Eight top tips for managing patients with medically unexplained symptoms

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Over time we develop unique ways of managing patients but rarely share our methods. With two pages free in this issue of *Frontline Gastroenterology* I outline my own unique tips on management of patients with medically unexplained symptoms and invite comment on whether this type of article should be a regular feature.

1. *Bristol Stool Scale* Until discovering the Bristol Stool Scale I spent many hours asking patients detailed questions about their stool. The Scale is worth a 1000 questions and I would no longer be in clinic without it. Patients' descriptions of their stool are often at variance with the Scale, and using the Scale is much faster than asking questions. The Scale provides a good estimate of transit time for constipated patients. It is easier using the Scale to explain constipation in terms of transit time and how it should be managed. Patients complaining of persistent diarrhoea with occasional type 1 (hard pellets) stool are almost certain to have an irritable bowel. This crucial detail is easy to miss with questions.
2. *A plain abdominal film* I often investigate patients with diarrhoea extensively only to find, relatively late in the process, they have solid stool visible on a plain abdominal film. This indicates a high probability of irritable bowel, in which case further investigation is rarely necessary. If you believe a cause will not be identified, perform a plain film early in the pathway – but only at a time they complain of diarrhoea.
3. *Manage expectations* If you think a patient will not have a medical explanation for their symptoms, tell them so before the consultation finishes, even if you plan further tests. It is more difficult to reassure after a sequence of negative tests if the patient expects a medical diagnosis. "I am confident we shall not find a medical diagnosis for your symptoms, but think we should do one or two tests to be sure". Your analysis/intuition will be right >95% of the time. When the tests are negative you declare this is what was expected, when positive you say it is just as well the tests were done.
4. *Believing the patient* Doctors have an uncanny knack of making patients think that they do not believe they have real symptoms, usually expressed as "you think it is all in my head". Dispelling this perception can be very difficult. It should be dealt with up front and not put to one side: firstly, by exploring understanding and perception; and secondly, by providing a credible explanation of how symptoms arise: such as disturbance in sensitivity or physiology.
5. *Exploring the patient's beliefs* Asking the patient what they believe is the cause of their symptoms has provided me with a solution to countless difficult consultations. The patient may need some encouragement to respond. With some persistence the question often reveals a concern that needs to be addressed. They may respond "do you think it could be stress?" The response should not be "yes" but "what makes you ask that question?" This response opens a door for a discussion of factors the patient recognises are contributing to their symptoms, completely changing the direction and tone of the consultation.
6. *Exploring the patient's expectations* A patient being asked what they want (or expect) from the consultation is a rare event and the doctor's understanding of what the patient wants might be

at odds with the patient's. I can guarantee that asking the patient what they want will produce surprises and help achieve a better outcome. It also saves time because the consultation becomes more focused. Because patients are asked this question so infrequently they haven't developed the skill to answer it. They may need help, so provide some options: "do you want an explanation and reassurance, diagnostic tests, treatment, or do your family or friends need reassurance?"

7. *Severe abdominal pain* Gastroenterologists will be referred patients who have had surgical admissions with severe, persistent abdominal pain. Most of these patients will be constipated and many of them will be taking narcotics such as Tramadol. They will usually have had unsatisfactory contact with doctors and feel that no one cares about them. Taking responsibility for them, resetting their expectations, stopping the narcotics and using laxatives will make

a difference. Seeing the patient soon and often might seem like the last thing you want to do, but it diffuses the situation and is key to success.

8. *Tricyclic antidepressants* The response to these drugs can be astonishing and some care is needed to avoid inadvertently underutilising their potential. Tricyclic antidepressants should be called tricyclic analgesics because they are rarely used for depression and mostly used for analgesia. A consequence of this labelling is that when the patient discovers the medication is an antidepressant, they are immediately suspicious and poorly compliant. Combine prescription with honest explanation – make it clear you are using the medication for its analgesic, not antidepressant properties.

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