A Symptom Checklist to Screen for Somatoform Disorders in Primary Care

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Current DSM-IV somatoform diagnoses may inadequately capture many somatizing patients in primary care. By using data from two studies (1,000 and 258 patients, respectively), the authors determined 1) the optimal threshold on a checklist of 15 physical symptoms to screen for a recently proposed somatoform diagnosis, multisomatoform disorder (MSD), and 2) the concordance between MSD and somatization disorder. The optimal threshold for pursuing a diagnosis of MSD was seven or more physical symptoms. The majority (88%) of the patients who met criteria for MSD had either full or abridged somatization disorder. MSD was intermediate between abridged and full somatization disorder in terms of its association with functional impairment, psychiatric comorbidity, family dysfunction, and health care utilization and charges.

(Psychosomatics 1998; 39:263–272)

Somatoform disorders are present in at least 10%–15% of primary care patients.1-3 Such disorders are characterized by prominent physical complaints that cause significant functional impairment but, despite appropriate evaluation, lack a physical explanation. Both clinicians and researchers have an interest in identifying such disorders for numerous reasons. First, somatoform disorders produce impairment in patient functioning and quality of life comparable to mood and anxiety disorders.4-7 Second, somatoform disorders are associated with increased health care costs and utilization as a result of excessive clinic visits, diagnostic testing, prescriptions, subspecialty referrals, and surgical procedures.4-8 Third, patients with these disorders are much more difficult and challenging to care for than patients with most other mental disorders.7,9 Fourth, effective treatment strategies have recently been developed for aiding in the management of the somatizing patient in primary care.10-12

Many primary care clinicians characterize patients with these disorders with informal labels such as somatizers, functional illness, or multiple somatic complaints. The DSM-IV classification has several limitations for diagnosing the somatizing patient in primary care. First, most patients do not meet the high symptom threshold required for somatization disorder, yet they still demonstrate considerable functional impairment, psychiatric comorbidity, and excess health care utilization.1,4-6,13-15 Second, the cli-
nician must inquire about not only current but also lifetime symptom experiences, a cumber-
some task usually not feasible in a busy primary care setting. Undifferentiated somatoform dis-
order is the DSM-IV diagnosis provided for the somatizing patient whose illness does not meet
criteria for somatization disorder. However, this diagnosis is a relatively recent arrival (first in-
cluded in DSM-III-R), may be overly inclusive (a single unexplained symptom suffices), and
lacks published evidence of its validity.

Multisomatoform disorder (MSD) has recently been proposed as an alternative to undif-
ferentiated somatoform disorder\(^7\) and is defined as three or more currently bothersome unex-
plained physical complaints (from a 15-
symptom checklist), plus a history of chronic so-
matization (i.e., unexplained symptoms, more
days than not, for at least 2 years). In a study of
1,000 primary care patients,\(^2\) MSD was present
in 8% of the cases and, compared with mood
and anxiety disorders, was associated with com-
parable functional impairment, more disability
days, and greater health care utilization.\(^7\)

Interviewing a patient to establish the pres-
ence or absence of a somatoform diagnosis can
be time-intensive, because the clinician must
gather sufficient information from the patient
and/or medical records to ascertain that a physi-
cal explanation for somatic complaints is un-
likely. If a symptom-count threshold with
suitable operating characteristics (sensitivity,
specificity, predictive value) could be deter-
memed, more detailed evaluation could be re-
served for the subset of patients most likely to
have clinically significant somatoform disor-
ders.

By using data from the Primary Care Eval-
uation of Mental Disorders (PRIME-MD) and
the Somatization in Primary Care studies, we ad-
dress two major questions: 1) What is the opti-
mal threshold on a screening checklist of 15
physical symptoms for prompting a primary care
clinician to pursue a diagnosis of a somatoform
disorder? and 2) What is the concordance be-
tween MSD and somatization disorder? In Table
1, the key terms used in this article are defined.

**TABLE 1. Definition of key terms**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Physical symptom</td>
<td>Any physical symptom reported by a patient, including both symptoms that have an adequate physical explanation as well as those that are unexplained (i.e., somatoform)</td>
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<tr>
<td>Somatoform symptom</td>
<td>A physical symptom that lacks an adequate physical explanation</td>
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<tr>
<td>Somatization disorder</td>
<td>Lifetime history of 13 or more somatoform symptoms from the DSM-III-R list of 35 physical symptoms</td>
</tr>
<tr>
<td>Abridged somatization disor-</td>
<td>Lifeline history of 6–12 somatoform symptoms in women, or 4–12 somatoform symptoms in men, from the DSM-III-R list of 35 physical symptoms</td>
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<tr>
<td>Multisomatoform disorder</td>
<td>Current history of 3 somatoform symptoms, from the PRIME-MD 1000 list of 15 physical symptoms, for 2 or more years</td>
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**METHODS**

**PRIME-MD 1000 Study**

To determine the optimal physical symptom threshold, data were analyzed from the PRIME-
MD 1000 study, a mental health survey of 1,000 patients in four primary care sites. The patients
had a mean age of 55 years (range: 18–91); 60% were women, 58% were white, and 28% were
college graduates. The Institutional Review
Boards of each site approved the study protocol,
and each patient gave signed, informed consent.
Details of the PRIME-MD study, including pa-
tient sampling procedures, have been previously
described.\(^2\)

All subjects were evaluated with PRIME-
MD, a validated diagnostic interview that con-
sists of a 26-item self-administered Patient
Questionnaire (PQ) and an accompanying Cli-
nician Evaluation Guide (CEG).\(^2\) Criteria-based
DSM-III-R diagnoses were made in five cate-
gories: mood, anxiety, somatoform, alcohol, and
eating. (With minor modifications, the revised
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