

A Two-Year Follow-Up Study of Patients With Somatoform Disorders

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Thirty inpatients with multiple somatoform symptoms admitted to a psychosomatic hospital were diagnosed using the Structured Clinical Interview for DSM-III-R and questionnaires. Two years later, a reexamination by interview and a follow-up questionnaire took place. The authors found high comorbidity rates not only for affective disorders (lifetime 86%), but also for anxiety disorders (lifetime 43%). Comorbidity is of high prognostic relevance: whereas patients with only somatoform disorders at first assessment may remit until second assessment, in those patients with comorbidity with other psychiatric disorders, some somatoform symptoms still remain. The rate of misdiagnosed organic disorders is estimated at lower than 10%.

(Psychosomatics 1995; 36:376-386)

The roots of the classification of somatic complaints without sufficient organic etiology go back to the concept of hysteria. The first attempt at a descriptive diagnosis of these symptoms was undertaken by Briquet in 1859.¹ As early as in the middle of the 19th century, Briquet described possible symptoms of the disorder, the strong association with depressive symptoms, the possible influence of life events, and the overproportional rate of patients from lower socioeconomic classes. Guze^{2,3} continued the development of Briquet's hysteria syndrome, which has been called "somatization disorder" in DSM-III. This is the prototype of somatoform disorders, but the definition criteria

are very restrictive. Patients must have 13 out of a list of 35 somatoform symptoms; the disorder must begin before the age of 30; symptoms must not occur only during panic attacks; and the symptoms must lead to doctor visits, medications, or lifestyle alterations.

Because of this restrictive definition, there is a low prevalence⁴ of somatization disorder, which does not reflect the high prevalence of somatizing patients seen in today's health care system. Therefore, Escobar et al.⁵ propose a new class for patients with multiple somatoform symptoms, the "abridged somatization disorder," or SSI-4/6. To reach the criteria for this class, male patients must have 4 and female patients must have 6 somatoform symptoms out of the list of 35 symptoms for somatization disorder. This new concept has already been used in some newer studies, which found a diagnostic class between somatization disorder and undifferentiated somatoform disorder to be useful, because patients with SSI-4/6 have nearly the same comorbidity patterns and reductions of life quality as patients with somatization disorder.^{6,7}

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In the past, many authors have warned against misdiagnosing organic disorders with labels such as hysteria or conversion.⁸⁻¹⁰ These authors usually refer to a well-known study of Slater and Glithero,¹¹ who reassessed 85 patients with the diagnosis of hysteria 9 years later. In their study, the diagnosis of hysteria was abandoned for 33% of the patients because organic explanations of the somatic complaints were later found. Although the results of some other studies imply that the rates of misdiagnoses found by Slater and Glithero¹¹ are not representative,¹²⁻¹⁷ their work is important because it stresses the necessity of intensive search for possible organic causes of "hysterical symptoms."

None of the follow-up studies cited earlier used either the operationalized approach of somatoform disorders, according to DSM-III (or DSM-III-R), or structured interviews for the diagnostic process. Therefore, it is questionable how stable the diagnosis of somatoform disorder, according to DSM-III-R, was. There is a lack of information about the course of disorders with multiple somatoform symptoms, but which do not fulfill the criteria of somatization disorder. A second point of interest concerns the stability of comorbidity patterns of patients with somatoform disorders. Following these topics, we examined the course of patients who had been diagnosed by structured clinical interviews as "somatoform disordered." This interview was repeated 2 years later, and questionnaires were also used at the second assessment.

METHODS

The study took place at a psychosomatic hospital in Germany. These kinds of hospitals for mental and psychosomatic disorders are part of the general health care system. Public and private coverages are accepted. As a result, a wide spectrum of patients from all socioeconomic classes is represented. In 1991, 1,300 persons were hospital inpatients, with a median age of 41 years and a gender ratio of 71% female:29% male. Forty-three percent of all inpatients had

not attended high school, 43% had a history of another inpatient treatment, and 49% had a history of outpatient psychotherapy. Most patients were referred by their family physicians (70%), but some were referred by their psychiatrists (27%) or internists (2%).

Psychodiagnostic Instruments

Mental disorders were assessed with the Structured Clinical Interview for DSM-III-R (SCID).¹⁸ This interview covers most psychiatric diagnoses by specific questions concerning the diagnostic criteria. By use of this instrument, reliable and valid diagnoses can be reached.

For the present study, an important self-rating scale was used: the Screening for Somatoform Symptoms (SOMS)¹⁹ (Appendix). This instrument checks for the presence of the 35 somatic symptoms relevant for somatization disorder, according to DSM-III-R. Items 36-42 concern further somatic symptoms, which may also be present in anxiety disorders or affective disorders (e.g., trembling, loss of appetite, or chronic fatigue). All symptoms without organic pathologies that have been present for the last 2 years should be marked. Further items (43-52) represent inclusion and exclusion criteria for subgroups of somatoform disorders. As possible variables, the positive symptom scores for items 1-35 (somatization index) and for items 1-42 (symptoms total) were computed. Earlier studies demonstrated good internal consistency for the scale (Cronbach's α 0.85; for men 0.87; for women 0.84 for the somatization index). Also, an investigation of the self-rating scale with a group of inpatients ($n = 51$) shows a good 72-hour retest reliability for this score ($R_{tt} = 0.85$). As already published,²⁰ the SCID confirmed a diagnosis of somatoform disorders for 30 of 41 patients with elevated scores on the SOMS (73%). Six of the 11 "misdiagnosed" patients had multiple somatic symptoms that were attributable to anxiety disorders; this points to a possible weakness of the instrument in differentiating somatic symptoms of somatoform disorders and somatic symptoms of anxiety disorders.

In addition, the symptom checklist SCL-90-R²¹ was administered. This questionnaire screens for the presence of 90 psychic and "psychosomatic" symptoms in the last 7 days. The answers were added to nine dimension scores, such as "somatization," "depression," "anxiety," and others. The self-rating scale has shown good discriminability in distinguishing between affective and anxiety disorders.²²

Subjects

By use of the questionnaire for somatoform symptoms and the SCL-90-R, 131 hospital patients were screened. The assessment took place for all consecutively admitted patients until an *N* of more than 100 could be expected when missing values were considered. All patients underwent an intensive physical examination with laboratory analyses and ECG to exclude organic origins of the symptoms. Anamnestic data were gathered and analyzed. Inpatients at high risk for somatoform disorders (at least five somatic symptoms without an adequate organic explanation) were examined with the SCID. For 30 patients, the SCID and SOMS indicated a diagnosis of somatoform disorders.

The 30 inpatients had a mean age of 38 years (range: 25–57 years); 43% were male, 57% female. The following subdiagnoses were given: somatization disorder (*n* = 5; 3 male, 2 female), abridged somatization disorder SSI-4/6 (*n* = 17; 5 male, 12 female), somatoform pain disorder (*n* = 7; 5 male, 2 female), conversion disorder (*n* = 1; female). Mean age at onset of the somatoform disorder was 23.8 years for women, 29.4 years for men; this implies a mean duration of 11.9 years for the disorder. For the somatoform subdiagnosis, mean age at onset was 21.6 years for somatization disorder (range: 18–25), 24.6 years for SSI-4/6 (range: 14–41), 33.6 years for somatoform pain disorders (range: 22–42), and 26 years for conversion disorder. However, because the data were gathered retrospectively, they must be interpreted with caution.

Two years later, the patients were reassessed by mailed questionnaires and a tele-

phone-conducted interview. Again, the interview consisted of the SCID, focusing on present-state diagnoses. In addition, the course of the disorder was investigated retrospectively by interview for the first 3 months after discharge, 4th to 6th month after discharge, 7th to 12th month after discharge, and for the last 3 months before the follow-up investigation using the categories listed in Table 1. The mailed questionnaire consisted of SCL-90-R, screening for somatoform symptoms, as well as further items concerning working disabilities, marital status, etc.

We were able to obtain at least either questionnaire or interview results for 29 of the 30 patients. One female patient is counted as a dropout: at a short telephone interview, she reported feeling well and willing to participate. But some days later, she went to the eastern part of Germany and did not leave her new address. With 25 patients (83%), we were able to complete both the questionnaire and interview; 2 (7%) only completed the diagnostic interview, 2 (7%) only completed the questionnaire. For these two latter patients, open diagnostic issues were resolved by using additional questionnaires with specific items of the SCID, so that the diagnostic status could be obtained.

During inpatient stay, the patients were

TABLE 1. Score categories for rating the course of somatoform disorders

0 = No somatoform symptoms
1 = Some periods without symptoms, some periods (but less than half) with less than 4 (men) or 6 (women) somatoform symptoms
2 = At least half of the time somatoform symptoms, but less than 4 (men) or less than 6 (women) somatoform symptoms <i>or</i> somatoform symptoms less than half of the time, but sometimes at least 4 (men) or 6 (women) symptoms
3 = Somatoform symptoms at least half of the time and sometimes at least 4 (men) or 6 (women)
4 = Most of the time at least 4 (men) or 6 (women) somatoform symptoms
5 = Always at least 4 (men) or 6 (women) somatoform symptoms

treated on the basis of an integrative behavioral medicine approach. Treatment consisted of individual psychotherapy; assertiveness training; problem-solving training; progressive muscle relaxation; and other cognitive-behavioral, emotional, and movement therapies. Because the main emphasis of the present study was on the analysis of the course of the disorder and not the efficacy of the intervention, details about the treatment program can be excluded.

RESULTS

Misdiagnosed Organic Diseases

Two of the 30 patients reported evidence for organic causes of the symptoms that had originally been considered as somatoform. One female patient came originally with back, neck, and leg pain, as well as trouble walking. The complaints had persisted for 4 years. She had pretreatments in the following hospitals: a general hospital after start of the complaints, an orthopedic rehabilitation center, and a hospital for acute orthopedic complaints. X rays, MRI tomography, and other clinical and radiological routines were conducted. The clinical diagnosis after all these investigations was "hysterical scoliosis" (conversion disorder, according to DSM-III-R). After inpatient treatment in our clinic, she requested financial compensation because of work disabilities, wherefore some diagnostic routines were repeated. Surprisingly, an MRI tomography revealed a prolapse syndrome of the thoracic vertebra. After surgical interventions, the patient recovered, was able to walk, was painless, and began working again. Therefore, we counted this patient as "misdiagnosed organic disease" (3%).

The second patient reported multiple pains over the entire body. Because of additional somatic symptoms, he fulfilled the criteria of somatization disorder with 16 out of the list of 35 symptoms. After discharge from our hospital, three inpatient stays in other hospitals followed. An incidental examination of possible toxic substances in the cell concentrations revealed elevated scores for PCB (polychlori-

nated biphenyl), a toxic substance that is used in the electronic and chemical industries. As a possible cause for the poisoning, the patient recalled that some years ago, while working in the electronic industry, a condenser imploded. However, his symptoms persisted for 10 years. The patient had lifetime comorbidity of obsessive-compulsive disorder (also 10 years ago), of social phobia as well as agoraphobia (3 years ago), and 2 phases of major depressions (1 year ago and present). We were not able to decide definitively if the organic explanation for the complaints was sufficient; some doubts arose if the complete symptomatology and comorbidity patterns were only consequences of the possible poisoning. Although we favor the interpretation of the symptoms as somatization disorder, following a conservative view, we counted this patient as "unclear" (3%).

The *diagnostic pattern* found for lifetime disorders, at first assessment, as well as at the second assessment 2 years later, are given in Table 2. Most patients ($n = 24$) with somatoform disorders also had a history of affective disorders. For these patients, the time interval between onset of the first depressive episode and onset of the first somatoform symptoms (as measured with the SCID) are computed and presented in Figure 1.

Remission of somatoform disorder was defined as less than 5 somatoform symptoms during the 2-year follow-up. Eight patients (27%) no longer fulfilled the criteria for somatoform disorders, according to this definition. At first assessment, these patients had multiple somatoform symptoms ($n = 7$) or somatoform pain disorder ($n = 1$). For the five patients with somatization disorder at first assessment, some symptoms still persisted at 2-year follow-up, whereas others remitted: two of these five patients still fulfilled the criteria for somatization disorder, two only fulfilled the criteria for multiple somatoform symptoms, and for one patient, it was unclear if an organic cause of the disorder was present (noted earlier). We also found decreases in the frequency of affective disorders and anxiety disorders.

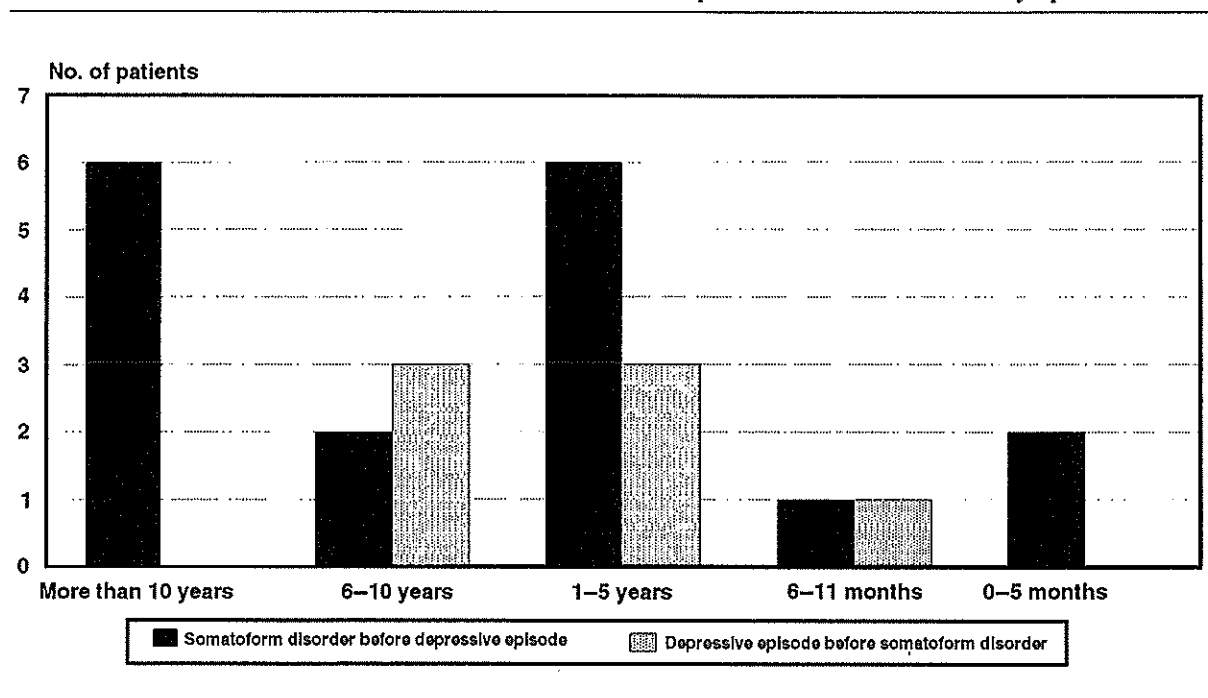
TABLE 2. Comorbidity of patients with somatoform disorders (N = 28)

	n (%)		
	Lifetime Diagnoses	Present Diagnoses at First Assessment	Present Diagnoses at Second Assessment
Depressive disorders	24 (86)	18 (64)	10 (36)
Major depression, dysthymia, depression not otherwise specified			
Anxiety disorders	12 (43)	9 (32)	4 (14)
Panic disorder, agoraphobia, obsessive-compulsive disorder, social phobia			
Schizophrenia	1 (4)	0 ^a	0 ^a
Other psychiatric disorder	11 (39)	7 (25)	1 (4)
Substance abuse, eating disorders, etc.			

Note: To assess even minor comorbidity diagnoses, categories like Depression Not Otherwise Specified or Social Phobia are included. Depression Not Otherwise Specified was diagnosed when all symptoms were present, but the time criteria were not fulfilled (2 years for dysthymia, 2 weeks for major depression). The two patients with unclear or probable organically caused disorders are excluded. Discrepancies to earlier results concerning lifetime comorbidity²² arise from two other patients, one avowed a schizophrenic episode, another avowed a bulimic episode in the past.

^aNo acute psychotic symptoms at time of examination.

FIGURE 1. Time interval between onset of the first affective episode and first somatoform symptoms



Patterns of Diagnostic Change

To get information about the patterns of change of subgroups of patients, we divided the group into the following categories: somatoform disorders (SFD), affective disorders, and other psychiatric disorders. The patterns of

change of these subgroups are shown in Table 3. We found that most patients with “no psychiatric disorder” at follow-up came from the group “only SFD” at the first examination, which means that when SFD are not accompanied by other psychiatric disorders, there seems to be a good chance for remission of the disorder.

der. On the other hand, when somatoform disorders are combined with affective disorders, they tend to persist. If a comorbidity pattern of three and more psychiatric disorders exists at first assessment, the results at 2-year follow-up seem unpredictable.

Somatoform Symptoms in the Last 2 Years

The SOMS checklist screens for the presence of the 35 possible symptoms of somatization disorder in the last 2 years. The mean number of somatization symptoms in the last 2 years was 12.7 (SD = 4.1) at first assessment and 8.4 (SD = 5.1) at second assessment ($F = 6.2$, $P < 0.001$). On average, the patients had 4.4 fewer somatoform symptoms at the 2-year follow-up when compared with the 2 years before admission. In addition, other psychopathological dimensions that had been used, such as SCL-90-R, showed significant reductions from first assessment to second assessment (Table 4).

Course of the Disorder

The improvements obtained may be positive developments, attributable to fluctuations of symptoms, or stable effects of the treatments. Therefore, we examined retrospectively the course of the symptoms, according to the categories in Table 1. For the first 3 months after discharge, the mean rating is 1.9 (SD = 1.8); for

the months 4 to 6 the mean rating is 1.7 (SD = 1.6); for the second half of the first year after discharge, the mean rating is 2.1 (SD = 1.7); and for the last 3 months before the follow-up assessment, the mean rating is 2.1 (SD = 1.8). These four ratings do not show statistically significant differences ($F = 1.3$). Symptom reduction took place during inpatient treatment. Thereafter, however, the course seems to remain constant.

Work Disability

Before the inpatient treatment, 10 patients (40%) were not able to work because of the disorder or were unemployed. At reassessment, this number fell to 5 patients (20%, considering the 25 patients with complete data; $\chi^2 = 4.2$; $P < 0.05$). A subjective rating for work ability revealed that before inpatient treatment, no patient believed himself/herself well enough to go to work regularly. At follow-up, 10 patients rated themselves as well enough for regular work. These data must be interpreted in relation to the long duration of the disorder, nearly 12 years.

DISCUSSION

In the present study, we examined a sample of 30 inpatients with a long history of somatoform disorders (11.9 years). We found high comorbidity rates not only for affective disorders, but

TABLE 3. Comparison of present state diagnosis at first and second assessment (2 years later)

Second Assessment	First Assessment				Sum
	Only SFD	SFD + AD	SFD + AD + Other	SFD + Other	
No disorder	5	2	1	0	8
(Probable) organic reasons	1	0	1	0	2
Only SFD	0	2	1	2	5
SFD + AD	0	5	1	1	7
SFD + AD + Other	1	0	1	0	2
SFD + Other	0	0	2	0	2
AD	0	0	1	0	1
Other disorder	0	0	2	0	2
Sum	7	9	10	3	29

Note: SFD = somatoform disorder; AD = affective disorder; Other = other mental disorder.

TABLE 4. Symptom Assessment ($N = 25$)

Variable	n (%)		t
	First Assessment	Second Assessment	
Number of somatoform symptoms in last 2 years	12.7 (4.1)	8.4 (5.1)	6.2**
Somatization scale (SCL-90-R)	1.4 (0.7)	0.9 (0.6)	5.3**
Depression scale (SCL-90-R)	1.6 (1.0)	1.0 (0.8)	3.2*
Anxiety scale (SCL-90-R)	1.4 (0.9)	0.8 (0.6)	3.4*
Phobic anxiety (SCL-90-R)	0.8 (0.8)	0.4 (0.4)	3.3*

* $P < 0.01$; ** $P < 0.001$.

also for other psychiatric disorders. The somatoform disorder seems to be the initial disorder presenting long before the onset of other disorders, but these results must be interpreted with caution because of the retrospective data sampling.²² Longitudinal studies are necessary because they allow a more valid assessment of time of onset. The high comorbidity rates for patients with somatization disorder and for patients with abridged somatization disorder are in accordance with the results of earlier studies.^{6,7} Because somatoform disorders are usually the initial psychiatric disorder,²² they seem to increase the risk for the development of other psychiatric disorders.

The comparison of the diagnoses at first assessment and the diagnoses at second assessment 2 years later revealed that patients with somatoform disorders, but no present comorbidity with other disorders, had a high probability of remission. If at the time point of first assessment, a depression coexisted, the prognosis was worse. From eight patients with somatoform and affective disorders at first assessment, five patients showed the same comorbidity pattern at 2-year follow-up. For those patients with more than two psychiatric disorders, the prognosis was difficult. Each of the previously diagnosed disorders may disappear or remain.

The course of the disorder after inpatient

treatment in a center for behavioral medicine in these patients was unexpectedly good. On average, the patients' number of somatoform complaints fell from 12.7 in the 2 years before treatment to 8.4 in the 2 years after treatment. There are some indices that work disability could also be reduced as well as other psychopathological variables. These results would contradict the widespread opinion that symptom improvement is not possible for patients with somatoform disorders. However, some methodological shortcomings, above all the lack of a control group, limits interpretation. The statistical effect of regression to the mean could also explain this finding. This effect implies that the more distant the values are from the mean at first assessment, the higher the probability is at second assessment that the person reach a value that is closer to the mean as the first value. Implying that the "real mean" number of somatoform symptoms is lower than the mean of our group at first assessment, such an effect could simulate the symptom reduction. If this effect explains our results, we should expect a high correlation between the number of somatoform symptoms at first assessment and "improvement." However, the correlation between initial value and number of symptom reduction is only $r = 0.11$; the initial number of symptoms cannot significantly predict the number of lost symptoms at second assessment.

The main purpose of the study was to test the stability of the diagnosis of somatoform disorders over time. Critique of the concept of "hysterical syndromes" came from earlier studies of Slater and Glithero,¹¹ who found the often-cited result that many patients with so-called hysteria have misdiagnosed organic disorders. Richtsmeier⁸ also warned against the "pitfalls in diagnosis of unexplained somatoform symptoms." Some other studies did not replicate the results of Slater and Glithero,^{11,14-16} yet some scepticism remained.

None of the follow-up studies cited before used structured clinical interviews for psychiatric diagnoses. However, the descriptive approach of DSM-III-R, as well as structured interviews, may help to increase the certainty in

the diagnostic process. Therefore, we used the SCID at first assessment as well as at the 2-year follow-up assessment. We found that only 1 of the 30 patients showed evidence for misdiagnosed organic origins of the complaints 2 years ago; the diagnosis of another patient remains unclear. This result has two implications. First, the diagnostic procedures were not perfect, and further approaches to improve the diagnostic security are necessary. In addition, psychiatrists must be on guard against the tendency to stop looking for organic pathology once a psychiatric diagnosis has been applied. Also, patients with somatoform disorders can develop other organic or neurological diseases. Second, for the difficult case of diagnosing somatoform disorders, the rate of misdiagnoses is lower than expected. However, this may be because we only included patients with multiple somatoform symptoms.

The less strictly defined criteria of SSI-4/6 may allow for a more accurate diagnosis for patients who are usually misdiagnosed with irritable bowel syndrome, fibromyalgia, or chronic fatigue syndrome. High symptom scores of our sample for bloating (83%), diarrhea (50%), joint pains (77%), pains in arms and legs (70%), and chronic fatigue (73%) demonstrate the possible overlap. However, these data also confirm that most patients have multiple symptoms at different body areas. Also, our

results may bolster support for Escobar et al.⁵ or Katon et al.,⁷ who propose that further developments of diagnostic systems like ICD-10 or DSM-IV should include a diagnostic class between the restrictively defined somatization disorder and the broad definition of undifferentiated somatoform disorder.

However, some shortcomings restrict the generalizability of our results. First, we have a selection of patients who were seeking inpatient treatment. They may differ from patients who undergo outpatient treatment, especially on variables such as chronicity, work disability, etc. Second, the small sample size only provides preliminary results, which must be replicated in larger studies. Furthermore, admission at possibly high symptom status may lead to regression to the mean at follow-up, as already mentioned. On the other hand, an average of 11.9 years of illness duration suggests that symptom status before treatment was relatively stable and changed only after treatment. Further investigations with control groups or waiting lists before treatment may allow broader interpretations.

The authors thank the following psychologists and physicians for their help: C. Stock, S. Erbs, L. Niepoth, G. Danuch, C. Kranhold, and R. Vossmerbaeumer.

APPENDIX. Screening for Somatoform Symptoms: self-rating scale

Name: _____ Date of Birth: _____

Date: _____ Ward No.: _____

Below you find a list of bodily symptoms. Please answer whether you have suffered from each of these symptoms in the past 2 years, either temporarily or continuously. Consider only those complaints for which no clear causes have been found by physicians, and which have affected your subjective well-being.

In the past 2 years, I have suffered from the following complaints:

	Yes	No		Yes	No
1. vomiting (other than during pregnancy)	<input type="checkbox"/>	<input type="checkbox"/>	23. fainting or loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>
2. abdominal pain (other than when menstruating)	<input type="checkbox"/>	<input type="checkbox"/>	24. seizure or convulsion	<input type="checkbox"/>	<input type="checkbox"/>
3. nausea (other than motion sickness)	<input type="checkbox"/>	<input type="checkbox"/>	25. trouble walking	<input type="checkbox"/>	<input type="checkbox"/>
4. bloating, gassiness	<input type="checkbox"/>	<input type="checkbox"/>	26. paralysis or muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>
5. diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	27. urinary retention or difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>
6. intolerance of several different foods	<input type="checkbox"/>	<input type="checkbox"/>	28. burning sensation in sexual organs or rectum (other than during intercourse)	<input type="checkbox"/>	<input type="checkbox"/>
7. pain in arms or legs	<input type="checkbox"/>	<input type="checkbox"/>	29. sexual indifference	<input type="checkbox"/>	<input type="checkbox"/>
8. back pain	<input type="checkbox"/>	<input type="checkbox"/>	30. pain during sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>
9. joint pain	<input type="checkbox"/>	<input type="checkbox"/>	31. impotence	<input type="checkbox"/>	<input type="checkbox"/>
10. pain during urination	<input type="checkbox"/>	<input type="checkbox"/>	For women only:		
11. other pain (excluding headaches)	<input type="checkbox"/>	<input type="checkbox"/>	32. painful menstruation	<input type="checkbox"/>	<input type="checkbox"/>
12. shortness of breath when not exerting oneself	<input type="checkbox"/>	<input type="checkbox"/>	33. irregular menstrual periods	<input type="checkbox"/>	<input type="checkbox"/>
13. palpitations	<input type="checkbox"/>	<input type="checkbox"/>	34. excessive menstrual bleeding	<input type="checkbox"/>	<input type="checkbox"/>
14. chest pain	<input type="checkbox"/>	<input type="checkbox"/>	35. vomiting throughout pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
15. dizziness	<input type="checkbox"/>	<input type="checkbox"/>	For men and women:		
16. amnesia	<input type="checkbox"/>	<input type="checkbox"/>	36. chronic fatigue	<input type="checkbox"/>	<input type="checkbox"/>
17. difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	37. loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>
18. loss of voice	<input type="checkbox"/>	<input type="checkbox"/>	38. constipation	<input type="checkbox"/>	<input type="checkbox"/>
19. deafness	<input type="checkbox"/>	<input type="checkbox"/>	39. trembling	<input type="checkbox"/>	<input type="checkbox"/>
20. double vision	<input type="checkbox"/>	<input type="checkbox"/>	40. sweating	<input type="checkbox"/>	<input type="checkbox"/>
21. blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	41. numbness and tingling	<input type="checkbox"/>	<input type="checkbox"/>
22. blindness	<input type="checkbox"/>	<input type="checkbox"/>	42. heat or cold showers	<input type="checkbox"/>	<input type="checkbox"/>