Editorial

Tony Townsend has been a general practitioner for 30 years. Although he has dabbled in medical politics, medical ethics, community-based teaching, university-based teaching, quality improvement and assessment, his passion remains clinical general practice. He is currently a full-time general practitioner in Whangamata.

The themes for this year's journals were chosen before I became editor. Functional somatic syndromes seemed like a strange choice. Yet it challenged me to think about what these syndromes really were. The more I thought about my practice, the more I realised how much unexplained illness there is. This ranges from self-limited specific syndromes such as the woman who recently consulted me with bilateral brachial neuropathy complicating leptospirosis, to chronic seriously disabling pain syndromes that control the lives of the sufferers.

Below the surface of general practice lurk complexities, frustrations and dilemmas that challenge us all. Delving into the literature was a mistake. These syndromes have been classified differently in the medical and psychiatric literature.[1] There is argument about which unexplained illness should be included in which classification.[2] More rational classification systems have been proposed, in particular to avoid the mind-body dichotomy which is emphasised in present taxonomies. It has even been suggested that the terms 'somatoform' and 'somatiser' should be abandoned, leaving only the category of somatisation disorder for those few patients who meet the diagnostic criteria.[3]

On one hand there is an attempt to medicalise these syndromes. For example it has been suggested that fibromyalgia represents a condition in which *'a characteristic peripheral nociceptive component is modulated by an interplay of complex central factors'*.[4] On the other hand there is a suggestion that these are simply 'fashionable' diagnoses allowing *'psychosocial distress to be comfortably hidden from both the patient and the physician'*.[5] Understandably, when pathophysiological explanations are lacking, management is controversial, and patients in primary care may not receive effective mental health interventions.[6] A recent systematic review found that cognitive behaviour therapy and behaviour therapy may help patients with chronic back pain and that patients with irritable bowel syndrome may improve with antidepressants, but the quality of the evidence was often poor.[6]

What is not in doubt is that unexplained illness is very common in both primary[3,6] and secondary care.[7] The difficulties that many doctors have in dealing with unexplained symptoms may result in dysfunctional consultations and inappropriate referral. Many people who have chronic unexplained illness become the patients whom doctors dread. A few will *'kindle aversion, fear, despair or even downright malice in their doctors'*.[8]

In this issue we have contributions from the general practice coalface, academic general practice, psychiatry and rehabilitation medicine. What appears to be common ground is that people who have chronic unexplained symptoms:

- need their illness to be recognised and acknowledged;
- are best helped from a patient-centred or systems perspective;
- should be assessed for co-morbidity;
- need care as much as cure;
- may benefit from cognitive behaviour therapy;
- require continuity of care and co-ordinated, multi-disciplinary management.

If up to two thirds of all patients[3] or one in five patients presenting for new consultations[6] in primary care settings have unexplained somatic symptoms, it behoves us to reflect on how we can best help people with functional somatic syndromes to restore some stability to their lives.

References

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