TOOLKIT GUIDE

Functional somatic disorders in the context of long-term Covid-19 symptoms

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Description of symptoms

The terms “functional somatic”, “somatoform” or “somatic symptom” disorders refer to the presence of somatic symptoms with no organic explanation, with no objectifiable lesion of the organ designated by the symptoms

These symptoms are recurrent, long-lasting or incapacitating, resulting in a need for care, the major impact of which is in contrast with the lack of clinical or paraclinical abnormalities capable of providing a full explanation.

The symptoms are frequently multiple. For example, **bodily distress syndrome** includes the following diagnostic criteria:

1. **The patient presents with at least 3 symptoms in at least one of the following groups:**

- cardiopulmonary or autonomic hyperexcitability: palpitations, precordial oppression, shortness of breath without exertion, hyperventilation, cold or hot sweats, dry mouth;
- gastrointestinal hyperexcitability: abdominal pain, soft or overly frequent stools, bloating, regurgitation, nausea, epigastric or chest burns;
- musculoskeletal tension: pain in the joints, muscles or limbs, backache, migratory pain, feeling of motor weakness, unpleasant numbness or tingling;
- systemic symptoms: concentration disorders, memory problems, headaches, vertigo or instability, excessive fatigue.

2. **The patient is disabled by these symptoms (their everyday life is disrupted)**

3. **Clinically relevant alternative diagnoses have been ruled out**

Presumed cause

These symptoms are of multifactorial origin and their cause is not clearly established, but they are most often sustained by *predisposing psychological and social factors* (psychological trauma and/or conducive personality).

Precipitating factors trigger symptoms, sometimes years later. After any acute medical event, including infection, some patients present with symptoms persisting after “biological recovery” (e.g. persistence of intestinal functional disorders after acute viral gastroenteritis).

Finally, disorders will be sustained by *maintenance factors*:

- symptom avoidance behaviours: avoidance of activities or circumstances triggering or exacerbating symptoms;
- avoidance behaviours of the well-justified uncertainty in this context (multiple medical opinions, Internet forum, etc.);
- attentional focus on the function of the organs designated by the symptoms;
- anxiogenic representations which maintain this attentional focus and avoidance behaviours;
- iatrogenesis and medical nomadism;
- denigration of the debilitating nature of symptoms, or even denial by relatives and healthcare professionals.

Functional somatic disorders are often – but not systematically – associated with anxiety or depression disorders.

Key point: they may be associated with (or triggered by) a well-characterised organic disease but always require specific management.

Clinical and paraclinical primary care assessment

- First and foremost, acknowledge that the symptoms are real and that the complaint is valid: acknowledge the distress and impacts caused, in particular, measure their impact on everyday life.
- Carry out a clinical assessment and summary of the objectifiable medical findings (positive and negative).
- Prescribe a reasoned, symptom-directed paraclinical assessment, completely avoiding conducting multiple additional tests of unproven benefit, which, far from reassuring the patient, would exacerbate the disorders.
- Focus the interview on how symptoms are perceived and managed, rather than on the potential diseases to be detected. Have the patient explain their fears (particularly of severe illness or of severe effects), their representations of the symptom, and their expectations from medicine.
- Characterise the avoidance behaviours caused by the symptoms (see above)

When should the patient be referred to specialists?

- The patient should be assured that close somatic follow-up will be carried out and that managing the functional component of their symptoms will be beneficial in any case.
- In the event of diagnostic uncertainty, request an opinion from an internal medicine doctor or from a specialist in the organ(s) most concerned, avoiding medical nomadism at all costs. Co-ordinate these opinions and prepare a summary shared with the patient.
- Referral to a psychiatrist is indicated in cases of severe associated anxiety or depression disorder, risk of suicide or at the patient's request, but should be presented as joint follow-up in the context of multidisciplinary care. The request should be explained both to the patient and to the psychiatrist.

Therapeutic management

Diagnostic delivery

- It is essential not to make do with "ruling out" somatic illnesses.
- The functional somatic **disorder should be named and explained** and stigmatising labels avoided, particularly any comparisons to psychiatric disorders. It may be acknowledged that the mechanisms of these disorders are still poorly elucidated, but that the mind and the body are closely linked: tachycardia, sweats, stress-induced diarrhoea, tears triggered by sadness, etc.
- Moreover, **the role of behavioural and cognitive vicious circles** such as hyperawareness of bodily sensations, muscle deconditioning, etc., should be explained.
- It is necessary to be able to establish (and agree on) reasonable therapeutic targets: aiming for symptom relief and improvement of quality of life rather than predicting a "cure".

Non-medicinal therapies

It is necessary to **break the vicious circles reinforcing disorders**. In particular, it is advised to take action to reduce avoidance behaviours and particularly prolonged rest causing muscle deconditioning, to improve sleep quality, and to raise awareness of the role of attentional focus.

Therefore, **exertional rehabilitation** is key: physical activity should be resumed gradually in the absence of contraindications (myocarditis, etc.), prioritising activities that the patient enjoys. Activities such as Tai Chi, Qigong, yoga, (Nordic) walking, swimming, cycling can be suggested as a first-line approach. If the patient lacks motivation or has concerns, this resumption of physical activity can be conducted with support from a physiotherapist (prescription of exercise therapy and strengthening of the 4 limbs) or in a rehabilitation centre.

Other so-called "mind-body" approaches (mindfulness meditation, hypnosis, sophrology or any other relaxation method), though not linked with a strong level of evidence, may be suggested.

If these methods, combined with physical rehabilitation, are insufficient, **cognitive behavioural therapy** should be suggested expeditiously.

Indications and non-indications of psychotropic drugs

As a general rule, medicinal products are often poorly tolerated (multiple side-effects) by patients with functional disorders and may be factors exacerbating their disorders.

In cases of pain, pain relief prescription must account for the risk of dependence and medicinal product interaction, and often proves to be ineffective.

Characterised anxiety and depression disorders of moderate to severe intensity can be treated with medication, in the event of doubt, request a psychiatric opinion.

In the absence of characterised depressive episodes, the prescription of certain antidepressants (tricyclics, SNRIs – particularly duloxetine), particularly for pain relief purposes, may be trialled, but is not formally recommended.

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