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Perspective

Understanding Somatic Symptom and Related Disorders in a Neuroimmunology Clinic: Implications for Clinical Practice

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DESCRIPTION

The diagnostic crossroads between neurology and psychiatry continues to present one of medicine's most intricate challenges. Nowhere is this more evident than in the case of Somatic Symptom and Related Disorders (SSRDs) a spectrum of conditions marked by disabling physical symptoms that lack a fully explanatory organic basis but are often rooted in complex psychological mechanisms. A recent retrospective study evaluating referrals to a tertiary neuroimmunology clinic between 2016 and 2023 sheds critical light on the presence and patterns of SSRDs in a highly specialized neurological context.

From a cohort of 898 referred patients, 204 were found to lack evidence of neuroimmunological disease. Among these, were diagnosed with SSRDs amounting to 6% of the total clinic population. This is a substantial proportion, particularly in a setting where referrals are often directed toward serious autoimmune neurological conditions such as Multiple Sclerosis (MS) or autoimmune encephalitis.

Demographic and diagnostic trends

Consistent with previous research, the majority of SSRD patients were female (74%), with a mean age of 42.5 years. Diagnoses included Functional Neurological Disorder (FND), somatic symptom disorder, illness anxiety disorder and unspecified SSRDs, with FND and somatic symptom disorder comprising the largest subsets. These findings underscore the heterogeneous nature of SSRDs in both presentation and etiology.

A particularly revealing statistic was the rate of misdirected referral: 79.6% of SSRD patients had been initially suspected of having MS, while 19.7% were referred with presumed autoimmune encephalitis. This diagnostic overreach suggests a systemic gap in recognizing functional and somatic symptomatology within neurologic contexts particularly when symptoms are vague, fluctuating, or difficult to correlate with radiological or serological markers.

Interestingly, nearly one-third of SSRD patients were self-referred, a figure unusually high for a tertiary specialty clinic. This may reflect a high level of health anxiety or persistent diagnostic uncertainty in this group. Notably, 20% of SSRD patients were healthcare workers, a demographic that, while often medically literate, may also be more vulnerable to internalized stress, hypervigilance to bodily sensations and difficulties seeking mental health support due to stigma or professional identity.

The study also observed that SSRD patients were more likely to be white and less likely to be Black, relative to patients with confirmed neuroimmunological disease. These differences suggest possible disparities in healthcare access, symptom reporting, diagnostic interpretation, or implicit bias in referral patterns. Future research should further explore how sociocultural factors influence the diagnostic trajectory and recognition of SSRDs.

Clinical and educational implications

This research delivers several take-home messages for clinical systems and education. First, the integration of neuropsychiatric expertise into subspecialty clinics is imperative. With over one-quarter of non-neuroimmunological referrals ultimately diagnosed with SSRDs, a multidisciplinary diagnostic approach can reduce testing, prevent iatrogenic harm and facilitate earlier psychiatric or psychological intervention.

Second, there is a pressing need for better medical education around SSRDs. Given the overlap in symptomatology between MS and conditions like FND, clinicians must be trained to apply diagnostic criteria carefully and empathetically. Teaching programs in neurology, primary care and internal medicine should incorporate focused instruction on recognizing and managing SSRDs.

Finally, clinicians must adopt a patient-centered communication strategy. Many patients with SSRDs report feeling invalidated or dismissed when psychiatric explanations are offered for physical complaints. It is essential to validate their experiences, avoid

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dualistic language and frame treatment plans in ways that emphasize function, recovery and resilience. Interdisciplinary models blending neurology, psychiatry, psychology, physiotherapy and occupational therapy represent the gold standard, even if resource constraints pose real-world challenges.

CONCLUSION

This comprehensive review of a tertiary neuroimmunology clinic highlights that SSRDs are not peripheral diagnoses, but rather central considerations in the evaluation of complex neurological symptoms. That one in four non-neuroimmunological patients met criteria for an SSRD is a compelling reminder that neurological complaints are not always neurologically rooted. As such, clinicians must cultivate diagnostic flexibility, pursue interdisciplinary collaboration and embrace empathetic engagement to effectively care for this patient population. In an era where the lines between neurology and psychiatry increasingly blur, understanding and managing SSRDs will be a defining challenge and opportunity of modern clinical neuroscience.