PSYCHIATRIC PATIENTS IN MEDICAL OPDs: A PHYSICIANS' DILEMMA

Muhammad Rasheed Khan Durrani[1✉], Tooba Fatima, Sarah Khan, Muhammad Qasim Naeem

ABSTRACT

OBJECTIVES: To determine the frequency of patients with underlying psychiatric disorders presenting with unexplained vague physical symptoms to medical outpatient department (OPDs) at Jinnah Postgraduate Medical Centre (JPMC), Karachi, Pakistan.

METHODS: A total of 1049 consecutive patients were enrolled in this study, over a period of 6 months from 1st January 2016 - 30th June, 2016 in Medical OPD, Department of Medicine Unit II (Ward 6), JPMC, Karachi, Pakistan. Adults of all ages and genders, regardless of socio-economic and educational status, attending medical OPD with unexplained vague physical symptoms and giving informed consent were included in study. Exclusion criteria consisted of patients with frank psychosis and (proven and/or suspected) major organic diseases.

RESULTS: Out of 1049 patients aged 14 years and above met our inclusion criteria, out of which 441(42%) were males and 608 (58%) were females. Out of 1049 enrolled patients, main underlying diagnosis were irritable bowel syndrome (n=357; 34%), somatization disorder (26.22%, n=275), depression (19.4%, n=204), hypochondriasis (11.6%, n=122), conversion disorder (6.7%, n=71) and globus hystericus (1.9%, n=20). Majority of the patients (64.5%, n=686) lived in home with income levels less than Rs. 25000. About 36.5% (n=383) patients were graduate and 63.5% (n=666) were non-graduates.

CONCLUSION: Psychiatric illness constitutes a significant bulk of patients that come to medical OPDs with unexplained vague physical symptoms and therefore; be inferred that psychiatric patients prove to be a dilemma for physicians regarding how they should be approached and subsequently handled.

KEY WORDS: Irritable Bowel Syndrome (IBS) (MeSH); Somatization Disorder (Non-MeSH); Depression (MeSH); Hypochondriasis (MeSH); Conversion Disorder (MeSH); Globus Hystericus (Non-MeSH).

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1 Ward-6, Medical Unit II, Jinnah Post Graduate Medical Centre, Karachi, Pakistan

Email✉:drrasheeddurrani@gmail.com

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INTRODUCTION

Patients attending medical outpatient departments (OPDs) usually present with symptoms which could be attributed to underlying physical or mental illnesses. In general, there are a few queries made by patients in OPDs) which if not addressed properly, result in patients visiting several doctors again and again in order to get a distinct diagnosis; a diagnosis which is mostly self-anticipated by patients themselves.[1] These queries being non specific, and more often undocumented and lacking any evidence, usually fetch a vague or unsatisfactory answer from the physician and ultimately lead to a hostile relationship between the doctors and such patients and their relatives. These non-specific questions which understandably have no satisfactory answers include (but are not restricted to) the following:[2-4]

- Fever (never documented by patients themselves)
- Migraine, generally as a status symbol
- Edema of the feet and even generalized edema
- Bloating
- Feeling upset or having a low mood
- Indigestion
- Headaches
- Dizziness, generally due to hypertension or hypotension
- Self explained low blood sugar
- Easy fatiguability
- Self explained high and low blood pressure as symptoms
- Vague chest pain mostly pointing towards cardiac pain
- Shortness of breath, choking sensation
- Generalized bodyaches

By presenting in this manner, patients and their attendants often want to dictate the terms of the consultation with respect to diagnosis. They also tend to suggest which investigations should be advised and what treatment should be offered. This is a very tricky and admittedly difficult situation, because any attempt by the physicians to adopt a blunt or strict approach can be a source of uneasiness, even major conflict. On the other hand, conceding to the patients will or dictation (in terms of their management) can result in a huge burden on health resources, for example: unnecessary laboratory services and treatment.[3] Such situations lead to a standstill of sorts, where the physicians are often unwilling to cater to fanciful whims while the patients are unwilling to budge on the preconceived notions about their (suspected) illness. As a result, a feeling of discontent towards the doctor, their parent institute and often times the entire system develops which, however uncalled for, reflects negatively upon the field of medicine.

It therefore comes as no surprise that a carefully tactical yet individualized approach is needed to finesse such situations and one has to camouflage the truth in a very diplomatic way. These

TABLE I: DEMOGRAPHICS OF PSYCHIATRIC PATIENTS IN MEDICAL OPD

Variable		Number (n =1049)	Percentage
Gender	Male	441	42
	Female	608	58
Education	Graduate	383	36.5
	Non-Graduate	666	63.5
Monthly Income	Up to 25000	686	65.4
	>25000	363	34.6

patients, whose number is considerably large, want and often end up, acquiring the diagnosis, diagnostic tests and even treatment of their liking. This happens because of several reasons some of which include a lack of knowledge and thus incompetency of doctors, over-burdened physicians who have to address a staggering bulk of patients (as is evident in government set ups), and sometimes the commercial approach of private institutes obsessed with 'money making'.

Ultimately, all such needless diagnostic tests and often times unnecessary management bears no fruit whatsoever but instead simply becomes a source of tension, hostility and frustration for both parties, especially doctors.[5]These unexplained symptoms may be seen in distinct disorders, alone or in combination,[6] yet have no proven organic basis.

Briefly discussed below are the six major medical illnesses which patients enrolled in this study were found to be suffering from:[7]

1: Irritable Bowel Syndrome (IBS): Although IBS is easy to diagnose, it is, however, difficult to treat and even difficult to convey the diagnosis to the patient. This is because they tend to press for investigations and treatment of their choice, and if not satisfactorily entertained, become annoyed and sometimes aggressive with the physician and even the institute.[8]

2: Somatization disorder: Patients present with a distinct focus on a particular symptom or symptoms such as pain and weakness all over the body. [9] These patients are generally resistant to analgesics.[10]

3: Depression may occur in isolation and/or in combination with other disorders. Patients present with vague weakness and pain, specifically at the inter-scapular region the latter is universally the most common symtoms.[10,11]

4: Hypochondriasis is a condition in which a very sensitive patient gives a long history of gastrointestinal complaints especially pain in right and/or left hypochondrium dating back several years. These patients have a constant fear that they are suffering from some grave disease.[7]

5: Globus Hystericus (difficulty in swallowing). Patients believe that they have a mass in the throat or neck, etc.[12]

6: Conversion disorders are a group of disorders in which patients simulate a serious disease with the intention of seeking attention and achieving relaxation and relief from their daily responsibilities.[13]

These disorders can occur alone and / or in various combinations. They are usually seen in the most discontent patients. Such patients usually have a prolonged history of sinister symptoms and multiple hospital and doctor visits. They also carry with them thick files of reports of various investigations.[14] OPDs in public sector hospitals are overloaded with patients having vague symptoms that can be attributed to both medical and psychiatric disorders and proper diagnosis can reduce the load of these patients in medical OPDs. As no such study was done in public sector hospitals of Karachi, the biggest city of Pakistan, this study was planned to determine the frequency of patients with underlying psychiatric disorders presenting with physical symptoms to medical outpatient department (OPDs) at Jinnah Postgraduate Medical Centre, Karachi, Pakistan.

METHODS

The study was carried out in General Medicine Ward-6, Medical Unit-II, Jinnah Post Graduate Centre (JPMC), Karachi, Pakistan for a time period of six months from 1st January 2016 to 30th June, 2016. JPMC is the largest tertiary medical care facility in the metropolis of Karachi and was chosen as the centre for this study due to the largest inflow of patients in medical OPDs in the city. A total of 1049 consecutive patients fulfilling the eligibility criteria were enrolled in the study.

Adults of all ages and genders, regardless of socio-economic and educational status, attending medical OPD with unexplained vague physical symptoms and giving informed consent were included in study. Exclusion criteria consisted of patients with frank psychosis and (proven and/or suspected) major organic diseases.

Data was collected on a proforma and was analyzed by SPSS windows version 19.

RESULTS

A total of 1049 patients aged 14 years and above met our inclusion criteria out of which 608 (58%) were females. Majority of the patients (64.5%, n=686) lived in home with income levels less than Rs. 25000. About 36.5% (n=383) patients were graduate (Table I).

Majority (n=320; 30.5%) were ranging in age from 14-30 years (Table II).

The most common diagnosis in our study was irritable bowel syndrome (n=357; 34%), followed by somatization disorder (n=75; 26.22%) and depression (n=204; 19.4%) [Table III].

TABLE II: AGE DISTRIBUTION IN PSYCHIATRIC PATIENTS

Age Range (years)	Number (n =1049)	Percentage
14-30	320	30.5
31-35	235	22.4
36-49	196	18.6
≥ 50	298	28.4

TABLE III: FREQUENCY OF PATIENTS IN MEDICAL OPD WITH PSYCHIATRIC DISORDERS

PSYCHIATRIC DISORDERS	Common Symptoms	No. of Patients (n=1049)	Percentage
Irritable Bowel Syndrome	Excessive bloating, day time diarrhoea, nausea & vomiting	357	34.0
Somatized Anxiety	Bodyache, headache, palpitation, sweating	275	26.2
Depression	Tiredness and feeling sad	204	19.5
Hypochondarism	Upper abdominal pain with feeling of something sinister	122	11.6
Conversion Disorder	Pain & difficulty in swallowing, weakness, paralysis of the arms or legs	71	6.8
Globus Hystericus	Pain, choking, or sensation of lump in throat, Hyperventilation	20	1.9

DISCUSSION

It was observed that majority of patients who presented in medical OPD actually had psychiatric ailments. Other studies have also documented that 50-70% of all patients in medical OPDs actually suffer from psychiatric ailments.[15-17] In fact only 5-10% of psychiatric illness patients reach the psychiatric department. Anxiety was documented in 26.2% of our patients which is supported by other published studies.[8,9] Major depressions was seen in 20%, which is also supported by other studies.[10,11]

Mental disorders are encountered commonly in practice. They may be primary or associated with co-morbidities.[19] It is estimated that 30% people either have psychiatric problems or substance abuse disorders.[20,21] In such cases the quality of life care can be assessed and advised based on disease seriousness[20] but only in the proper psychiatric facilities. The fact that patients with a poor socio-economic status were more commonly affected points towards a clear root cause behind such inferential statistics and this can be evaluated and studied in depth in future studies.

Mental disorders consume approximately 4-10 fold of health resources (of the entire population) around the world.[22] A comprehensive psychiatric evaluation is therefore essential as most of the so-called psychiatric patients actually have non-specific symptoms.

The Diagnostic and Statistical Manuel (DSM), of Mental Health Disorders is easily available as well as Primary Care Evaluation of Mental Disorders (PRIME-MD) and a number of other diagnostic tools and questionnaires for assessment and diagnosis of psychiatric illness. The use of such tools however, is not a part of common practice because patients tend to easily get offended by questionnaires asking leading or sensitive questions.[23-25]

Suffice to say, patients with psychiatric illnesses visiting medical OPDs pose as a true test for both physicians and the system. The unnecessary utilisation of health services by these patients is a burden.[26] Also, the practice of directly or indirectly labelling a presenting complaint as a non-emergency and not of consequence has been shown to instigate hostility towards the physicians as in most cases, patients (and their overly concerned attendants) simply refuse to accept, leading to the provision of an incentive for the patients to argue and opt for hostile behaviour which then proves to hinder doctors from effectively managing other patients. Such scenarios call for a need of proper counselling of the physicians and this again, is an avenue which can be further explored in future studies. This remain a major concern, that hostility on part of patient and their relatives on non-issue and source of anxiety for physician at least, their heart tend to beat faster in these situation. The reason why these patients are in medical OPD, can be social stigma of being psychiatric patient, back of proper screening clinics, patient looking for excuse for their short comings or responsibilities etc.[27]

CONCLUSION

Psychiatric illness constitutes a significant bulk of patients that come to medical OPDs with unexplained vague physical symptoms and are posing a great challenge for the system and doctors. They are very difficult to diagnose (wrong people in the wrong place). They tend to utilize a significant chunk of the health services and resources quite unnecessarily. Psychiatric patients prove to be a dilemma for physicians regarding how they should be approached and subsequently handled.

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AUTHOR'S CONTRIBUTION

Following authors have made substantial contributions to the manuscript as under:

MRKD: Concept & study design, acquisition of data, drafting the manuscript, final approval of the version to be published

TF: Drafting the manuscript, critical review, final approval of the version to be published

SK & MQN: Acquisition, analysis & interpretation of data, final approval of the version to be published

Authors agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved

CONFLICT OF INTEREST

Authors declared no conflict of interest

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