OPINION

A response, and rebuttal, to Roland Valori's 'top tips for managing patients with medically unexplained symptoms'

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While this is a new departure for *Frontline Gastroenterology*, the editorial team felt that there were pressing arguments in favour of publishing the response to a published article from a highly experienced gastroenterologist. Coupled with the author's rebuttal, the exchange of views illustrates how important it is to learn from each other, especially about things that are not readily available in textbooks or just not taught in hospitals.

Response

I applaud the concept of this type of article, which, in my experience, has been pioneered by our neurological colleagues in helping those less experienced in this discipline to tease out organic disease. I accept they are difficult articles to write, as every experienced clinician has their own way of doing things.

In the article by Valori, I am assuming that the article is indeed focusing on a voyage around the irritable bowel syndrome (IBS) in its various guises. Those phenotypes of which, I recognise and deliberately categorise (which in itself helps the patient from the outset), are:

- Diarrhoeal
- Constipating
- Alternating
- Pure recurrent abdominal pain

I respond to the current article because it addresses one of the more challenging aspects of a time-constrained gastroenterological consultation from a perspective assuming that there is indeed nothing wrong. This is a far cry from 'unexplained' abdominal symptoms. Irritable bowel is a disease in its own right affording respect, and, of course, we should not need reminding that even the hysteric will inevitably develop organic disease.

Winning the patient's confidence is fundamental; you are the expert in conventional medical gastroenterology. My experiences with the initial, pivotal, luxurious 20-minute consultation are that a focused approach on finding or excluding a named organic condition is productive. Wandering into the diversionary world of speculation of test results, and delving into patient expectation and beliefs, sometimes emanating from the sphere of complementary medicine, is positively counterproductive at the early stage. This sort of stuff may come later when indeed objective tests looking for structural disease are indeed returned negative and a balanced view can be proffered based on your and prior evidence.

I offer these alternative tips:

- If a second or higher opinion, the consultant should see the patient.
- Be absolutely familiar with previous opinion and review previous results looking for omissions and the quality of those tests.
- The Bristol Stool Chart functions best as a research tool. Loose, formed or pellet stools are the three descriptions that are only required to direct me towards a line of investigation.
- Nocturnal diarrhoea is virtually always a symptom of organic disease.
- In cases of sharp localised abdominal pain, always perform Carnett's test (see box). A positive result defines an abdominal neuralgic syndrome, which can be treated independently and is often the underlying condition in its own right.
- The plain abdominal film is indeed wonderful, and it is the colonic gas pattern that may help. However, pitfalls exist: stool to the rectum is found in overflow states and proximal loading can be a feature of more distal mucosal disease.

Carnett's sign

- ▶ The patient lying on her back is asked to lift the head in order to tense the abdominal muscles (alternatively both legs can be raised with straight knees).
 - ▶ An increase in pain (a 'positive' result) indicates the likelihood that the abdominal wall and not intra-abdominal pathology is the source of the pain. The commonest causes of a positive result are abdominal hernia, abdominal wall haematoma and rib tip syndrome.
- Perform tests that are appropriate to the history with diarrhoea, inevitably, being the most fully investigated. Repeat those already performed if they are substandard and explain to the patient and specifically do not speculate. Is it not intuitive for the patient to reason that if the expert is doing tests that he is speculating to be normal, then the wrong tests are being done?
 - Once results are back, discuss them in detail and then the significance of normality.
 - Low dose tricyclics (with or without 1 mg perchlorphenazine), I agree, are excellent drugs for those patients with IBS and bloating.

So what can be found? In my 28 years or so my list has regularly included: cancer, Crohn's, C1 esterase inhibitor deficiency (both types), coeliac disease, Addison's, self-harm, true anorexia, familial Mediterranean fever, collagenous colitis (rarely missed now), intestinal ischaemia and chronic pancreatitis, to mention a few. Interestingly, there has been very little organic gynaecology.

Rebuttal

I very much welcome Dr Shepherd's response to my eight top tips. We disagree on a few key issues, but I am sure we agree more than we disagree. Let us not forget we are expressing opinions, not absolutes. It is for the reader to decide whether a tip is worth trying and whether it should be incorporated into every day practice.

Of course, it is critical to rule out organic disease. It is a particularly exciting challenge to find something that has been missed in patients referred for a second opinion, but in my experience this is usually a fruitless exercise. Rarely have I found any of the diseases Dr Shepherd mentions, even though I am always on the lookout for them.

There are some key signs of pathology such as nocturnal diarrhoea. But there are also many pointers to no pathology—Carnett's sign being one of them. The reality is that most gastroenterologists know within a very short space of time (more like 5 min, not 20) whether there is likely to be a medical diagnosis, and being frank about this to the patient is being both honest and helpful. In no way is it being disrespectful of them or their concerns; usually, it is exactly what they are expecting. My experience of this approach

is almost universally positive: the only time it has not been helpful is when the patient has a fixed view that there is a medical explanation for their symptoms. Thankfully, these patients are rare.

Labelling is an interesting topic. IBS is a label which is now in common parlance and, as such, has some value. However, it can do the patient a disservice by detracting the doctor from the issues that are important to the patient. In my interviews with patients, I explore and ask the patient to reflect on the psychological agenda, possible triggers and factors that perpetuate symptoms. I am interested in the impact the symptoms have on the quality of life and vice versa. Patients and their relatives are highly responsive to this approach and there is evidence that addressing these factors benefits patients. A striking observation in patients who have responded to hypnosis (the majority) is that they report being in control of their symptoms for the first time. The symptoms often have not changed much, but the impact on their life has—because they now feel in control.

I prefer to use the term medically unexplained symptoms because it conveys meaning to the patient: yes, you have symptoms but there is no medical explanation for them. Patients often have a whole host of symptoms that doctors ignore because they do not fit in a neat medical box. Using the medically unexplained box keeps the doctor's mind open, and the door open for the patient. It is, of course, critical to point out that experiencing symptoms for which there is no medical explanation is a very common experience (I have loads of them). Hysterical, in this context, is a pejorative term I never use.

I defend the use of the stool chart. It takes less time than asking 'are your stools loose, formed or pellets?' and then waiting for a response. It saves time, especially for the 10 million people for whom English is a second language.

Perhaps, the most important tip we can offer any doctor (trainee and consultant) is to do the occasional joint consultation with colleagues, to spend a few moments afterwards describing and reflecting on what has happened and, finally, to commit to doing things differently next time. A record of the salient points of such an exercise would be well regarded in a portfolio of evidence to support revalidation.

Competing interests None

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Reference

Valori R, Eight top tips for managing patients with medically unexplained symptoms. *Frontline Gastroenterology* 2011;2(4):197–198