude pathology – particularly neoplasia – as a cause of hoarseness. However, reflux, voice abuse, poor breath support and cervical neck tension can all contribute to this condition.[42] Approximately one fifth of affected patients experience muscular tension or functional hypertensive dysphonia, but this diagnosis may not always be due to non-organic problems alone. There are often contributing factors as mentioned above and these are best dealt with by a multidisciplinary team.[42–44] Nevertheless, functional dysphonia is associated with multiple psychosocial factors as in many other medically unexplained symptoms.[45,46]

The findings of a meta-analysis support the effectiveness of comprehensive voice therapy comprising both direct and indirect therapy techniques in the treatment of functional dysphonia.[47,48] Cognitive behaviour therapy has been shown to ameliorate the psychological distress in patients with functional dysphonia.[49]

Treatment

Medical explanations of somatising symptoms often differ from patients' perceptions and this is often because most explanations reject the reality of the symptoms.[50] Patients are more likely to be satisfied and empowered by explanations that recognise the symptoms and offer a tangible and involving explanation.[12,51] By legitimising the patient's symptoms, yet not colluding with the patient by acquiescing to their explanation, and offering a tangible mechanism that the patient 'owns', as well as giving them an opportunity for self-management, patients are less likely to make further demands on health care.[52] The presentation of normal test results accompanied by reassurance has little effect on patients' doubts and anxieties.[51] The identification of the patient's fears is central to making a difference to the patient.[53] A two-year outcome study showed that those patients with a functional disorder were more likely to have a decline in physical and mental health.[52] Cognitive behaviour therapy, the treatment of comorbid depression and anxiety, and psychiatric help for patients with moderate psychological problems, are the mainstay of treatment for medically unexplained physical symptoms and somatoform disorder.[54]

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