

‘Sufferers with Functional Problems – patients with nothing wrong?’

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One of the biggest challenges facing clinicians is the huge and probably rising prevalence of functional problems. Consultations for such problems seem to dominate virtually every speciality. In gastroenterology the majority of out patient consultations are for functional problems, such as Irritable Bowel Syndrome (IBS). This is reflected in other specialities; chest pain clinics report that over half of patients seen do not have a cardiological lesion, rheumatologists carry a huge workload of patients who do not have a specifically identifiable rheumatological problem and generalists see large numbers of patients with no clearly delineated lesions, e.g. patients with tiredness or malaise. These are not inappropriate referrals – rather, it is that we do not have conventional explanations for what are genuine complaints. It has been estimated that well over 50% of all consultations in primary and secondary care are for such problems, a huge burden considering that the NHS has to cope with several million consultations per week. No speciality is exempt, even psychiatry having its quota of patients who do not easily fit into diagnostic categories.

Defining functional problems is a challenge. One definition refers to a variable combination of chronic or recurrent symptoms not explained by structural or biochemical abnormalities. No bodily system appears exempt; in addition to the above, musculoskeletal, respiratory and urogenital, pelvic and neurological symptoms are common. Some problems, such as fibromyalgia and IBS, can be categorised by clusters of symptoms. A common thread in these clusters is somatic hypersensitivity and in mental health, perhaps, psychological hypersensitivity. In fibromyalgia, muscular tenderness is seen almost as a diagnostic indicator and in IBS, hypersensitivity of the bowel is a delineating feature. Tiredness seems a consistent feature across these syndromes and the symptoms frequently overlap between one kind of clustered problem and another. Frequently, the symptoms are changeable from one body system to another and between syndromes.

These problems are ill understood. Sometimes their existence as syndromes is subject to hot debate – in myalgic encephalopathy (ME) syndrome there is a history of clashes between those who support this as a specific entity and those who vehemently oppose it. ME syndrome sufferers, often through representative groups, have held that they have an identifiable diagnostic label requiring proper recognition, research and treatment, whilst many clinicians have found it difficult to come to terms with this view. Some feel many such syndromes have been created or exploited by the pharmaceutical industry to further interests in expensive, new products.

The overall message is that clinicians do not have an understanding of the basis of these problems and we lack what the anthropologists refer to as convincing Explanatory Models (EMs). Working without a palpable framework

makes it difficult for the clinician to understand and communicate about the problem and to find ways of dealing with it effectively. Transmitting uncertainty and not knowing quite what to do are a problem for the doctor.

The psychological component of the functional problems is ill understood and confusing. Anxiety and depression are known to be more prevalent in sufferers but are not a hallmark. Stress plays a part. Further, most people with anxiety or depression do not get somatic functional symptoms. Some studies have suggested a strong background of past abuse. Treatment with psychotropic medication has some limited value in most sufferers, suggesting that it is of augmenting rather than of prime value. A further feature of patients with functional problems is their high response to placebo – ranging from 20 -60% for some problems. This makes the evaluation of new therapies a challenge within the constraints of conventional randomised, placebo controlled trials. This has restricted the development and availability of new therapies. Also, outcomes from drug trials for functional problems are notoriously difficult to interpret; in many instances patients do not experience a statistically significant improvement in specific symptoms but report an overall improvement in quality of life! In IBS, hypnotherapy and cognitive behaviour therapy (CBT) have been shown to be of value.

What then, might be the brain-body link in functional problems? Much research is being devoted to finding explanations in this field. The discovery of hormones that emanate from the brain, including the hypothalamus, and which affect somatic perception and function has provided promising openings. These agents, some of which might affect, say, gut motility, provide a clue to the possible mediating mechanisms from the brain to the body, but it is difficult to explain what leads to their secretion and how higher brain function might influence this. Recent research using functional MRI scanning has identified areas in the cortex which respond to painful stimulation and there are indications of MRI changes in individuals responding to placebo. Thus, both upward and downward mechanisms are now being explored and mapped.

Nonetheless, the entire concept of the function disorders, their underlying mechanisms and the role of the mind, remains intriguing. How these disorders develop, their role within the adaptive environment of the individual and how best to describe and treat them are challenges. A view reflected by some psychiatrists about the need to reach out to the spiritual dimension of the individual may provide a key to the better understanding of sufferers and our ability to utilise a more humanities-based approach towards management.

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