SOLK en somatoforme stoornissen

Deze richtlijn is tot stand gekomen op initiatief van Nederlandse Vereniging voor Psychiatrie

Inhoudsopgave

Startpagina - Somatisch onvoldoende verklaarde klachten

Waar gaat deze richtlijn over?
Deze richtlijn richt zich op wat volgens de huidige maatstaven de beste zorg is voor patiënten met somatisch onvoldoende verklaarde klachten (SOLK). In de richtlijn komen de volgende onderwerpen aan de orde:

- Wat de verwachting van het beloop is van SOLK
- Hoe groot de kans is dat bij SOLK alsnog een lichamelijke aandoening wordt vastgesteld die de klachten verklaart
- Of het mogelijk is om een patiënt met SOLK te onderscheiden van een patiënt met lichamelijk verklaarde klachten op basis van stress in de omgeving
- Of de kwaliteit van de arts-patiëntrelatie bij SOLK het beloop van de ziekte kan beïnvloeden
- Welke middelen om een onderliggende psychiatrische aandoening vast te stellen toepasbaar zijn bij de huisarts, in het ziekenhuis of in een academisch centrum
- Wat het stappenplan is om SOLK vast te stellen bij de huisarts en in het ziekenhuis en welke rol een bedrijfsarts speelt in het vaststellen van SOLK
- Wat specifieke kenmerken zijn van patiënten met SOLK en welke zorgverleners patiënten met SOLK het beste kunnen behandelen
- Op welke wijze de zorg voor patiënten met SOLK en somatoforme stoornissen het best kan worden georganiseerd, zodat er een aantoonbare verbetering van klachten en een kosteneffectieve behandeling wordt bereikt
- Wat er voor wetenschappelijk bewijs is om SOLK door de huisarts, een psycholoog of door middel van medicatie te behandelen
- Welke behandeling wetenschappelijk bewezen de beste behandeling is voor een conversiestoornis
- Welke psychologische en medicamenteuze behandeling wetenschappelijk bewezen de beste behandeling van hypochondrie is
- Welke psychologische en farmacologische behandeling er wetenschappelijk bewezen het beste is voor de behandeling van Body Dysmorphic Disorder (BDD)
- Welke behandeling wetenschappelijk bewezen de beste behandeling van ernstige somatoforme stoornissen, chronische buikpijn bij vrouwen en pijnlijk menstruatie is
- Wat de effectiviteit is van verschillende behandelingsvormen voor prikkelbaredarmsyndroom, zoals medicatie, vezels, psychologische behandeling, acupunctuur, placebo-effect en zelfhulp
- Welke meetinstrumenten er zijn op het gebied van prikkelbaredarmsyndroom
- Welke wetenschappelijke onderbouwing er is voor de effectiviteit van het voorkómen van SOLK en somatoforme stoornissen in de gehele bevolking of voor een specifieke groep mensen
- Welke wetenschappelijke onderbouwing er is voor de invloed van arts-patiëntcommunicatie, geruststellen en patiënteninformatie op het voorkómen van SOLK en somatoforme stoornissen

Voor wie is deze richtlijn bedoeld?
Deze richtlijn is bestemd voor alle zorgverleners die betrokken zijn bij de zorg voor patiënten met somatisch onvoldoende verklaarde klachten.

Voor patiënten

Somatisch Onvoldoende verklaarde Lichamelijke Klachten (SOLK) zijn lichamelijke klachten die langer dan een paar weken duren en waarbij geen lichamelijke oorzaak wordt gevonden die de klachten voldoende verklaren. Bij sommige patiënten met lichamelijke klachten wordt wél een lichamelijke oorzaak gevonden, maar zijn de klachten erger of duren ze langer of zorgen ze ervoor dat een patiënt zich minder goed voelt dan te verwachten is. Ongeveer 20 tot 30 procent van de patiënten met SOLK houdt langdurig last van zijn klachten. Deze patiënten voelen zich ongezond en vaak ongerust, hebben een lagere kwaliteit van leven en melden zich vaak ziek. Ook bezoeken deze patiënten vaak verschillende artsen en ondergaan ze veel onderzoeken en behandelingen zonder goed effect. Ongeveer 2,5 procent van de mensen lijdt aan (ernstige) SOLK.

Meer informatie over somatisch onverklaarde lichamelijke klachten is te vinden op Thuisarts:
http://www.thuisarts.nl/onvoldoende-verklaarde-lichamelijke-klachten/ik-heb-onvoldoende-verklaarde-lichamelijke-klachten-sol

Meer informatie over somatisch onverklaarde lichamelijke klachten is ook te vinden op de website van de psychiaters:
http://www.nvvp.net/website/patinten-informatie/aandoeningen-/onverklaarde-lichamelijke-klachten

Hoe is de richtlijn tot stand gekomen?

Het initiatief voor deze richtlijn is afkomstig van de Nederlandse Vereniging voor Psychiatrie (NVvP). De richtlijn is opgesteld door een multidisciplinaire commissie met vertegenwoordigers vanuit de huisartsen, psychiaters, psychotherapeuten, internisten, verpleegkundigen, verzekeringsartsen, psychologen, fysiotherapeuten, revalidatieartsen, arbo- en bedrijfsartsen, neurologen en gynaecologen. Inbreng van patiëntenperspectief vond plaats door een commissie cliëntenparticipatie.

SOLK Diagnostiek

Mensen ervaren bijna dagelijks allerlei signalen in hun lichaam die zij, afhankelijk van de hinder of ongerustheid die de signalen opleveren, als klachten duiden. Voor een deel van deze klachten bestaan eenvoudige fysiologische verklaringen, zoals hartkloppingen bij iemand die opgejaagd is, voor een ander deel is een onderliggend pathofysiologisch mechanisme waarschijnlijk. Voor een groot deel van de klachten vinden artsen echter geen bevredigende verklaring. Bij deze laatste categorie is het de vraag hoe ver je moet gaan bij het uitsluiten van een lichamelijke oorzaak voor de klachten. In principe kan elke klacht - of het nu gaat om duizeligheid, buikpijn of kniepijn - berusten op een fysiologisch of een pathofysiologisch proces, maar het kan ook onderdeel zijn van het brede palet van de SOLK. Een eenvoudig diagnostisch algoritme is dan ook niet op te stellen.
Lichamelijke klachten kunnen ook uiting zijn van een depressie of angststoornis, waarbij nogal eens de lichamelijke klachten op de voorgrond staan.
Het beloop van SOLK is erg variabel, bij een aanzienlijk deel van de mensen verdwijnen de klachten na verloop van tijd weer, maar bij 10-30% verergeren de klachten. Het identificeren van mensen die at risk zijn voor een ongunstig beloop is een belangrijk onderdeel van het diagnostisch proces. De patientprofielen die beschreven staan in hoofdstuk 4 kunnen daarbij een handvat bieden. Op basis van een knelpuntenanalyse heeft de werkgroep de volgende uitgangsvragen geformuleerd.

Uitgangspunten voor het diagnostisch proces bij SOLK en somatoforme stoornissen
Bij het verrichten van diagnostiek zijn drie differentiaal diagnostische overwegingen van groot belang: het uitsluiten van een onderliggende organische aandoening of middelen- misbruik voor de klachten, het vaststellen van tevens bestaande lichamelijke comorbidi- teit, en het vaststellen van eventuele psychiatrische comorbiditeit. Met name angst en depressie komen veel voor bij mensen met SOLK en somatoforme stoornissen.
Belangrijk onderdeel van het diagnostisch proces is het opstellen van een patiënt- profiel waarin het risico op iatrogene schade en chroniciteit houvast kan bieden voor het behandelbeleid.

Fysiologie of pathologie?
Om de klachten die onderdeel uitmaken van het dagelijkse leven - 80% van de mensen ervaart in een willekeurige periode van twee weken, een of meer lichamelijke klachten- te onderscheiden van SOLK is de mate van ervaren hinder en beperkingen in het dagelijks functioneren een belangrijke maatstaf. De interpretatie van de lichamelijke verschijnselen bepaalt voor een deel de hinder die mensen ervaren. Misinterpretatie van normale fysiologische verschijnselen kan fysiologische effecten versterken of nieuwe effecten oproepen. Als iemand bonzen van het hart bij lichamelijke inspanning interpreteert als een het signaal dat er iets mis gaat met het hart, kan dat paniek of stress veroorzaken. Die stress kan leiden tot een drukkend gevoel op de borst en mogelijk tot een ‘dreigend' hartinfarct. In deze situatie is het lastig om vast te stellen of er een lichamelijke ‘oorzaak' voor de symptomen is. Angstig, depressief of meer in het algemeen gestrest zijn gaat altijd gepaard met lichamelijke equivalenten. Deze equivalenten zijn soms oorzaak van de depressieve klachten, maar vaker waarschijnlijk het gevolg. De aanvankelijke fysiologische verstoring kan leiden tot pathofysiologie omdat terugkeer naar de normale basale fysiologie niet meer lukt, de balans is

zoek (allostasis). Anders gezegd: de allostatic load is teveel geweest. Deze processen worden vermoed maar kunnen niet makkelijk worden bewezen. Daarom spreken we ook van somatisch onvoldoende verklaarde lichamelijk klachten.
De eerste diagnostische opdracht is dan ook aannemelijk maken dat ziekte of middelengebruik geen verklaring voor de klachten vormt.
In veel gevallen is tevens sprake van comorbide lichamelijke ziekte, maar verklaart die de klacht niet of slechts gedeeltelijk. In dat geval is het van belang om duidelijk te onderscheiden welke klachten door een ziekteproces worden veroorzaakt, en welke klachten op een ander wijze begrepen en behandeld moeten worden (de tweede diagnostische opdracht).
De derde diagnostische opdracht is nagaan of de lichamelijke klachten uiting kunnen zijn van een psychiatrische stoornis zoals een depressie of angststoornis. Met name depressie en angststoornissen komen veel voor bij mensen met SOLK.
Een biopsychosociale benadering waarbij de arts aandacht besteedt aan alle relevante dimensies van de klachten, is een voorwaarde om juist op het terrein van de SOLK en somatoforme stoornissen een zorgvuldig diagnostisch proces tot stand te brengen.

Uitgangsvragen
Het onderwerp 'Diagnostiek' wordt uitgewerkt in de volgende submodules:

- Wat is de prognose van SOLK?
- Hoe groot is de kans dat bij SOLK alsnog een somatische einddiagnose wordt gesteld die de klachten verklaart?
- Kan op basis van de aanwezigheid van psychosociale stressoren de patiënt met SOLK worden onderscheiden van de patiënt met somatisch verklaarde klachten?
- Beïnvloedt de kwaliteit van de arts-patiëntrelatie bij SOLK de klinische prognose?
- Welke instrumenten om een onderliggende psychiatrische stoornis te diagnosticeren bij patiënten met SOLK zijn toepasbaar in de eerste, tweede en derde lijn?

Specifieke aanbevelingen en onderbouwing kunt u vinden in deze (sub)modules.

Verantwoording

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Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Prognose

Uitgangsvraag

Wat is de prognose van SOLK?

Aanbeveling

Bij deze module zijn geen aanbevelingen geformuleerd.

Overwegingen

Onderzoek in tweedelijnspopulaties bij mensen met lichamelijk onverklaarde buikpijn of met functionele syndromen laat zien dat de prognose veel ongunstiger is. Vaak duren de klachten vijf jaar of langer. Voor een deel hangt dit samen met het feit dat bij deze populatie de klachten ernstiger zijn en dat - bij de functionele syndromen per definitie - sprake is van meer klachten. Dit zijn de twee factoren die samenhangen met een ongunstig beloop bij SOLK in de eerste lijn.

Onderbouwing

Achtergrond

Er is maar weinig prospectief onderzoek verricht naar de prognose van SOLK. Lastig bij het interpreteren van de gegevens van onderzoek naar de prognose is dat de startsitu- atie in de verschillende onderzoeken vaak verschillend is. Wanneer en op welke gronden is vastgesteld dat er sprake is van SOLK? In welk stadium van het proces bevonden de patiënten zich?

Conclusies

Niveau 1	Bij 50-75% van de mensen met SOLK in een eerstelijnspopulatie nemen de klachten af in de loop van het eerste jaar tot vijftien maanden. Bij 10-30% nemen de klachten echter toe in de tijd. *A1 Olde Hartman e.a., 2009*

Samenvatting literatuur

De auteurs van een meta-analyse identificeerden na een uitgebreide search slechts 6 onderzoeken naar de prognose van SOLK in een brede patiëntenpopulatie, dat wil zeggen een populatie die overeenkomt met een eerstelijnspopulatie (Olde Hartman e.a., in druk). Uit deze onderzoeken blijkt dat bij 50 tot 75% van de patiënten de klachten verbeteren tijdens de follow-upperiode die varieert van 6 tot 15 maanden. 10-30% van de patiënten verslechtert echter tijdens de follow-upperiode. Bij de meeste onderzoeken is het onduidelijk in hoeverre er sprake is geweest van behandeling. Uit deze 6 onderzoeken blijkt dat een groter aantal symptomen bij de eerste meting een slechtere prognose heeft. Dat geldt ook voor de ernst van de symptomen; hoe ernstiger de klachten bij de eerste meting hoe groter de kans dat de klachten niet verdwijnen. Bij psychiatrische comorbiditeit bleek er sprake van tegengestelde effecten, daar is op basis van deze onderzoeken geen uitspraak over te doen.

Verantwoording

Laatst beoordeeld : 01-01-2010
Laatst geautoriseerd : 01-01-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Verklarende somatische einddiagnose

Uitgangsvraag

Hoe groot is de kans dat bij SOLK alsnog een somatische einddiagnose wordt gesteld die de klachten verklaart?

Aanbeveling

De werkgroep beveelt aan om van meet af aan een tweesporenbeleid te hanteren dat bestaat uit:

1. de klachten monitoren en bij verandering van klachtenpatroon of niet goed te verklaren toename van de klachten opnieuw diagnostiek inzetten, en
2. psychosociale aspecten in kaart brengen en zo nodig de patiënt leren om te gaan met zijn klachten en zich er zo min mogelijk door te laten beperken.

Overwegingen

Gezien de onzekerheid over de kans op een onderliggend lichamelijk ziektebeeld bij SOLK is het van meet af aan inzetten van een tweesporenbeleid in de hulpverlening gewenst. Het ene spoor volgend dienen huisartsen en andere hulpverleners de patiënt te begeleiden bij het (leren) omgaan met zijn klachten. Het andere spoor is het volgen van de klachten in de tijd. Bij een veranderd klachtenpatroon of bij toename van de ernst van de klachten in de tijd dienen huisartsen, maar ook andere hulpverleners, opnieuw de klachten zorgvuldig te evalueren. Soms is alsnog aanvullende diagnostiek nodig om een somatische aandoening op te sporen.

Onderbouwing

Achtergrond

Een belangrijke onzekere factor voor arts en patiënt is de kans dat een patiënt ten onrechte wordt gediagnosticeerd als lijdend aan een somatoforme stoornis, maar uiteindelijk een ernstig lichamelijk lijden onder de leden blijkt te hebben. Daarbij wordt ervan uitgegaan dat de klachten gerelateerd waren aan de niet gediagnosticeerde ziekte en geen toeval zijn. Die kans is de afgelopen jaren door betere mogelijkheden tot beeldvormend en ander geavanceerd onderzoek weliswaar gedaald, maar nog steeds aanwezig.
Bij deze uitgangsvraag hebben we ons beperkt tot gastro-intestinale klachten, namelijk het prikkelbaredarmsyndroom, en tot de conversiestoornis. Voor afzonderlijke klachten, zoals moeheid en duizeligheid zijn wel enige gegevens bekend over de verdeling van diagnosen die gesteld worden bij die klacht. Maar gegevens over hoe vaak er alsnog een specifieke diagnose gesteld wordt, zijn niet goed te interpreteren omdat informatie ontbreekt in hoeverre de klachten als SOLK werden beschouwd.

Conclusies

Niveau 1	De kans dat uiteindelijk een organisch ziektebeeld de als SOLK geduide klachten blijkt te kunnen verklaren, is alleen onderzocht voor conversieverschijnselen en voor de diagnose prikkelbaredarmsyndroom (PDS). Bij PDS is die kans uitermate klein, bij conversie varieert de kans van 0-12%. *A1 Harvey e.a., 1987; Owens e.a., 1995; Moene e.a., 2000*

Samenvatting literatuur

In twee onderzoeken werd prospectief nagegaan hoe betrouwbaar de diagnose prik- kelbaredarmsyndroom (PDS) was. Harvey e.a. (1987) volgde 104 patiënten met PDS 5 jaar. In alle gevallen bleek de diagnose correct gesteld te zijn.
Owens e.a. (1995) volgde 112 patiënten met PDS gemiddeld 29 jaar. Bij 3 mensen werd in de loop van de tijd een ziekte van het maagdarmkanaal vastgesteld, waarbij het in 2 van de 3 gevallen zeer onwaarschijnlijk was dat de PDS-klachten voortkwamen uit de aandoening. In 1 geval hielden de als PDS geduide klachten mogelijk wel verband met de aandoening die later gevonden werd.
Voor de invoering van nieuwe beeldvormende technieken als MRI en CT-scans bleek dat tussen de 10 en de 30% van de als conversie geduide klachten na jaren follow-up mogelijk toch verklaard werd door een lichamelijke aandoening. Deze kans is echter afgenomen nu beter beeldvormend onderzoek mogelijk is geworden (Moene e.a., 2000). Bij de differentiatie tussen conversieve symptomen en organische beelden blijken drie variabelen voorspellende waarde te hebben: het bestaan van een eerdere verdenking op een neurologische aandoening, oudere leeftijd bij het ontstaan en langere duur van de symptomen zijn gecorreleerd met organiciteit. In een systematische review kwamen zij uit op een kans van 11,8% op een organische aandoening bij conversie (Moene e.a., 2000).

Verantwoording

Laatst beoordeeld : 01-01-2010
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Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Psychosociale stressoren

Uitgangsvraag

Kan op basis van de aanwezigheid van psychosociale stressoren de patiënt met SOLK worden onderscheiden van de patiënt met somatisch verklaarde klachten?

Aanbeveling

Bij deze module zijn geen aanbevelingen geformuleerd.

Overwegingen

Onderzoek naar de diagnostische waarde van dergelijke psychosociale factoren voor de ‘diagnose' SOLK en somatoforme stoornissen is er nauwelijks gedaan. Psychosociale factoren kunnen waarschijnlijk alleen maar gebruikt worden in een multivariaat model waarin ook altijd andere factoren zijn opgenomen, zoals andere gegevens uit anamnese en lichamelijk onderzoek dan wel aanvullende diagnostiek.

Onderbouwing

Achtergrond

Bij SOLK spelen vaak psychosociale stressoren een rol, bijvoorbeeld werkproblemen, stress, een ernstig trauma zoals een ramp of vroege traumatisatie zoals seksueel misbruik op kinderleeftijd. Veel artsen hebben het idee dat dit soort factoren veel vaker aanwezig is bij patiënten met SOLK en somatoforme stoornissen dan bij patiënten met lichamelijk verklaarde klachten. De vraag is in hoeverre de aanwezigheid van psychosociale stressoren de kans dat de klachten uiteindelijk onder de noemer SOLK te scharen zijn vergroot.

Conclusies

Niveau 3	Er is weinig onderzoek verricht naar de voorspellende waarde van psychosociale factoren bij de diagnostiek van SOLK en somatoforme stoornissen. Voor zover onderzoek daarnaar is verricht, blijkt er geen eenduidige conclusie te trekken over de voorspellende waarde van levensomstandigheden en negatieve live events als seksueel misbruik voor het bestaan van SOLK dan wel een somatoforme stoornis. B Drossman, 1990; Walker, 1993; Bleijenberg, 1989

Samenvatting literatuur

Walker (1993) heeft kinderen met steeds terugkerende buikpijn vergeleken met kinderen met een organische maagaandoening, met kinderen met emotionele problemen en met gezonde kinderen. Kinderen met RAP rapporteerden minder negatieve life events dan kinderen met emotionele problemen, ze hadden in dezelfde mate last van emotional distress als kinderen met een maagaandoening.
Bleijenberg (1989) heeft in de jaren tachtig onderzocht of patiënten met functionele buikklachten te onderscheiden waren van mensen met organische verklaarde buikklachten op basis van anamnese en psychologische factoren. Dat bleek niet het geval te zijn.

Uit een onderzoek in een derdelijnspopulatie van patiënten met buikklachten blijkt dat seksueel misbruik in de voorgeschiedenis vaker voorkomt bij mensen met PDS dan bij mensen met colitis (Drossman, 1990).

Verantwoording

Laatst beoordeeld : 01-01-2010
Laatst geautoriseerd : 01-01-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Kwaliteit van arts-patiëntrelatie

Uitgangsvraag

Beïnvloedt de kwaliteit van de arts-patiëntrelatie bij SOLK de klinische prognose?

Aanbeveling

Bij deze module zijn geen aanbevelingen geformuleerd.

Overwegingen

Het operationaliseren van het begrip 'kwaliteit van de arts-patiëntrelatie is lastig. Daar vallen zowel verbale en non-verbale communicatieve aspecten onder, alsook meer emotionele aspecten, zoals empathie. Kwalitatief onderzoek zou een bijdrage kunnen leveren aan het vergroten van inzicht in de bijdrage van de arts-patiëntcommunicatie aan het herstelproces bij SOLK. Tevens is onderzoek naar het effect op lange termijn gewenst.

Onderbouwing

Achtergrond

De kwaliteit van de arts-patiëntrelatie speelt in het hulpverleningsproces een belangrijke rol, daar is iedereen het over eens. Als er geen vertrouwensrelatie is tussen hulpverlener en hulpvrager, verloopt niet alleen het contact stroef, maar kan ook het hulpverleningsproces niet goed op gang komen. Dat klemt misschien wel het meest bij SOLK en somatoforme stoornissen, waar vaak een discrepantie bestaat tussen de verwachtingen van de patiënt en de mogelijkheden van de arts. De vraag is of de kwaliteit van de hulpverlener-patiëntrelatie ook de prognose gunstig kan beïnvloeden, en aan welke kenmerken die relatie dan zou moeten voldoen.

Conclusies

Niveau 1	Er is weinig onderzoek gerapporteerd naar de invloed van de arts-patiëntrelatie op de prognose van patiënten met SOLK. Als patiënten de arts-patiëntrelatie positief waarderen neemt de kans toe dat ze minder klachten ervaren, een grotere mate van welbevinden hebben en zich beter aan het voorgestelde beleid houden. *A2 Grepmair e.a., 2007; Ayarzaguena e.a., 2007; Dobkin e.a., 2006*

Samenvatting literatuur

Grepmair e.a. (2007) toonden in een RCT aan dat als psychotherapeuten mindfulness toepasten, dus gericht bezig waren met waar hun aandacht naartoe ging, hun patiënten minder klachten hadden dan een vergelijkbare groep patiënten, onder andere op een somatisatieschaal.
Aiarzaguena e.a. (2007) toonden in een cluster RCT aan dat als huisartsen speciale communicatietechnieken toepasten, hun somatiserende patiënten significant verbeterden op een aantal schalen van de SF-36, waaronder de fysieke gezondheid, lichamelijke pijn en mental health. Het effect was tot 12 maanden

aanwezig. De communicatietechnieken hielden in dat de arts een fysiologische uitleg (hormonale factoren) gaf en gevoelige onderwerpen indirect benaderde.
Bieber e.a. (2006) onderzochten het effect van ‘shared decision making' in een RCT bij 85 patiënten met fibromyalgie. Zowel artsen als patiënten waren significant meer tevreden over de kwaliteit van de relatie als ‘shared decision making' werd toegepast, maar er waren geen verschillen tussen beide groepen op gezondheidsuitkomsten.
Dobkin e.a. (2006) keken welke factoren compliantie met het beleid, en in het bijzonder met het medicamenteuze beleid, voorspelden bij 142 patiënten met fibromyalgie. Hoe minder discordantie tussen arts en patiënt, hoe beter de patiënten zich hielden aan het voorgestelde beleid en hoe beter ze zich voelden.
Owens e.a. (1995) toonden aan dat een positieve arts-patiëntrelatie, aan de hand van te voren opgestelde criteria afgeleid uit het dossier van 112 PDS-patiënten, samenhing met minder consulten tijdens de follow-upperiode.

Verantwoording

Laatst beoordeeld : 01-01-2010
Laatst geautoriseerd : 01-01-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Onderliggende psychiatrische stoornis

Uitgangsvraag

Welke instrumenten om een onderliggende psychiatrische stoornis te diagnosticeren bij patiënten met SOLK zijn toepasbaar in de eerste, tweede en derde lijn?

Aanbeveling

Bij deze module zijn geen aanbevelingen geformuleerd.

Overwegingen

In de eerste lijn gebruiken met name huisartsen en fysiotherapeuten de 4-DKL en de PHQ om te screenen op psychiatrische aandoeningen. Op basis van het beschikbare onderzoek kan de werkgroep deze lijsten niet aanbevelen voor dit doel. Wel blijkt dat het bespreken van de scores op deze lijsten met de patiënt een handvat biedt om over andere aspecten van de klachten te spreken dan alleen lichamelijke aspecten.

Onderbouwing

Achtergrond

Om het profiel van de patiënt met betrekking tot risico op iatrogene schade dan wel chronisch beloop te bepalen is het zinvol om bij het doorlopen van het diagnostisch proces bij patiënten met SOLK of somatoforme stoornis ook diagnostiek te verrichten naar een comorbide depressie of angststoornis. Er zijn diverse screeningslijsten en
meetinstrumenten in omloop die gebruikt worden om een psychiatrische stoornis op te sporen. Sommige lijsten, zoals de PHQ en de 4-DKL die ontwikkeld zijn voor eerstelijnspopulaties, bestaan uit een aantal schaler voor verschillende psychiatrische aandoeningen, waaronder steeds angst en depressie. Andere instrumenten, zoals de CES-D, zijn alleen bedoeld om een specifieke aandoening, in dit geval depressie, op te sporen. Deze lijsten worden zowel in de open populatie als in eerste- en tweedelijnspopulaties toegepast in onderzoek en in de dagelijkse praktijk.

Conclusies

Niveau 4	De validiteit, betrouwbaarheid en toepasbaarheid van instrumenten om een onderliggende psychiatrische stoornis te diagnosticeren bij patiënten met SOLK en somatoforme stoornissen in de eerste, tweede en derde lijn is niet onderzocht.

Samenvatting literatuur

Een zoekactie naar onderzoek waarin de waarde en toepasbaarheid van instrumenten om een onderliggende psychiatrische stoornis te diagnosticeren bij patiënten met SOLK en somatoforme stoornissen in de eerste, tweede en derde lijn, leverde geen relevante hits op. Instrumenten zoals de MINI of de SCID objectiveren de symptomen en geven een indicatie van de classificatie van de stoornis. Het Mini Internationaal Neuropsychiatrisch Interview (MINI en de uitgebreidere versie MINI-Plus) is een gestructureerd diagnostisch interview dat op systematische wijze DSM-IV- en ICD-10-diagnosen vaststelt. Het afnemen ervan neemt minder tijd in beslag dan bestaande diagnostische interviews, zoals het Structured Clinical Interview for DSM-IV Disorders

(SCID), het Composite International Diagnostic Interview (CIDI) of de Schedules for Clinical Assessment in Neuropsychiatry (SCAN). De goede psychometrische karakteristieken suggereren dat de MINI(-Plus), in tegenstelling tot andere gestructureerde interviews, breed ingezet kan worden bij onderzoek, ook bij grote groepen. In de dagelijkse klinische praktijk is de MINI(-Plus) door zijn korte afnameduur van 20-30 minuten eveneens zeer bruikbaar.

Verantwoording

Laatst beoordeeld : 01-01-2010
Laatst geautoriseerd : 01-01-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Diagnostisch stappenplan voor de eerste en tweede lijn

Uitgangsvraag

Wat is het diagnostisch stappenplan voor de eerste en tweede lijn?

Aanbeveling

Bij deze module zijn geen aanbevelingen geformuleerd.

Overwegingen

Bij deze module zijn geen overwegingen geformuleerd.

Onderbouwing

Achtergrond

Vaststellen of het bij patiënten met lichamelijke klachten om SOLK of een somatoforme stoornis gaat is niet eenvoudig. In principe kan elke klacht die patiënten presenteren, na verloop van tijd en na nadere analyse lichamelijk niet of onvoldoende te verklaren blijken.
Uit het tot nu toe verrichte onderzoek zijn wel een paar kenmerken van patiënten en klachten naar voren gekomen die de kans dat er sprake is van SOLK, vergroten, maar ze bieden onvoldoende houvast voor een onderscheid tussen lichamelijk verklaarde en lichamelijk onvoldoende verklaarde klachten. In het kader van deze richtlijn is het ondoenlijk om voor elke klacht een volledig diagnostisch protocol op te stellen. Voor de afzonderlijke klachten en klachtenclusters verwijzen we naar de monodisciplinaire en multidisciplinaire richtlijnen die uitgebracht zijn. Zoals in de inleiding gesteld, biedt een biopsychosociale benadering de mogelijkheid om zowel diagnostiek als beleid bij klachten die mogelijk lichamelijk onvoldoende verklaard zijn, optimaal vorm te geven.

Samenvatting literatuur

Diagnostisch stappenplan in de huisartsenpraktijk
Als na adequate, dat wil zeggen bij de klachten en context passende diagnostiek geen lichamelijke verklaring voor de klachten wordt gevonden, is (per definitie) sprake van SOLK. In het merendeel van de gevallen accepteert de patiënt de gegeven uitleg en adviezen en blijft het bij één consult. Als een patiënt terugkomt voor dezelfde klacht kan blijken dat er toch sprake is van een onderliggende aandoening (de huisarts heeft de tijd als diagnosticum ‘gebruikt').

De eerste stap is dan opnieuw een anamnese afnemen, waarbij alle relevante dimensies van de klachten aan bod komen, en gericht lichamelijk onderzoek doen. De tweede stap is nagaan of er mogelijk sprake is van een psychiatrische stoornis. De derde stap is nagaan welke in stand houdende of klachten bevorderende factoren mogelijk een rol spelen bij deze patiënt. In toenemende mate melden patiënten met klachten van het bewegingsapparaat zich rechtstreeks bij de fysiotherapeut. Ook hier kan het beschreven stappenplan met name voor psychosomatische fysiotherapeuten een handreiking bieden.

Eerste stap: anamnese en lichamelijk onderzoek

Exploratie (anamnese)
Bij de diagnostiek bij patiënten met mogelijk SOLK of somatoforme stoornissen dient de arts de tijd te nemen voor een grondige exploratie van de klachten en de gevolgen daarvan. Idealiter omvat deze exploratie vijf klachtdimensies: de somatische, de cognitieve, de emotionele, de gedrags- en de sociale dimensie (SCEGS).

- Aandacht besteden aan de *somatische dimensie* van de klacht houdt in: grondig uitvragen van de klachten, begeleidende symptomen, gebruikte medicatie (en alcohol/ drugsgebruik) en gericht lichamelijk onderzoek.
- Vragen passend bij de *cognitieve dimensie* zijn: Wat ziet de patiënt als verklaring voor zijn klachten, heeft hij zelf ideeën over de mogelijke oorzaak? Ziet hij zichzelf als iemand die vatbaar is voor ziektes, denkt hij dat bepaald gedrag ziektebevorderend is of de klachten verergert? Welke verwachting heeft hij over het beloop van de klachten? Wat verwacht hij van medische hulp?
- De *emotionele dimensie* omvat vragen als: Wat doet de klacht met iemand? Wordt hij er wanhopig, moedeloos of juist opstandig van? Is hij erg ongerust over de klachten? Waarover maakt hij zich dan precies ongerust? Wat is de aanleiding voor die ongerustheid?
- Bij de *gedragsdimensie* horen vragen als: Wat doet iemand als hij klachten heeft? En helpt dat of juist niet? Zijn er activiteiten die achterwege gelaten worden sinds er klachten zijn of toen de klachten toenamen? Welke activiteiten? Wat is de reden om ze achterwege te laten? Denkt de patiënt dat ze schadelijk zijn, of heeft hij ook daadwerkelijk gemerkt dat ze de klachten verergeren?
- Bij de *sociale dimensie* ten slotte gaat het om vragen als: Welke gevolgen hebben de klachten in sociaal opzicht? Hoe reageert de omgeving erop: (over)bezorgd, negatief of juist steunend? Welke invloed hebben de klachten op het werk en thuis? Kan de patiënt nog werken met de klachten en naar tevredenheid functioneren in allerlei opzichten?

Lichamelijk onderzoek en aanvullend onderzoek
Het lichamelijk onderzoek wordt gedaan op geleide van de klachten. Dat geldt ook voor aanvullend laboratorium- of beeldvormend onderzoek. Voor een aantal veelvoorkomende klachten (zoals lage rugpijn, duizeligheid en prikkelbaredarmsyndroom) zijn NHG-standaarden beschikbaar.

Tweede stap: nagaan psychiatrische stoornissen
Na deze eerste exploratie maakt de huisarts de balans op: als er geen sprake is van een lichamelijke aandoening, zijn er dan mogelijk aanwijzingen voor een psychiatrische stoornis? Zowel een angststoornis als een depressie, die beide veel voorkomen, kunnen samengaan met lichamelijke klachten en zich vaak in eerste instantie manifesteren in lichamelijke klachten. De diagnostiek van angststoornissen en depressie staat beschreven in de NHG-standaarden en de multidisciplinaire richtlijnen Angststoornissen en Depressie. Indien gewenst kan in deze fase een consulent psychiater worden geraadpleegd.

Derde stap: nagaan in stand houdende en prognostisch ongunstige factoren
Om de prognose te kunnen inschatten en een adequaat beleid te kunnen opstellen is het belangrijk om prognostisch gunstige en ongunstige factoren te identificeren. Ernstige klachten en een grotere hoeveelheid klachten zijn prognostisch ongunstig. Als de huisarts concludeert dat er sprake is van SOLK zonder prognostisch ongunstige factoren, kan hij de patiënt zelf begeleiden.

Afsluiting diagnostisch proces in de eerste lijn
De huisarts vat de bevindingen samen uit de exploratie, het lichamelijk onderzoek en eventuele aanvullende diagnostische testen. Belangrijk is dat de huisarts hierbij zo veel mogelijk positieve termen gebruikt, dus niet ‘er is niets gevonden', maar ‘uw rug is recht en kan alle bewegingen maken die hij moet maken'. vervolgens geeft de huisarts uitleg over de klachten, waarbij hij aansluit bij de vragen, zorgen of angst van de patiënt. De huisarts vertelt dat er geen aanwijzing voor ziekte als oorzaak voor de klachten zijn, maar dat klachten om allerlei redenen aanwezig kunnen blijven. Hij geeft uitleg over vicieuze cirkels en over de gevolgen daarvan voor de klachten.

Verwijzing naar de somatische tweede lijn
Als de huisarts een onderliggende somatische aandoening naar eigen oordeel onvoldoende kan uitsluiten, is een verwijzing naar de somatische tweede lijn geïndiceerd. Als de patiënt hardnekkige somatische attributies koestert, c.q. erg ongerust is over een mogelijk somatische aandoening, kan een verwijzing naar de somatische tweede lijn eveneens een noodzakelijke volgende stap zijn, omdat de patiënt in dat geval niet open staat voor een ander beleid.

Diagnostiek in de somatische tweede lijn
Anamnese
Bij de diagnostiek van SOLK en somatoforme stoornissen dient de arts de tijd te nemen voor een uitgebreide anamnese om de klachten zo goed mogelijk in kaart te brengen. Ook in de tweede lijn omvat de exploratie idealiter alle klachtdimensies (SCEGS, zie hiervoor 3.4.1). Met name in de somatische tweede lijn staat het aantonen dan wel uitsluiten van een somatische oorzaak voor de klachten op de voorgrond. Reden voor de verwijzing is immers dat de huisarts onvoldoende zekerheid hierover kan verkrijgen, dan wel dat de patiënt niet gerust te stellen is. Ook in de tweede lijn dient de arts aandacht te hebben voor de mogelijkheid dat er sprake is van een psychiatrische stoornis.

Lichamelijk onderzoek
Ook in de tweede lijn geldt dat de klachten uitgangspunt vormen voor het lichamelijk onderzoek dat verricht wordt. Zowel in het kader van geruststelling als in het kader van het aantonen dan wel uitsluiten van een diagnose kan men besluiten tot een gericht lichamelijk onderzoek.

Aanvullend onderzoek
Aanvullend laboratoriumonderzoek of beeldvormende diagnostiek dient op geleide van de klachten plaats te vinden. Het risico van ongerichte oriënterende diagnostiek is dat er afwijkingen gevonden worden die bij nadere analyse geen betekenis hebben. Het geruststellende effect dat dan beoogd wordt, wordt door een foutpositieve uitslag teniet gedaan. Als de patiënt zich niet laat geruststellen door een grondige anamnese en lichamelijk onderzoek, is het een optie om toch aanvullende diagnostiek te (laten) doen. Voorwaarde is dan dat de patiënt ervan overtuigd is dat dit het juiste onderzoek is om de ziekte in kwestie aan te tonen en dat hij zich neerlegt bij de uitslag van dat onderzoek.

Afronding van het diagnostisch proces in de tweede lijn
Als het diagnostisch proces in de tweede lijn tot doel heeft een lichamelijke verklaring van de klachten aan te

tonen dan wel af te sluiten, bespreekt de specialist zijn bevindingen met de patiënt en rapporteert die tevens aan de huisarts. Mocht er geen verklaring voor de klachten gevonden zijn en de patiënt accepteert dat er niet verder gezocht hoeft te worden naar een lichamelijke oorzaak, dan verwijst de specialist terug naar de huisarts. Mocht er wel een lichamelijke verklaring zijn gevonden, dan zet de specialist het daarbij gewenste beleid in en verwijst desgewenst terug naar de huisarts of behandelt de patiënt zelf.
Als tijdens het consult in de tweede lijn duidelijk wordt dat psychosociale problematiek een belangrijke rol speelt bij (het in stand houden van) de klachten overlegt de specialist met de huisarts over het verdere beleid.

Als er tevens sprake is van een psychiatrische stoornis overlegt de specialist met de huisarts of deze wil verwijzen naar de GGZ of de patiënt zelf wil begeleiden. Ook de behoefte aan nadere psychiatrische diagnostiek kan een reden voor verwijzing naar de tweedelijns GGZ zijn.

Diagnostiek in de tweedelijns GGZ
Veel wat in de vorige paragrafen gezegd is over diagnostiek geldt ook voor de tweedelijns GGZ. Bij voorkeur ziet een psychiater of een huisarts een patiënt die naar de tweedelijns GGZ verwezen wordt met SOLK of een somatoforme stoornis. De diagnostiek bestaat uit vijf stappen:

1. Stilstaan bij de vraag of de klachten of stoornis niet beter verklaard kunnen worden door middelengebruik in de ruimste zin (geneesmiddelen, drugs, alcohol e.d.).
2. Nagaan of er sprake is van een nagebootste stoornis of simulatie of aggravatie van de klachten. Bij een nagebootste stoornis weet de patiënt wat hij of zij doet, maar snapt zijn motieven niet (meestal de ziekenrol of aandacht verkrijgen). Bij simulatie is er sprake van bewust gewin en bij aggravatie van ‘normale' klachten is er vaak angst voor een ziekte.
3. Nagaan of de klachten beter te verklaren zijn door een andere psychiatrische stoornis, zoals een depressie, een angststoornis of een psychotische stoornis.
4. Nagaan of het klachtenpatroon voldoet aan een van de somatoforme stoornissen
5. Nagaan of de klachten voldoen aan een somatoforme stoornis in ruime zin. Is er sprake van een subklinische (niet aan het vereiste aantal symptomen voldoend) soma- tisatiestoornis, verstoorde lichaamsbeleving of hypochondrie? Als er bij de voorgaande stappen geen specifieke diagnose te stellen valt, is er per definitie sprake van SOLK.

Verantwoording

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Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK De rol van de diagnostiek bij bedrijfsarts

Uitgangsvraag

Wat is de rol van de diagnostiek bij bedrijfsarts?

Aanbeveling

Bij deze module zijn geen aanbevelingen geformuleerd.

Overwegingen

Bij deze module zijn geen overwegingen geformuleerd.

Onderbouwing

Samenvatting literatuur

De bedrijfsarts start een consult met een multifactoriële probleemanalyse. Onderstaande aandachtspunten zijn met name van belang in de bedrijfsgeneeskundige of een verzeke- ringsgeneeskundige setting bij patiënten met SOLK of somatoforme stoornissen.

Klacht en behandeling
Het stappenplan zoals hierboven beschreven voor de eerste lijn is ook in deze setting goed toepasbaar. Bij werknemers met SOLK kan het functioneren op alle domeinen, maar met name het fysiek functioneren, beperkt zijn. Ook dient er aandacht te zijn voor eerder verzuim, omdat het een belangrijke voorspellende factor is voor nieuw langdurig verzuim.

Werksysteem
Van belang is na te gaan of de werknemer het idee heeft dat zijn werkomgeving hem serieus neemt in zijn klachtbeleving en of er consensus is over de mate waarin de werknemer kan functioneren. De bedrijfsarts dient te exploreren of er oorzakelijke of onderhoudende factoren in de werkomgeving zijn. Hij gaat na of de werknemer controleverlies ervaart in de re-integratie ten aanzien van de aard van het werk of in de communicatie met werkgever.

Privésysteem
De bedrijfsarts gaat na hoe het privésysteem functioneert. Een ondersteunend privésysteem kan een positieve invloed op het beloop van klachten hebben. Als het privésysteem de klachten medicaliseert, dan wel oorzakelijke of onderhoudende factoren bevat, dan werkt dat remmend op het beloop.

Coping
De bedrijfsarts dient met name cognities, emoties en gedrag ten aanzien van de klacht te exploreren en toe te spitsen op ervaren beperkingen en mogelijkheden. De eigen opvatting over de prognose van de werknemer is een belangrijke prognostische factor voor de duur van het verzuim (Hansen e.a., 2005; Koopmans e.a., 2008).

Bovenstaande factoren dient de bedrijfsarts te betrekken bij het vaststellen van de probleemdiagnose bij de werknemer met SOLK. De probleemanalyse is uitgangspunt voor het bepalen welke interventies mogelijk effectief zijn.
Een apart aandachtspunt is de overlap van SOLK met distress, angst en depressie. De herziene NVAB-richtlijn psychische klachten (NVAB, 2008) en de LESA overspanning geven hier handvatten voor.

Arbeidsongeschiktheid
Voor de beoordeling van langdurige arbeidsongeschiktheid door de verzekeringsge- neeskundige wordt verwezen naar de criteria van het medisch arbeidsongeschiktheidscriterium (MAOC) (LISV, 1996) en de relevante verzekeringsgeneeskundige protocollen. In algemene zin is de wetenschappelijke onderbouwing van de beoordeling tot functioneren en participeren ronduit mager. Om de beeldvorming te voorkomen dat SOLK op dit punt een uitzonderingspositie innemen, hecht de werkgroep eraan dat de openstaande vraagstukken rond de beoordeling van de mogelijkheden tot functioneren en participeren niet anders zijn dan bij veel andere aandoeningen.
Ook voor de bedrijfsarts is het aangewezen om bij langer bestaande SOLK te beoordelen of de aangegeven beperkingen consistent, congruent en objectiveerbaar zijn. Het serieus nemen van de beleefde beperkingen sluit aan op het serieus nemen van de beleefde klachten (Smith, 1995). Dit is iets anders dan de ervaren beperkingen als uitgangspunt nemen voor de reïntegratie. Zie hiervoor verder module ‘Preventie’.

Verantwoording

Laatst beoordeeld : 01-01-2010
Laatst geautoriseerd : 01-01-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Behandeling van SOLK en somatoforme stoornissen

In deze module wordt de evidentie besproken van een tweetal hoofdgroepen van stoornissen en klachten, namelijk: (1) de somatoforme stoornissen (zoals die in de DSM-IV-TR (APA, 2000) zijn opgenomen) en (2) de somatisch onvoldoende verklaarde lichamelijke klachten (SOLK). Gezien de grote omvang van laatstgenoemde domein zullen daaruit slechts enkele klachten als voorbeeld worden besproken. Het betreft met name die klachten waarover uit een literatuursearch enige vorm van systematisch onderzoek naar voren kwam.

De werkgroep heeft voor een aantal SOLK en somatoforme stoornissen aanbevelingen opgesteld naar aanleiding van evidence vanuit interventiestudies. Daarnaast heeft de werkgroep bestaande richtlijnen geraadpleegd en andere wetenschappelijke literatuur over de diagnostiek, de prognose en de behandeling van SOLK en somatoforme stoornissen. Op grond daarvan heeft de werkgroep een aantal overwegingen en aanbevelingen geformuleerd die in dit hoofdstuk aan de orde zullen komen. Hierbij is een stapsgewijze procedure gevolgd.
Eerst is een knelpuntenanalyse gedaan. Hieruit kwam naar voren dat, omdat SOLK vanuit verschillende disciplines worden behandeld en onderzocht, onderzoek niet alleen te vinden is onder DSM-IV-categorieën, maar ook onder andere omschrijvingen. Bovendien was een knelpunt dat er aandoeningen bestonden die weliswaar tot op zekere hoogte lichamelijk verklaard werden, maar waar de presentatie dan wel het omgaan met de klachten toch dermate disfunctioneel kon zijn dat van een SOLK gesproken kon worden. Dit is bijvoorbeeld bij dysmenorroe en het prikkelba- redarmsyndroom het geval. Derhalve worden deze syndromen ook in dit hoofdstuk behandeld. Een derde knelpunt was dat chronische pijn, dat door de werkgroep als SOLK wordt opgevat, dermate omvangrijke literatuurvermeldingen had, dat het in het tijdsbestek van de werkgroep en in het format van deze richtlijn niet doenlijk was om chronische pijn daarin op te nemen. Derhalve adviseert de werkgroep voor chronische pijn een aparte richtlijn te ontwikkelen en zal dit niet in dit hoofdstuk behandeld worden.

Voordat de evidentie voor de behandeling van specifieke stoornissen wordt beschreven (in D en E), zal beargumenteerd worden dat de problematiek van de hier beschreven pati- enten op een aantal factoren kan worden beschreven (zie A: patiëntenkenmerken).
Ook in de verleende zorg is er een sprake van grote diversiteit en het (samen) werken van diverse disciplines in verscheidene echelons. Een korte opsomming beoogt de beroepsgroepen te inspireren tot het formuleren van eigen competenties en profielen ten aanzien van het werken met de hier genoemde patiënten (zie B: zorgverleners).
Ten derde wordt een begin gemaakt met het formuleren van aanbevelingen voor een mogelijk effectieve aanbieding van zorg aan patienten met verschillende soorten en ernst van klachten (zie C: zorgstrategie).

Uitgangsvragen
Het onderwerp 'Behandeling' wordt uitgewerkt in de volgende submodules:

- Patientkenmerken
- Zorgverleners
- Zorgstrategie

Specifieke aanbevelingen en onderbouwing kunt u vinden in deze submodules.

Verantwoording

Laatst beoordeeld : 01-01-2010
Laatst geautoriseerd : 01-01-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Patiëntkenmerken

Uitgangsvraag

Patientkenmerken

Aanbeveling

De werkgroep beveelt aan onderzoek te doen naar de voorspellende waarde van de indicatoren en de validiteit en betrouwbaarheid van mogelijke risicoprofielen.

Overwegingen

Bij deze module zijn geen overwegingen geformuleerd.

Onderbouwing

Samenvatting literatuur

Het vertrekpunt van de organisatie van de zorg is de problematiek van de patiënt. Er is echter sprake van grote verscheidenheid in de klachten en stoornissen die de patiënten presenteren, alsook in de hulp die zij zoeken of aangeboden krijgen, en de resultaten van deze hulpverlening. Somatoforme stoornissen en SOLK variëren van kortdurend tot chronisch en van enkelvoudig tot complex. Ook worden zij gekenmerkt door verschillende factoren die elkaar op hun beurt beïnvloeden. In de diagnostiek en indicatiestelling zal daarmee rekening gehouden moeten worden. Idealiter zou de praktijk gebaat zijn bij specifieke profielen van patiënten waarop eenduidige beslissing omtrent behandeling kunnen worden gebaseerd. De werkgroep heeft hierover lang van gedachten gewisseld, heeft verschillende voorstellen daartoe besproken en is tot de conclusie gekomen dat het nog te vroeg is om nu al risicoprofielen of patiëntprofielen te presenteren. De voornaamste reden is dat het vooralsnog aan empirische steun ontbreekt voor een dergelijke profilering.
Er zijn in de werkgroep echter wel mogelijke indicatoren naar voren gekomen voor het in kaart brengen van de problematiek van patiënten met SOLK en somatoforme stoornissen. Deze zijn als volgt samen te vatten:

De aard, ernst en duur van SOLK en somatoforme stoornissen
In termen van de DSM-IV-criteria (As-I) wordt de aard van de problematiek benoemd, alsmede de mate waarin deze voorkomt en de duur van de klachten of symptomen. Van belang daarbij is voorts om de cognities, emoties en gedragingen van de patiënt met betrekking tot de lichamelijke klachten in kaart te brengen, en om zicht te krijgen op mogelijke pathofysiologische processen.
De aard van de klachten (bijzonder of gewoon, enkele of veel klachten), de ernst (intensiteit, en beperkingen) en de duur van de klachten zijn mogelijk voorspellend voor het verloop.

De mate van inzicht van de patiënt
Het inzicht dat de patiënt in zijn omstandigheden heeft, zou een belangrijke prognostische factor kunnen zijn. Het betreft dan met name het inzicht in het zien van een verband tussen lichamelijke verschijnselen enerzijds en vroegere of actuele psychische en psychosociale factoren anderzijds.

De mate van functionele en sociale beperkingen

De gevolgen van SOLK en somatoforme stoornissen kunnen variëren van licht tot zeer ingrijpend. Beperking kunnen bijvorobeeld betrekking hebben op beweging, ADL en sociale en arbeidsparticipatie. De mate van functionele en sociale beperkingen kunnen worden omschreven conform de International Classification of Functioning ICF; WHO), dan wel worden uitgedrukt in termen van de DSM, As-IV (sociale probleemgebieden) en As-V (Global Assessment of Functioning; GAF-scores).

Comorbiditeit met andere psychische en lichamelijke stoornissen
Hieronder wordt verstaan het samen voorkomen van SOLK of somatoforme stoornissen met andere psychische stoornissen op DSM As-I (klinische syndromen) en As-II (persoonlijkheids en ontwikkelingsstoornissen), alsook op As-III lichamelijke comorbiditeit. Het gaat hierbij om de aard zowel als de ernst van de bijkomende problematiek. Verwacht wordt dat patiënten met comorbide stoornissen op de As-I een betere prognose hebben dan patiënten zonder comorbide stoornissen op de As-I, terwijl een comorbide stoornis de As-II een slechtere prognose voorspelt.

Predisponerende factoren
In verband met het vaststellen van de aard van het risicoprofiel is het belangrijk mogelijke predisponerende in kaart te brengen. De relatie tussen deze factoren en SOLK/ somatoforme stoornissen wordt in het hoofdstuk over de etiologie nader belicht. Verwacht wordt dat de kans op succesvolle behandeling bij patiënten die in hun jeugd verwaarloosd zijn of slachtoffer waren van geweld of seksueel misbruik kleiner is dan bij patiënten die deze ervaringen niet hebben.

Luxerende factoren
Stressvolle gebeurtenissen en verandering van levensomstandigheden (zoals onder meer financieel, relationeel of arbeidsgerelateerd) kunnen aanleiding geven tot het optreden van SOLK. Dergelijke stressoren brengen meestal een verergering of verminderen van de symptomen teweeg. Het heeft dus zin om bij een opleving van de klachten de agenda te verbreden en naar opgetreden stressvolle gebeurtenissen te vragen.

De kwaliteit van de behandelaar-patiëntrelatie in de huidige en eerdere hulpverlening
Een mogelijke invloed op de effectiviteit van de behandeling is de kwaliteit van de behandelaar-patiëntrelatie in de huidige en eerdere hulpverlenersrelaties. Daaronder wordt onder meer verstaan de mate van overeenstemming over de diagnose, over de behandeling, en over de rollen (zoals een actieve opstelling van de patiënt, de rol van terughoudende deskundige van de arts) die door behandelaar en patiënt vervuld dienen te worden.

Positieve of negatieve iatrogene effecten
Behandelingen kunnen zowel leiden tot positieve (gewenste) resultaten, als tot negatieve (ongewenste) resultaten. Het is bij de diagnostiek en het formuleren van een behandelplan voor SOLK en somatoforme stoornissen belangrijk om te weten wat de resultaten tot dusverre zijn geweest, aangezien ze prognostische waarde kunnen hebben. Iatrogene schade, dat wil zeggen lichamelijke of psychische complicaties door medisch handelen, is een zeer reële risicofactor bij deze patiënten, want iedere diagnostische of therapeutisch bedoelde ingreep brengt nu eenmaal risico's met zich mee in de zin van toegenomen morbiditeit, traumatisering of zelfs mortaliteit.

Verantwoording

Laatst beoordeeld : 01-01-2010
Laatst geautoriseerd : 01-01-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Zorgverleners

Uitgangsvraag

Zorgverleners

Aanbeveling

De werkgroep doet de aanbeveling om per beroepsgroep specifieke competenties te formuleren die bijdragen aan een optimale zorg voor patiënten met SOLK en somatoforme stoornissen.

Onderwijs in het herkennen en behandelen van SOLK en somatoforme stoornissen dient herkenbaar deel uit te maken van opleidingen voor beroepen die onder de wet BIG vallen en met name voor artsen, verpleegkundigen, fysiotherapeuten, GZ-psychologen, psychotherapeuten, verzekeringsartsen, klinisch psychologen, psychiaters, bedrijfsartsen en medisch specialisten.

De werkgroep doet de aanbeveling om per beroepsgroep specifieke nascholing te organiseren met het doel de algemene en discipline specifieke competenties voor de begeleiding en behandeling van patiënten met SOLK en somatoforme stoornissen op peil te brengen.

De werkgroep beveelt aan dat de bedrijfsarts en verzekeringsgeneeskundige aanvullend geschoold worden voor consulten met werknemers met SOLK. Belangrijke elementen zijn:

- hantering van de multifactoriële probleemanalyse met een toegespitst werkmodel. Het SCEGS- model is ons inziens hiertoe geëigend;
- toepassen van gedragsregels voor communicatie;
- toepassen van de specifieke diagnostische beslisboom.

De werkgroep doet de aanbeveling om per beroepsgroep specifieke nascholing te organiseren met het doel de algemene en discipline specifieke competenties voor de begeleiding en behandeling van patiënten met SOLK en somatoforme stoornissen op pijl te brengen.

Onderwijs in het herkennen en behandelen van SOLK en somatoforme klachten en stoornissen dient herkenbaar deel uit te maken van opleidingen voor beroepen die onder de wet BIG vallen en met name voor artsen, verpleegkundigen, fysiotherapeuten, GZ-psychologen, psychotherapeuten, verzekeringsartsen, klinisch psychologen, psychiaters, bedrijfsartsen en medisch specialisten.

De werkgroep beveelt aan om meer cognitiefgedragstherapeuten te trainen in de behandeling van patiënten met een somatisatiestoornis, hypochondrie en body dysmorphic disorder.

De werkgroep beveelt aan om interdisciplinaire teams, in de eerste, tweede en derde lijn integraal bij te scholen.

Overwegingen

Bij deze module zijn geen overwegingen geformuleerd.

Onderbouwing

Samenvatting literatuur

De International Classification of Functioning (ICF; WHO, 2002) onderscheidt drie aspecten aan het functioneren, namelijk fysieke afwijking, activiteiten en participatie, en geeft aan dat er op veel niveaus verstoringen kunnen optreden en dat er op al deze niveaus mogelijkheden tot aanpak zijn. Dit onderscheid impliceert tevens dat voor verschillende disciplines rollen weggelegd zijn in de zorg voor patiënten met SOLK en somatoforme stoornissen.
Uitgangspunt bij dit deel is de vraag welke professionals een rol spelen in de diagnostiek, behandeling en begeleiding van patiënten met SOLK en somatoforme stoornissen. In de (te ontwikkelen) monodisciplinaire richtlijnen van de respectievelijke disciplines kan dit aspect nader worden uitgewerkt. De werkgroep beoogt hiertoe een bescheiden aanzet te geven. Een niet uitputtende lijst van beroepen en hun activiteiten in de diagnostiek en behandeling van SOLK en somatoforme stoornissen ziet er als volgt uit:

Huisarts
De huisarts vervult als medisch generalist in de eerste lijn de belangrijkste rol aan de poort, verzorgt de primaire diagnostiek en behandeling in de eerste lijn, en treedt op case manager bij complexe problematiek. De huisarts volgt een ‘tweesporenbeleid' dat wil zeggen aandacht voor zowel somatische als psychische/psychosociale factoren in de diagnostiek en behandeling.

Psychiater
De psychiater vervult een rol in de tweede en derde lijn als behandelaar, en functioneert in de eerste lijn als consulent van de huisarts. Tot de taken kunnen onder andere worden gerekend de diagnostiek, de behandeling inclusief farmacotherapeutische behandeling, indicatiestelling voor behandeling en verwijzing, de supervisie en de coördinatie van behandelingen, het formuleren van een behandelplan en overdragen daarvan op andere behandelaars en de patiënt.

Psycholoog
De psycholoog werkt in de eerste, tweede en derde lijn. In de eerste lijn werkt de psycholoog nauw samen met de huisarts, onder meer door het geven van patiënteneducatie en het toepassen van kortdurende ondersteunende begeleiding of therapie. In de tweede en derde lijn treden GZ-psychologen, psychotherapeuten en klinisch psychologen en medisch-psychologen op als behandelaars die getraind zijn in de behandeling van pati- enten met SOLK en somatoforme stoornissen. Kort- en langdurende behandelingen worden daarbij vaak uitgevoerd in de context van multidisciplinaire teams.

Medisch specialist
In de tweede en derde lijns somatische gezondheidszorg komen patiënten met SOLK en somatoforme stoornissen op verwijzing van hun huisarts of collega-specialist. Soms wordt de specialist gevraagd een somatische oorzaak voor de aanhoudende klacht(en) vast te stellen dan wel uit te sluiten en daarna de patiënt terug te verwijzen. Het kan ook zijn dat een advies voor behandeling gevraagd wordt gezien het maar voortduren van de lichamelijke klachten.

Bedrijfsarts
Wettlijk is vastgelegd dat werkgevers de bedrijfsarts moeten inschakelen voor advies bij verzuim (in het kader van de Wet verbetering poortwachter) en ten aanzien van de medische aspecten bij risico-inventarisatie en preventief medisch onderzoek. Het advies van de bedrijfsarts is gericht op herstel of behoud van functioneren en op de aanpak van werkgerelateerde factoren die een oorzakelijke of onderhoudende rol spelen. Hiertoe adviseert deze werknemer en werkgever.

Verzekeringsarts
De verzekeringsgeneeskundige heeft de taak een medische beoordeling te doen als een werknemer een beroep doet op de WIA (na twee jaar arbeidsongeschiktheid), op vergelijkbare uitkering door particuliere arbeidsongeschiktheidsverzekeringen of op de ziektewet (werknemers van met name uitzendburo's, bij doorlopende ziekte na afloop van een tijdelijk contract en bij ziekmelding van zwangere vrouwen). De verzekerings- geneeskundige stelt vast of de arbeidsongeschiktheid in rechtstreeks verband staat met ziekte of gebrek en wat de beperkingen en mogelijkheden voor arbeid zijn.

Verpleegkundige
Als nurse practitioner of praktijkondersteuner GGZ of wijkverpleegkundige treedt deze op in de eerste lijn, en daarnaast in de tweede en derde lijn als mede-uitvoerder van behandelingen. Opvallend bij de bestudering van de literatuur is het relatieve gebrek aan literatuur op verpleegkundig gebied ten aanzien van de somatoforme stoornissen.

Fysiotherapeut
De fysiotherapeut richt zich op het voorkomen en behandelen van klachten in het bewegend functioneren van de mens. Een gerichte anamnese, observatie, onderzoek en analyse van het bewegen enerzijds en het in overleg opstellen van een behandelplan anderzijds, behoren tot de specifieke deskundigheid van de fysiotherapeut. Klachten aan het bewegingsapparaat worden gezien als een neerslag van de interne wensen, mogelijkheden en beperkingen van een individu (biologisch-medisch én psychologisch) enerzijds en de externe mogelijkheden en beperkingen van de omgeving anderzijds. Meer dan algemene fysiotherapeut houdt de psychosomatische fysiotherapeut zich bezig met het beïnvloeden van de complexiteit van de relatie tussen lichamelijk functioneren en psychisch functioneren.

Verantwoording

Laatst beoordeeld : 01-01-2010
Laatst geautoriseerd : 01-01-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Zorgstrategie

Uitgangsvraag

Op welke wijze kan de zorg voor patiënten met SOLK en somatoforme stoornissen het best worden georganiseerd, zodat er er een klinisch significant en kosteneffectief behandelresultaat wordt gerealiseerd?

Aanbeveling

De werkgroep beveelt aan bij actieve behandeling een stepped-carebenadering toe te passen waarbij evaluatie van het behandeleffect (monitoring) regelmatig plaatsvindt, bijvoorbeeld elke zes weken.

Cognitieve gedragstherapie dient onderdeel te zijn van het standaard medisch handelen in bij SOLK en somatoforme stoornissen niet anderszins omschreven.

De toepassing van een meer intensieve psychologische behandeling, zoals klinische opname, moet worden gelimiteerd tot de categorie patiënten met hardnekkige klachten.

Een diseasemanagement aanpak op geleide van patientprofielen wordt aanbevolen.

Bij behandeling van SOLK en de somatoforme stoornis niet anderszins omschreven is een stepped care benadering, geïnitieerd door de huisarts aan te bevelen.

De werkgroep beveelt aan om voor zowel lichte als ernstige vormen van SOLK en somatoforme stoornissen met de lichtste, effectieve, nog niet toegepaste, interventie te beginnen. Derhalve is van groot belang uit te vragen welke behandelingen in de voorgeschiedenis reeds hebben plaatsgevonden.

Bij niet-farmacologische behandeling van SOLK en somatoforme stoornis niet anderszins omschreven zijn maatregelen die een actieve participatie van de patiënt verlangen aan te bevelen.

De toepassing van meer intensieve psychologische behandeling moet worden gelimiteerd tot de categorie patiënten met hardnekkige klachten.

De werkgroep beveelt aan methoden te ontwikkelen om die patiënten met SOLK en somatoforme stoornissen bij wie de klachten zonder behandeling zullen voortduren, zo snel mogelijk te herkennen.

De werkgroep beveelt aan om bij patiënten met hypochondrie of BDD met een lichte comorbide depressie te kiezen tussen behandeling met een SSRI of cognitieve gedragstherapie en bij pati- enten met een ernstige comorbide depressie direct te starten met een SSRI.

Overwegingen

Bij deze module zijn geen overwegingen geformuleerd.

Onderbouwing

Achtergrond

Vaak komt het voor dat patiënten ofwel niet op de juiste plek of niet bij een gespecialiseerde behandelaar terecht komen, ofwel lang moeten wachten alvorens vervolgzorg geboden kan worden. Bij de ontwikkeling van deze richtlijn is een knelpuntenanalyse gedaan. Vanuit de verschillende disciplines kwam als knelpunt de complexiteit en de heterogeniteit van de patiëntengroep waarover deze richtlijn gaat naar voren. Dit leidt in de dagelijkse praktijk tot problemen in de afstemming tussen behandelaar en patiënt, en tussen de vele behandelaars die bij de zorg van deze patiënten betrokken raken. Dit strekt zich uit over alle zorgsettingen. Tegelijkertijd was de werkgroep van mening dat een advies over een gemeenschappelijke visie en zorgmodel juist tot die nodige onderlinge afstemming zou kunnen leiden.

Samenvatting literatuur

Stepped care

Henningsen e.a. (2007) doen op grond van uitvoerig literatuuronderzoek de aanbeveling om in eerste en tweede lijn een stepped-carebenadering te hanteren. Stepped care is een meer flexibele behandelmethode dan traditionele vormen van behandeling. Het houdt in dat verschillende interventies van een verschillende intensiteit na elkaar aangeboden worden afhankelijk van het effect van een eerdere stap (Bower & Gilbody, 2005). Stepped care behandeling steunt op een drietal aannamen. De eerste is dat de minimale interventies die gebruikt worden in stepped care (zoals bijvoorbeeld patiënteneducatie) significant positief effect op de klachten kunnen hebben gelijk aan dat van traditionele psychologische behandelingen, ten minste voor een gedeelte van de patiënten. Ten tweede is er de aanname dat het gebruik van minimale interventies ervoor zal zorgen dat voorzieningen binnen de geestelijke gezondheidszorg effectiever gebruikt gaan worden. De derde aanname stelt dat minimale interventies en de gehele stepped care benadering acceptabel zijn voor zowel de patiënt als de behandelaar (Bower & Gilbody, 2005).
In het geval van SOLK en somatoforme stoornissen houdt stepped care in dat op grond van het risicoprofiel van de patiënt de lichtst mogelijke effectieve behandeling wordt gekozen. De keuze hangt onder meer af van de ervaringen met en effecten van eerdere behandelingen, en van de aard van de klachten.
De navolgende stappen zijn gerangschikt in de mate van intensiteit en volgen de aanbevelingen van Henningsen e.a. (2007). De algemene lijn is het beginnen bij de focale klachten, en de aanpak desgewenst (op geleide van behaalde resultaten) uit te breiden tot het bredere functioneren van de patiënt.

1. vraagverheldering
2. doelmatige diagnostiek
3. uitleg en patiënteneducatie
4. behandeling van comorbiditeit zoals bijvoorbeeld depressie en somatische aandoeningen
5. verwijzing binnen de eerste lijn
6. consultatie van de tweede lijn.

Bij al deze benaderingen is het belangrijk dat een expliciet doel wordt geformuleerd, en dat monitoring van het verloop en de uitkomst van de interventie plaatsvindt. Bij onvoldoende effect wordt doorgegaan naar een volgende (intensievere) stap in het zorgaanbod. Aangezien in deze stepped-carebenadering verschillende disciplines een rol spelen, is hun onderlinge communicatie van eminent belang, alsmede de centrale rol van de huisarts als case manager.

Monitoring
Bij een patiënt met een ernstiger vorm van SOLK die verwezen wordt is de grote lijn bij het doorlopen van het zorgkanaal stapsgewijze diagnostiek en behandeling, revalidatie en terugvalpreventie, ingegeven door de risicoprofielen. Zoals reeds eerder aangeduid, is het uitgangspunt om ook indien de klachten c.q. het risicoprofiel ernstig lijken, na te gaan of in de behandelvoorgeschiedenis geen essentiële eerste stappen, zoals bijvoorbeeld patiënteneducatie, zijn overgeslagen. Indien dat het geval is, kan het het zinvol zijn om toch die lichte interventie te doen, alvorens tot zwaardere behandelingen over te gaan. Het stepped-careprincipe vereist bij actieve behandeling een regelmatige evaluatie van het behandeleffect. Dit betekent dat de huisarts of andere casemanager bijvoorbeeld elke zes weken nagaat hoe het gaat met lichamelijke klachten, welbevinden en voortgang van de behandeling. Een dergelijke monitoring bij behandeling is reeds door Smith e.a. (1986) effectief bevonden.
De empirische evidentie voor een stepped-carebenadering voor SOLK en somato- forme stoornissen ontbreekt echter vooralsnog.

Zorgprogramma
In de tweede en derde lijn zijn de laatste jaren steeds meer zorgprogramma's ontwikkeld voor het optimaliseren van de zorg voor specifieke doelgroepen. Deze programma's integreren de kennis en het handelen die nodig zijn voor het aanbieden van een effectieve en op evidentie gebaseerde zorg voor patiënten met SOLK en somatoforme stoornissen. In de zorgprogramma's is per stoornis een aantal onderdelen van het zorgproces nader uitgewerkt. Dat betreft de diagnostiek en de differentiaaldiagnostiek, de beslissingen op grond waarvan tot een volgende stap wordt besloten (bijvoorbeeld doorverwijzing, of een bepaalde interventie), en de overweging om een specifieke behandeling toe te passen. Een zorgprogramma organiseert in principe de beslissingen de de handelingen die daaruit voort vloeien.

Disease management
Disease management gaat uit van een stoornisspecifieke benadering waarbij rekening gehouden wordt met de context van de patiënt, de verschillen in aard, ernst en beloop van de problematiek en eventuele comorbide problematiek. Disease management sluit aan bij vraaggestuurde en vraaggerichte zorg. In het disease-managementmodel wordt in de samenwerking tussen huisarts, patiënt en medisch specialist de rol van casemanager geïntroduceerd. Ziektebeelden die zich goed lenen voor disease management kenmerken zich door een chronisch of episodisch beloop en een complexe of langdurige zorgbehoefte. Er valt veel gezondheidswinst en verbeterde behandelresultaten te behalen door kwali- teits- en doelmatigheidsbevordering van de verleende zorg (Van der Feltz-Cornelis e.a., 2006). Disease-managementmodellen blijken werkzaam en kosteneffectief voor depressie (o.e. Neumeijer-Gromen e.a., 2004; Badamgarav e.a., 2003; Gilbody, 2007). Hoewel nog onderzoek verricht moet worden naar de haalbaarheid en kosteneffectiviteit van disease management voor somatoforme stoornissen, zijn er enkele redenen om dit model hier verder uit te werken. In de eerste plaats zijn de somatoforme stoornissen zeker op te vatten als chronisch en complex, en de patiënten met deze stoornissen neigen tot sterke medische consumptie in velerlei settingen. In de tweede plaats heeft de NICE-richtlijn voor CVS (2007) ook disease-managementprincipes aanbevolen. En in de derde plaats blijkt uit het onderzoek dat is besproken in het hoofdstuk over behandeling dat goede afstemming van de zorg, multidisciplinaire samenwerking en een behandeling gericht op het beheersen van de medische consumptie effectief en kosteneffectief zijn.

Met een diseasemanagement benadering zou deze problematiek voor de praktiserend arts en collega hulpverleners goed te hanteren kunnen zijn. Dit vanwege de neiging tot chroniciteit van de klachten, de hoge zorgconsumptie, de problemen in de arts-patient communicatie, de versnippering in de zorg, en de daardoor optredende complicaties en sociale problematiek bij patiënten.

Patiëntprofielen
De hoofdlijnen van deze aanpak liggen in (1) het hanteren van patiëntprofielen, waarbij het risico op iatrogene schade en langdurig beloop wordt ingeschat; (2) het hanteren van een stepped care benadering, waarbij de patiënt instapt op een niveau passend bij diens profiel; en (3) het optreden van de huisarts, en in ernstige gevallen van de medisch specialist of psychiater, als caremanager die de zorgconsumptie kanaliseert.
De kans op iatrogene schade en op een langdurig beloop neemt toe bij bepaalde patiënt kenmerken, die onder A reeds zijn genoemd, zoals reeds langdurig bestaande klachten, hoge zorgconsumptie, het ondergaan hebben van operatieve ingrepen vanwege SOLK, ernstig verstoorde behandelrelaties, het verloren gaan van sociale competenties (relaties, beroep), en het optreden van comorbiditeit. Een indeling in drie profielen wordt aangeraden.

Licht
Het lichte profiel is dat van de facultatieve somatiseerder, die wanneer daar door de huisarts een opening voor wordt geboden niet alleen somatische, maar ook psychosociale aspecten exploreert, die nog niet lang klachten heeft, met minder dan 6 weken arbeidsverzuim. In dit geval is behandeling door de huisarts met een tweesporenbeleid en psychoeducatie aangewezen, eventueel in combinatie met kortdurende Cognitieve Gedragstherapie (CGT). De prognose is goed.

Matig ernstig
Het matig ernstige profiel is dat waarbij comorbiditeit een rol speelt, hetzij een como- rbide depressie of angststoornis, dan wel een lichamelijke comorbide ziekte, die het beeld compliceert. Het functioneren kan flink belemmerd zijn en ook het ziekteverzuim kan langer zijn, hetgeen risico's met zich meebrengt op het gebied van werkhervatting. Hoewel dit een aanpak vereist waarin hier expliciet aandacht aan wordt geschonken, en waarin de comorbiditeit expliciet herkend, benoemd en behandeld wordt, is de prognose gunstig indien dit gebeurt. Afhankelijk van de mate en aard van de comorbide problematiek kan een medisch specialist, psychiater, of de huisarts, al dan niet ondersteund door een consulent psychiater, de casemanager zijn. Voor de behandeling van de comorbiditeit kan zowel aan medicatie als aan CGT worden gedacht.

Ernstig
Het ernstige profiel betreft patiënten met somatoforme stoornissen van langere duur, die al medische ingrepen hebben ondergaan en verstoorde behandelrelaties hebben (gehad). In dit geval is het somatiseren een gegeven dat geaccepteerd moet worden en staat casemanagement en beperken van de iatrogene schade op de voorgrond. Indien de patiënt daartoe te motiveren is, is CGT zeker aangewezen. De prognose is afhankelijk van de mate waarin een goed behandelcontact op te bouwen is, en van de motivatie om daadwerkelijk CGT te volgen. In ernstige gevallen kan opname in een derdelijns instelling en multidisciplinaire behandeling aangewezen zijn.

Verantwoording

Laatst beoordeeld : 01-01-2010

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Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Somatisatiestoornis eerste lijn

Uitgangsvraag

Wat is de wetenschappelijke evidentie voor eerste lijns behandeling van een somatisatiestoornis?

Aanbeveling

Bij deze module zijn geen aanbevelingen geformuleerd.

Overwegingen

Er is geen duidelijk bewijs dat de gebruikelijke zorg van de huisarts minder effectief is dan meer intensieve behandelingen door de huisarts zelf. Reattributietraining van de huisarts heeft geen aangetoonde meerwaarde voor de patiënt en heeft mogelijk een negatieve effect op de kwaliteit van leven. Het is mogelijk dat een specifieke training van de huisarts in Nederland geen duidelijke meerwaarde heeft omdat de huisartsopleiding onderwijs geeft in strategieën bij SOLK.
Behandelingen die in de eerste lijn wel effectief zijn, maken gebruik van een multidisciplinaire benadering zoals consultatie door een psychiater met daaraan toegevoegd een consultation letter voor de huisarts, bij patiënten met Medically Unexplained Symptoms of patienten die werden omschreven als Distressed High Utilizers (Van der Feltz-Cornelis e.a., 2006; Katon e.a., 1992), of diagnostische screening door een multidisciplinair team met daaraan gekoppeld het verstrekken van een consultation letter aan de huisarts bij de somatisatiestoornis (Rost e.a., 1994; Smit e.a., 1986, Smit e.a., 1995; Dickinson e.a., 2003). Ook uit de review van Kroencke e.a. (2007) kwam naar voren dat er effect is gebleken van de consultatiebrief aan de huisarts. Een consultatiebrief verbetert het fysieke functioneren in vier van vijf RCT's en vermindert de kosten. Effect op de somatische symptomen werd gerapporteerd in 1 RCT. De ernst en frequentie van de lichamelijke klachten is de voor de patiënt meest relevante uitkomstmaat. De onderzoeken naar het gebruik van een consultation letter bij de somatisatiestoornis zijn meer dan 13 jaar geleden uitgevoerd in de Verenigde Staten.
Gezien het feit dat ook in een Nederlandse studie consultatie in combinatie met een consultation letter bij SOLK, maar ook bij de somatisatiestoonis, effectief bleek in vergelijking met Care As Usual, is het mogelijk dat deze werkwijze ook effectief zou zijn in de huidige Nederlandse situatie. Zowel diagnostiek door een multidisciplinair team in de tweedelijnssetting resulterend in een consultation letter voor de huisarts als een psychiatrisch consult in de huisartssetting met een consultation letter kan zinvol zijn. Consultatie kan de huisarts mogelijkheden bieden ter ondersteuning en kan helpen bij het effectueren van andere mogelijk effectieve strategieën, zoals het voorschrijven van medicatie of verwijzing voor psychotherapie bij een psychiatrische stoornis, en het beperken van overmatige somatische diagnostiek en verwijzingen naar een somatisch specialist. Door de laagdrempeligheid van het consult is de kans groter dat de patiënt daartoe te motiveren is dan naar een rechtstreekse verwijzing naar de GGZ.
In de Nederlandse situatie is geen onderzoek verricht naar de inzet van een praktijk- verpleegkundige bij de behandeling van SOLK in de huisartspraktijk in samenwerking met de huisarts. In de Amerikaanse studie bleek hiervoor een intensief trainingsprogramma van 84 uur en een wekelijkse supervisieprogramma nodig.
De review van Henningsen (2007) heeft niet alleen betrekking op somatisch onvoldoende verklaarde lichamelijke klachten en somatoforme stoornissen niet nader gespecificeerd. Het gaat in op het brede scale een ongecompliceerde en gecompliceerde somatoforme klachten en syndromen. Conclusies en

aanbevelingen zijn daarom ook van toepassing op het gehele veld van somatoforme stoornissen en klachten.

Onderbouwing

Conclusies

Niveau 1	Reattributietraining door de huisarts is niet effectief. Er zijn aanwijzingen dat reattributietraining door de huisarts een negatief effect heeft op de kwaliteit van leven. *B Aiarzaguena, 2007 B Blankenstein, 2001 A2 Larisch, 2004 A2 Morriss, 2007 A2 Rosendal, 2007*
Niveau 1	Het is aangetoond dat behandelingen die in de eerste lijn effectief zijn, gebruikmaken van een multidisciplinaire benadering zoals consultatie door een psychiater of vanuit een multidisciplinair team, waarbij een consultation letter wordt verstrekt. Het is aangetoond dat multidisciplinaire behandeling in de huisartspraktijk waarbij de huisarts samenwerkt met andere disciplines zoals een getrainde en gesuperviseerde verpleegkundige of psychotherapeut effectief is. *A2 Katon e.a., 1992 A2 Van der Feltz-Cornelis, 2006 A2 Rasmussen, 2006 A2 Smith, 2006*
Niveau 1	Het is aangetoond dat niet-farmacologische behandeling van SOLK en somatoforme stoornis niet anderszins omschreven die een actieve participatie van patiënten met zich meebrengen, zoals oefening en psychotherapie, effectiever zijn dan behandelingen die passieve fysieke maatregelen betreffen, zoals injecties en operaties. Het is aangetoond dat bij behandeling van SOLK en de somatoforme stoornis niet anderszins omschreven een balans tussen biomedische, orgaan-georiënteerde en cognitieve interpersoonlijke benaderingen het meest geschikt is. *A1 Henningssen, 2007*
Niveau 1	Het is aangetoond dat een ‘consultation letter' aan de huisarts van een patiënt met een somatisatiestoornis tot afname van de medische kosten leidt. *A2 Rost e.a., 1994; Smit e.a., 1986; Smit e.a., 1995*
Niveau 2	Er zijn aanwijzingen dat training van de huisarts in cognitief-gedragsmatige technieken effectief is bij minder ernstige klachten. *A2 Rief, 2006 B Arnold (in druk)*

Samenvatting literatuur

Preventieve interventie gericht op kostenbesparing

‘Consultation letter' brief met aanbevelingen aan de huisarts (Rost e.a., 1994; Smith e.a., 1986, Smith e.a., 1995)

De huisarts krijgt van de psychiater, psychotherapeut of het multidisciplinair team dat de patiënt eenmalig in de tweedelijnssetting aan uitvoerige diagnostiek onderwerpt, een brief over de patiënt bij wie een somatisatiestoornis is vastgesteld. In deze brief staat dat bij de patiënt een somatisatiestoornis is vastgesteld

en dat deze gekenmerkt wordt door een chronisch verloop met terugvallen, maar een lage morbiditeit en mortaliteit kent. Geadviseerd wordt om de patiënt elke 4-6 weken op het spreekuur te zien volgens vaste afspraken. De frequentie wordt zo gekozen dat spontane bezoeken aan de huisarts worden voorkomen. Geadviseerd wordt bij elke gepland bezoek lichamelijk onderzoek te verrichten gericht op het orgaansysteem of de klacht waar de patiënt zich mee presenteert. Tijdens het onderzoek wordt gekeken naar de aanwezigheid van ziektekenmerken. Ziekenhuisopnames, diagnostische onderzoeken, operaties en laboratoriumonderzoeken worden afgeraden tenzij daarvoor een duidelijke indicatie bestaat. Ten slotte wordt afgeraden om de validiteit van de klachten in twijfel te trekken of de patiënt de indruk te geven dat hij/zij zich aanstelt of zichzelf de klachten heeft aangepraat.
Het effect van de ‘consultation letter' op de medische kosten is aanzienlijk en varieert van 33-53% reductie. De reductie is vooral het gevolg van een afname van het aantal opnames en blijft behouden bij follow-up (Smit e.a., 1986). De uitkomsten op de SF-36 (secundaire uitkomstmaat) laten een afname zien in de fysieke beperkingen en een toename van het fysieke functioneren (Smit e.a., 1995; $p = 0,002$; Smit e.a., 1986, ns; Rost e.a., $p < 0,05$).

Preventieve interventie gericht op vermindering van fysieke beperkingen
‘Consultation letter' brief met aanbevelingen aan de huisarts (Dickinson e.a., 2003)
In deze studie werd gekeken naar het effect van een ‘consultation letter' op de fysieke beperkingen volgens de SF-36. Er werd 12 maanden na het versturen van de brief een afname van 5.5 punten gevonden ($p < 0,001$), hetgeen overeenkomt met een klein effect ($d = 0,48$). Er werd geen effect gevonden op de psychische beperkingen als gevolg van de klachten.

Zoeken en selecteren

Somatisatiestoornis wordt in geen van bestaande multidisciplinaire richtlijnen behandeld. Gezocht is naar systematische reviews, meta-analyses en gerandomiseerde en gecontroleerde trials naar de effectiviteit van behandelingen voor somatisatiestoornis volgens de DSM-IV (of III). Er werden geen systematische reviews of meta-analyses gevonden. Wel leverde de zoekactie in PubMed zeven artikelen op die aan de zoekcri- teria voldeden en waarbij de primaire uitkomstmaat de ernst van de klachten en/of de beperkingen als gevolg van de lichamelijke klachten was. Hier worden de studies die geheel of gedeeltelijk in de eerste lijn werden verricht besproken. Er werden vier studies gevonden waarbij niet de ernst van de klachten maar de medische kosten de primaire uitkomstmaat vormden, en een studie waar de ernst van de klachten wel een uitkomst was. In deze studies werd het effect onderzocht van het verstrekken van een ‘consulta- tion letter' aan de huisarts na uitvoerige diagnostiek door een multidisciplinair team als eenmalige consultatie bij patiënten met een somatisatiestoornis volgens de DSM-III of -IV, (Smith e.a., 1995; Smith e.a., 1986; Rost e.a., 1994; Dickinson e.a., 2003).
De zeven geïncludeerde gerandomiseerde trials variëren voor wat betreft de methodologische kwaliteit (zie bijlage III evidencetabellen).

Verantwoording

Laatst beoordeeld : 01-01-2010
Laatst geautoriseerd : 01-01-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Somatisatiestoornis psychologische behandeling

Uitgangsvraag

Wat is de wetenschappelijke evidentie voor psychologische behandeling van een somatisatiestoornis?

Aanbeveling

Cognitieve gedragstherapie dient onderdeel te zijn van het standaard medisch handelen in de tweede lijn bij SOLK en somatoforme stoornissen NAO.

Overwegingen

De cognitieve gedragstherapie is uitgeschreven en gepubliceerd en bestaat uit tien individuele sessies (Woolfolk en Allen, 2006). De behandeling wordt nog niet breed aangeboden binnen de GGZ in Nederland. De werkgroep is dan ook van mening dat meer cognitief gedragstherapeuten getraind moeten worden in de behandeling van mensen met een somatisatiestoornis.

Onderbouwing

Conclusies

Niveau 1	Het is aangetoond dat cognitieve gedragstherapie uitvoerbaar en effectief is in de tweedelijns ambulante behandeling van patiënten met SOLK en somatoforme stoornis niet anderszins omschreven. *A1 Henningssen, 2007; Kroencke, 2007; Sumathipala, 2007* *A2 Speckens, 1995* *B Escobar, 2007* *B Hellman, 1990* *B Sumathipali, 2000*

Niveau 2	Het is aannemelijk dat cognitieve gedragstherapie effectief is als behandeling voor somatisatiestoornis en tot een verdere afname van de kosten leidt boven op die van een 'consultation letter'. *A2 Allen e.a., 2006*

Samenvatting literatuur

Acht studies beschrijven het effect van een psychologische behandeling door een psychotherapeut na verwijzing door de huisarts. Vijf van de 8 studies waren van matige kwaliteit door methodologische problemen zoals kleine omvang, inadequate controlegroep of slechte rapportage van de uitkomstmaten.
In 6 studies betrof het een vorm van cognitieve gedragstherapie, de duur varieerde van 1 sessie van 3-4 uur tot 6 tot 12 sessies van 30 tot 60 minuten. In 1 studie was de methode variabel of eclectisch en afhankelijk van de expertise van de psychotherapeut.
In 1 studie werd disclosure door een getrainde arts onderzocht gedurende 2-3 sessies van 1-2 uur.

Alle studies die cognitieve gedragstherapie onderzochten rapporteerden positieve effecten. De 2 studies met disclosure en behandeling met variabele of eclectische methoden vonden geen positieve effecten. De studie van Speckens (1995) betreft een Nederlandse studie waar patiënten in een somatische setting werden geïncludeerd. Speckens bestudeerde de meerwaarde van cognitieve gedragstherapie (N=39) voor patiënten met medisch onverklaarde lichamelijke klachten in vergelijking met geoptimaliseerde medische zorg (N=40) op een polikliniek interne geneeskunde van een universiteits ziekenhuis. De interventiegroep kreeg tussen de zes en zestien sessies cognitieve gedragstherapie. Bij zes en twaalf maanden follow up bleek de interventiegroep beter hersteld.
De reviews van Sumathipala (2007), Kroencke e.a. (2007) en Henningsen (2007) laten zien dat cognitieve gedragstherapie effectief is bij het behandelen van medisch onverklaarde klachten in de tweede lijn.

Cognitieve gedragstherapie
In de studie van Allen e.a. (2006) werd het effect van CGt onderzocht bij patiënten van wie de huisarts eerder een ‘consultation letter' ontving. De behandeling werd gegeven door cognitief gedragstherapeuten en vond plaats op een polikliniek psychiatrie. De
individuele cognitief gedragstherapeutische behandeling volgens het behandeldraaiboek van Woolfolk & Allen (2006) bestaat uit de volgende onderdelen: ontspanningsoefeningen gericht op het verminderen van de spierspanning, activiteiten verdelen over de dag en op tijd stoppen (‘activity pacing'), het opbouwen van de lichamelijke conditie en het uitbreiden van plezierige en betekenisvolle bezigheden, bewuster worden van emoties, veranderen van disfunctionele cognities, verbeteren van de communicatie over gedachten en gevoelens en het verminderen van de bekrachtiging van het ziektegedrag door de partner.
Als primaire uitkomstmaat werd gebruikgemaakt van de CGI voor somatisatie stoornis. Daarnaast werd een klachtendagboek bijgehouden en de SF-36 (fysiek functioneren) afgenomen. In vergelijking tot de wachtlijstcontrole werden 3 maanden na het begin van de behandeling significant (p=0,001) meer (40% vs 5%) patiënten die CGt kregen, op basis van de CGI beoordeeld als ‘veel' of ‘heel veel' verbeterd. De lichamelijke klachten (dagboek) namen significant af (p<0,001), het fysiek functioneren verbeterde significant (p=0,02) en de medische kosten namen meer af dan in de controle groep (p<0,1). De resultaten bleven behouden bij follow-up na 9 en 15 maanden.

Zoeken en selecteren

De effectiviteit van cognitieve gedragstherapie (Allen e.a., 2006) en van groepstherapie (Kashner e.a. 1995) is steeds slechts in één studie onderzocht. De studie van Kashner e.a. (1995) naar het effect van groepstherapie wordt gekenmerkt door een hoog aantal weigeraars (55%) en uitval. Slechts 11 van de 44 patiënten namen deel aan ten minste 5 van de 8 groepsbijeenkomsten. De uitkomsten van deze studie zijn niet meegenomen in deze richtlijn.

Verantwoording

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Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Somatisatiestoornis farmacologische behandeling

Uitgangsvraag

Wat is de wetenschappelijke evidentie voor farmacologische behandeling van een somatiesatiestoornis?

Aanbeveling

Bij deze uitgangsvraag zijn geen aanbevelingen geformuleerd.

Overwegingen

Het effect van sint-janskruid is aanzienlijk (81% ‘veel' of ‘heel veel' verbeterd), maar er is ook sprake van een groot (50%) placebo-effect. Daar staat tegenover dat de medicatie weinig bijwerkingen geeft en tot weinig uitval leidt. Sint-janskruid wordt in Nederland niet regulier voorgeschreven en staat niet vermeldt in het Farmacotherapeu- tisch Kompas. We adviseren het preparaat niet voor te schrijven zo lang de vermelde dosis en de samenstelling van het preparaat niet is gegarandeerd. Daarnaast is weinig bekend over de langetermijneffecten.

Onderbouwing

Conclusies

Niveau 1	Het is aangetoond dat farmacologische middelen met een werking op het centraal zenuwstelsel bij behandeling van SOLK en somatoforme stoornis niet anderszins omschreven meer consistent effectief lijken dan geneesmiddelen die zich richten op herstel van de perifere fysiologisch disfunctie. *A1 Henningssen e.a., 2007*

Niveau 1	Het is aangetoond dat sint-janskruid LI 160 (600 mg/d) effectief is als behandeling voor de somatisatiestoornis. A2 Muller e.a., 2004; Volz e.a., 2002

Samenvatting literatuur

Farmacologische middelen met een werking op het centraal zenuwstelsel lijken meer consistent effectief dan geneesmiddelen die zich richten op herstel van de perifere fysiologisch disfunctie (Henningsen e.a., 2007). Het effect van farmacologische behandelingen die zich primair richten op perifere fysiologische verstoringen verband houdend met de verschillende SOLK's en somatoforme stoornissen niet anders omschreven lijken variabel over de verschillende klachten en stoornissen waarbij het meeste effect wordt gezien bij functioneel gastrointestinale syndromen, en een klein effect bij vele andere functionele somatische syndromen. Het middelmatig tot goede effect van een antidepressieve behandeling lijkt echter wel gelijkelijk verdeeld over de verschillende functionele somatische syndromen.

Sint-janskruid
Sint-janskruid LI 160 (600 mg/d) is effectief gebleken in twee gerandomiseerde gecontroleerde trials bij patiënten met een somatisatiestoornis of een ongedifferentieerde somatoforme stoornis. De duur van de studie was 6 weken. Het effect trad op na 28 dagen. Onbekend is wat er gebeurd na het staken van de medicatie. Als uitkomstmaat werd in beide studies gebruikgemaakt van de Hamilton Anxiety Scale (somatische angst, psychische angst en totaal score), de SCL-90-R (somatische klachten en totaal score) en de Clinical Global Improvement-schaal.
In beide studies wordt een reductie vastgesteld van meer dan 50% op de HAM- schalen (HAM-SOM p=0,001) en de SCL-90 (SCL-90-R SOM p=0,0001) en een significante reductie op de CGI.
In vergelijking tot de wachtlijstcontrole werden na afloop van de behandeling significant meer patiënten die sint-janskruid kregen, beoordeeld als ‘veel' of ‘heel veel' verbeterd (Muller e.a., 2004; 45% vs 21% (p=0,0006); Volz e.a., 2002; 81% vs 50%
(p=0,0001)).
De gecombineerde Cohens' size (Muller e.a., 2004) voor de HAM, SCL-90 en CGI, is 0,68 hetgeen overeenkomt met een middelgroot effect. De behandeling is effectief en veilig gebleken. Er worden weinig bijwerkingen gerapporteerd. De effectiviteit is onafhankelijk van de aanwezigheid van een depressieve stemming (Volz e.a., 2002).

Zoeken en selecteren

De effectiviteit van cognitieve gedragstherapie (Allen e.a., 2006) en van groepstherapie (Kashner e.a. 1995) is steeds slechts in één studie onderzocht. De studie van Kashner e.a. (1995) naar het effect van groepstherapie wordt gekenmerkt door een hoog aantal weigeraars (55%) en uitval. Slechts 11 van de 44 patiënten namen deel aan ten minste 5 van de 8 groepsbijeenkomsten. De uitkomsten van deze studie zijn niet meegenomen in deze richtlijn.

Verantwoording

Laatst beoordeeld : 01-01-2010
Laatst geautoriseerd : 01-01-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Conversiestoornis

Uitgangsvraag

Wat is de wetenschappelijke evidentie voor behandeling van een conversiestoornis?

Aanbeveling

Een ambulante interventie met hypnotherapie voor patiënten met motorische conversieklachten is aan te bevelen.

Overwegingen

Mensen met een conversiestoornis zijn er vaak van overtuigd dat er een duidelijke biologische basis voor hun invaliditeit is en daarom verwachten zij een biologische interventie. Het wordt in brede kring door clinici onderkend dat een voor de patiënt acceptabele rationale essentieel is willen psychosociale interventies acceptabel zijn voor mensen met een conversiestoornis. De ambulante interventie met hypnotherapie bij patiënten met een motorische conversie is een interventie met geringe veiligheidsrisico's die een relatief geringe tijdsinvestering van patiënten en therapeuten (dus geringe kosten) vraagt.
Belangrijk is dat er voldoende BIG geregistreerde psychotherapeuten, klinisch psychologen of psychiaters zijn met een officiële hypnotherapie-opleiding (NvvH).

Onderbouwing

Achtergrond

De conversie stoornis behelst een verandering in of verlies van fysiek functioneren, dat een lichamelijk ziekte suggereert, maar waar na adequaat onderzoek, geen lichamelijk oorzaak voor gevonden wordt. Het gaat om niet opzettelijke uitval van een of meer sensorische of motorische functies. Veelvoorkomend zijn spierzwakte, spierspasmen, moeite met praten, ongevoeligheid voor pijn, doofheid, visuele verstoringen, toevallen en convulsies. Deze verschijnselen doen denken aan een neurologische aandoening, maar missen daarvoor de medische verklaring. Psychische factoren (stress en/of conflict) worden geacht een etiologische betekenis te hebben in interactie met culturele opvattingen, opvattingen over ziekte en aangeleerde tekorten in aanpassingsgedrag (Silver, 1996). De incidentie wordt geschat op 5 tot 10 per 100.000 en de prevalentie op 40 per 100.000. 60 tot 80% van de patiënten is vrouw en de gemiddelde leeftijd is 39 jaar (Krem, 2004). De meeste conversiebeelden zijn van het motorische type. Prognostisch heeft men volgens de weinige studies die er zijn, een goede kans op snel herstel, maar er is een grote kans op terugval. Wanneer het conversieve beeld een acuut begin kent en snel wordt behandeld, is de kans op hestel groter.

Conclusies

Niveau 2	Er zijn aanwijzingen dat hypnotherapie conversieve klachten van het motorisch type kan verminderen. *A2 Moene, 2003*

Samenvatting literatuur

De drie geïncludeerde RCT's (Ataoglu, 2003; Moene, 2002 en Moene, 2003) in de systematische review van Ruddy & House (2005) zijn over het algemeen van matige methodologische kwaliteit, onder meer omdat de controlecondities volgens Ruddy & House onvoldoende vergelijkbaar zijn met de behandelcondities. In de controlecondities werd behandeling geboden of het was een wachtlijstgroep, hetgeen zij methodologisch als een zwak punt beschouwden. Ruddy & House meenden ook dat de studies te veel verschilden qua interventie en dat daardoor de resultaten niet gecombineerd konden worden. Zij concludeerden dan ook dat vanwege de slechte methodologische kwaliteit en de onderlinge verschillen van de studies geen uitspraken gedaan kunnen worden over het nut (en de schade) van psychosociale interventies bij de behandeling van de conversiestoornis.
Indien echter een wachtlijstgroep wel als voldoende relevante controlegroep wordt beschouwd met betrekking tot de vraag of de behandeling effectief is (afgezien van de
vraag wat er effectief was), kan de studie van Moene (2003) wel tot een op zichzelf staande conclusie leiden. Moene (2003) vergeleek het effect van hypnotherapie met geen behandeling (wachtlijstgroep) bij poliklinische patiënten met een conversie van het motorische type (N=44). Deze patiënten kregen gedurende de studie geen andere therapieën en de medicatie werd constant gehouden. De interventie bestond uit tien wekelijkse sessies van één uur waarin met hypnotische technieken gewerkt werd aan klachtreductie en aan het oplossen van het onderliggende conflict. De hypnosegroep vertoonde een hoog significante verbetering wat betreft de fysieke symptomen vergeleken met de wachtlijstgroep.
Ruddy & House zijn van mening dat de studies van Moene (2002, 2003) suggereren dat psychosociale interventies in het algemeen acceptabel zijn voor mensen met een conver- siestoornis omdat de uitval laag blijkt. Dit is van belang omdat mensen met een conversie- stoornis er vaak van overtuigd zijn dat er een duidelijke biologische basis voor hun invaliditeit is en zij daarom een biologische interventie verwachten (Ruddy & House, 2005).
Daarnaast stellen zij dat meer gecontroleerd onderzoek naar de effectiviteit van psychosociale interventies bij conversies gedaan moet worden.

Zoeken en selecteren

Een search in PubMed leverde een systematische Cochrane review (Ruddy & House, 2005) op waarin twee artikelen van Moene (2002, 2003) en de studie van Ataoglu (2003) waren geïncludeerd. Andere studies werden in de search niet aangetroffen. In de systematische review werden 260 artikelen op het gebied van psychosociale interventies bij de conversie stoornis beoordeeld. Puur biologische interventies werden niet meegenomen. Alleen de gerandomiseerde gecontroleerde trials die voldeden aan de richtlijnen van de Cochrane Foundation werden geselecteerd. Omdat in de PubMed search ook geen puur biologische interventies werden gevonden kunnen alleen conclusies worden getrokken over psychologische interventies.

Verantwoording

Laatst beoordeeld : 01-01-2010
Laatst geautoriseerd : 01-01-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Hypochondrie psychologische behandeling

Uitgangsvraag

Wat is de wetenschappelijke evidentie voor psychologische behandeling van hypochondrie?

Aanbeveling

De werkgroep beveelt aan om bij patiënten met hypochondrie te beginnen met psycho-educatie en als hier onvoldoende effect mee wordt gerealiseerd, over te gaan op cognitieve gedragstherapie. Wanneer cognitieve gedragstherapie onvoldoende effect heeft, dan kan de behandeling worden uitgebreid met een module stressmanagement of behandeling met een SSRI worden gestart.

De werkgroep beveelt aan patiënten die behandeld worden met een SSRI zeker in het begin frequent (eenmaal per week) op het spreekuur te zien en grondig voor te lichten over de bijwerkingen.

Overwegingen

De werkgroep is van mening dat meer cognitief gedragstherapeuten getraind moeten worden in de behandeling van mensen met een hypochondrie.
Psycho-educatie en cognitieve gedragstherapie zijn beide effectief gebleken. Het aantal drop-outs bij psycho-educatie (8%) is laag in vergelijking tot cognitieve gedragstherapie (25-28%).

Er zijn voldoende aanwijzingen uit de klinische praktijk en case series om te veronderstellen dat naast paroxetine ook andere SSRI's effectief zijn (Fallon, 2004). Er zijn geen gerandomiseerde en gecontroleerde studies gedaan naar het effect van SSRI's of antipsychotica bij hypochondrie met weinig inzicht (waanachtige vorm). Patiënten met hypochondrie verdragen slecht de bijwerkingen van medicatie, omdat ook deze lichamelijke verschijnselen aanleiding geven tot misinterpretatie en angst.
Daarom wordt aanbevolen patiënten die behandeld worden met een SSRI zeker in het begin frequent (eenmaal per week) op het spreekuur te zien en grondig voor te lichten over de bijwerkingen. Ondanks dat patiënten met hypochondrie de bijwerkingen slecht verdragen, is er nauwelijks meer uitval (30%) dan in de CGt-conditie (25%).
Op de langere termijn doen patiënten die behandeld zijn met cognitieve gedragstherapie minder een beroep op de GGZ dan patiënten die behandeld zijn met paroxetine (Greeven e.a., 2007). Bij de behandeling van hypochondrie gaat daarom de voorkeur uit naar behandeling met cognitieve gedragstherapie. Echter, wanneer er sprake is van een ernstige comorbide depressieve stoornis, dan gaat de voorkeur uit naar behandeling met paroxetine, omdat de depressie dan gelijk meebehandeld wordt. Zie multidisciplinaire richtlijn depressie (Landelijke Stuurgroep Multidisciplinaire Richtlijn ontwikkeling, 2005).

Onderbouwing

Achtergrond

Hypochondrie wordt omschreven als de preoccupatie met de vrees of opvatting een ernstige ziekte te hebben, gebaseerd op een verkeerde interpretatie van lichamelijke verschijnselen. Deze preoccupatie houdt aan ondanks adequaat medisch onderzoek en geruststelling. Wanneer betrokkene voor het grootste deel van

de tijd in de huidige episode niet beseft dat de bezorgdheid over het hebben van een ernstige ziekte overdreven of onredelijk is, dan wordt gesproken van hypochondrie met gering inzicht. Hier wordt de hypochondrie behandeld zoals in bijlage I van de DSM-IV-TR wordt omschreven.

Conclusies

Niveau 1	Cognitieve gedragstherapie is effectief gebleken als behandeling voor hypochondrie. *A1 Thompson & Paige, 2007*
Niveau 1	Psycho-educatie is effectief gebleken als behandeling voor hypochondrie. *A2 Fava, 2000; Buwalda, 2006*
Niveau 2	Het is aannemelijk dat bibliotherapie effectief is als behandeling voor hypochondrie. *A2 Buwalda, 2007*
Niveau 2	Het is aannemelijk dat stressmanagement effectief is als behandeling voor hypochondrie. *A2 Clark, 1988*
Niveau 2	Het is aannemelijk dat cognitieve gedragstherapie en exposure met responspreventie even effectief zijn. *A2 Bouman & Visser, 1998; Visser & Bouman, 2001*
Niveau 2	Het is aannemelijk dat op de korte termijn cognitieve gedragstherapie effectiever is dan stressmanagement, maar dat op de langere termijn (12 mnd.) er geen verschil is in effectiviteit. *A2 Clark e.a., 1998*

Niveau 2	Het is aannemelijk dat paroxetine effectief is als behandeling voor hypochondrie. *A2 Greeven e.a., 2007*

Niveau 2	Het is aannemelijk dat paroxetine op de korte termijn even effectief is als cognitieve gedragstherapie als behandeling voor hypochondrie *A2 Greeven e.a., 2007*

Samenvatting literatuur

De zeven geïncludeerde RCT's en de systematische review variëren voor wat betreft de methodologische kwaliteit (zie evidencetabellen). De weergave van een van de studies (Fallon e.a., 1996) was van dien aard dat de kwaliteit van de studie niet was te beoordelen. Omdat het hier een verslag betrof van de resultaten van de eerste fase van een studie en de uiteindelijke resultaten nooit zijn gepubliceerd, zijn de conclusies hiervan niet meegenomen.

In de Cochrane Review van Thomson & Page (2007) wordt verslag gedaan van de gerandomiseerde en gecontroleerde studies bij volwassenen met hypochondrie waarin het effect van psychologische behandelingen op de ernst van de ziekteangst wordt onderzocht. Wanneer er geen formele diagnose hypochondrie was gesteld of niet alle patiënten voldeden aan de criteria, werden de studies uitgesloten.

Psychologische behandelingen
De gemiddelde effectsize van de psychologische behandeling is groot (d=-0,86) (Thomson & Page, 2007). De meeste studies maken gebruik van de Illness Atttitude Scale en/of Whitely Index als uitkomstmaat voor de ernst van de hypochondere klachten.

Bibliotherapie (Buwalda & Bouman, 2007)
Van de psychologische behandelingen is bibliotherapie het minst intensief. De patiënt werkt thuis aan opdrachten zonder dat er direct contact is met een hulpverlener. Deze minimale interventie heeft een groot effect (d=0,86). Alhoewel als gevolg van de interventie veel (73%) patiënten klinisch significant verbeteren, herstelt ook de helft van de patiënten zonder enige interventie. Onduidelijk is wat hier van de oorzaak is. De duur van de follow-up bedroeg drie maanden. Langetermijneffecten zijn niet bekend.

Psycho-educatie (Buwalda e.a., 2007; Fava e.a., 2000)
Bij psycho-educatie (individueel of groepsgewijs) krijgt de patiënt informatie over hypochondrie en de rol van cognities en gedrag, zonder dat er gebruik wordt gemaakt van specifieke cognitieve en gedragstherapeutische technieken. Buwalda e.a. (2006) vinden een groot effect (d=1,21, na 6 mnd fu).
Ook ‘explanatory therapy' kan beschouwd worden als een vorm van psycho- educatie. Fava e.a. (2000) vinden een significante reductie van de IAS-score (p<0,05) en een afname van het artsbezoek (p<0,01).

Cognitieve gedragstherapie (Barsky & Ahern, 2004; Bouman & Visser, 1998; Clark e.a., 1998; Greeven, 2007; Thomson & Page, 2007; Visser & Bouman, 2001; Warwick e.a., 1996)
Bij de cognitief gedragstherapeutische behandeling van hypochondrie worden de volgende interventies gebruikt: uitleggen wat het doel is van de behandeling, onderzoeken (bespreken van argumenten voor en tegen de overtuiging een ernstige ziekte te hebben) en toetsen (gedragsexperimenten) van catastrofale cognities en exposure met responspreventie.
Het doel van de cognitief gedragstherapeutische behandeling is het verminderen van de angst als gevolg van de lichamelijke klachten/verschijnselen en niet het verminderen van de klachten/verschijnselen. Er is sprake van een middelgroot effect in vergelijking tot placebo voor de completers (d=0,53) en een klein effect voor de ‘intention to treat'- populatie (0,40) (Greeven, 2007).

Stressmanagement (Clark e.a., 1998)
Bij stressmanagement voor hypochondrie wordt gebruikgemaakt van: relaxatietraining, probleemoplossen, assertiviteitstraining en tijdmanagement. Stressmanage- ment geeft een significante (p<0,01) afname van klachten bij follow-up na twaalf maanden.

Vergelijking tussen psychologische behandelingen
Cognitieve therapie en exposure met responspreventie zijn even effectief (F=0,44; p<0,77) en beide effectiever dan geen behandeling (F=4,23; p<0,001) (Bouman & Visser, 1998; Visser & Bouman, 2001).

Cognitieve gedragstherapie en stressmanagement zijn beide een jaar na de behandeling even effectief. Na een jaar is er op negen van de tien maten geen significant verschil meer tussen cognitieve gedragstherapie en stressmanagement. Met cognitieve gedragstherapie worden echter sneller (nog tijdens de behandeling) resultaten behaald (Clark e.a., 1998).

Farmacologische behandeling
Paroxetine (Greeven e.a., 2007)
Met betrekking tot paroxetine (20-60 mg p/d) is er sprake van een middelgroot effect in vergelijking tot placebo voor de completers (d=0,58) en een klein effect voor de 'intention to treat'-populatie (d=0,44).

Fluoxetine (Fallon et al., 1996)
Fallon verwijst in verschillende publicaties naar de resultaten van de eerste fase van een gerandomiseerde en gecontroleerde studie naar het effect van fluoxetine. Alhoewel de resultaten suggereren dat fluoxetine mogelijk effectief zou kunnen zijn, waren de gevonden verschillen niet statistisch significant. Omdat de uiteindelijke studie nooit is gepubliceerd en de resultaten van de eerste fase slechts globaal zijn beschreven in een artikel over farmacotherapie bij hypochondrie, hebben we besloten deze resultaten niet op te nemen in de richtlijn.

Vergelijking tussen psychologische en farmacologische behandelingen
Cognitieve gedragstherapie (CGt) en paroxetine zijn beide effectiever dan placebo. Het effect van CGt en paroxetine in vergelijking tot placebo is gelijk. Er is sprake van een middelgroot effect in vergelijking tot geen behandeling. De beide behandelingen zijn op de korte termijn even effectief (d= 0,09).
Van de patiënten die medicatie kregen voorgeschreven viel 30% uit, maar dat is nauwelijks meer dan in de groep die CGt kreeg (25% Greeven, e.a. 2007; 28% Visser & Bouman, 2001).

Zoeken en selecteren

Hypochondrie is opgenomen in de multidisciplinaire richtlijn angststoornissen (Landelijke Stuurgroep Multidisciplinaire Richtlijnontwikkeling, 2009). In deze richtlijn zijn ook de resultaten gegeven van open medicatie trials en case series. De resultaten van deze studies zijn in de huidige/onderhavige aanbeveling buiten beschouwing gelaten. Sinds het verschijnen van de richtlijn is er nog een aantal studies en een Cochrane Review gepubliceerd. Met de resultaten van deze studies is rekening gehouden bij het opstellen van de aanbeveling.
Gezocht is naar systematic reviews, meta-analyses en gerandomiseerde en gecontroleerde trials naar de effectiviteit van behandelingen voor hypochondrie. Een zoekactie in PubMed leverde acht artikelen op die aan deze criteria voldeden; een systematische Cochrane review, een proefschrift (Bruwalda) en zes artikelen gepubliceerd in peer reviewed tijdschriften. In de systematische review worden zes artikelen op het gebied van psychosociale interventies bij hypochondrie beoordeeld.
De systematische review is als uitgangspunt gekozen. Omdat hierin echter alleen de vergelijking met wachtlijst of controleconditie werd besproken en niet de vergelijking tussen behandelingen onderling, is ervoor gekozen de individuele studies te beschrijven. Alleen de gerandomiseerde gecontroleerde trials die voldoende valide en toepasbaar waren, werden geselecteerd.

De zeven geïncludeerde RCT's en de systematische review variëren voor wat betreft de methodologische

kwaliteit (zie evidencetabellen). De weergave van een van de studies (Fallon e.a., 1996) was van dien aard dat de kwaliteit van de studie niet was te beoordelen. Omdat het hier een verslag betrof van de resultaten van de eerste fase van een studie en de uiteindelijke resultaten nooit zijn gepubliceerd, zijn de conclusies hiervan niet meegenomen.
In de Cochrane Review van Thomson & Page (2007) wordt verslag gedaan van de gerandomiseerde en gecontroleerde studies bij volwassenen met hypochondrie waarin het effect van psychologische behandelingen op de ernst van de ziekteangst wordt onderzocht. Wanneer er geen formele diagnose hypochondrie was gesteld of niet alle patiënten voldeden aan de criteria, werden de studies uitgesloten.

Verantwoording

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Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Body Dysmorphic Disorder (BDD)

Uitgangsvraag

Wat is de wetenschappelijke evidentie voor psychologische en farmacologische behandeling van Body Dysmorphic Disorder (BDD)?

Aanbeveling

De werkgroep beveelt aan om patiënten met BDD te behandelen met een SSRI of met cognitieve gedragstherapie. De voorkeur gaat uit naar een SSRI wanneer er sprake is van een comorbide depressie. Bij onvoldoende effect van de ene behandeling op de klachten, kan de andere behandeling worden toegevoegd.

Aanbevolen wordt om patiënten met een waanachtige vorm van BDD te behandelen met een SSRI zonder toevoeging van een antipsychoticum.

Overwegingen

Er zijn geen gerandomiseerde en gecontroleerde studies gedaan waarin het effect van SSRI's en cognitieve gedragstherapie is vergeleken. In de meta-analyse van Williams e.a. (2006) waarin ook case series zijn meegenomen, wordt een gemiddelde effectsize van 0,92 gevonden (groot effect) voor farmacotherapie en van 1,63 (zeer groot effect) voor psychologische interventies. In 9 van de 10 studies waarin een psychologische interventie werd onderzocht, is niet gecontroleerd voor medicatiegebruik. In 5 studies ontbrak informatie over de medicatie en in 4 studies gebruikten (een deel van) de patiënten medicatie. Slechts bij een (deel)studie van N=10 was zeker dat de patiënten geen medicatie gebruikten. Het lijkt dus zeer waarschijnlijk dat een deel van het effect zoals gevonden bij de psychologische behandelingen kan worden verklaard door het effect van de medicatie.
De medicatie lijkt goed te worden verdragen. Er vielen iets meer patiënten uit die een placebo kregen (15%) dan die fluoxetine kregen (9%) (Phillips e.a., 2002). Onbekend is hoeveel patiënten terugvallen na het staken van de medicatie.
Wanneer er sprake is van een comorbide depressie dan is het wenselijk dat wordt gestart met een SSRI, aangezien hiermee zowel de depressie als de BDD kan worden behandeld. Voor informatie over de effectiviteit van SSRI's bij de behandeling van depressieve stoornissen, zie richtlijn Depressie (Landerlijke Stuurgroep Mulidisciplinaire Richtlijnontwikkeling, 2005).
De werkgroep is van mening dat meer cognitief gedragstherapeuten getraind moeten worden in de behandeling van mensen met een body dysmorphic disorder.
Er is weining bekend over het langetermijneffect van SSRI's en cognitieve gedragstherapie en het effect van het staken van de medicatie op de klachten bij patiënten die wel of niet ook een cognitiefgedragstherapeutische behandeling hebben gehad.

Onderbouwing

Achtergrond

BDD wordt omschreven als de preoccupatie met een vermeende, onvolkomenheid van het uiterlijk. Indien er

een geringe lichamelijke afwijking aanwezig is, dan is de ongerustheid van betrokkene duidelijk overdreven.
De preoccupatie veroorzaakt in significante mate lijden of beperkingen in het sociaal of beroepsmatig functioneren of het functioneren op andere belangrijke terreinen.
De preoccupatie is niet eerder toe te schrijven aan een andere psychische stoornis (bijvoorbeeld ontevredenheid over de lichaamsvorm of omvang bij anorexia nervosa).
Wanneer betrokkene voor het grootste deel van de tijd in de huidige episode niet beseft dat de ongerustheid over het aspect van het uiterlijk overdreven of onredelijk is, dan wordt gesproken van BDD met gering inzicht (waanachtige type). Hier wordt de BDD behandeld zoals omschreven in de DSM-IV-TR-termen in de bijlage.

Conclusies

Niveau 1	SSRI's zijn effectief gebleken als behandeling voor BDD. *A1 Williams e.a., 2006; Phillips e.a., 2002*
Niveau 1	Cognitieve gedragstherapie is effectief gebleken als behandeling voor BDD. *A1 Williams e.a., 2006; Rosen e.a., 1995; Veale e.a., 1996*
Niveau 2	Het is aannemelijk dat bij een waanachtige vorm van BDD toevoeging van een antipsychoticum geen beter resultaat geeft dan een SSRI alleen. *A2 Phillips, 2005*

Samenvatting literatuur

De drie geïncludeerde RCT's en de meta-analyse zijn alle van voldoende kwaliteit.
Rosen e.a. (1995) gebruikten de BDDE en Veale e.a. (1996) de BDD-YBOCS als uitkomstmaat. De case series gebruikten op twee na de BDD-YBOCS als uitkomstmaat.

Psychologische behandeling

Cognitieve gedragstherapie (Rosen e.a., 1995; Veale e.a., 1996)
De cognitief gedragstherapeutische behandeling heeft een zeer groot (d=2,18; Rosen e.a., 1995) tot groot effect (d=1,18; Veale e.a., 1996) in vergelijking met geen behandeling en een wachtlijst controleconditie. CGt bestaat uit het uitdagen van cognities over de implicaties van de vermeende lelijkheid en het doen van gedragsexperimenten om de voorspellingen te toetsen (Veale e.a., 1996). Met alleen exposure en responspreventie worden echter ook goede resultaten behaald (Rosen e.a., 1995). Omdat niet bekend is of de patiënten ten tijde van het onderzoek medicatie gebruikten, valt niet uit te sluiten dat het hier gaat om het gecombineerde effect van SSRI en CGt. De gemiddelde effect- size (d) van de zeven case series waarbij (C)Gt werd toegepast en die de BDD-YBOCS als uitkomstmaat hanteerden, is groot en bedraagt 1,40. In een deel van deze studies gebruikten de patiënten medicatie, van andere studies is het gebruik niet bekend.

Farmacologische behandeling

Fluoxetine (Phillips e.a., 2002; Williams e.a., 2006)
Fluvoxamine (40-80-mg/d) is effectief gebleken bij de behandeling van BDD (Phillips e.a., 2002). De

behandeling met fluoxetine is effectief (d=0,98). Er zijn daarnaast echter ook voldoende aanwijzingen om te veronderstellen dat ook andere SSRI's (clomipramine, fluvoxamine en citalopram) effectief zijn (Williams e.a., 2006). De gemiddelde effectsize (d) van de vier case series bedraagt 1,20, hetgeen overeenkomt met een groot effect.

Pimozide (Phillips, 2005)
Het betreft hier pimozide (2-10 mg/d) toegevoegd aan fluoxetine (40-80-mg/d). Pati- enten met een waanachtige vorm van BDD reageren even goed op SSRI's als patiënten zonder waanachtige vorm. Het toevoegen van een anti-psychoticum aan een SSRI leidt niet tot een beter resultaat (Phillips, 2005). De effectsize (d) bedraagt 0,23.

Zoeken en selecteren

BDD wordt in geen van bestaande multidisciplinaire richtlijnen behandeld. In PubMed is gezocht naar systematische reviews, meta-analyses en gerandomiseerde en gecontroleerde trials naar de effectiviteit van behandelingen voor BDD volgens de DSM-IV (of -III).
PubMed leverde vier artikelen op die aan deze criteria voldeden: een meta-analyse en drie gerandomiseerde en gecontroleerde studies. De meta-analyse is als uitgangspunt gekozen, maar omdat in de meta-analyse ook de resultaten van case series worden beschreven, zijn ook de resultaten van de individuele gerandomiseerde en gecontroleerde studies beschreven. Alleen de gerandomiseerde gecontroleerde trials die voldoende valide en toepasbaar waren, werden geselecteerd.

Verantwoording

Laatst beoordeeld : 01-01-2010
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Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Ernstige somatoforme stoornissen

Uitgangsvraag

Wat is de wetenschappelijke evidentie voor behandeling van ernstige somatoforme stoornissen?

Aanbeveling

Bij een hoog risico patiëntprofiel kunnen de volgende stappen worden overwogen:

- Verwijs naar tweedelijns ambulante multidisciplinaire behandeling of revalidatie met bijvoorbeeld aandacht voor symptoombehandeling, activerende fysiotherapie en psychotherapie.
- Denk hierbij aan gespecialiseerde tweedelijnsinstellingen, zoals een gespecialiseerd centrum (bijvoorbeeld reguliere centra voor psychosomatiek, conversie, onverklaarde pijn, etc.) of een academisch ziekenhuis.
- Wanneer deze behandeling niet afdoende blijkt, moet verwezen worden naar een gespecialiseerde derdelijnsinstelling.

Bij het middelmatig en hoog risico patiëntprofiel kan een consultaanvraag bij een gespecialiseerde hulpverlener op het gebied van SOLK en somatoforme stoornissen zoals een deskundige psychiater, psychotherapeut of revalidatiearts worden overwogen, indien de te zetten stappen moeilijk uitvoerbaar blijken.

De werkgroep beveelt voor de groep chronische patiënten die geen baat blijken te hebben bij intensieve klinische of deeltijd multidisciplinaire behandeling, geoormerkte voorzieningen aan, zoals ambulante begeleidingsgroepen voor chronische patiënten, die zich vooral richten op de verbeteren en stabiliseren van de kwaliteit van leven.

Overwegingen

Bij klinische niet-somatische multidiscipliniare behandeling speelt ook het dagelijkse leefklimaat een belangrijke rol in het creëren van mogelijkheden tot verandering. Het bewerken van dit therapeutische milieu is vooral het werkterrein van sociotherapeuten en verpleegkundigen.
Op grond van het bovenstaande en de klinische ervaring van de werkgroepleden is men op grond van consensus tot de volgende aanbevelingen gekomen.

Onderbouwing

Achtergrond

Deze module gaat over de klinische behandeling van ernstige somatoforme stoornissen in de derde lijn.

Conclusies

Niveau 1	Het is aangetoond dat in het algemeen klinische (en deeltijd) behandeling bij ernstige SOLK en somatoforme stoornissen effectief is. *A1 Steffanowski e.a., 2007; Wiegand e.a., 2008*

Samenvatting literatuur

Er is vrij weinig onderzoek gedaan naar de effectiviteit van niet-somatische klinische behandeling. Er zijn wel enkele RCT's bekend (zie bijvoorbeeld Alaranta e.a., 1994; Harkapaa, 1989; Moene, e.a., 1998; Nezu, Nezu & Lombardo 2001; Ataoglu e.a., 2003; Nickel e.a., 2006), maar de behandelde stoornissen en behandelmodaliteiten zijn daarin te verschillend om tot algemene conclusies met hoge bewijskracht te komen.

Met name in Duitsland is onderzoek gedaan naar de aldaar dikwijls toegepaste klinische psychosomatische revalidatie (rehabilitation) behandeling met landelijk ongeveer 16.000 bedden. Deze behandelingen zijn vaak multimodaal en altijd multidisciplinair met een combinatie van medische/lichaamsgerichte en psychologische therapieën. Men behandelt meestal een scala aan psychische stoornissen, zoals depressie, angststoornissen, aanpas- singsstoornissen en somatoforme stoornissen (11%) (Schauenburg, e.a., 2007). Dit betekent, dat er circa 1800 bedden zijn voor patiënten met somatoforme stoornissen. Uit recente meta-analyses hiervan (Steffanowski e.a., 2007; Wiegand e.a., 2008) blijkt dat de studies meestal niet gerandomiseerde gecontroleerde trials zijn, maar effectonderzoek (met bijvoorbeeld alleen een pré- en een posttherapiemeting) via cohortstudie, waarbij men soms gebruikmaakt van controlegroepen. Effecten van deze behandeling worden duidelijk gerapporteerd met gemiddelde tot grote en effectsterkten en voldoende hoge significantie. Hierbij wordt ook specifiek naar de diagnosegroep somatoforme stoornissen gekeken. Met name de kosten-batenanalyses laten zien dat effect ook na behandeling positief doorwerkt op werkinzetbaarheid, artsenbezoeken, ziekenhuisopnames en medicatieconsumptie (Koch e.a., 2008). Wat het relatieve belang of de effectiviteit van de verschillende therapiecom- ponenten is, is echter vaak niet duidelijk, omdat het om multimodale methodieken gaat met bijvoorbeeld als ingrediënten CGT, psychodynamische en systeemtherapieën.
Er werd slechts één RCT gevonden naar effecten van klinische behandeling van SOLK en somatoforme stoornis niet anderszins omschreven (Bleichhardt, 2004). Deze studie vergeleek twee klinische behandelcondities met elkaar waardoor geen conclusies kunnen worden getrokken over de effecten van klinische behandeling op zich. In Nederland is effectonderzoek gedaan (geen RCT) naar de multidisciplinaire behandeling van ernstige somatoforme stoornissen en SOLK bij een gespecialiseerd centrum voor behandeling van psychosomatiek (Veselka e.a., 2005). Dit onderzoek maakte deel uit van het zogenaamde STEP-onderzoek (Standaard evaluatieproject), een landelijk initiatief van een vijftiental klinische GGZ-afdelingen met als doel landelijke cijfers over de effectiviteit en doelmatigheid te verkrijgen. Het gaat bij de onderhavige studie om evaluatie van intensieve klinische, meerdaagse of eendaagse multidisciplinaire behandeling. Geconcludeerd werd dat in geval van ernstige tot zeer ernstige SOLK en somatoforme stoornissen er sterke aanwijzingen zijn dat een intensieve (bijvoorbeeld dagklinisch of klinisch) integratieve multidisciplinaire benadering effectief kan zijn met betrekking tot afname van klachten, toename van de kwaliteit van leven en afname van medische consumptie (Veselka e.a., 2005).

Zoeken en selecteren

Er werd gezocht naar zowel RCT-studies als naar niet-RCT-studies.
Binnen de algemene search van deze richtlijn naar behandeling van somatisch onvoldoende verklaarde lichamelijke klachten en somatoforme stoornissen werd gezocht naar studies over klinische behandelingen. Vervolgens werd van hieruit ook via de sneeuw- balmethode in literatuur verwijzingen naar studies over klinische behandeling gezocht. Ook werd in twee reviews over SOLK en somatoforme stoornissen (Kroenke e.a., 2007; Sumathipala, 2007) gekeken naar studies over klinische behandeling.
Twee recent verschenen Duitstalige boeken over effect van klinisch behandeling in Duitsland (Steffanowski e.a., 2007; Wiegand e.a., 2008) werden onderzocht en Nederlands onderzoek bij het Kenniscentrum voor psychosomatiek De Eikenboom werd erbij betrokken.

Verantwoording

Laatst beoordeeld : 01-01-2010
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Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Chronisch buikpijn bij vrouwen

Uitgangsvraag

Wat is de wetenschappelijke evidentie voor specifieke behandeling van chronische buikpijn bij vrouwen?

Aanbeveling

Er is te weinig evidentie om tot een aanbeveling voor een specifieke behandeling te komen bij chronisch buikpijn bij vrouwen. De werkgroep onderschrijft de reeds bestaande consensus dat er aandacht dient te zijn voor zowel de somatische als psychosociale factoren bij de behandeling van chronisch buikpijn. De werkgroep adviseert dan ook een structurele samenwerking tussen medisch specialist en psychologisch geschoolden. Daarnaast dient ook aandacht te zijn voor afstemming van de zorg met hulpverleners in de eerste lijn.

Overwegingen

Methodologisch gezien was de kwaliteit van de verschillende studies matig. Aan slechts 4 van de 9 studies werd een level of evidence A2 toegekend. Zo waren de onderzoeksgroepen soms zeer klein, was er veel uitval tijdens de studie en follow-up, en was het primaire doel van een behandeling niet altijd gericht op pijnvermindering. Ook waren de gebruikte maten om de ernst van de pijn te meten niet altijd gestandaardiseerd. Replicatie van onderzoek lijkt dan ook zinvol, waarbij een hypothese met name in een grotere patiëntenpopulatie getoetst dient te worden.
Het is opvallend dat tot nu toe geen onderzoek onder vrouwen met chronisch buikpijn gepubliceerd is waarbij het effect van behandelingen geëvalueerd wordt die voor de behandeling van chronische pijn in het algemeen effectief zijn gebleken, zoals cognitieve gedragstherapie. Toekomstig onderzoek zal moeten uitwijzen of dezelfde interventies effectief zijn of dat er specifieke aanpassingen nodig zijn voor een effectieve behandeling van vrouwen met chronisch buikpijn.
Bestudering van de richtlijnen die tot nu toe verschenen zijn laat zien dat er consensus bestaat over het feit dat er in de zorg voor vrouwen met chronisch buikpijn niet alleen aandacht voor medisch, somatische pathologie moet zijn, maar ook voor verschillende psychosociale factoren.
Tot op heden zijn er geen resultaten van onderzoek verschenen waarbij de organisatie van de zorg en daarmee de samenwerking en afstemming met de eerste lijn onderwerp van onderzoek is geweest.

Onderbouwing

Achtergrond

Diverse literatuuronderzoeken binnen de werkgroep naar specifieke somatisch onvoldoende verklaarde lichamelijke klachten (SOLK) brachten aan het licht dat er maar over een beperkt aantal van deze klachtengebieden uitvoering onderzoek is verricht.
Dit betreft onderzoek naar:

- chronisch buikpijn bij vrouwen
- dysmenorroe
- prikkelbaredarmsyndroom

De bespreking van deze klachtengebieden dient ook als illustratie van hetgeen gewenst zou zijn voor andere klachten en stoornissen die somatisch gezien onvoldoende verklaard zijn.

Chronisch buikpijn bij vrouwen wordt gedefinieerd als continue of intermitterende pijn die voornamelijk in de onderbuik gelokaliseerd is en die langer dan zes maanden bestaat, waarbij de pijn niet alleen samenhangt met de menstruatiecyclus (dysmenorrhoe) of het hebben van gemeenschap (diepe dyspareunie) (Williams, 2004). Meestal kan geen medische verklaring voor de klachten gevonden worden. In ongeveer de helft van de gevallen kan een afwijking zoals endometriose, adhesies, vleesbomen of cysten worden vastgesteld, terwijl deze bevindingen ook gezien worden bij 40% van de vrouwen die niet klagen over buikpijn (Howard, 2000). Er wordt een overlap gevonden in het soort klachten dat gepresenteerd wordt en andere somatisch onvoldoende verklaarde lichamelijke klachten, zoals het prikkelbaredarmsyndroom (PDS) (Whitehead, 2002). Chronisch buikpijn kan een enorme impact hebben op verschillende facetten van het dagelijks leven van de vrouw (Grace e.a., 2006). Naast economische kosten ten gevolge van ziekteverzuim, zijn ook de uitgaven voor onderzoek en behandeling in het medische circuit hoog (Howard, 2000). Uit epidemiologisch onderzoek komt naar voren dat 15 tot 25% van de vrouwen in de algemene bevolking met enige regelmaat buikpijnklachten heeft (Matthias, 1996, Zondervan, 2001), dat slechts een deel van hen (4%) de huisarts hiervoor bezoekt en dat maar een enkeling naar een specialist wordt verwezen (Zondervan, 1999a, 1999b).

Conclusies

Niveau 2	Het is aannemelijk dat zowel sertraline (50 mg 2dd) als lofexidine (200-600 |jg 2dd) niet effectief zijn als behandeling van pijn bij vrouwen met chronisch buikpijn. *B Stones, 2001; Engel, 1998*
Niveau 2	Het is aannemelijk dat adhesiolysis niet effectief is als behandeling van pijn bij vrouwen met chronisch buikpijn en adhesies. *A2 Swank, 2003*
Niveau 2	Het is aannemelijk dat LUNA (laparoscopisch doornemen van nervus uterina) niet effectief is als behandeling van pijn bij vrouwen met chronisch buikpijn. *A2 Johnson, 2004*
Niveau 2	Het is aannemelijk dat 'disclosure' effectief is als behandeling van de beleving van pijn bij vrouwen met chronisch buikpijn. *A2 Norman, 2004*
Niveau 2	Het is aannemelijk dat het tonen van de bevindingen van een laparoscopie niet effectief is als behandeling van pijn bij vrouwen met chronisch buikpijn. *A2 Onwude, 2004*
Niveau 3	Er zijn aanwijzingen dat 'mensendieck-somato-cognitieve therapie' effectief is als behandeling van pijn bij vrouwen met chronisch buikpijn. *B Haugstad 2006*
Niveau 3	Er zijn aanwijzingen dat een statisch magnetisch veld niet effectief is als behandeling van pijn bij vrouwen met chronisch buikpijn. *B Brown, 2002*
Niveau 3	Er zijn aanwijzingen dat GnRH analoga effectiever zijn dan progestativa ten minste tot een jaar na het stoppen van een zes maanden durende behandeling bij vrouwen met chronisch buikpijn en aanwijzingen voor pelvic congestion. *B Soysal, 2001*

Samenvatting literatuur

De 9 trials zijn 'single studies', dat wil zeggen dat de effectiviteit van een bepaald soort behandeling bij vrouwen met chronisch buikpijn slechts eenmaal is onderzocht.
Er kan een grof onderscheid gemaakt worden in onderzoeken waarbij de medische (medicamenteuze of operatieve) interventies worden samengevat versus de niet- medische (zie 'zoekverantwoording'). Alle onderzoeken zijn verricht in de tweede of derde lijn.
De methodologische kwaliteit van de studies varieert. De definities van chronisch buikpijn van de

geïncludeerde patiënten verschillen tussen de studies onderling. Sommige hanteren een klachtenduur van meer dan 3 maanden, andere includeren vrouwen met buikpijnklachten die langer dan 6 maanden bestaan, weer andere hebben de pijnklachten van de vrouwen in de onderzoeksgroep niet gedefinieerd.
Ook is er een groot verschil in het aantal vrouwen dat participeert in de onderzoeken. De studiepopulaties variëren van 25 tot bijna 250. De duur van de behandelingen varieert van eenmalig (een operatie, een consult) tot 6 maanden bij medicamenteuze therapie. De follow-up is relatief kort: van 4 weken tot 18 maanden na start van de behandeling.
Als primaire uitkomstmaat worden per studie verschillende pijnmaten gebruikt, zoals de visuele analoge schaal, de McGill Pain Questionnaire (MPQ) of alleen de kwalitatieve pijndomeinen of een samengestelde pijnscore zoals beschreven door Biberoglu (Biberoglu & Behrman, 1981) op basis van lichamelijk onderzoek en enkele vragen tijdens het consult naar de ernst van de klacht en beperkingen. In slechts 4 onderzoeken (Soysal, 2001; Engel,1998; Swank, 2003; Norman, 2004) zijn naast de pijn ook scores voor lichamelijke beperkingen, algemeen welbevinden en/of angst en depressie als secundaire uitkomstmaat meegenomen.

Medicamenteuze behandeling
In het onderzoek van Soysal (2001) werd primair onderzocht wat het verschil in effect was van 2 verschillende medicaties (gonadotrofine releasing hormoon antagonist (GnRH-a) subcutaan eenmaal per maand toegediend versus continu progestativa oraal (een tablet) op de uitkomst van een vaatonderzoek. De onderzoeksgroep betrof vrouwen met langdurige buikpijnklachten bij wie bij venografie (een vaatonderzoek met opspuiten van de veneuze plexus rondom de baarmoeder) verwijde bloedvaten werden gezien (pelvic congestion). Een dergelijke meting werd vooraf en 12 maanden na staken van de behandeling uitgevoerd. Secundair werd nagegaan wat het effect van de medicamenten op de buikpijnklachten was. De venografiescore verbeterde significant bij het gebruik van beide medicamenten: de verandering in de scores tussen baseline en follow-up was groter in de GnRH-a-groep dan in de progestativagroep. Beide medicamenten verminderden ook de ernst van de pijn (Biberoglu) significant, en deze vermindering van pijn was voor GnRH-a significant groter dan voor de progestativa medicatie, gemeten aan het einde van de behandeling en 12 maanden na het stoppen van de behandeling.
Engel (1998) en Stones (2001) onderzochten het effect van centraal werkende middelen die de pijnbeleving zouden kunnen beïnvloeden. Zowel een behandeling met sertraline (50 mg 2dd) als lofexidine (200-600 pg 2dd) gedurende 6-8 weken had geen invloed op de gerapporteerde pijn.

Chirurgische behandeling
Het verwijderen van adhesies per laparoscopie (Swank, 2003) en het doornemen van de ligamenta sacro uterina met daarin de nervus uterina (Johnson, 2004) leverde geen verbetering van de pijnklachten op ten opzichte van het verrichten van louter een laparoscopie.

Psychologische aspecten
Drie trials (Norman, 2004; Onwude, 2004; Haugstadt, 2006) vergeleken interventies die aangrijpen op psychologische factoren waarvan verwacht wordt dat deze de mate van pijn beïnvloeden. Norman (2004) liet vrouwen met buikpijn 3 dagen schrijven over de negatieve aspecten van hun pijn. Deze ‘disclosure' resulteerde in een significante vermindering van de evaluatieve aspecten van de gerapporteerde pijnintensiteit. Onwude (2004) vond dat het post-operatief laten zien van een foto met de bevindingen tijdens de ingreep (laparoscopie) aan vrouwen met buikpijn geen effect had op de intensiteit van de pijn, hoewel

verondersteld werd dat deze interventie, door geruststelling, tot pijnvermindering zou leiden. Haugstadt (2006) onderzocht een bepaalde vorm van mensendiecktherapie waarbij gebruikgemaakt wordt van een cognitieve benadering om het lichaamsbewustzijn te versterken. Deze vorm van behandeling leidde tot een significante vermindering in de gerapporteerde ernst van de pijn (VAS), terwijl in de controleconditie geen significant verschil in pijnscores werd gevonden. In de behan- delgroep werd ongeveer 50% reductie in pijnintensiteit vastgesteld, wat als klinisch relevant geachte vermindering van klachten beschouwd wordt.

Overige behandeling
Er werd geen effect op de pijn gevonden bij het plaatsen van een statisch magnetisch veld op een welomschreven pijnplek (Brown, 2002).

Zoeken en selecteren

De zoekstrategie die gebruikt is om de patiëntenpopulatie te definiëren is uitgebreid onder kopje ‘ zoekverantwoording’ beschreven. Voor dit hoofdstuk werden publicaties geselecteerd met de MESH-term ‘pelvic pain' of het titelwoord ‘chronic pelvic pain syndrome'.

In de Cochrane Review van Stones (Stones e.a., 2005) zijn alle gerandomiseerde en gecontroleerde studies (RCT) naar het effect van behandeling van chronisch buikpijn bij vrouwen, beoordeeld. De search werd uitgevoerd in januari 2005 en had betrekking op alle RCT's gerubriceerd in Medline, Embase, Cinahl and PSYCinfo van voor die tijd.

De search leverde 19 studies op, waarvan er slechts 14 in de beoordeling betrokken werden omdat de kwaliteit van de andere 5 onvoldoende was. Deze kwalificatie vond plaats aan de hand van door de Cochrane Collaboration opgestelde richtlijnen gericht op gegevens over randomisatie, blindering, samenstelling van de onderzoeks- en controlegroep, het gebruik van ‘intention to treat analyses' etc. In het kader van de onderhavige richtlijn zijn van de 14 in het hierboven genoemde review 6 studies geëxcludeerd, omdat deze vóór 1997 gepubliceerd werden. Na 2005 verschenen nog 4 RCT's over dit onderwerp (Haugstad, 2006; Sator-Katsenschlager, 2005; Heyman, 2006; Palomba, 2006) in peer reviewed tijdschriften. Drie daarvan zijn om methodologische redenen geëxcludeerd (Sator-Katsenschlager, 2005; Heyman, 2006; Palomba, 2006). In de studie van Sator-Katschenslager varieerde de interventie (medicatiedosis en soort) per persoon. In de studie van Heyman bood dezelfde persoon de behandeling aan, nam het assessment af en voerde de controle-interventie uit. In de studie van Palomba werd een operatieve interventie op twee verschillende manieren uitgevoerd (vaginaal en laparoscopisch), waarbij de einduitkomst primair het verschil in kosten en comorbiditeit was en secundair het effect op buikpijn werd gemeten.
De richtlijnen die uitgebracht zijn door de gynaecologische beroepsverenigingen in Engeland (RCOG Royal College of Obstetricians and Gynaecologist; RCOG, 2005), Amerika (ACOG (American College of Obstetricians and Gynaecologist); ACOG, 2004) en Canada (SCOG (Society of Obstetricians and Gynaecologist Canada); Jarrel, 2005) zijn ook geraadpleegd, waarbij geen andere dan de reeds gevonden RCT's werden gevonden.

Verantwoording

Laatst beoordeeld : 01-01-2010
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Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Hypochondrie farmacologische behandeling

Uitgangsvraag

Wat is de wetenschappelijke evidentie voor farmacologische behandeling van hypochondrie?

Aanbeveling

De werkgroep beveelt aan patiënten die behandeld worden met een SSRI zeker in het begin frequent (eenmaal per week) op het spreekuur te zien en grondig voor te lichten over de bijwerkingen.

Overwegingen

Er zijn voldoende aanwijzingen uit de klinische praktijk en case series om te veronderstellen dat naast paroxetine ook andere SSRI's effectief zijn (Fallon, 2004).
Er zijn geen gerandomiseerde en gecontroleerde studies gedaan naar het effect van SSRI's of antipsychotica bij hypochondrie met weinig inzicht (waanachtige vorm). Patiënten met hypochondrie verdragen slecht de bijwerkingen van medicatie, omdat
ook deze lichamelijke verschijnselen aanleiding geven tot misinterpretatie en angst. Daarom wordt aanbevolen patiënten die behandeld worden met een SSRI zeker in het begin frequent (eenmaal per week) op het spreekuur te zien en grondig voor te lichten over de bijwerkingen. Ondanks dat patiënten met hypochondrie de bijwerkingen slecht verdragen, is er nauwelijks meer uitval (30%) dan in de CGt-conditie (25%).
Op de langere termijn doen patiënten die behandeld zijn met cognitieve gedragstherapie minder een beroep op de GGZ dan patiënten die behandeld zijn met paroxetine (Greeven e.a., 2007). Bij de behandeling van hypochondrie gaat daarom de voorkeur uit naar behandeling met cognitieve gedragstherapie. Echter, wanneer er sprake is van een ernstige comorbide depressieve stoornis, dan gaat de voorkeur uit naar behandeling met paroxetine, omdat de depressie dan gelijk meebehandeld wordt. Zie multidisciplinaire richtlijn depressie (Landelijke Stuurgroep Multidisciplinaire Richtlijn ontwikkeling, 2005).

Onderbouwing

Achtergrond

Hypochondrie wordt omschreven als de preoccupatie met de vrees of opvatting een ernstige ziekte te hebben, gebaseerd op een verkeerde interpretatie van lichamelijke verschijnselen. Deze preoccupatie houdt aan ondanks adequaat medisch onderzoek en geruststelling. Wanneer betrokkene voor het grootste deel van de tijd in de huidige episode niet beseft dat de bezorgdheid over het hebben van een ernstige ziekte overdreven of onredelijk is, dan wordt gesproken van hypochondrie met gering inzicht. Hier wordt de hypochondrie behandeld zoals in bijlage I van de DSM-IV-TR wordt omschreven.

Conclusies

Niveau 2	Het is aannemelijk dat paroxetine effectief is als behandeling voor hypochondrie *A2 Greeven e.a., 2007*

Niveau 2	Het is aannemelijk dat paroxetine op de korte termijn even effectief is als cognitieve gedragstherapie als behandeling voor hypochondrie. *A2 Greeven e.a., 2007*

Samenvatting literatuur

Paroxetine (Greeven e.a., 2007)
Met betrekking tot paroxetine (20-60 mg p/d) is er sprake van een middelgroot effect in vergelijking tot placebo voor de completers (d=0,58) en een klein effect voor de 'intention to treat'-populatie (d=0,44).

Fluoxetine (Fallon et al., 1996)
Fallon verwijst in verschillende publicaties naar de resultaten van de eerste fase van een gerandomiseerde en gecontroleerde studie naar het effect van fluoxetine. Alhoewel de resultaten suggereren dat fluoxetine mogelijk effectief zou kunnen zijn, waren de gevonden verschillen niet statistisch significant. Omdat de uiteindelijke studie nooit is gepubliceerd en de resultaten van de eerste fase slechts globaal zijn beschreven in een artikel over farmacotherapie bij hypochondrie, hebben we besloten deze resultaten niet op te nemen in de richtlijn.

Vergelijking tussen psychologische en farmacologische behandelingen
Cognitieve gedragstherapie (CGt) en paroxetine zijn beide effectiever dan placebo. Het effect van CGt en paroxetine in vergelijking tot placebo is gelijk. Er is sprake van een middelgroot effect in vergelijking tot geen behandeling. De beide behandelingen zijn op de korte termijn even effectief (d= 0,09).
Van de patiënten die medicatie kregen voorgeschreven viel 30% uit, maar dat is nauwelijks meer dan in de groep die CGt kreeg (25% Greeven, e.a. 2007; 28% Visser & Bouman, 2001).

Zoeken en selecteren

Hypochondrie is opgenomen in de multidisciplinaire richtlijn angststoornissen (Landelijke Stuurgroep Multidisciplinaire Richtlijnontwikkeling, 2009). In deze richtlijn zijn ook de resultaten gegeven van open medicatie trials en case series. De resultaten van deze studies zijn in de huidige/onderhavige aanbeveling buiten beschouwing gelaten. Sinds het verschijnen van de richtlijn is er nog een aantal studies en een Cochrane Review gepubliceerd. Met de resultaten van deze studies is rekening gehouden bij het opstellen van de aanbeveling.
Gezocht is naar systematic reviews, meta-analyses en gerandomiseerde en gecontroleerde trials naar de effectiviteit van behandelingen voor hypochondrie. Een zoekactie in PubMed leverde acht artikelen op die aan deze criteria voldeden; een systematische Cochrane review, een proefschrift (Bruwalda) en zes artikelen gepubliceerd in peer reviewed tijdschriften. In de systematische review worden zes artikelen op het gebied van psychosociale interventies bij hypochondrie beoordeeld.
De systematische review is als uitgangspunt gekozen. Omdat hierin echter alleen de vergelijking met wachtlijst of controleconditie werd besproken en niet de vergelijking tussen behandelingen onderling, is ervoor gekozen de individuele studies te beschrijven. Alleen de gerandomiseerde gecontroleerde trials die voldoende valide en toepasbaar waren, werden geselecteerd.

De zeven geïncludeerde RCT's en de systematische review variëren voor wat betreft de methodologische kwaliteit (zie evidencetabellen). De weergave van een van de studies (Fallon e.a., 1996) was van dien aard dat de kwaliteit van de studie niet was te beoordelen. Omdat het hier een verslag betrof van de resultaten van de eerste fase van een studie en de uiteindelijke resultaten nooit zijn gepubliceerd, zijn de conclusies hiervan niet meegenomen.
In de Cochrane Review van Thomson & Page (2007) wordt verslag gedaan van de gerandomiseerde en gecontroleerde studies bij volwassenen met hypochondrie waarin het effect van psychologische behandelingen op de ernst van de ziekteangst wordt onderzocht. Wanneer er geen formele diagnose hypochondrie was gesteld of niet alle patiënten voldeden aan de criteria, werden de studies uitgesloten.

Verantwoording

Laatst beoordeeld : 01-01-2010
Laatst geautoriseerd : 01-01-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Dysmenorroe

Uitgangsvraag

Wat is de wetenschappelijke evidentie voor specifieke behandeling van dysmenorroe?

Aanbeveling

De werkgroep beveelt aan bij toekomstig onderzoek niet alleen aandacht te besteden aan de methodologische aspecten van de studie maar ook aan de uitkomstmaat, waarbij geadviseerd wordt deze breed te definiëren, namelijk als het effect van de behandeling op pijn, algemeen welbevinden en school- en werkverzuim, en gestandaardiseerde en gevalideerde uitkomstmaten te gebruiken.

De werkgroep is van mening dat de evidentie van de huidige klinische praktijk (behandeling van primaire dysmenorroe met OAC's en NSAID's) versterkt dient te worden door nieuwe trials op te zetten, zeker gezien het op de markt komen de laatste jaren van lager gedoseerde OAC's.

De werkgroep beveelt aan onderzoek te starten naar de effectiviteit van het gebruik van verschillende soorten pijnstillers bij de behandeling van primaire dysmenorroe.

De werkgroep beveelt aan onderzoek te starten naar de effectiviteit van gedragsmatige interventies bij primaire dysmenorroe, gezien pijn multidimensioneel is.

De werkgroep beveelt aan bij toekomstig onderzoek niet alleen aandacht te besteden aan de methodologische aspecten van de studie maar ook aan de uitkomstmaat, waarbij geadviseerd wordt deze breed te definiëren, namelijk als het effect van de behandeling op pijn, algemeen welbevinden en school- en werkverzuim, en gestandaardiseerde en gevalideerde uitkomstmaten te gebruiken.

Overwegingen

Op basis van de voorhanden zijnde publicaties van onderzoek naar de behandeling van vrouwen met primaire dysmenorroe kan gesteld worden dat er tot op heden geen ideale behandeling gevonden is.
Sinds de introductie van de pil in 1960 is het gebruik van OAC gemeengoed. Onlangs is ook de effectiviteit van een laag gedoseerde OAC (< 30 mcg oestrogenen) op de klacht primaire dysmenorroe aangetoond (Davis e.a., 2005). De effectiviteit en de geschiktheid van andere hormonale middelen als progestativa oraal, intramusculair of lokaal (IUD) zijn tot nu toe niet in RCT's onderzocht.
Naast OAC's worden NSAID's regelmatig voorgeschreven en gebruikt bij primaire dysmenorroe. Gezien de systemische bijwerkingen van NSAID's zou nader onderzocht kunnen worden of het gelijktijdig gebruik van verschillende soorten pijnstillers met verschillende werkingsmechanismen effectief is bij primaire dysmenorroe en resulteert in rapportage van minder bijwerkingen.
Hoewel operatief ingrijpen bij primaire dysmenorroe veelbelovend lijkt, dient bij het besluit daartoe meegewogen te worden dat iedere ingreep kan leiden tot ongewenste complicaties. PSN kan alleen worden uitgevoerd door een zeer ervaren operateur. Er zijn meer en ernstiger complicaties beschreven, zoals schade aan ureter, dan bij LUNA.
Terwijl medicamenteuze en operatieve behandelingen voor primaire dysmenorroe effectief zijn, heeft 20-25%

van de vrouwen er geen baat bij. Complementaire (alternatieve) behandelingen dienen zich aan, zoals het gebruik van kruiden, voedingssupplementen, verschillende soorten fysiotherapie, acupunctuur en TENS. De veiligheid en beschikbaarheid van (Chinese) kruiden en voedingssupplementen is nog onvoldoende duidelijk. Bij de opzet en uitvoer van alle studies komen methodologische problemen naar voren. Een aandachtspunt zou moeten zijn dat de meeste studies zijn uitgevoerd bij vrouwen die gemiddeld al 6 jaar klachten van dysmenorroe hebben (pijn sinds de menarche: twaalfde jaar; leeftijd van studiedeelnemers gemiddeld 18 jaar en ouder), wat de interne en externe validiteit van de bevindingen beïnvloedt. Daarnaast zijn er ook andere struikelblokken, zoals: hoe adequaat te blinderen (onderzoeksdeelnemer, behandelaar en beoordelaar), wat is een echte ‘sham'-ingreep, hoe is de integriteit van de behandeling te bewaken, en hoe om te gaan met het effect van meerdere behandelaars? Daarnaast blijkt het gebruik van gestandaardiseerde uitkomstmaten nog geen gemeengoed, waarbij er niet alleen aandacht zou moeten zijn voor het effect van de behandeling op pijn, maar ook op algemeen welbevinden en school- en werkverzuim. De bevindingen over de operatieve en complementaire behandelingen moeten daarom ook met enige voorzichtigheid worden bekeken gezien verschillende methodologische tekortkomingen van de studies gecombineerd met de kleine ‘sample sizes'.

Onderbouwing

Achtergrond

Diverse literatuuronderzoeken binnen de werkgroep naar specifieke somatisch onvoldoende verklaarde lichamelijke klachten (SOLK) brachten aan het licht dat er maar over een beperkt aantal van deze klachtengebieden uitvoering onderzoek is verricht.
Dit betreft onderzoek naar:

- chronisch buikpijn bij vrouwen
- dysmenorroe
- prikkelbaredarmsyndroom

De bespreking van deze klachtengebieden dient ook als illustratie van hetgeen gewenst zou zijn voor andere klachten en stoornissen die somatisch gezien onvoldoende verklaard zijn.

Dysmenorroe is gedefinieerd als krampende, koliekachtige pijn in de onderbuik, die kan uitstralen naar bovenbenen en rug, die optreedt tijdens de menstruatie, soms ook al enkele dagen tot uren voor de menses begint, en 2-3 dagen duurt. De pijn kan gepaard gaan met misselijkheid, braken, diarree en algehele malaise. Een pijnlijke menstruatie komt wel bij 50% van de vrouwen voor. Slechts een deel van hen ondervindt zoveel hinder van de pijn, dat zij zich ziek moeten melden (Weissman e.a., 2004). Niet alleen ethniciteit en cultuurgebonden taboes ten aanzien van menstruatie, maar ook psychologische factoren, zoals de neiging tot somatiseren, kunnen een rol spelen bij het ervaren en rapporteren van pijn bij de menstruatie (Goldstein-Ferber e.a., 2006; Patel e.a., 2006).
Er wordt een onderscheid gemaakt tussen primaire en secundaire dysmenorroe. Van primaire dysmenorroe spreekt men wanneer de klacht sinds de menarche (eerste menstruatie) aanwezig is. Meestal is er geen somatische verklaring voor de klacht te vinden. Secundaire dysmenorroe ontwikkelt zich in de loop van de tijd en kan samenhangen met afwijkingen aan de genitalia interna, zoals endometriose en/of myomen (vleesbomen).

Dysmenorroeklachten worden vaak door vrouwen gemeld in samenhang met andere chronische (onverklaarde) pijnklachten, zoals chronisch buikpijn (Zondervan e.a., 2001), prikkelbaredarmsyndroom (Jamieson, 1996) en fibromyalgie (Yunus e.a., 2004), maar wordt ook vaak gezien bij vrouwen met premenstrueel syndroom (Johnson, 2004).
Er is geen consensus over de etiologie van dysmenorroe. Mogelijk is er sprake van een overproductie van prostaglandines en/of vasopressine in de uterus, die verondersteld worden een mediërende rol te spelen bij de mate van krampen van de baarmoeder en pijnperceptie. Daarnaast wordt nogal eens gesuggereerd dat dysmenorroe samen zou kunnen hangen met angst, emotionele instabiliteit, een negatief beeld op seksualiteit en/of afwijzing van de rol als vrouw. Men gaat er echter van uit dat met name primaire dysmenorroe valt onder de zogenaamde somatisch onvoldoende verklaarde lichamelijke klachten (Patel e.a., 2006). De klachten van een pijnlijke menstruatie blijven aanwezig zo lang de vrouw menstrueert, hoewel de ernst van de pijn kan afnemen na een voldragen zwangerschap en met het ouder worden (Weissman e.a., 2004). Een samenhang tussen roken, socio-economische klasse, ras en bijkomende aandoeningen als diabetes mellitus enerzijds en het beloop van de klachten anderzijds is niet duidelijk, omdat bevindingen in studies onderling verschillen (Sundell e.a., 1990; Harlow & Park, 1996).

Conclusies

Niveau 1	Het is aangetoond dat OAC's (combinatiepreparaten) effectief zijn als behandeling van primaire dysmenorroe. *D Proctor, 2001*
Niveau 1	Het is aangetoond dat NSAID's effectief zijn als behandeling van primaire dysmenorroe. *D Majoribanks, 2003*

Niveau 1	Het is aangetoond dat LUNA na twaalf maanden effectief is als behandeling voor primaire dysmenorroe. *A2 Proctor, 2005 (Johnson, 2004; Lichten, 1987)*
Niveau 2	Er zijn aanwijzingen dat PSN na zes maanden effectiever is dan LUNA. *A2 Proctor, 2005 (Chen, 1996)*
Niveau 2	Er zijn aanwijzingen dat PSN meer obstipatieklachten geeft dan LUNA. *A2 Proctor, 2005 (Chen, 1996)*

Niveau 4	Er is geen uitspraak te doen over de effectiviteit van gedragsinterventies bij de klacht primaire dysmenorroe. *D Proctor, 2007*

Niveau 1	Het is aangetoond dat 'high frequency TENS' effectief is in de behandeling van dysmenorroe in vergelijking met placebo. *D Proctor, 2002*
Niveau 4	Er is onvoldoende bewijs om een uitspraak te doen over de effectiviteit van 'high frequency TENS' ten opzichte van NSAID's in de behandeling van dysmenorroe. *D Proctor, 2002*
Niveau 4	Er is onvoldoende bewijs om een uitspraak te doen over de effectiviteit van 'low frequency TENS' in de behandeling van primaire dysmenorroe. *D Proctor, 2002*
Niveau 1	Het is aangetoond dat acupunctuur effectief is in de behandeling van primaire dysmenorroe. *D Proctor, 2002*
Niveau 4	Spinale manipulatie lijkt niet effectief voor de behandeling van primaire dysmenorroe, met uitzondering van de Toftness-techniek. *D Proctor, 2006*
Niveau 1	Het is aangetoond dat vitamine B1 en magnesium effectief zijn in de behandeling van primaire dysmenorroe. *D Proctor, 2001*
Niveau 1	Het is aangetoond dat sommige Chinese kruiden effectief zijn in de behandeling van primaire dysmenorroe. *D Zhu, 2007*

Samenvatting literatuur

Medicamenteuze behandelingen

Hormonaal (orale anticonceptiva, OAC)

Het effect van het nemen van oestrogenen/progesteron in de vorm van OAC is gebaseerd op de vooronderstelling dat OAC de ovulatie onderdrukt en de hoeveelheid slijmvlies dat in de baarmoeder aangemaakt wordt, vermindert. Dientengevolge zal de hoeveelheid prostaglandines dat vrijkomt bij het afstoten van het slijmvlies minder zijn, waardoor de pijn tijdens de menstruatie afneemt.

In de Cochrane review (Proctor e.a., 2001) zijn slechts 5 studies opgenomen die allemaal ongeveer 30 jaar geleden zijn gepubliceerd. Vier van deze studies konden worden gebruikt voor een meta-analyse. Er zijn aanwijzingen dat combinatieprepa- raten (met > 50 mcg oestrogeen en eerste- en tweedegeneratie progestagenen) ten opzichte van placebo effectief zijn wanneer gekeken wordt naar pijnreductie (OR 2,01;

95% CI 1,22-3,33). Eén onderzoek vond dat OAC-gebruik voor dysmenorroeklachten school- en werkverzuim significant verminderde ten opzichte van placebo. Het gemelde aantal bijwerkingen, gerapporteerd in slechts 1 onderzoek, was in de behandel- en placebogroep niet significant verschillend.

NSAID's (non-steroid anti-inflammatoire middelen)
Deze middelen, zoals aspirine, naproxen, ibuprofen en diclofenac, blokkeren de prostaglandineproductie en verminderen daarmee de krampen in de baarmoeder en dientengevolge de pijn tijdens de menstruatie. Idealiter moet ongeveer 24 uur voordat de pijnlijke krampen optreden met de medicatie gestart worden.
63 studies werden in de Cochrane review (Majoribanks e.a., 2003) opgenomen. Op basis van 14 van de 36 studies die geschikt waren voor een meta-analyse, kan geconcludeerd worden dat NSAID's significant effectiever zijn dan placebo voor wat betreft vermindering van pijn (OR 7,91; 95% CI 5,65-11,09). Er is geen significant verschil gevonden in het effect op pijn en veiligheid tussen de verschillende NSAID's onderling. Het gebruik van deze middelen gaat echter wel gepaard met significant meer bijwerkingen zoals maagpijn, duizeligheid en hoofdpijn dan het nemen van placebo (OR 1,52; 95% CI 1,09-2,12). In 3 van de 63 studies is gevonden dat vrouwen die NSAID's gebruikten significant minder beperkt werden in hun dagelijkse activiteiten dan vrouwen die toegewezen waren aan de placeboconditie (bij gepoolde data: OR 0,36; 95% CI 0,20-0,64). In 2 van de 63 studies werd nagegaan wat effect van de medicatie op werk- en schoolverzuim was. Vrouwen die NSAID's gebruikten bleken significant minder vaak werk- en school te verzuimen dan wanneer zij een placebo namen (bij gepoolde data: OR 0,20; 95% CI 0,12-0,34).

Operatieve behandeling
Het doornemen van de nervi uterina (UNA, uterine nerve ablation) of de presacrale plexus (PSN = presacrale neurectomie) zijn beide meestal laparoscopisch uitgevoerde operatieve ingrepen waarbij zenuwbanen worden doorgenomen die een rol spelen bij pijnprikkelgeleiding vanuit de baarmoeder.
Acht studies werden opgenomen in de Cochrane review (Proctor e.a., 2005). Slechts 3 RCT's betroffen interventies bij vrouwen met primaire dysmenorroe. In 2 studies werd tijdens een laparoscopie de nervi uterina doorgenomen (LUNA). Na follow-up van 6 maanden werd er geen verschil in effectiviteit gevonden tussen de groep waarbij wel of geen interventie tijdens laparoscopie werd uitgevoerd. Bij 12 maanden was in de interventiegroep de pijn significant verminderd in vergelijking met geen interventie (2 RCT's; N=68; OR 6,12; 95% CI 1,78-21,03). In 1 RCT werd PSN vergeleken met LUNA. Bij een follow-up van meer dan 6 maanden leek PSN wat effectiever in pijnvermindering dan LUNA (1 RCT; N=68; OR 0,10; 95% CI 0,03-0,32), terwijl PSN gepaard ging met significant meer obstipatieklachten.

Psychologische behandeling
In totaal zijn 5 trials in de Cochrane review (Proctor e.a., 2007) opgenomen, waarbij verschillende interventies zijn onderzocht (ontspanningstraining, biofeedback, pijnma- nagement en vergroten copingstrategieën). Alle studies zijn meer dan 20 jaar geleden uitgevoerd. Gezien de heterogeniteit van de studies was een meta-analyse niet mogelijk. Mogelijk is er een positief effect van de verschillende interventies. Duidelijke uitspraken zijn echter niet te doen, gezien de methodologische onvolkomenheden van de RCT's zoals bijvoorbeeld het kleine aantal studiedeelnemers, gemis aan integriteit in de behandelingen, en weinig gestandaardiseerde en gevalideerde uitkomstmaten.

Overige behandelingen

TENS (transcutaneous electrical nerve stimulation)
Met TENS wordt vermindering van pijn nagestreefd door de huid te stimuleren met stroomstootjes met wisselende frequentie en intensiteit. Er wordt een onderscheid gemaakt tussen 'high dose' (frequency: 50-120 Hz, low intensity) en 'low dose' (frequency:1-4 Hz, high intensity). De elektrodes worden ter plaatse van de pijn of op acupunctuurlocaties gefixeerd. Pijnperceptie wordt beïnvloed door TENS.
In 4 studies geïncludeerd in de Cochrane review (Proctor e.a., 2002) werd 'high frequency TENS' vergeleken met placebo, waarbij 'high frequency TENS' resulteerde in een significant verschil in pijnvermindering ten opzichte van placebo (OR 7,2; 95% CI 3,1-16,5). Het gebruik van 'low frequency TENS' leverde geen significant verschil in pijnvermindering op in vergelijking met placebo (2 studies). 'High frequency TENS' was effectiever dan 'low frequency' (OR 3,9; 95% CI 1,1-13,0). In 1 studie was het gebruik van ibuprofen effectiever in pijnvermindering dan 'high frequency TENS' (OR 0,3; 95% CI 0,1-0,8), terwijl in een ander onderzoek geen verschil in effectiviteit werd gevonden tussen gebruik van naproxen en 'high frequency TENS'.

Acupunctuur
Acupunctuur, gebaseerd op eeuwenoude Chinese tradities, kan pijnperceptie ook beïnvloeden. Het werkingsmechanisme van TENS en acupunctuur is vergelijkbaar. Echter bij TENS heeft de patiënt zelf in principe de frequentie en intensiteit van de stimulatie in handen, terwijl acupunctuur door een behandelaar wordt uitgevoerd. Een studie werd opgenomen in de Cochrane review (Proctor e.a., 2002). Acupunctuur bleek effectief te zijn en leidde tot significante pijnvermindering in vergelijking met placebo (OR 9,5; 95% CI 1,7-51,8) en controle (OR 16,4; 95% CI 3,2-84,8).

Spinale manipulatie
Er wordt verondersteld dat disfuncties in de wervels de beweeglijkheid van de wervelkolom kan beperken waardoor zenuwbanen worden aangedaan die de bloedvoorzie- ning van de bekkenorganen voorzien, wat zou kunnen resulteren in dysmenorroe op basis van vasoconstrictie. Een andere hypothese is dat dysmenorroe een gevolg is van gerefereerde pijn vanuit de wervelkolom.
In de Cochrane review (Proctor e.a., 2006) is de effectiviteit van de verschillende spinale manipulaties onderzocht, zoals chiropraxie, osteopathie en manuele therapie. Er werden 5 studies gevonden. Pooling van de resultaten was niet mogelijk omdat het soort behandeling, de duur, de controlegroep, de uitkomstmaat et cetera verschillend waren. Er werd geen verschil in effectiviteit ten aanzien van pijnvermindering gevonden tussen HVLA-behandeling ('high velocity, low amplitude rotatie manipulatie') en een 'sham'- ofwel 'nep'-procedure in 4 studies. De Toftness-techniek, een bepaalde chiro- praxietechniek, toegepast gedurende een behandeling van 3 maanden leek effectiever dan de 'sham-procedure' bij een follow-up na 6 maanden (1 studie) (WMD.-1,40; 95% CI -2,21 tot -0,59).

Kruiden en dieet
Zeven studies zijn geïncludeerd in de Cochrane review (Proctor e.a., 2001). Vitamine B1 bleek effectief te zijn in een dosis van 100 mg per dag gedurende de menstruatie in vergelijking met placebo (1 studie). Het gebruik van magnesium leek effectiever dan placebo te zijn voor het verminderen van pijn bij dysmenorroe (5 studies). Voor de andere producten (vitamine B6, vitamine E, Omega-3-vetzuren en Japanse kruidencom-binatie) werd geen duidelijk positief effect op de klachten gevonden. Voor alle studies gold dat zij methodologisch ernstige tekortkomingen hadden, met name kleine sample size, onduidelijke randomisatie en geen gebruik van gestandaardiseerde en gevalideerde uitkomst maten.

Chinese kruiden
De resultaten van 39 studies zijn opgenomen in de review, waarvan er slechts 3 in het Engels zijn gepubliceerd. Hoewel het gebruik van Chinese kruiden al honderden jaren oud is, is de effectiviteit ervan nog nauwelijks wetenschappelijk onderzocht.
De diagnose dysmenorroe wordt in de Chinese geneeskunde meestal ook nader onderverdeeld aan de hand van het soort bijkomende klachten, zodat een uiteindelijke beschrijving van de klachten ontstaat zoals bijvoorbeeld 'het vasthouden van koude' of 'stagnatie van Qi en bloed'. Afhankelijk van deze beschrijving wordt het soort kruiden vastgesteld. In de verschillende onderzoeken is gestreefd naar uniformiteit in de behandeling, hoewel in de klinische praktijk het soort kruiden dat toegediend wordt in de loop van de tijd kan wijzigen op basis van het beloop van de aandoening en de bijkomende klachten.
In de geïncludeerde RCT's (Zhu e.a., 2007) werd de effectiviteit van de Chinese kruiden vergeleken met geen behandeling, placebo, bij de drogist verkrijgbare middelen of westers georiënteerde behandeling, zoals NSAID's en OAC. Bijwerkingen werden in slechts 8 van de 19 studies gerapporteerd. Methodologisch gezien waren de studies zwak: nauwelijks vermelding van randomisatiemethode, klein aantal deelnemers per studie, het gemis aan gevalideerde uitkomstmaten etc.
Op basis van de gegevens uit de verschillende studies kan geconcludeerd worden dat het gebruik van Chinese kruiden (met name 'regelen en versterken van Qi en bloed', 'het binnenste verwarmen', 'lever en nieren versterken') veelbelovend is en de ernst van de pijn tijdens de menstruatie duidelijk doet verminderen. De effectiviteit is groter in vergelijking met placebo, geen behandeling, het gebruik van NSAID's, OAC, acupunctuur en warmte compressen.

Zoeken en selecteren

De 8 Cochrane reviews over primaire dysmenorroe die de afgelopen jaren zijn verschenen over dit onderwerp, zijn als uitgangspunt voor deze richtlijn genomen. Daarnaast zijn de richtlijn van de Canadese gynaecologenvereniging (SCOG) (Lefebre e.a., 2005) evenals de meest recente Pain Clinical Update (Tu e.a., 2007) ook geraadpleegd. Hoewel primaire dysmenorroe per definitie optreedt vanaf de menarche (gemiddeld twaalfde levensjaar) zijn de vrouwen die geïncludeerd zijn in de verschillende studies gemiddeld 18 jaar en ouder (range 14-45 jaar).

Verantwoording

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Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Prikkelbaredarmsyndroom

Het prikkelbaredarmsyndroom (PDS) is een chronische functionele gastro-intestinale aandoening met een geschatte prevalentie van 14 tot 24% bij vrouwen en 5 tot 19% bij mannen (Webb e.a., 2007). De aandoening wordt gekarakteriseerd door terugkerende episodes van buikpijn en veranderde stoelgangpatronen. De diagnose mag alleen gesteld worden als er geen aanwijzingen voor organische pathologie zijn. De diagnose wordt, in de specialistische praktijk, vaak gesteld aan de hand van expert-based diagnostische criteria, zoals de Rome-III-criteria:

- Ten minste drie maanden, met een begin van minstens zes maanden geleden, last van terugkerende pijn of ongemak (ongemak betekent een onprettige sensatie niet beschreven in termen van pijn), samengaand met twee of meer van de volgende kenmerken:
- verbetering na de ontlasting en/of
- het begin is geassocieerd met een verandering in de frequentie van de ontlasting en/ of
- het begin is geassocieerd met een verandering van vorm (uiterlijk) van de ontlasting.

Men kan een onderscheid maken in subtypen van het PDS met predominante obstipatie, het PDS met predominante diarree en mengvormen. In de huisartsenpraktijk worden minder stringente tijdscriteria gebruikt en spelen vooral de predominante klachten en het profiel van de patiënt een grote rol bij de totstandkoming van de diagnose.
Van alle mensen met klachten die passen bij het PDS, zoekt 33-50% hulp. In Nederland wordt naar schatting 90% van de patiënten in de eerste lijn behandeld (NIVEL), in Engeland ligt dit percentage op 66% (Guthrie & Thompson, 2002). Ongeveer de helft van de patiënten die in de eeste lijn voor darmklachten worden gezien, hebben een somatisch onvoldoende verklaarde maag-darmstoornis, de meesten het PDS (Guthrie & Thompson, 2002).
De schattingen van hoeveel patiënten van elke verwijzing naar de MDL-artsen in de tweede lijn met een PDS worden gediagnosticeerd, lopen sterk uiteen (25-70%).
Het PDS leidt regelmatig tot ernstige invaliderende klachten voor de patiënt, met bijvoorbeeld een hoger jaarlijks ziekteverzuim dan door de griep (Smout, 2001).
De maatschappelijke kosten worden geschat op $ 348 tot 8.750 per patiënt jaarlijks aan directe kosten en $ 355 tot 3.344 aan indirecte kosten. Het aantal dagen werkverzuim varieerde in onderzoek tussen de 8,5 tot 21,6 dagen per jaar (Maxion-Bergemann e.a., 2006). Een andere review geeft de totale directe jaarlijkse kosten van 45,6 miljoen
pond Sterling in de UK en $ 1,35 biljoen in de VS, met een jaarlijks productiviteitsverlies van $ 205 miljoen in de VS (Inadomi e.a., 2003).
De symptomen van het PDS lijken een fysiologische basis te hebben. Momenteel wordt het PDS beschouwd als een biopsychosociale aandoening van de brein-darm- as, mogelijk samenhangend met drie op elkaar inwerkende mechanismen (Guthrie & Thompson, 2002):

- een verhoogde sensitiviteit van de darmen (viscerale hypersensitiviteit genoemd)
- veranderde beweging en doorstroming van de darmen
- psychosociale factoren.

De viscerale hypersensiviteit kan bijvoorbeeld ontstaan na een heftige darminfectie.

Uitgangsvragen
Wat is de wetenschappelijke evidentie voor specifieke behandeling van prikkelbaredarmsyndroom?

- De effectiviteit van vezels en bulkvormers bij de behandeling van het PDS
- De effectiviteit van medicatie bij de behandeling van het PDS
- Psychologische behandelmethoden
- Behandeling met kruiden
- Behandeling met acupunctuur
- Placebo-effect
- Zelfhulp
- Meetinstrumenten op het gebied van het Prikkelbare Darm Syndroom

Specifieke aanbevelingen en onderbouwing kunt u vinden in deze submodules.

Verantwoording

Laatst beoordeeld : 01-01-2010
Laatst geautoriseerd : 01-01-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Vezels en bulkvormers bij de behandeling van PDS

Uitgangsvraag

Wat is de effectiviteit van vezels en bulkvormers bij de behandeling van het PDS?

Aanbeveling

Aan patiënten met PDS met obstipatie dient geen advies gegeven te worden om meer onoplosbare vezels te eten (graan, tarwe-zemelen). Op proef kunnen oplosbare bulkvormers voorgeschreven worden.

Overwegingen

Hoewel de wergebroek de conclusie van de Cochrane collaboration volgt, geeft het onderzoek van Bijkerk e.a. (2004) wel een interessante mogelijke richting aan om verder onderzoek te doen en daarbij oplosbare en onoplosbare vezels te onderscheiden. Zijn onderzoek geeft duidelijk aan dat het advies wat veel patiënten met obstipatie krijgen, om meer onoplosbare vezels (graan, tarwe-zemelen) te eten, zelfs een verergering van de klachten kunnen geven.

Onderbouwing

Conclusies

Niveau 1	Bulkvormers zijn niet effectief gebleken voor het verbeteren van de globale symptomen of pijnklachten bij patiënten met het PDS. A1 Quartero e.a., 2007

Samenvatting literatuur

In de studie van de Cochrane Collaboration (Quartero e.a., 2007) komt men op grond van 11 studies tot de conclusie dat, hoewel bulk laxantia veel worden voorgeschreven bij het PDS, het poolen van de resultaten aangeeft dat er geen effecten zijn voor de pijn of algemene symptomen. De meeste studies waren echter van matige kwaliteit en slechts 6 van de studies hadden een onderzoeksgroep van 30 of meer patiënten. Acht studies betroffen de tweede lijn, in 3 studies was de setting onduidelijk. De geïnclu- deerde studies werden uitgevoerd tussen 1976 en 1992.
Bijkerk e.a. komen in een systematische review die betrekking heeft op onderzoeken uit de periode 1977-1999 tot andere conclusies (Bijkerk e.a., 2004). Zij includeren 17 studies, waarvan geen enkele in de eerste lijn. Zij maakten een onderscheid tussen de effecten van oplosbare en niet-oplosbare vezels. Oplosbare vezels (Psyllium, Ispa- ghulacalcium en Polycarbophil) lieten een signficante verbetering zien bij patiënten met het PDS en obstipatie, wat betreft de globale symptomen en de obstipatie, terwijl niet-oplosbare vezels (graan, tarwe-zemelen) in sommige gevallen de symptomen verergerden, hoewel er geen significant verschil was, vergeleken met placebo.

Zoeken en selecteren

Een search in PubMed gaf 112 artikelen (2003-2007). Na screening van de abstracts bleven 91 artikelen die met de behandeling van het PDS te maken hebben, ter beoordeling over. De onderzoeken kunnen opgedeeld worden in:

- onderzoek naar vezels en kruiden (27)
- onderzoek naar medicatie (34)
- onderzoek naar psychologische behandelmethoden (21)
- onderzoek naar alternatieve behandelmethoden (5)
- onderzoek naar het placebo-effect (1)
- onderzoek naar zelfhulp (1)
- onderzoek naar kosten (2)

Verantwoording

Laatst beoordeeld : 01-01-2010
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Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Medicatie bij de behandeling van PDS

Uitgangsvraag

Wat is de effectiviteit van medicatie bij de behandeling van het PDS?

Aanbeveling

Het spasmolyticum Buscopan kan overwogen worden voor verbetering van de globale PDS- symptomen. Voor de werking van Mebeverine is geen bewijs.

Wanneer er sprake is van ernstige pijnklachten, kan het gebruik van tricyclische antidepressiva in een lage dosering overwogen worden.

Ook valt het gebruik van bovengenoemde probiotica te overwegen, vooral bij winderigheid.

Het antidiarreemiddel Loperamide of non-steroide anti-imflammatoire medicijnen dienen niet voorgeschreven te worden bij patiënten met het PDS.

Overwegingen

Aangezien Alosteron en Tegaserod niet op de Europese markt verkrijgbaar zijn, zijn er van het gebruik van deze medicatie nog geen grote verbeteringen te verwachten. Wanneer er sprake is van ernstige pijn, kan het gebruik van tricyclische antidepressiva in een lage dosering overwogen worden.

Onderbouwing

Conclusies

Niveau 2	Het probioticum VSL^3 geeft een significante verbetering van winderigheid en vertraagde darmtransitie, maar niet van andere symptomen van het PDS. A2 Hussain e.a., 2006
Niveau 2	Een mix van het probioticum Lactobacillus Rhamnosus GG, L.Rhamnosus LC 705, Bifidobacterium breve Bb 99 en Propionibacterium Freudenreichii ssp, Shermani JS geeft een reductie van de symptomen van het PDS met constipatie. A2 Kajander, 2005
Niveau 2	Een supplement van een drankje bevattende 5 x 10^7 cfu/ml van Lactobacillus plantarum (DSM 9843) en 0,01 g/ml haver, geeft een significante verbetering op winderigheid, maar niet van pijn of opgeblazenheid bij PDS-patiënten. A2 Kajander, 2005
Niveau 1	De effectiviteit van Tegaserod bij CPDS en Alosetron bij DPDS is bewezen, maar zijn, gezien de kans op ernstige complicaties, niet op de Europese markt. A1 Evans e.a., 2007; Lesbros-Pantoflickova, 2004

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Samenvatting literatuur

De middelen waarnaar het meeste onderzoek verricht is voor de behandeling van het PDS zijn: spasmolytica, antidepressiva, probiotica, 5-HT3 en 4-agonisten en -antagonisten.
Opvallend bij de onderzoeken naar de werking van medicatie is de vaak korte follow-uptijd van een aantal weken. Dit is des te merkwaardiger, omdat het PDS een episodisch beloop heeft waarin klachtenperiodes afgewisseld worden met klachtenvrije episodes. Er kan dus niets gezegd worden over of de werking hetzelfde blijft bij langere follow-up.

Spasmolytica
Volgens het overzicht van de Cochrane Collaboration (Quartero e.a., 2007) blijken de spasmolytica Pinaverium en Scopolamine effectief te zijn voor de behandeling van het PDS. Volgens Lesbros-Pantoflickova e.a. (2004) is Pinaverium bromide ineffectief. Volgens deze studie is alleen Octylonium bromide effectief, maar dit op basis van twee studies. Ook is het oordeel over de werking van deze middelen bij het PDS onmogelijk te geven vanwege de heterogeniteit van de trials, de verschillende groepen patiënten en meetmethodes, het kleine aantal geïncludeerde patiënten en het hoge aantal drop-outs (tot 60%).
Ook volgens Tack e.a. (2006) zijn er wel aanwijzingen dat de middelen effectief kunnen zijn, maar er zijn volgens hen nog te weinig gegevens om hier goede conclusies aan te verbinden. Hij verwijst naar een review uit 2002 van de American College of Gastroenterology, die geconcludeerd heeft dat er onvoldoende data waren om een
aanbeveling te doen over de effectiviteit van spasmolytica die verkrijgbaar zijn op de Amerikaanse markt. Voor de bewijstabellen verwijzen wij naar de genoemde studies.
In Nederland zijn de middelen Mebeverine en Butilscopolamine (Buscopan) op de markt. Van Mebeverine wordt in de Cochrane studie geconcludeerd dat er geen enkel significant bewijs voor de werking is. Anders ligt dit voor Scopolamine, daar werd wel een positief effect op de globale symptomen aangetoond.

Antidepressiva
Wat betreft het gebruik van antidepressiva concluderen Tack e.a. (2006) in hun syste- matic review dat:

'hoewel er level II bewijs is voor het feit dat tricyclische antidepressiva positieve effecten hebben bij het behandelen van de pijnklachten van het PDS, is er nog geen overtuigend bewijs dat de TCA's globale PDS-symptomen verbeteren. Zij dienen in een lage dosering, dat wil zeggen lager dan gebruikelijk is voor de behandeling van een depressieve stoornis, gebruikt te worden.' Voor het effect van SSRI's is nog geen consistent bewijs. Vahedi e.a. (2005) geven in een RCT bij patiënten met pijn en constipatie als voornaamste klacht (N=44) als uitkomst, dat alle 5 symptomen van de Rome-II-criteria significant verbeterden met fluoxetine, terwijl er geen bijwerkingen waren die tot stoppen noopten. Lesbros-Pantoflickova (2004) geeft in haar meta-analyse aan dat tricyclische antidepressiva in een lage dosis effectief zijn in het verlichten van de chronische pijn bij PDS-patiënten, maar zij moeten volgens haar, gezien de vaak ernstige bijwerkingen, alleen gegeven worden aan patiënten met vooral ernstige pijnsymptomen. Quartero e.a. (2005) vinden in een meta-analyse geen duidelijke evidentie voor de werking van antidepressiva, maar de onderzoeken waar zij naar verwijzen zijn merendeels uit de jaren tachtig van de vorige eeuw.
De onderzoeken die Tack in zijn review opneemt, zijn van veel recentere datum dan die van Lesbros en Quartero. Daarom hebben we ervoor gekozen om Tacks onderzoeken in een evidentietabel op te nemen.
Het antidiarreemiddel Loperamide kan volgens Lesbros en Tack gebruikt worden bij pijnloze diarree, maar aangezien er volgens de Rome-III-criteria sprake moet zijn van pijnklachten, kunnen we ons afvragen of hier dan van PDS-patiënten gesproken kan worden.

Probiotica
Zowel in de RCT's van O'Mahony e.a. (2005) en van Whorwell e.a. (2006) wordt een significant positief effect gevonden van de probiotica B-infantis 35624 voor de pijnklachten en andere symptomen van het PDS. Ook Kajander e.a. (2005) bewijst dat een capsule met een mix van verschillende probiotica effectief is voor de PDS-groep met constipatie. Zij vonden geen verschil met placebo bij de groep met PDS en diarree. Ook Hussain e.a. (2006) beschrijven in hun systematische review, op basis van 4 studies (waarvan 1 die van O'Mahony, bovengenoemd), het toenemend bewijs voor de effectiviteit van bepaalde probiotica, zoals VSL *3 en B-infantis 35624 op de vermindering van de PDS-symptomen. Opvallend is dat zowel bij Kajander als bij Whorwell geen effect op de kwaliteit van leven gevonden wordt, ondanks de significante verbetering voor de PDS-symptomen.

Tegaserod en Alosetron
Er zijn veel onderzoeken naar de effectiviteit van Tegaserod en Alosetron. Beide zijn niet in Europa verkrijgbaar.
Tegaserod 4 mg en 12 mg geeft een bescheiden verbetering van de stoelgang bij het PDS met obstipatie, maar geen verbetering voor de pijn en het ongemak (Evans e.a., 2007; Heading e.a., 2006; Lesbros-Pantoflickova, 2004). Het meeste onderzoek is bij vrouwen gedaan. Dit middel werd in maart 2007 in Amerika van de markt gehaald in verband met een toename van ischaemische cardiovasculaire incidenten en mag nu alleen nog onder strikte voorwaarden worden voorgeschreven.
Alosetron, een selectieve 5-HT3-antagonist, is effectiever dan het placebo bij het verminderen van het ongemak en pijn en verbetering van de stoelgang bij vrouwen met een PDS met diarree. Ook dit middel werd in 2000 in Amerika van de markt gehaald in verband met complicaties van ernstige obstipatie, ischaemische colitis en darmperforatie. Door patiëntenacties is het onlangs weer toegelaten voor patiënten die aan stricte voorwaarden voldoen.

Aangezien beide middelen niet op de Europese markt verkrijgbaar zijn, verwijzen wij naar het literatuuroverzicht van de Cochrane collaboration (Evans e.a., 2007) en de meta-analyse van Lesbros-Pantoflickova e.a. (2004), en nemen wij deze onderzoeken niet op in een bewijstabel.

Heading e.a. (2006) wijzen erop dat van vele in Europa gebruikte geneesmiddelen de veiligheid en verdraagbaarheid onbekend zijn.
Agrawal & Whorwell (2006) waarschuwen tegen het feit dat er vaak non-steroide anti-imflammatoire medicijnen worden voorgeschreven tegen de pijnklachten van het PDS. Deze kunnen de symptomen verergeren.

Zoeken en selecteren

Een search in PubMed gaf 112 artikelen (2003-2007). Na screening van de abstracts bleven 91 artikelen die met de behandeling van het PDS te maken hebben, ter beoordeling over. De onderzoeken kunnen opgedeeld worden in:

- onderzoek naar vezels en kruiden (27)
- onderzoek naar medicatie (34)
- onderzoek naar psychologische behandelmethoden (21)
- onderzoek naar alternatieve behandelmethoden (5)
- onderzoek naar het placebo-effect (1)
- onderzoek naar zelfhulp (1)
- onderzoek naar kosten (2)

Verantwoording

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Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Psychologische behandelmethoden bij PDS

Uitgangsvraag

Wat is de effectiviteit van psychologische behandelmethoden bij het behandelen van het PDS?

Aanbeveling

Gezien het geringe aantal benodigde zittingen (4) is het het meest effectief om de behandeling van het PDS te beginnen met een relaxatietraining. Bij onvoldoende resultaat wordt vervolgens hypnotherapie gericht op de werking van de darmen en de pijnklachten van het PDS aanbevolen voor volwassenen en kinderen (6-12 zittingen). CGt bij volwassenen is de volgende optie.

Overwegingen

Zowel relaxatietherapie, cognitieve gedragstherapie als hypnotherapie voor het PDS zijn goed toepasbaar voor daartoe opgeleide therapeuten.
Een voordeel van de therapieën is dat er met een welomschreven aantal zittingen gewerkt wordt, waarbij een actieve bijdrage van de patiënt verwacht wordt.
Bij relaxatietherapie en hypnotherapie worden de oefeningen op een cd-rom mee naar huis gegeven. Deze kunnen te allen tijde worden toegepast en kunnen dus ook dienen ter terugvalpreventie. Hetzelfde geldt voor oefeningen van de CGt, die vaak met literatuur in de vorm van een zelfhulpboek ondersteund wordt. Deze oefeningen kunnen de patiënten, ook wanneer de therapie beëindigd is, blijven voortzetten of later weer oppakken.

Onderbouwing

Conclusies

Niveau 1	Hypnotherapie is effectief gebleken voor de behandeling van het PDS bij volwassenen. De algemene PDS-symptomen, angst- en depressieve klachten en somatisatie verbeterden. A1 Gholamrezaei e.a.,2006; Whitehead e.a., 2006; Wilson, 2006
Niveau 1	Hypnotherapie is effectief gebleken voor het verminderen van pijnfrequentie en -intensiteit bij kinderen met het PDS. A2 Vlieger e.a., 2007
Niveau 2	Er zijn aanwijzingen dat cognitieve gedragstherapie effectief kan zijn voor het verbeteren van de lichamelijke symptomen en het psychische welbevinden bij de behandeling van het PDS. A1 Hutton e.a., 2005; Toner, 2005
Niveau 2	Er zijn aanwijzingen dat relaxatietherapie effectief kan zijn voor het verbeteren van de algemene symptomen en kwaliteit van leven en het reduceren van het aantal doktersvisites bij de behandeling van het PDS. A2 Van der Veek e.a., 2007

Samenvatting literatuur

Het meeste onderzoek naar de psychologische behandelmethoden van het PDS is gedaan op het gebied van de cognitieve gedragstherapie en de hypnotherapie. Opvallend bij dit onderzoek, vergeleken met het onderzoek naar medicatie, is de vaak langere follow-up: een half tot 5 jaar. In zijn systematische review en meta-analyse geeft Lackner (Lackner e.a., 2004) in zijn algemeenheid aan dat psychologische interventies zoals relaxatietraining, biofeedback, hypnose, (cognitieve) gedragstherapie en kortdurende psychodynamische interpersoonlijke psychotherapie, effectief zijn.
Hij kan op grond van de gereviewde onderzoeken niet aangeven welke methode effectiever is dan de andere.

In alle reviews betreffende het effect van cognitieve gedragstherapie of hypnotherapie wordt gewezen op methodologische tekortkomingen van het onderzoek. In de bestudeerde artikelen was vooral het ontbreken van een controlegroep met evenveel contacttijd en aandacht het zwakke punt. De RCT's zijn meestal niet vergelijkbaar in termen van studiepopulatie, uitkomstmaten en follow-upperiode.
In een review van Hutton e.a. (2005) en Toner (2005) betreffende het effect van de cognitieve gedragstherapie, geven beiden aan dat er enig beperkt, maar nog geen conclusief, bewijs is voor de effectiviteit van de CGt voor het verbeteren van de lichamelijke symptomen en het psychologische welbevinden. Als extra moeilijkheid bij de vergelijking van onderzoek, geeft Toner aan dat CGt niet een specifieke benadering of set van technieken vertegenwoordigt, maar dat het uit allerlei verschillende componenten kan bestaan, zoals verschillende vormen van cognitieve therapie, verschillende (verdiepende) relaxatietechnieken, assertiviteitstraining en pijnmanagement. Voor de beschrijving van de gereviewde onderzoeken verwijzen wij naar de tabellen in deze artikelen.
In een recent verschenen studie van Van der Veek e.a. (2007) tracht men de effectiviteit van juist 1 element, namelijk de relaxatie, eruit te lichten. Vier zittingen met relaxatietraining in kleine groepjes gaf een significante verbetering van 23% na een follow-up van 1 jaar te zien, versus 3 % in de controlegroep.
In een overzicht van behandelingen voor het PDS in het British Medical Journal (De Wit e.a., 2006) komen de auteurs tot de conclusie dat er nog geen algemene conclusie betreffende de effectiviteit van CGt of hypnotherapie getrokken kan worden. Hoewel er een gering positief resultaat is van de CGt's op korte termijn, geven studies met een langere follow-up aan dat dit niet zou kunnen beklijven. (NB: twee van de recente RCT's (Boyce e.a., 2003 en Kennedy e.a., 2005) worden zowel in het overzicht van De Wit e.a. (2006) als van Toner (2005) opgenomen.)
In 2006 verschenen drie systematische reviews betreffende de effectiviteit van hypnotherapie (Gholamrezaei e.a., 2006; Whitehead e.a.,2006; Wilson e.a.,2006). Gholamrezaei e.a. concluderen op grond van 15 geïncludeerde studies, dat hypnotherapie alle symptomen van het PDS verbetert, evenals de kwaliteit van leven en angst- en depressieve klachten. Whitehead e.a. concluderen op grond van 5 gecontroleerde studies die zij includeren dat, hoewel de onderzoeken bovengenoemde significante beperkingen hebben, het onderzoek toch consistent wijst op het positieve therapeutische effect van hypnotherapie bij het PDS, zelfs voor patiënten die niet op de standaard medische interventies reageren. De mediane respons rate is 87%, symptomen verbeteren met de helft, psychologische symptomen en functioneren verbeteren en deze verbeteringen beklijven over jaren.
Wilson e.a. drukken zich in hun conclusies wat voorzichtiger uit. Van de 3 systematische reviews gebruikten zij de meest uitgebreide zoekstrategiën en werden de studies van beide andere reviews hierin opgenomen. Hun conclusie luidt: ‘het gepubliceerde bewijs geeft aan dat hypnotherapie effectief is bij de behandeling van het PDS. Een RCT van hoge interne validiteit is nodig om de effectiviteit van hypnotherapie vast te stellen.' Voor een overzicht van de bewijstabellen, zie Wilson e.a. (2006).

Een recent verschenen RCT van Vlieger e.a. (2007) over de effectiviteit van hypnotherapie bij kinderen gaf een positieve uitkomst. Hier werd wel vergeleken met een controlegroep met evenveel contacttijd en aandacht. Ook na een follow-up van 1 jaar was 85% van de groep met de interventie door middel van hypnotherapie verbeterd, vergeleken met 25% van de controlegroep.

Zoeken en selecteren

Een search in PubMed gaf 112 artikelen (2003-2007). Na screening van de abstracts bleven 91 artikelen die met de behandeling van het PDS te maken hebben, ter beoordeling over. De onderzoeken kunnen opgedeeld worden in:

- onderzoek naar vezels en kruiden (27)
- onderzoek naar medicatie (34)
- onderzoek naar psychologische behandelmethoden (21)
- onderzoek naar alternatieve behandelmethoden (5)
- onderzoek naar het placebo-effect (1)
- onderzoek naar zelfhulp (1)
- onderzoek naar kosten (2)

Verantwoording

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Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Behandeling met kruiden bij PDS

Uitgangsvraag

Wat is de effectiviteit van kruiden bij het behandelen van het PDS?

Aanbeveling

Kruiden, mits erkend als geneesmiddel door het CBRG voor de behandeling van het PDS, dienen alleen voorgeschreven te worden door daarin gespecialiseerde artsen.

Overwegingen

Gezien de geringe ervaring in onze cultuur met dergelijke kruiden en het probleem van controle op de samenstelling ervan, adviseren wij deze alleen te gebruiken na voorschrijven door hierin gespecialiseerde artsen.

Onderbouwing

Conclusies

Niveau 1	Een standaard Chinese kruidenformule, de Chinese kruiden STW-5 en STW-52, het Tibetaanse kruid Padma lax (voor PDS met constipatie), de Chinese kruidencompositie Tongxie Yaofang (voor PDS met diarree) en Ayurvedische medicijnen zijn effectief gebleken bij de behandeling van het PDS. *A1 Liu, 2006*

Samenvatting literatuur

In een uitgebreide systematic review van de Cochrane Collaboration van Liu e.a. (2006) over de toepassing van kruiden bij het PDS, worden significante verbeteringen gemeld van een standaard Chinese kruidenformule, de Chinese kruiden STW-5 en STW-52, het Tibetaanse kruid Padma lax (voor PDS met constipatie) en de Chinese kruidencompositie Tongxie Yaofang (voor PDS met diarree). Ook een Indiase Ayurvedische formule van twee kruiden (voor PDS met diarree) kan verlichting van de symptomen geven. Voor de bewijstabellen verwijzen wij naar de review van de Cochrane Collaboration.

Zoeken en selecteren

Een search in PubMed gaf 112 artikelen (2003-2007). Na screening van de abstracts bleven 91 artikelen die met de behandeling van het PDS te maken hebben, ter beoordeling over. De onderzoeken kunnen opgedeeld worden in:

- onderzoek naar vezels en kruiden (27)
- onderzoek naar medicatie (34)
- onderzoek naar psychologische behandelmethoden (21)
- onderzoek naar alternatieve behandelmethoden (5)
- onderzoek naar het placebo-effect (1)

- onderzoek naar zelfhulp (1)
- onderzoek naar kosten (2)

Verantwoording

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Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Behandeling met acupunctuur bij PDS

Uitgangsvraag

Wat is de effectiviteit van acupunctuur bij het behandelen van het PDS?

Aanbeveling

Bij deze uitgangsvraag zijn geen aanbevelingen geformuleerd.

Overwegingen

Bij deze uitgangsvraag zijn geen overwegingen geformuleerd.

Onderbouwing

Conclusies

Niveau 1	Er zijn geen aanwijzingen dat acupunctuur effectief kan zijn bij de behandeling van het PDS. *A1 Lim e.a., 2006*

Samenvatting literatuur

Lim e.a. (2006) concluderen in een review van de Cochrane Collaboration uit 2006, dat er geen bewijs is voor de positieve werking van acupunctuur bij het PDS. Zie deze review voor de bewijstabellen.

Zoeken en selecteren

Een search in PubMed gaf 112 artikelen (2003-2007). Na screening van de abstracts bleven 91 artikelen die met de behandeling van het PDS te maken hebben, ter beoordeling over. De onderzoeken kunnen opgedeeld worden in:

- onderzoek naar vezels en kruiden (27)
- onderzoek naar medicatie (34)
- onderzoek naar psychologische behandelmethoden (21)
- onderzoek naar alternatieve behandelmethoden (5)
- onderzoek naar het placebo-effect (1)
- onderzoek naar zelfhulp (1)
- onderzoek naar kosten (2)

Verantwoording

Laatst beoordeeld : 01-01-2010
Laatst geautoriseerd : 01-01-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Placebo-effect bij behandeling van PDS

Uitgangsvraag

Wat is de effectiviteit van het placebo effect bij het behandelen van het PDS?

Aanbeveling

Gezien het grote placebo-effect bij de behandeling van het PDS, is het bij studies naar behandelingsmethoden voor het PDS van belang de Rome-III-criteria voor het stellen van de diagnose stringent toe te passen en altijd gebruik te maken van een controlegroep met, bij psychologisch onderzoek, hetzelfde aantal contacturen als bij de interventiegroep.

Overwegingen

Bij deze uitgangsvraag zijn geen overwegingen geformuleerd.

Onderbouwing

Conclusies

Niveau 1	Bij de behandeling van het PDS speelt het placebo-effect een grote rol. *A1 Patel e.a., 2005*

Samenvatting literatuur

Patel e.a. (2005) geven in een meta-analyse over onderzoek naar het placebo-effect aan, dat dit effect groot is bij de behandeling van het PDS. Onder het placebo-effect wordt hier verstaan het fysiologisch effect van psychologische inbeelding. Een meer stringente toepassing van de Rome-III-criteria en een groter aantal contacturen vermindert dit effect.

Zoeken en selecteren

Een search in PubMed gaf 112 artikelen (2003-2007). Na screening van de abstracts bleven 91 artikelen die met de behandeling van het PDS te maken hebben, ter beoordeling over. De onderzoeken kunnen opgedeeld worden in:

- onderzoek naar vezels en kruiden (27)
- onderzoek naar medicatie (34)
- onderzoek naar psychologische behandelmethoden (21)
- onderzoek naar alternatieve behandelmethoden (5)
- onderzoek naar het placebo-effect (1)
- onderzoek naar zelfhulp (1)
- onderzoek naar kosten (2)

Verantwoording

Laatst beoordeeld : 01-01-2010

Laatst geautoriseerd : 01-01-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Zelfhulp als behandeling van PDS

Uitgangsvraag

Wat is de effectiviteit van zelfhulp bij het behandelen van het PDS?

Aanbeveling

In de eerste lijn is het gebruik van zelfhulpliteratuur als eerste stap te overwegen.

Overwegingen

Bij deze uitgangsvraag zijn geen overwegingen geformuleerd.

Onderbouwing

Conclusies

Niveau 2	Het is aannemelijk dat zelfhulpliteratuur een rol kan spelen bij de vermindering van klachten bij patiënten met het PDS. A2 Robinson e.a., 2006

Samenvatting literatuur

Er werd één onderzoek gevonden naar de toepassing van een zelfhulpboek voor patiënten met PDS (Robinson e.a., 2006). Dit boek gaf een reductie van 60% van eerstelijnsconsulten en een significante verbetering van de ernst van de ervaren klachten te zien.

Zoeken en selecteren

Een search in PubMed gaf 112 artikelen (2003-2007). Na screening van de abstracts bleven 91 artikelen die met de behandeling van het PDS te maken hebben, ter beoordeling over. De onderzoeken kunnen opgedeeld worden in:

- onderzoek naar vezels en kruiden (27)
- onderzoek naar medicatie (34)
- onderzoek naar psychologische behandelmethoden (21)
- onderzoek naar alternatieve behandelmethoden (5)
- onderzoek naar het placebo-effect (1)
- onderzoek naar zelfhulp (1)
- onderzoek naar kosten (2)

Verantwoording

Laatst beoordeeld : 01-01-2010
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Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Meetinstrumenten op het gebied van PDS

Uitgangsvraag

Wat zijn meetinstrumenten op het gebied van het Prikkelbare Darm Syndroom?

Aanbeveling

De Adequate Relief Question is de eerste keuze wanneer men de globale symptomatologie als uitkomstmaat wil nemen bij PDS-studies.
Voor een meer gedetailleerde symptoommeting is de IBS-Severity Scoring System te prefereren.
Ten slotte kan de IBS-Quality of Life schaal gebruikt worden om veranderingen in de gezond-heidsgerelateerde kwaliteit van leven te meten.

Overwegingen

Bij deze uitgangsvraag zijn geen overwegingen geformuleerd.

Onderbouwing

Samenvatting literatuur

Volgens Bijkerk e.a. (2003) is de Adequate Relief Question de eerste keuze wanneer men de globale symptomatologie als uitkomstmaat wil nemen bij PDS-studies.
Voor een meer gedetailleerde symptoommeting is de IBS-Severity Scoring System te prefereren. Ten slotte kan de IBS-Quality of Life schaal gebruikt worden om veranderingen in de gezondheidsgerelateerde kwaliteit van leven te meten.
Alle drie de schalen zijn in het Nederlands vertaald door Bijkerk, De Wit, Muris e.a.

Zoeken en selecteren

Een search in PubMed gaf 112 artikelen (2003-2007). Na screening van de abstracts bleven 91 artikelen die met de behandeling van het PDS te maken hebben, ter beoordeling over. De onderzoeken kunnen opgedeeld worden in:

- onderzoek naar vezels en kruiden (27)
- onderzoek naar medicatie (34)
- onderzoek naar psychologische behandelmethoden (21)
- onderzoek naar alternatieve behandelmethoden (5)
- onderzoek naar het placebo-effect (1)
- onderzoek naar zelfhulp (1)
- onderzoek naar kosten (2)

Verantwoording

Laatst beoordeeld : 01-01-2010
Laatst geautoriseerd : 01-01-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Preventie

Preventie van SOLK en somatoforme stoornissen: wat kunnen we ons daarbij voorstellen? Het af en toe hebben van lichamelijke klachten die vaak somatisch onvoldoende verklaard blijven, hoort onvermijdelijk bij het leven en lijkt niet te voorkómen. In module ‘Diagnostiek’, in de submodules over verklaringsmodellen, zagen we echter al dat er onnoemelijk veel predisponerende, uitlokkende en in stand houdende factoren een rol kunnen spelen bij het ontstaan en blijven bestaand van SOLK en somatoforme stoornissen, en dat voor elke individuele patiënt een unieke constellatie van factoren bepalend kan zijn.
Factoren die een mogelijk aangrijpingspunt vormen voor preventie zijn: chronische stress (zowel psychisch als fysiek), trauma, angst en depressie, gebrek aan sociale steun, irrëele cognities, ongerustheid en een passieve copingstijl. We kondigen alvast aan dat we voor de meeste risicofactoren geen onderzoek naar preventieve interventies hebben gevonden.
Bij de keuze van een preventiemodel heeft de werkgroep het VTV-rapport ‘Gezond verstand' gevolgd. (Meijer, 2006). Hierin worden vier soorten preventie onderscheiden.

- Universele preventie. Dit is preventie gericht op de algemene bevolking, met als doel de prevalentie van risicofactoren in de bevolking te verlagen. Universele preventie wordt meestal uitgevoerd op maatschappelijk macroniveau (overheid, media inclusief internet) of mesoniveau (school, werk, wijkcentrum)..
- Selectieve preventie. Deze is gericht op risicogroepen die nog geen klachten hebben. Hier wordt geprobeerd aanwezige risicofactoren te beïnvloeden. Selectieve preventie kan zowel op macro-, meso- als individueel/kleine groepsniveau worden aangeboden.
- Geïndiceerde preventie. Hierbij gaat het om het voorkómen van verergering bij mensen die al klachten hebben. In ons geval gaat het om het voorkómen dat beginnende SOLK zich verder kan ontwikkelen tot somatoforme stoornissen met langdurig beloop en functiebeperkingen. Geïndiceerde preventie wordt meestal via de gezondheidszorg aangeboden, individueel of in kleine groepen.
- Terugvalpreventie. Deze vorm wordt niet in deze module uitgewerkt, maar maakt deel uit van de module over behandeling.

Uitgansvragen
Het onderwerp 'Preventie' wordt uitgewerkt in de volgende uitgangsvragen:

- Welke wetenschappelijke onderbouwing is er voor de effectiviteit van universele preventie van SOLK en somatoforme stoornissen?
- Welke wetenschappelijke onderbouwing is er voor de effectiviteit van selectieve preventie van SOLK en somatoforme stoornissen?
- Welke wetenschappelijke onderbouwing is er voor de effectiviteit van geïndiceerde preventie bij SOLK op preventie van somatoforme stoornissen? Deelvragen:
- Welke wetenschappelijke onderbouwing is er voor de invloed van arts-patiënt- communicatie bij SOLK op preventie van somatoforme stoornissen?
- Welke wetenschappelijke onderbouwing is er voor de invloed van geruststellen bij SOLK op preventie van somatoforme stoornissen?

- Welke wetenschappelijke onderbouwing is er voor de invloed van patiënteninformatie over SOLK op preventie van somatoforme stoornissen?

Specifieke aanbevelingen en onderbouwing kunt u vinden in deze submodules.

Verantwoording

Laatst beoordeeld : 01-01-2010
Laatst geautoriseerd : 01-01-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Effectiviteit van universele preventie

Uitgangsvraag

Welke wetenschappelijke onderbouwing is er voor de effectiviteit van universele preventie van SOLK en somatoforme stoornissen?

Aanbeveling

Bij deze module zijn geen aanbevelingen geformuleerd.

Overwegingen

De werkgroep acht mediapresentaties over SOLK en somatoforme stoornissen die uitdragen dat lichamelijke klachten lang niet altijd op ziekte wijzen, zoals tv-series over huisartsenspreekuren en de artikelenserie van journaliste Evelien Brandt in dagblad Trouw, een mogelijk effectieve vorm van universele preventie. De werkgroep heeft echter geen effectevaluatie van mediapresentaties gevonden.

Onderbouwing

Conclusies

Niveau 4	De werkgroep concludeert dat er geen onderzoek is waaruit blijkt dat universele preventieprogramma's leiden tot minder SOLK en somatoforme stoornissen.

Samenvatting literatuur

We vonden enkele preventieprojecten gericht op stressvermindering op school of werk, waarbij effecten op gezondheid zijn geëvalueerd in vergelijking met een controlegroep. Een anti-pestprogramma op Nederlandse basisscholen leidde tot 25% minder pesten en tot minder depressie, maar had geen invloed op het ontstaan van psychosomatische klachten (Fekkes e.a., 2006).
Een lesmodule over gezondheidsbevordering had geen invloed op de op school ervaren stress en op het ontstaan van fysieke en psychische symptomen (Buddeberg- Fischer e.a., 2000).
Stress-managementtraining leidde bij studenten tot een reductie van stress en irrationele opvattingen in vergelijking met de niet getrainde controlegroep. Gezondheidseffecten zijn niet gemeten (Decker e.a., 1982).
Onder werknemers hadden stress-managementtraining, fysieke training en een geïntegreerd gezondheidsprogramma geen effect op werkstress, ervaren gezondheid of ziekteverzuim (Eriksen e.a., 2002).

Verantwoording

Laatst beoordeeld : 01-01-2010
Laatst geautoriseerd : 01-01-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Effectiviteit van selectieve preventie

Uitgangsvraag

Welke wetenschappelijke onderbouwing is er voor de effectiviteit van selectieve preventie van SOLK en somatoforme stoornissen?

Aanbeveling

Bij deze module zijn geen aanbevelingen geformuleerd.

Overwegingen

De werkgroep is van mening dat therapeutische zelfhulpprogramma's (via internet of boeken) waarmee mensen hun depressieve of angstklachten kunnen leren hanteren mogelijk kunnen bijdragen aan selectieve preventie van SOLK en somatoforme stoornissen. Effecten van deze programma's op het voorkómen van SOLK of somatoforme stoornissen zijn echter niet onderzocht.

Onderbouwing

Conclusies

Niveau 4	De werkgroep concludeert dat er enig bewijs is voor effect van selectieve preventie: bij situaties die vaak somatisatie uitlokken (luxerende factoren) kan gerichte patiënteneducatie bijdragen aan het voorkómen van SOLK en somatoforme stoornissen.

Samenvatting literatuur

Selectieve preventie is preventie gericht op risicogroepen. De werkgroep heeft gezocht naar gecontroleerd preventieonderzoek gericht op mensen met risicofactoren voor het ontwikkelen van SOLK en somatoforme stoornissen. We vonden preventieonderzoek gericht op mensen met:

- een acute collectieve ramp. New-Yorkers die na de WTC-ramp op het werk twee tot drie crisis-interventiesessies kregen (geen debriefing, maar gerichte therapeutische gesprekken), hadden na twee jaar onder andere minder somatisatie dan mensen zonder interventie. Uitgebreidere interventies leverden geen betere uitkomsten op (Boscarino e.a., 2005).
- acute aandoeningen die vaak leiden tot somatiseren. Na een aanrijding van achteren leidde een educatieve video tot minder pijn na zes maanden (Brison e.a., 2005). Een systematische review geeft aan dat psycho-educatie bij mononucleosis-infectie in de eerste lijns zorg preventief werkt tegen het ontstaan van langdurige moeheid (Candy e.a., 2004).
- hoge fysieke belasting. Een systematische review van zestien RCT's bij werknemers met rugbelastend werk toonde geen preventief effect van lumbale steun of educatie op rugklachten, oefenen had wel enig preventief effect (Van Poppel e.a., 2004).

Verantwoording

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Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Effectiviteit van geïndiceerde preventie

Uitgangsvraag

Welke wetenschappelijke onderbouwing is er voor de effectiviteit van geïndiceerde preventie bij SOLK op preventie van somatoforme stoornissen?

Aanbeveling

Geïndiceerde preventie zal meestal door medische of psychosociale hulpverleners op individueel niveau worden aangeboden. Belangrijk is hierbij dat het medisch en communicatief handelen van hulpverleners bij patiënten met SOLK aansluit op de bezorgdheid van de patiënt.

Overwegingen

Bij deze module zijn geen overwegingen geformuleerd.

Onderbouwing

Conclusies

Niveau 1	Fysieke inspanning heeft matig sterk effect op het voorkómen van chroniciteit, functiebelemmering en werkverzuim bij rugklachten. *A1 Linton & Van Tulder, 2001 B Hurwitz, 2005*
Niveau 2	CGT (ook na vijf jaar) heeft matig sterk effect op het voorkómen van chroniciteit, functiebelemmering en werkverzuim bij rugklachten. *A2 Linton, 2000, 2006, 2001*
Niveau 4	Voor de meeste SOLK is geen onderzoek gedaan naar effecten van geïndiceerde preventie.

Samenvatting literatuur

Geïndiceerde preventie is gericht op patiënten die kortdurend SOLK hebben en daar nog geen of eenmalig medische hulp voor gevraagd hebben. Doel is te voorkómen dat deze SOLK zich verder ontwikkelt tot somatoforme stoornis. Khan heeft gekeken welke factoren voorspellend waren voor een chronisch beloop van SOLK: eerstelijnspatiënten bij wie de behandelend arts de klachten duidde als psychiatrisch dan wel idiopathisch, werden twaalf maanden gevolgd. Een kwart hield klachten. Onafhankelijke predictoren van het persisteren van klachten waren: eerder bezoek aan de huisarts voor dezelfde klachten, klachttype (hoofdpijn, rugpijn), mannelijke geslacht, grote medische comor- biditeit (zeven of meer medische diagnosen) (Khan e.a., 2003).
In de modules ‘Diagnostiek’ worden factoren besproken die SOLK in stand houden: biologisch (conditieverlies, chronische stress), psychisch (angst, ongerustheid, zich niet serieus genomen voelen, vermijding) en sociaal (gebrek aan sociale contacten en het niet hebben van werk). Geïndiceerde preventie komt in wezen neer op interveniëren op deze in stand houdende factoren bij mensen met beginnende SOLK.

De werkgroep vond veel onderzoek naar preventie van chroniciteit door vroeg interveniëren bij rug- en

nekklachten. Veel van dit onderzoek is uitgevoerd bij werknemers in bedrijven.
Bij lage rugklachten hing recreatieve fysieke inspanning samen met minder lage rugpijn (zowel op het moment zelf als later), met minder rugpijngerelateerde beperkingen en minder psychische spanning. Rugoefeningen daarentegen hingen zowel crosssectioneel als longitudinaal samen met meer rugpijn en meer rugpijngerelateerde disability (Hurwitz e.a., 2005).
In een RCT bij 250 mensen met recidiverende rug- of nekpijn die hiermee geen arts bezocht hadden, leidde 6 groepssessies cognitieve gedragstherapie tot minder vermijdingsgedachten, meer pijnvrije dagen en driemaal minder langdurig ziekteverzuim (Linton & Ryberg, 2001). Bij patiënten met (sub)acute rugpijn die zelf voelden dat ze risico liepen op chroniciteit, was het relatieve risico op langdurig ziekteverzuim in de CGT-groep negenmaal zo laag (Linton & Andersson, 2000) als bij een informatiefolder of informatiepakket. Na 5 jaar (respons 97%!) rapporteerde de CGT-groep significant minder pijn, betere kwaliteit van leven en een betere gezondheid dan de controlegroep. Gebruik van medische zorg verschilde niet, ziekteverzuim en totale kosten waren wel aanzienlijk lager in de CGT-groep (Linton & Nordin, 2006).
Een systematische review van 27 (R)CT's naar preventieve interventies bij mensen met rug- en nekpijn die daar zelf geen medische hulp voor hadden gezocht, evalueerde effecten op preventie van langdurige pijn, disfunctie, gebruik van medische zorg en werkverzuim (Linton & Van Tulder, 2001). Van 9 RCT's over rugscholen was er slechts één die positieve effecten rapporteerde. De RCT's over lumbale steun waren alle negatief. De RCT's naar oefeningen toonden consistent matig grote positieve resultaten. Over ergonomische interventies kon geen uitspraak worden gedaan.
In een RCT onder 64 huisartsbezoekers met acute lage rugpijn werd het effect onderzocht van een folder waarin visies van patiënten en medische hulpverleners over lage rugpijn beschreven stonden (Roberts e.a., 2002). In vergelijking met gebruikelijke huisartsenzorg had de interventiegroep een betere zithouding na 2 en 13 weken en een betere tiltechniek gedurende het hele follow-upjaar. De folder had geen effect op functionele uitkomsten.

Verantwoording

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Laatst geautoriseerd : 01-01-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Invloed van arts-patiëntcommunicatie

Uitgangsvraag

Welke wetenschappelijke onderbouwing is er voor de invloed van arts-patiëntcommu nicatie bij SOLK op preventie van somatoforme stoornissen?

Aanbeveling

Bij deze module zijn geen aanbevelingen geformuleerd.

Overwegingen

De werkgroep is van mening dat bovengenoemde aspecten van patiëntgericht consult- voeren voor patiënten met SOLK extra relevant zijn, om de volgende redenen:

- SOLK zijn vaak moeilijk te duiden, wat klachtexploratie noodzakelijk maakt.
- Patiënt en arts hebben vaak een verschillende visie op het probleem, dus het zoeken naar een gemeenschappelijke probleemdefinitie verdient aandacht.
- Het te voeren beleid vergt vaak een actieve rol van de patiënt. Dit beleid heeft alleen kans van slagen als het door gezamenlijke besluitvorming tot stand komt. Daar zal soms onderhandeling voor nodig zijn.

De werkgroep is van mening dat bij het plannen en uitvoeren van beleid elementen van motiverende gespreksvoering, met name het gebruiken van verandertaal, patiënten met SOLK kunnen stimuleren tot verandering van in stand houdende factoren. Dit kan mogelijk bijdragen aan geïndiceerde preventie (Miller & Rollnick, 2005).

Onderbouwing

Conclusies

Niveau 1	Het is aangetoond dat patiëntgerichte consultvoering met een brede klachtexploratie plus aandacht voor een gemeenschappelijke probleemdefinitie en gemeenschappelijke besluitvorming een gunstige invloed heeft op de volgende gezondheidsuitkomsten: emotionele gezondheid, symptomen, functioneren, fysiologische parameters en pijn. Dit is niet specifiek onderzocht voor SOLK. *A1 Stewart, 1995*

Niveau 3	Er zijn aanwijzingen dat artsen en SOLK-patiënten het over de meeste te voeren strategieën eens zijn: beschikbaarheid (langer consult) communicatie (luisteren, serieusnemen, continuïteit van zorg), zoeken naar de klachtoorzaak (tests, verwijzing), uitleg (symptomen, beloop, verband met psychosociale factoren). *C Andersen e.a., 2008*

Samenvatting literatuur

In een systematische review van 10 RCT's en 11 CT's en cohortstudies werd de relatie tussen arts-patientcommunicatie en gezondheidsuitkomsten voor de patiënt onderzocht (Stewart, 1995). In 16 van de 21 onderzoeken werd een positieve invloed gevonden
van de kwaliteit van de communicatie op de gezondheidsuitkomsten. Communicatie had invloed op (in afnemende volgorde): emotionele gezondheid, vermindering en verdwijnen van symptomen, functioneren, fysiologische maten zoals bloeddruk en bloedglucose, en pijnvermindering.
De volgende communicatieaspecten waren van invloed op de gezondheidsuitkomsten:

- een brede klachtexploratie naar zowel somatische als emotionele en cognitieve aspecten en verwachtingen en naar de door de patiënt ervaren invloed van de klachten op het functioneren;
- een gedeelde visie op het probleem en een gemeenschappelijk ontwikkeld beleid (shared decision making), waarbij de patiënt gelegenheid krijgt om nadere informatie te vragen en eigen reacties te geven.

In een observationeel onderzoek (Epstein e.a., 2007) kregen 100 huisartsen elk 2 under-coversimulatiepatiënten op het spreekuur: één met medisch verklaarde klachten en één met SOLK. De consulten werden stiekem opgenomen en de reacties van de artsen op door de simulatiepatiënten geuite bezorgdheid werden geanalyseerd. Daarnaast kregen 50 echte patiënten vragen over de persoonsgerichtheid van hun arts. Resultaten: de artsen gaven gemiddeld 3.1 reacties op de geuite bezorgdheid. Medische vragen en acties, ongespecificeerde erkenning en geruststelling kwamen veel voor. Empathie, het laten blijken van onzekerheid en exploratie van psychosociale factoren en emoties kwamen weinig voor, ook bij SOLK. Dokters die empathisch reageerden direct nadat de simulatiepatiënt zijn zorg had geuit, kregen van hun echte patiënten hogere scores voor persoonsgerichtheid.
In een Amerikaanse kwalitatieve studie (Andersen e.a., 2008) werden 36 eerstelijnsartsen en 47 van hun patiënten met SOLK geïnterviewd over welke strategieën de arts het best kon gebruiken. Effectief volgens zowel artsen als patiënten waren: medische behandeling, zoeken naar oorzaken door middel van testen en verwijzingen, aandachtig luisteren, erkennen van klachten, continuïteit van zorg bieden, langere consulten toestaan, op telefoontjes van de patiënt terugbellen, duidelijke uitleg geven over symptomen en beleid en een verklaringsmodel geven voor het verband tussen psychosociale factoren en lichamelijke klachten. Verder noemden de patiënten strategieën effectief waar de artsen moeite mee hadden: aanvragen van onnodige tests, spreekuurafspraken naar behoefte en slaapmiddelen voorschrijven. De auteurs benadrukken het belang van continuïteit in de relatie en een zorgorganisatie die arts-patiëntcommunicatie faciliteert.

Verantwoording

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Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK De invloed van geruststellen

Uitgangsvraag

Welke wetenschappelijke onderbouwing is er voor de invloed van geruststellen bij SOLK op preventie van somatoforme stoornissen?

Aanbeveling

Bij deze module zijn geen aanbevelingen geformuleerd.

Overwegingen

De werkgroep ziet effectieve geruststelling bij SOLK als een wezenlijke stap in het voorkómen van verergering van SOLK tot somatoforme stoornissen. Alleen zeggen ‘U hoeft zich over deze klacht geen zorgen te maken' leidt zonder verdere uitleg niet tot geruststelling van patiënten met SOLK. Volgens de werkgroep vereist effectief geruststellen het sensitief oppikken en serieus nemen van ongerustheid en het geven van bij de patiënt aansluitende, normaliserende uitleg.

Onderbouwing

Achtergrond

Warwick & Salkovskis (1985) omschrijven effectief geruststellen als het verstrekken van nieuwe informatie die relevant is voor de klinische toestand van de patiënt. Zij stellen dat artsen op ongeruste patiënten te veel reageren met herhaalde ongerichte geruststelling en aanvullend onderzoek. Wij hebben gezocht naar onderzoek naar de effecten van aanvullend onderzoek op ziekteangst bij SOLK en somatoforme stoornissen. Daarnaast hebben we gezocht naar onderzoek over de manier waarop artsen uitleg geven over SOLK en de effecten daarvan op ongerustheid van patiënten.

Conclusies

Niveau 2	Het is aannemelijk dat normale uitslagen van aanvullend en specialistisch onderzoek ongerustheid bij patiënten met SOLK vaak niet wegnemen. *A2 RCT Howard, 2005 C McDonald, 1996; Mayou, 1999*
Niveau 3	Er zijn aanwijzingen dat artsen vaak ineffectieve geruststellingstechnieken gebruiken, zoals niet bij de patiënt aansluitende uitleg, bagatelliseren en medische acties. *C Dowrick, 2004; Ring, 2004; Donovan, 2000; Epstein, 2007*
Niveau 3	Er zijn aanwijzingen dat (huis)artsen in consulten over SOLK het merendeel van de door patiënten aangegeven psychosociale cues missen. *C Salmon, 2004*

Samenvatting literatuur

Wij vonden verschillende onderzoeken naar de mate waarin een normale uitslag van aanvullend onderzoek patiënten met SOLK geruststelt.
In een observationeel onderzoek werden 38 volwassenen die verwezen waren voor een echocardiogram en bij wie de echo-uitslag normaal was, geïnterviewd vóór en na de echo en 9-12 maanden later. Tien mensen waren verwezen met klachten, de overige 28 wegens een toevallig ontdekte hartruis. Alle mensen met klachten waren voor de echo
ongerust over hun hart en bij allen bleef die ongerustheid na de normale uitslag bestaan. Twintig van de mensen zonder klachten waren voor de echo ongerust. De normale uitslag stelde 3 van hen gerust, 6 twijfelden en 11 bleven ongerust over hun hart. Ongerustheid hing sterk samen met niet-begrijpen dat een hartruis en klachten kunnen blijven bestaan ook als het hart normaal is. Na 9-12 maanden waren 8 mensen met klachten en 11 mensen zonder klachten nog steeds ongerust over hun hart (McDonald e.a., 1996).
In een RCT onder 150 patiënten met chronische hoofdpijn in de huisartspraktijk kreeg de interventiegroep een MRI-scan aangeboden. De interventie leidde alleen in de subgroep met angst of depressie tot afname van medische kosten en gebruik van medische hulp. De interventiegroep was na 3 maanden iets minder bang dat hun hoofdpijn door een ernstige ziekte veroorzaakt werd. Na een jaar was er geen verschil meer met de controlegroep. Op preoccupatie met ziekte, zoeken van geruststelling en invloed van de hoofdpijn op het dagelijks leven had de interventie geen effect. De auteurs concluderen dat de scan niet zozeer de patiënten geruststelt alswel de arts, waardoor deze een consistenter beleid kan voeren met minder onnodige verwijzingen (Howard e.a., 2005).
In een observationeel onderzoek over ongerustheid werden 35 patiënten die met gewrichtsklachten door hun huisarts waren verwezen voor en na het consult met de reumatoloog thuis geïnterviewd. Uit de op band opgenomen consulten bleek dat geruststelling een grote rol speelde in de gesprekken, zowel bij duidelijke artritis als bij overige klachten. De reumatologen benadrukten de mildheid, het vroege stadium of de geringe ernst van de ziekte en de grote kans dat de patiënt zou herstellen. De nadruk op mildheid en het vroege stadium stelde patiënten niet gerust, maar wekte juist gedachten op aan toekomstige pijn en invaliditeit. Patiënten die merkten dat de dokter hun problemen erkenden, voelden zich meer gerustgesteld (Donovan & Blake, 2000).
Van 133 patiënten met niet-cardiale pijn op de borst, die (met of zonder angiografie) werden gerustgesteld door de cardioloog, waren 56 na 6 weken nog ongerust. Zij werden in een RCT gerandomiseerd naar CGT of gebruikelijke zorg. In beide groepen hield de meerderheid klachten, de CGT-groep had minder distress. De onderzoekers adviseren bij niet-cardiale pijn op de borst stepped care, met als eerste stap geruststellen met of zonder angiografie, en als tweede stap CGT (Mayou e.a., 1999).
Verschillende auteurs (Dowrick e.a., 2004; Salmon e.a., 2004; Ring e.a., 2004) analyseerden kwalitatief hoe huisartsen uitleg geven over SOLK. In 36 consulten van 21 huisartsen werd gekeken welke aanknopingspunten patiënten de arts bieden om in te gaan op psychosociale aspecten en om uitleg te geven over de klachten en om mogelijke samenhang met psychosociale factoren te bespreken. Vrijwel alle patiënten gaven de arts duidelijke kansen om op psychosociale aspecten in te gaan, suggereerden dat er misschien geen ziekte achter de klachten zat, uitten ongerustheid of vroegen om uitleg. De artsen lieten het merendeel van deze kansen liggen. De auteurs introduceren het concept ‘normaliseren', waarmee ze aanduiden dat de klachten als normaal verschijnsel en niet als ziekte geduid worden. De artsen normaliseerden de klacht 42 keer waarvan 31 keer zonder enige uitleg (dit is geen ziekte /de test is normaal), 11 maal gaven ze er een uitleg bij die 6 keer wel en 5 keer niet aansloot bij de door de patiënt geuite bezorgdheid, 4 keer werd een verband tussen klacht en psychosociale factoren benoemd. De artsen stelden

meestal een medisch beleid in (medicijnen, onderzoek), terwijl de patiënten dat zelden expliciet eisten. Wel stuurden veel patiënten indirect op medisch beleid aan, door bijvoorbeeld suggestieve taal of somatische klachtinterpretaties.

Verantwoording

Laatst beoordeeld : 01-01-2010
Laatst geautoriseerd : 01-01-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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SOLK Invloed van patiënteninformatie

Uitgangsvraag

Welke wetenschappelijke onderbouwing is er voor de invloed van patiënteninformatie over SOLK op preventie van somatoforme stoornissen?

Aanbeveling

Bij deze module zijn geen aanbevelingen geformuleerd.

Overwegingen

De werkgroep vond verschillende Nederlandse voorlichtingsfolders over SOLK.
Door het Canisius-Wilhelmina Ziekenhuis in Nijmegen samen met het Psychiatrisch Ziekenhuis Reinier van Arkel in Den Bosch is een 'opstap'-folder gemaakt die landelijk verspreid is en ook op internet staat. Hierbij is een uitgebreide informatiebrochure te bestellen. De proefversie is geëvalueerd door huisartsen en patiënten. Naar aanleiding van hun reacties is in de folder minder nadruk komen te liggen op psychiatrie en meer aandacht besteed aan gewone lichamelijke reacties en spanningsklachten (Buis e.a., 1995). Positieve reacties van hulpverleners en patiënten worden beschreven, maar een systematische evaluate van effecten hebben wij niet gevonden.
Het Nederlands Huisartsen Genootschap heeft in 1999 een patiëntenbrief uitgebracht die ook op internet staat. Hierin staat dat SOLK veel voorkomen en dat wat iemand denkt en voelt lichamelijke klachten kan geven. Het bijhouden en met de huisarts bespreken van een klachtendagboek wordt aangeraden. Bij navraag blijkt dat geen effectevaluatie van de patiëntenbrief heeft plaatsgevonden.

Onderbouwing

Conclusies

Niveau 1	Het is aangetoond dat betrouwbare patiënteninformatie over (effecten van) behandelingen voor lichamelijke klachten bijdraagt aan realistische verwachtingen, een actieve rol in de medische besluitvorming en besluiten die beter passen bij de waarden van de patiënt. *A1 O'Connor e.a., 2003*
Niveau 3	Er zijn aanwijzingen dat het voor patiënten erg moeilijk is betrouwbare informatie te vinden over effecten van geneeskundige behandelingen voor lichamelijke klachten. *C Glenton e.a., 2005*
Niveau 4	Er is wel voorlichtingsmateriaal voor patiënten met SOLK, maar voor zover ons bekend zijn er geen evaluaties van de effecten op SOLK en somatoforme stoornissen.

Samenvatting literatuur

De werkgroep vond drie effectevaluaties van patiënteninformatie over lichamelijke klachten.
In een Cochrane review naar effecten van patiënteninformatie concluderen de onderzoekers dat betrouwbare informatie over beschikbare behandelingen voor lichamelijke klachten en hun effecten kan bijdragen aan

meer realistische verwachtingen, een meer actieve rol van de patiënt in de medische besluitvorming, minder langdurige besluiteloosheid en keuzen die beter overeenkomen met de opvattingen en waarden van de patiënt (O'Connor e.a., 2003).
Een inventarisatie van de inhoud van vier door de overheid geredigeerde Engelstalige gezondheids-portals op internet, leverde weinig specifieke informatie over het effect van behandelingen. De onderzoekers concluderen dat patiënten zelden betrouwbare informatie vinden over de effecten van geneeskundige behandelingen voor lichamelijke klachten (Glenton e.a., 2005).
In een Noors kwalitatief onderzoek werd geëvalueerd hoe rugpijnpatiënten een publiekswebsite met evidence-based informatie over rugpijn beoordeelden. Uit vier focusgroepen van in totaal achttien deelnemers bleek dat rugpijnpatiënten vaak wantrouwen koesterden tegen 'wetenschappelijke resultaten', evenals tegen de reguliere gezondheidszorg. De onderzoekers concluderen dat makers van publieksvoorlichting er rekening mee moeten houden dat mensen met SOLK relatief veel wantrouwen hebben tegen het gezondheidszorgsysteem (Glenton e.a., 2006).

Verantwoording

Laatst beoordeeld : 01-01-2010
Laatst geautoriseerd : 01-01-2010

Voor de volledige verantwoording, evidence tabellen en eventuele aanverwante producten raadpleegt u de Richtlijnendatabase.

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