The Primary Care Physician's Guide to Common Psychiatric and Neurologic Problems

Advice on Evaluation and Treatment from Johns Hopkins

Edited by Phillip R. Slavney, M.D., and Orest Hurko, M.D.

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For Amanda and Gordon Grender
P. R. S.

For Victoria Reed Hurko and Alexander Reed Hurko
O. H.

Contents

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Preface and Acknowledgments

Primary care physicians must now evaluate and treat complaints that only several years ago were thought to need the prompt attention of specialists. These new responsibilities demand new knowledge, but many general practitioners may not have the time to read long, detailed texts; they want to understand the essence of the problem and do something to help their patients. Under the circumstances, a small book dealing with common or worrisome psychiatric and neurologic complaints should be of value to busy physicians.

Our book has 12 problem-focused chapters, the titles of which generally reflect words patients use. In each, the author describes the usual presentation of the problem in adults and enumerates its major causes. The reader is then advised on clinical assessment, initial treatment, and referral to specialists. The chapter authors define basic concepts and make practical recommendations based on their extensive experience as consultants to primary care physicians. When the first person pronoun is used, the author is giving his or her personal advice. In addition to the 12 problem-focused chapters, 2 chapters outline screening evaluations for psychiatric and neurologic disorders in general.

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PART I

Psychiatric Problems

ONE

The Screening Psychiatric Evaluation

Karin J. Neufeld, M.D.

For primary care doctors, screening for the presence of psychiatric disorders includes both reviewing specific aspects of the history and evaluating the patient's mood and cognitive ability. A skillful patient interview will facilitate early detection and appropriate treatment of psychiatric disorders, especially in patients whose initial complaints suggest nonpsychiatric illness. Although psychiatric disorders are often misunderstood and feared by the general public, an interested, matter-of-fact diagnostic approach by the primary care physician is reassuring to patients with psychiatric problems and informative to those without. Asking questions about psychiatric disorders as part of a complete medical evaluation validates their importance as common illnesses that can and should be treated.

History

Family Psychiatric History

A family history of psychiatric disorder is best elicited at the same time the rest of the family history is obtained. A positive response to a general question such as "Has anyone in your family ever had emotional problems?" should be followed with more specific questions regarding symptoms, diagnoses, and treatments. Supplementary questions such as "Has anyone in your family ever tried to harm himself or herself, or has anyone needed psychiatric treatment?" sometimes elicit important information that may go unreported with a single screening question. Knowledge that a relative has attempted or completed suicide, for example, can be very helpful to the physician in estimating the patient's risk of self-injury.

Personal Psychiatric History

Inquiries regarding the presence of psychiatric problems are most easily made within the general review of systems. Responses to questions such as "Have you ever had any emotional problems?" allow further exploration about the nature of the illness, its treatment, and the level of disability. This is especially important when the patient reports having had a "nervous breakdown," as this term has no diagnostic utility.

When patients respond in the affirmative to the initial screening question about emotional problems, the physician should ask them about thoughts of suicide. These thoughts are unlikely to be reported spontaneously by the patient and give information about the potential for self-injury. Such questions might be formulated as "Have you ever felt so bad that you wished you were dead?" or "Have you ever felt so bad that you thought of taking your life?"

Personality

Assessment of the patient's personality helps the primary care physician understand that individual's enduring strengths and weaknesses and reveals patterns of behavior that might be anticipated in times of stress. It is important to ask patients to describe themselves as they usually are, rather than how they are feeling at the moment. Information about the patient's personality obtained from other sources (e.g., family members) will aid in understanding that individual's baseline traits. Questions regarding the patient's usual mood, tendency to worry (e.g., "Are you the type of person who worries a lot, or are you relatively carefree?"), suspiciousness (e.g., "Do you tend to trust people, or do you suspect that they are taking advantage of you?"), and propensity to anger (e.g., "Are you a person who is easily angered, or does it take a great deal to get you mad?") should all be asked.

Becoming familiar with the patient's personality at baseline also allows the physician to ascertain when there has been a change from the established pattern. Such changes may indicate the onset of a psychiatric disorder. For example, the physician should consider major depression as one reason why someone who is usually cheerful and carefree has now become morose and apprehensive.

Mental Status Examination

A mental status examination should be part of any thorough clinical assessment. Some aspects of the patient's mental state can be inferred from his or her behavior, but others must be inquired about. Although family and personal psychiatric history and information about premorbid personality can be gathered adequately during the initial evaluation of the patient, the primary care physician should perform a mental status examination (however brief) at each patient encounter.

Appearance and Behavior

Observation of the patient's appearance and behavior is important to all aspects of medical examination. Many clues to underlying emotional distress or disorder can be gleaned from such observations, and the physician should note the patient's grooming, dress, degree of eye contact, facial expression, and engagement in the interaction. For example, a slumped posture, disheveled appearance, and downcast gaze may be manifestations of a major depression.

Speech and Language

It is useful to distinguish between the characteristics of speech (e.g., rate, rhythm, volume) and those of language (e.g., vocabulary, connectedness of ideas). Speech often indicates a patient's emotional state, while language reflects his or her cognitive ability. Thus, in dementia, speech may be prompt and brisk while language content is impoverished and marked by word-finding errors; in major depression, speech tends to be slow and brief, but the use of language is normal.

Mood and Suicidal Thinking

An assessment of mood is based on both the physician's observation of the patient's emotional state and the patient's responses to questions such as "What is your mood like today?" The reported mood is usually congruent with that observed; when it is not, further evaluation is needed. Most often, a mismatch occurs when someone describes feeling "OK" but appears sad

and tearful. If a patient reports being sad, frustrated, or angry, it is important for the physician to ask about suicidal thoughts, as described above under "Personal Psychiatric History." Whenever the patient describes an unpleasant mood, subsequent questions (e.g., "What is upsetting you?") will flow quite naturally.

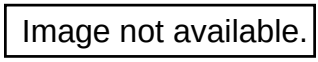
Hallucinations, Illusions, and Delusions

Hallucinations and delusions are rare among people living in the community, and their presence should lead the physician to consider disorders such as delirium, dementia, manic-depressive illness, schizophrenia, and drug abuse. Hallucinations are perceptions without stimuli and can occur in any sensory modality. Auditory and visual hallucinations are the most common types, and the physician can ask about them while reviewing the patient's hearing and vision (e.g., "Have you been hearing noises or voices that people who were with you couldn't hear?" "Have you been seeing things—with your eyes open—that people who were with you couldn't see?"). Remember that hallucinations are experienced as real perceptions, so questions such as "Did you ever hear/see/feel something that wasn't there?" may not elicit an accurate response.

Hallucinations must be distinguished from illusions, in which an environmental stimulus is misidentified (e.g., a chair is seen as a person). Illusions are more frequent in patients with sensory deficits and when stimuli are ambiguous (e.g., at dusk). Thus, although illusions can occur in psychiatric disorders, patients without such conditions also experience them.

Delusions are fixed, false, idiosyncratic beliefs. In the primary care setting, delusions of persecution, disease, and self-blame are probably the most common. Delusions may be revealed spontaneously in the course of history taking or elicited by questions such as "Have you been thinking you're ill because other people want you to suffer or are trying to hurt you?" and "Despite what I've told you, have you been worried that you have some terrible disease?" When the physician discovers hallucinations or delusions, a psychiatric consultation is almost always indicated.

Table 1.1. Median Mini-Mental State Examination Score by Age and Educational Level



Cognitive Ability: The Mini-Mental State Examination

Cognitive impairment, which is central to delirium, dementia, and mental subnormality, often is not detected on cursory examination of an affected individual. The most widely used screening tool for assessing a patient's cognitive ability is the Mini-Mental State Examination (MMSE). The MMSE is not a diagnostic test and therefore does not indicate the cause of impairment; it is designed only to detect the presence of impairment. A perfect score is 30/30, and scores below 24 are regarded as abnormal in most individuals. As seen in Table 1.1, performance on the MMSE varies with educational level and with age. Once cognitive impairment has been detected, further history taking, psychiatric and neurologic examination, and laboratory studies are required to determine the cause of the dysfunction. The MMSE can also be used to track the course of cognitive function over time, and it is therefore helpful to obtain baseline results in individuals who are currently well but at risk for cognitive impairment.

The MMSE can be given just before the physical examination and introduced as another aspect of a thorough assessment (e.g., "I'd like to do your physical exam now, but first I'd like to test your memory, concentration, and