

Correspondence

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Do 'numbers' count?

The article by Tomenson *et al*¹ raised some interesting questions. The study concluded that total somatic symptom score predicted health status and healthcare use. We would like to highlight that another important parameter that could have been included is the duration of the symptoms. The measures that were used in the trials studied were all different and assessed current or lifetime symptoms and not duration or severity of symptoms. This could have an impact on healthcare use. Other drawbacks relate to care pathways and age of participants. In low- and middle-income countries, where there are many coexisting healthcare systems, relying only on allopathic setups may be difficult. Hence, traditional health systems would be an important aspect that could have been taken into consideration. The mean age range in the studies included in Tomenson *et al*'s analysis was highly variable (18–75 years) and could result in both medically explained and unexplained symptoms or both existing in the same individual. Measuring bothersome somatic symptoms or those that interfered with functioning, which again varied across the different instruments, may alone not indicate severity. The intensity of symptoms can have a bearing on severity as has been demonstrated by Kroneke *et al*.² Another important component on health status and healthcare use would be the concept of abnormal illness behaviour.³ Abnormal illness behaviour could also determine significant healthcare use. Tomenson *et al* have made efforts to consider health anxiety as a variable, which could again influence health status. Thus, it is not only the number of somatic symptoms that account for health outcome but other variables mentioned above too. Future research should focus on both current and lifetime symptoms, number, duration and severity of symptoms, and abnormal illness behaviour to better understand health status and healthcare use.

- 1 Tomenson B, Essau C, Jacobi F, Ladwig KH, Leiknes KA, Lieb R, et al. Total somatic symptom score as a predictor of health outcome in somatic symptom disorders. *Br J Psychiatry* 2013; **203**: 373–80.
- 2 Kroenke K, Spitzer RL, Williams JB. The PHQ-15: validity of a new measure for evaluating the severity of somatic symptoms. *Psychosom Med* 2002; **64**: 258–66.
- 3 Pilowsky I. Abnormal illness behaviour. *Br J Med Psychol* 1969; **42**: 347–51.

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Authors' reply: We thank Desai & Chaturvedi for their interest in our paper. We agree that additional dimensions could be included as possible predictors of health status and healthcare use and that the latter would be influenced by the nature of local

healthcare facilities. It was impossible to include such additional measures in our study because we were restricted to those measures that had been used in the original studies.

Desai & Chaturvedi mention duration and severity of symptoms as possible predictors of outcome. Duration is important but may not predict number of subsequent doctor visits.¹ Severity is important and five of our studies used questionnaires (including the Patient Health Questionnaire-15) which assessed the degree of bothersomeness of each somatic symptom, a subjective measure of severity. The distinction between intensity and severity is complex, but one study noted that severity of pain did not explain the association between number of somatic symptoms and subsequent health status.²

The point raised by Desai & Chaturvedi regarding the co-occurrence of medically explained and unexplained symptoms is very important and forms one of the main points of the paper. Such co-occurrence of symptoms is common and constitutes one of the main difficulties of trying to make a diagnosis purely on the presence of medically unexplained symptoms. In the four sites where data were available, we found that the association of somatic symptoms with health status, after adjustment for confounders, was stronger for total somatic symptom score than for number of medically unexplained symptoms. We could not test this in relation to healthcare use but the association between number of somatic symptoms with healthcare use appears similar for medically explained and unexplained symptoms.³

Assessing abnormal illness behaviour is difficult in population-based studies using self-administered questionnaires, as most measures include items about how often the respondent visits doctors, which would overlap with our outcome measure of healthcare use. A better dimension might be a person's general tendency to visit doctors even for minor reasons; this is a predictor of healthcare use independent of number of bothersome somatic symptoms.⁴

The other dimension mentioned by Desai & Chaturvedi, health anxiety, is very important. In two studies a high number of somatic symptoms and pronounced health anxiety were both independent predictors of primary healthcare contacts (see Tomenson *et al*⁵). Two other studies have shown a complex interaction between these dimensions, with health anxiety being a predictor of subsequent healthcare use only in respondents without a high number of somatic symptoms or who also have serious medical illnesses.^{3,5}

This field of research suffers from lack of prospective studies. The correlates, or predictors, of healthcare use are somewhat different for past use and future use.^{5,6} One paper made the intriguing, but plausible, suggestion that frequent visits to the physician could increase health anxiety and precipitate more somatic symptoms rather than the other way round.⁶ Further prospective studies using well-validated questionnaires are needed.⁷

Declaration of interest

F.C. has been a member of the American Psychiatric Association DSM-5 work group on somatic distress disorders and is a member of the World Health Organization ICD-11 working group on the classification of somatic distress and dissociative disorders.

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