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Physical Illness in Psychiatric Out-Patients

By D. WYNNE DAVIES

Patients with somatic symptoms who fear serious organic disease are frequently encountered in medical practice. Chest pain and palpitation for example may give rise to concern about heart disease, and abdominal pain to fear of cancer. Every case warrants careful consideration, including examination and investigation where necessary. As a result, some will be relieved both of anxiety and symptoms by simple explanation and reassurance, if their fears were ill-founded or misplaced. The outcome may not be so favourable in others, also free of physical disease, who may need expert psychiatric help. Davies, B. (1964), reviewing the literature, reported a mean incidence of 27·3 per cent. of medical out-patients with purely psychiatric illness, and a further 10–40 per cent. with mixed organic and psychiatric conditions in those attending general hospital clinics.

On the other hand, patients with dominant psychiatric symptoms and less obvious physical disease are likely to be referred to a psychiatrist. New psychiatric out-patients were therefore studied to detect any with masked serious physical disease and to ascertain those who might benefit from additional general medical appraisal. A record of out-patients referred to the general physician by his psychiatric colleagues was also made, to determine the problems where they sought assistance and to illustrate the advantages of combined assessment in these cases.

Patients

All the new out-patients referred to one psychiatrist (Dr. C. M. Ross) at a psychiatric clinic on one day of each week were seen as well by a general physician. They readily accepted examination by a second doctor working in collaboration, and obviously regarded a "physical check-up" as usual practice in a hospital clinic. Each was assessed immediately after the psychiatric interview and investigated appropriately, some requiring admission to hospital usually for psychiatric reasons. Where physical disability seemed to be contributory, appropriate measures in treatment were instituted as a necessary part of the overall management of the case. Thirty-four patients had been referred by general practitioners and two by other consultants. The psychiatric diagnosis was always made by the psychiatrist.

The findings in 36 out-patients referred consecutively by four psychiatrists to the same general physician were also recorded, with the psychiatric diagnosis and reason for referral. Three were sent by their general practitioner, with the approval of the psychiatrist concerned. In all these cases, the psychiatrists have indicated the problems in which they considered assistance worth while, and thus the nature of the contribution required of a general physician. These may be considered along with the findings in the first 36 patients, who would normally have been assessed physically by the psychiatrist alone initially.

Findings

1. *New Out-patients Attending Psychiatric Clinic on One Day each Week* (*36*)

(*a*) Without present physical disease (15)
(*b*) With probably unrelated physical disease (6)
(*c*) With probably related physical disease (15)

(*a*) The psychiatric state was usually the only obvious disturbance, mainly depression or anxiety. Associated physical disease would have been unlikely in some, for example a 17-year-old girl who had become suicidal after an emotional quarrel with her mother. In seven, physical

review was nevertheless advantageous for differing reasons. A woman of 36 had depression and anxiety, with possible compensation factors, following chest injury complicated by persistent localized thoracic pain. An alcoholic man aged 35, who had an anxiety state, was a heavy cigarette smoker. He had chest pain and palpitation with considerable fear of heart disease. Among the remainder: a 39-year-old woman, a neurotic personality, with anxiety and depression following fractured skull, a woman of 40 with atypical depression after a "flu-like" illness, a youth with nocturnal enuresis, and a young schizophrenic man who had subjective muscle stiffness. Finally, a 20-year-old woman had physical deformity (camptocormia), which was the manifestation of hysteria; she had a compensation neurosis, but responded satisfactorily to psychiatric treatment reinforced at a somatic level by physiotherapy.

(*b*) The organic lesion was considered to have no bearing upon the psychiatric illness in these cases, because they were free of related symptoms and unaware of its existence (three); or, if aware, not significantly troubled by it at the time (three). Medical diagnoses, in the former, were: compensated rheumatic mitral incompetence (M. 34 years), mild essential hypertension (F. 60 years), idiopathic hypercholesterolaemia (F. 40 years). In the latter: moderate chronic bronchitis (M. 43 years), vasomotor rhinitis (F. 21 years), cervical spondylosis with root irritation and mild hemiparesis (M. 50 years). Medical treatment was only necessary in the hypercholesterolaemic woman. She presented with a depressive illness, but marked arcus senilis and cutaneous xanthomata were noted and her blood cholesterol levels varied between 365 and 535 mg. per 100 ml.

(*c*) These patients are shown in Table I.

TABLE I

Fifteen New Out-patients in Psychiatric Clinic with Associated Physical Disease

Case No.	Age (yr.) and Sex	Psychiatric Diagnosis	Accessory Features	Medical Summary
22	48 M	Depression	Peri-anal pain	Sacral spinal chordoma
23	39 F	Depression	With anxiety	Lesser curve gastric ulcer
24	52 M	Agitated depression	—	Duodenal ulcer
25	50 F	Depression	—	Resolving pleural effusion, following "pleurisy"
26	36 M	Anxiety state	With depression	Chronic bronchitis, considerable dyspnoea
27	60 M	Depression	Worry over physical health	Chronic bronchitis, moderate dyspnoea
28	35 M	Depression	Worry over physical health	Bronchiectasis (lobectomy) moderate dyspnoea
29	41 M	Anxiety state	Worry over physical health	Recurrent pansinusitis, deviated nasal septum
30	65 M	Anxiety state	Worry over physical health	Post "influenzal" malaise; peripheral vascular disease
31	53 F	Involutional depression	With anxiety	Chlorpromazine jaundice
32	49 M	Anxiety	With depression	Chronic bronchitis, moderate dyspnoea
33	59 M	Paranoid reaction	With depression	Atherosclerosis; coronary, cerebral, peripheral vascular disease
34	53 M	Transient confusion	—	Atherosclerosis; coronary, cerebral, peripheral vascular disease
35	55 M	Atherosclerotic dementia	—	Atherosclerosis; cerebrovascular disease
36	53 M	Atherosclerotic dementia	—	Atherosclerosis; alcoholism

Anxiety or depression was a feature in Cases 22 to 26, in whom organic lesions with significant symptoms or disability were found, usually in association with other predisposing factors (psychological, constitutional or environmental). Improved physical health, as the result of appropriate treatment, could only contribute favourably to their psychiatric management. Case 22 was perhaps reasonably depressed. Before his attendance at psychiatric clinic, he had been investigated and assured that there was no organic cause for his acquired peri-anal pain, which was, however, getting worse. He was admitted to our psychiatric hospital for further study, where a new growth was demonstrated. After the histology of the lesion had been established elsewhere, he was given radiotherapy, his pain improved and his depression lifted.

Cases 27 to 32 described various worries concerning their physical health as well as other problems. They had definite physical disorder, as the basis of these fears. Reassurance and relief of symptoms were no less important for them, although their disability was generally less than in the first group.

Generalized arterial degenerative disease was found in Cases 33 to 36, with evidence of cerebrovascular disease in three. Review of their physical disabilities was clearly necessary, including careful consideration of treatment, as in Case 33. He was a poor witness, who had difficulty in describing his cardiac ischaemic pain and intermittent claudication, which needed treatment. On the other hand he had at one time been given anti-hypertensive therapy for mainly systolic hypertension, which seemed inadvisable since the injudicious use of drugs could well have jeopardized his cerebral circulation. He has since died of a cerebral thrombosis.

2. *Consecutive Out-patients Referred to General Physician by Four Psychiatrists (36)*

(*a*) Without present physical disease (20)
(*b*) With probably unrelated physical disease (5)
(*c*) With probably related physical disease (11)

(*a*) The reasons for referral in these cases are shown in Table II.

The psychiatric disturbance was attributed to anxiety or tension states in 13, schizophrenic disorder in three, psychopathic personality in two and chronic depression in two. The psychiatrists selected these from a much larger group of out-patients, because a need for further physical review was felt.

In some cases they wanted to ensure that a physical condition was not being overlooked, particularly in those with persisting symptoms,

TABLE II

Reasons for Referral in 20 Psychiatric Out-patients without Physical Disease

Main Reason	No. of Patients	Accessory Features	No. of Patients
Fear of heart disease	4	Palpitation	1
		Previous rheumatic fever; "? mitral stenosis"	1
		Hyperventilation and paraesthesiae	1
Hyperventilation	3	Paraesthesiae	2
Lassitude	4	Abdominal discomfort	1
		Somnolence	1
		Diffuse muscle pain	1
		?Adreno-cortical insufficiency	1
Irritable colon	2	Diarrhoea	1
		Abdominal pain, fear of cancer	1
Giddiness, without rotation	2	Diffuse muscle pain	1
Labile hypertension, ?significant	2	—	—
Syncopal attacks	1	"Panic"	1
? Hyperthyroidism	1	—	—
Constipation	1	Anorexia, marked weight loss	1

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although prior examination had not indicated significant organic disease. For example, the diagnosis of hyperthyroidism had been made three years previously in a woman of 37 with an anxiety state, who was now euthyroid. Similarly a worried 39-year-old man had been told he had mitral stenosis, but there was in fact no evidence of a cardiac lesion. One woman of 44 with chronic depression described severe lassitude, anorexia and significant weight loss. She had excessive pigmentation in skin and mucous membranes, postural hypotension and radiological changes of old pulmonary tuberculosis. Since the clinical findings could well have been due to adreno-cortical insufficiency, careful investigation was necessary to exclude this possibility.

In others there was an advantage when a physically-orientated doctor reinforced the psychiatrist's reassurances. Some patients rejected the suggestion that their bodily symptoms might be due to psychological causes. The general physician could lend support by confirming the absence of a physical lesion and thus the need for psychiatric treatment. A youth, aged 22 years, was referred with fear of heart disease, complaining of palpitation, inframammary pain and laboured breathing. This followed the sudden death of an older friend from coronary thrombosis in his presence. He had sufficient insight to suspect that it was "probably all imagination", but this did not relieve his symptoms. He departed satisfied after careful review and emphatic reassurance. In contrast, an educated woman of 53 with chronic hypochondriasis and personality disorder presented with lassitude and abdominal discomfort. She refused to accept her psychiatrist's assurance that she needed his help, but persisted in the belief that all her symptoms had a basis of disordered physical function. In spite of detailed investigation she could not be convinced otherwise.

(*b*) The referral of three of these patients was prompted by symptoms finally deemed to be psychogenic, but coincident medical conditions were noted: a depressed woman of 40, with "globus hystericus" and fear of cancer, who had idiopathic hypercholesterolaemia. A paranoid 58-year-old woman with depression and known essential hypertension, was referred because of increasing headache and vomiting. No change in her hypertensive disease had occurred, but a recent psychological upset accounted for her deterioration. A schizoid youth of 19, giving a history of renal calculus, had transient hyperuricaemia. He was referred for abdominal pain, which resolved after his academic examinations.

In the remaining two, organic disease was discovered accounting for physical symptoms but not obviously related to the psychiatric illness. A man, aged 47 years, with treated dementia paralytica, was shown to have a gastric ulcer. A man of 46, an inadequate personality with hypochondriasis and mild depression, had moderate sustained hypertension with obesity, which responded to simple measures in treatment.

(*c*) These patients are shown in Table III, together with the reason for their referral.

The usual need for further consideration of these was either, as before, to discover any significant physical lesion, where physical symptoms persisted (Cases 62, 63, 64, and 65) or to advise on treatment, when known organic disease existed (Cases 66 and 67). An assessment of the contribution of physical factors to the patient's psychiatric state was required in Cases 68 and 69. Finally, the physical symptoms in Cases 70, 71 and 72 were to some extent affected by the underlying psychiatric condition, or its treatment.

Mutual deliberation between psychiatrist and general physician was always helpful. For example, the psychiatrist indicated that some of the psychological disturbance in Case 66 was secondary to prolonged physical disability and hyposomnia from nocturnal cough and dyspnoea. Her tension state was partially relieved by psychotropic drugs, and more so when her bronchitis was better controlled by medical therapy. The same psychiatrist distinguished between this kind of problem and that in Case 71, who had a psychopathic personality unamenable to treatment. He was a heavy cigarette smoker with recurrent bronchitis, which needed attention, but which played little or no part in his psychological difficulties.

TABLE III

Eleven Referred Out-patients in Psychiatric Clinic with Associated Physical Disease

Case No.	Age (yr.) and Sex	Psychiatric Diagnosis	Reason for Referral	Medical Summary
62	18 F	Anxiety state with hypochondriasis	Occipital pain	Early cervical osteoarthritis (old injury)
63	42 M	Anxiety state	Chest pain	Coronary artery disease
64	65 F	Depression with agitation	Abdominal pain	Duodenal ulcer
65	63 M	Depression	Previous episode of coma	Probable cerebro-vascular disease
66	41 F	Tension state	Recurrent severe dyspnoea	Chronic bronchitis
67	51 F	Depression	Assessment hypertension	Essential hypertension; requiring anti-hypertensive therapy
68	46 F	Dementia in pre-senile era	?Remediable lesion	Transferred for special investigation
69	29 M	Personality disorder; recent change	?Intra-cranial space-occupying lesion	Known multiple neurofibromatosis; no recent extension
70	27 F	Hysterical depression; mental subnormality	Abdominal distension; fear of pregnancy	Cryptogenic epilepsy
71	29 M	Psychopathic personality	Moderate dyspnoea (heavy smoker)	Recurrent bronchitis
72	56 M	Alcoholism, dementia	Syncopal attacks	Attributable to psychotropic drugs

Finally, a mixture of aetiological factors affecting some patients is best illustrated by Case 67. This lady had significant hypertensive disease for several years, treated with anti-hypertensive drugs including rauwolfia alkaloids. She gave a family history of psychiatric illness, and her son had recently committed suicide. Treatment with rauwolfia had been wisely terminated by her physician a week before she attended the psychiatric clinic. She subsequently recovered from her depressive illness, after admission to hospital for observation and carefully planned treatment.

DISCUSSION

It is not suggested that psychiatric out-patients should be examined by more than one doctor routinely. Such a practice would be wasteful in time and is patently unnecessary. Recognition of possible physical disease and its detection in these patients can be safely left to the discretion of any competent psychiatrist, who should be able to seek the assistance of colleagues from other disciplines freely when he so wishes. The placing of psychiatric out-patient clinics in hospitals where there are full facilities for physical investigation and referral is thus essential. Improved liaison between psychiatrists and their colleagues in other spheres should be facilitated in the planned District General Hospitals. There should be no reason why team work of this sort should prove any less applicable in individual cases than, for example, that which exists between physician and surgeon in the assessment of a case of congenital heart disease.

It has been shown in the present study that physical disease of greater or lesser degree, was present in 21 out of 36 routinely-examined new patients attending a psychiatric clinic. That patients with serious physical disease may be referred to a psychiatrist, with the implicit assumption that their symptoms are merely psychogenic, is well illustrated by Case 22, who was subsequently shown to have an invasive new growth. Even in the remaining 15 cases without demonstrable organic disease, the possibility of an associated physical condition was suggested by the history in seven. The psychiatrist would normally have attended to the physical aspects of many of the patients in

this first group. Thus the findings underline the emphasis placed by the psychiatrists upon the need for physical as well as psychiatric assessment in every case and illustrate the inherent danger of misinterpreting physical symptoms in psychiatric patients, if these are dismissed as psychogenic without due consideration.

The kind of problem in which four psychiatrists have elected to seek further assistance is shown in the second group of 36 referred cases. Physical conditions were noted in 16. A general physician in these circumstances can assist by establishing the organic diagnosis, assessing with his psychiatric colleague the contribution made by physical disability to psychiatric disturbance in a given case, and advising about treatment. Anxiety, tension or depression, even if only partly related to physical symptoms or disability, can be lessened by attention to the latter and reassurance, if they have assumed an undue importance in the patient's mind.

A suspicion of possible organic disorder was raised in 20 in whom no physical disease was discovered. Nevertheless, a double purpose was served. The psychiatrist could thereafter concentrate his attention upon psychiatric measures in treatment, and a doubtful patient was usually more willing to accept a psychological explanation for emotionally determined symptoms. This does not imply that the psychiatrist's examination had been inadequate or unskilled, but rather that particular patients might be more effectively reassured after a second review by a general physician. The greater proportion of cases without evident physical disease amongst the referred patients might be taken to imply that those with indeterminate physical symptoms are the very cases in which psychiatrists are most likely to seek assistance. Certainly a variety of problems were encountered in which combined assessment was advantageous, although psychiatrists quite properly investigate and treat the majority of their patients with organic disease. There must be many in which general physicians and others could provide useful help as well.

The need for determining the relative importance of coincident psychiatric and physical factors in the illnesses of individual patients was also stressed by Kenyon and Rutter (1963), who described their findings in patients referred for psychiatric assessment in a general hospital. Although there may be inherent difficulties in the introduction of psychiatric patients to the general hospitals (*British Medical Journal*, 1962; *Lancet*, 1962), Little (1963) has emphasized some of the advantages in his description of a busy and effective psychiatric unit in a large general hospital. A welcome result of the change should be improved facilities for special investigation and consultation in the management of psychiatric patients, which have often been deficient in the past (*Lancet*, 1962). These have proved valuable in patients in a psychiatric hospital (Davies, D. W., 1964), and are obviously equally necessary for the growing psychiatric out-patient services in this country.

Summary

Thirty-six new out-patients, referred to a psychiatrist, were examined routinely by a general physician in attendance at a psychiatric clinic to ascertain the occurrence and significance of organic disease in them. Each was investigated appropriately, including admission to hospital where necessary, which was usually for psychiatric reasons. Fifteen had no physical disease, but in seven of these the history indicated a particular need for physical assessment. Coincident physical conditions, unrelated to the psychiatric disorder, were noted in six, and probably related physical disease in 15. One had an invasive new growth, accounting for his persistent local symptoms.

The findings in a further 36 psychiatric out-patients, referred to a general physician by four psychiatrists, are also recorded. In these, the psychiatrists have indicated the problems with which they sought assistance. Twenty had no physical disease, but needed physical appraisal for different reasons. Organic conditions seemingly unrelated to the psychiatric disorder were found in five and probably related physical disease in 11.

The advantages of combined assessment by a psychiatrist and general physician in certain cases are discussed, and the importance of recognizing both physical and psychiatric factors in cases of mixed aetiology.

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D. Wynne Davies, M.B., M.R.C.P., *Physician, Hollymoor Hospital, Northfield, Birmingham, 31*