psychiatric patient in OPD

by Rasheed Khan

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PSYCHIATRIC PATIENTS IN MEDICAL OPDs: A PHYSICIANS' DILEMMA

NAME OF AUTHOR:

Dr. M. Rasheed Durrani: MBBS, MCPS, FCPS Associate Professor of Medicine at Medical unit II Jinnah Post Graduate Medical Centre, Karachi

Tooba Fatima: MBBS, Resident of Medicine at Medical unit II Jinnah Post Graduate Medical Centre, Karachi

Sarah Khan: MBBS Resident of Medicine at Medical unit II Jinnah Post Graduate Medical Centre, Karachi

NAME OF DEPARTMENT/INSTITUTION

Jinnah Post Graduate Medical Centre, Karachi

NAME AND ADDRESS OF THE CORRESPONDENCE ETC.

Dr. M. Rasheed Durrani, National Poison Centre, Medical Unit II, (Ward 6), Jinnah Post Graduate Medical Centre, Karachi

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PSYCHIATRIC PATIENTS IN MEDICAL OPDs: A PHYSICIANS' DILEMMA

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KEY WORDS

Irritable Bowel Syndrome (IBS), somatized anxiety, depression, hypochondrism , conversion disorder, globus hystericus

ABSTRACT

Aim:

To document a neglected aspect of medical care, whereby, a large number of psychiatric patients claiming medical issues, report to medical outpatient departments (OPDs).

Setting:

Medical OPD, Department of Medicine Unit II, Ward 6, Jinnah Postgraduate Medical Centre (JPMC), Karachi.

Material & Method:

A total of 1570 consecutive patients were enrolled after following strict inclusion and exclusion criteria. Adults of all ages and gender regardless of socio-economic and education status were included. Exclusion criteria included patients with frank psychosis and major organic diseases.

Results: Out of 1570 patients that were enrolled in the study, 1049 (63.5%) patients met the inclusion criteria, whereas remaining (36.5%) were seen to be suffering from some major medical illness. Of the former, 357(35%) had Irritable Bowel Syndrome (IBS) , 275 (27%) had somatized anxiety, 204 (20%) had depression, 122 (12%) had hypochondrism , 71 (7%) had conversion disorder and 20(3%) had globus hystericus. There was no significant impact of age, gender and socioeconomic education status.

Conclusion:

The results of this study were consistent with the fact that psychiatric illness constitutes the bulk of medical suffering in humans, which is reflected in medical OPDs where mental disorders are commonly seen and addressed.

Keywords:

Irritable Bowel Syndrome (IBS), somatized anxiety, depression, hypochondrism , conversion disorder, globus hystericus.

INTRODUCTION

In general, there are a few queries made by patients which if not addressed properly result in patients visiting doctors again and again in order to get a proper diagnosis (which is mostly self anticipated by patients themselves)[1]. These queries being non specific usually fetch a vague or unsatisfactory answer from the physician and often lead to a hostile relationship between the doctors and patients (and their relatives). These non specific questions which generally have no satisfactory answers include (but are not restricted to) the following.

- Fever (never documented by patients themselves)[2] .
- Migraine generally as a status symbol.
- Oedema feet and even generalized oedema
- Bloating
- Indigestion
- Headaches, dizziness generally due to hypertension
- Self explained low blood sugar
- Easy fatigability
- Self explained high and low blood pressure as symptoms.
- Vague chest pain mostly pointing toward cardiac pain.
- Generalized body ache.

By presenting in this manner, they (patients and their attendants) generally want to dictate the terms with respect to diagnosis (including investigations) treatment and also counseling. This is a very tricky and difficult situation, where any attempt by the physicians to adopt a blunt or strict

approach can be a source of uneasiness or 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] There is as such usually no benefit to patients and can ultimately lead to feeling of discontent towards doctors, system and institute. A very tactical, honest, individualized approach is needed and one has to camouflage the truth in a very diplomatic way. These patients whose number is sizeable want and often acquire the diagnosis, diagnostic tests and even treatment of their liking. This happens generally because of lack of knowledge, in competency of doctors, overwork and sometimes commercial approach of private institutes. Ultimately all this goes in vain except for being a source of tension, hostility and frustration for both parties especially doctors.[4] These unexplained symptoms may be seen in distinct disorders, alone or in combination. [5, 6]

Irritable Bowel Syndrome: It is easy to diagnose, difficult to treat and even difficult to convey the diagnosis to the patient. They tend to press for investigations and treatment of their choice or else otherwise become annoyed with the physician and the institute.[7]

Somatized Anxiety: Anxiety presenting with somatic symptoms especially pain in every segment of the body from head to toe. These patients are generally resistant to analgesics.[8,9]

Depression: May occur in isolation and/or in combination with other disorders. Patients present with vague weakness and pain in interscapular region which is its universal symptom.[10,11]

Hypochondriasis: A condition in which a very sensitive patient always remains preoccupied with gastrointestinal complaints especially pain in right and left hypochondrium for many years. These patients often consider themselves suffering from some grave disease.[7]

Globus Hystericus: Difficulty in swallowing, patients believe that they have a mass in throat, neck etc.[12]

Conversion Disorders: This mean simulating a grave disease with intention of seeking attention, achieving relaxation and getting relief from their responsibilities.[13]

These disorders occur alone and in various combinations as well. They are usually seen in the most discontented patients who generally have a prolonged history of sinister symptoms and carry a medical history of multiple hospital and doctor visits and also a bundle of reports of investigations.[14]

MATERIAL & METHODS

The study was carried out in Ward-6, Medical Unit-II, Jinnah Post Graduate Centre which is largest tertiary medical facility in the metropolis of Karachi. A total of 1,570 consecutive patients were enrolled after following strict inclusion and exclusion criteria. Adults of all ages and gender regardless of socio-economic and education status were included. Exclusion criteria included patients with frank psychosis and major organic diseases.

RESULTS

There were different categories of psychiatric patients who are diagnosed in OPD . Irritable bowel syndrome, somatized anxiety and depression were common and these disorders were also seen in various combinations (Table.1). There were no major differences related to age. However, females, patients of low socio-economic status and patients with less education / uneducated patients were affected (Table.2 & 3). It was observed that 64% patients actually had psychiatric ailments . Other studies have also documented that 50-70% of all patients in medical OPDs actually suffer from psychiatric ailments. [15, 16, 17]. In fact only 5-10% of psychiatric illness patients properly reach the psychiatric department. Like our study, other studies have also shown flat patients with low socio-economic status were more commonly affected. [17]Major depression was seen in 20%, which is also supported by other studies [10,11]Anxiety was documented in 33% of our patients which is also supported by other studies [8,9].

DISCUSSION

Mental disorders are encountered commonly in practice. They may be primary or associated with co-morbids. It is estimated that 30% people either have psychiatric problems or substance abuse disorders [18,19,20,21] mental disorders consume approximately 4-10 fold of all health resources all around the world. [22] A comprehensive psychiatric evaluation is essential as most of the so-called psychiatric patients actually have non-specific symptoms.

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Diagnostic and statistical manual of Mental Health Disorders (DSM) and PRIME-MD and number of diagnostic tools and questionnaires for assessment and diagnosis of psychiatric illness are available, but these are not used as patients generally get offended by questionnaires having leading or sensitive questions[23, 24,25, 26].

Patients coming to Medical OPDs with psychiatric illnesses constitute a test for the system and doctors. They are very difficult to diagnose (wrong persons in the wrong place) . They generally have attitude problem and they want everything including diagnosis to tests to management and counseling according to their terms. They tend to utililize most of the health services quite unnecessarily. They challenge primary physicians and their competency and ability to differentiate patients with organic diseases from them. All this results in unfair and unnecessary usage of hospital resources which ultimately is a burden on the doctors , hospital and community. No good comes out of this, rather a lot of discontentment and disapproval is observed among physicians. They are caught in a difficult and unfortunate situation which is a source of frustration, helplessness and grievances. Overall environment becomes hostile and the physicians competency and confidence are challenged at every level.

Table-1: Number and percentage of patients in Medical OPD with psychiatric disorders (n =1049):

	No. of Patients	Percentage
IBS	357	34.0
Somatized Anxiety	275	26.2
Depression	204	19.4
Hypochondarism	122	11.6
Conversion Disorder	71	6.7
Globus Hystericus	20	1.9
Total	1049	104

Table 2: Age Distribution in Psychiatric patients (n= 1049)

Age Range in Years	Number	%
14-30	320	30.5
30-35	235	22.4
35-49	196	18.6
> 50	298	28.4

Table 3: Demographics of psychiatric patients in Medical OPD (n =1049)

		Number	%
Gender	Male	441	42
	Female	608	58
Education	Graduate	383	36.5
	Non-Graduate	666	63.4

Monthly Income	< 25000	686	65.3
	> 25000	363	34.60

Limitation:

- It is a tertiary care center based study.

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