Reviewer’s report

Title: Bodily distress syndrome: A new diagnosis for functional disorders in primary care?

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Reviewer: frederick sundram

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Overall
The authors have provided a manuscript that reads well and contains important concepts that will be relevant to the practising primary care physician. The concept of functional syndromes, somatoform disorders, somatic symptom disorders and BDS is often difficult for healthcare practitioners to understand and the authors are to be commended for attempts to reduce such confusion and also overcome disease labelling relevant to that specific specialty a patient presents to. The changes and comments mentioned below correspond to minor essential revisions.

Abstract
The abstract reads well

Background
The literature review is sound and the concept of BDS, though reported in the literature previously, is currently presented to a wider readership in primary care. One consideration of such a catch-all category which captures a spectrum of disorders is how to classify severity, duration and level of associated disability – currently it is unclear the duration required for a diagnosis of BDS. The literature would also indicate that the longer someone has a disorder (somatoform/functional/etc.), the increased likelihood for intractability. The current model does not comment on this and if patients were tracked longitudinally, this could lead to varying findings given that cohorts of people with BDS may not exactly correspond e.g. one group of BDS may have a median illness duration for 1 year versus another cohort with mean illness duration for 8 years.

There are numerous cultures that have a tendency to somatise and the construct of BDS has been validated in predominantly Western contexts, how this translates to other settings is yet to be seen.

Discussion
Page 11 (line 224) – there appears to be a missing word/concept

While there is acceptability of of the term BDS for patients – what is their
understanding of aetiology or contributors to the disorder?

Box 1 –
Minor tweak under severity to state: Single-organ BDS (mild-moderate): involves one or two “of” the symptom groups. Where are non-epileptic seizures included?
Where would non-cardiac chest pain be found?
Would pain be a separate useful category (regardless of organ/system affected?)
In primary care, it might be difficult to rule out differential diagnoses unless a service had access to appropriate investigations – when referring to their hospital-based colleagues, would people with BDS be viewed as potential or possible BDS rather than arrive with this diagnosis?
As severity can change longitudinally i.e. someone can start off as mild, how does the classification take into account illness progression?
There are people with intractable chest-pain or non-epileptic seizures who might fall under the mild category given the symptom count but in reality be disabled with intractable symptoms and therefore on the severe end of clinical categorisation, how does that match up with the severity indicators currently proposed?

**Level of interest:** An article of outstanding merit and interest in its field

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**
I declare that I have no competing interests