Family Practice

Recognition of organic mental disorders by physicians

M. OLUWAFEMI AGBAYEWA,* MB, BS, DIP PSYCH, MRC PSYCH, FRCP[C]

To test the ability of nonpsychiatrist physicians to correctly diagnose organic mental disorders in patients who present with psychiatric symptoms a multiple-choice questionnaire was distributed. Given six brief case histories, little more than half (55%) of the respondents made the right choice even half of the time. The results strongly suggest a need among physicians for increased familiarity with the psychiatric manifestations of medical–surgical conditions.

Un questionnaire à choix multiples à été distribué à des médecins non psychiatres dans le but de mettre à l'épreuve leur compétence à diagnostiquer correctement les affections mentales organiques chez les patients qui manifestent des symptômes psychiatriques. Sur six brèves descriptions de cas, à peine plus de la moitié (55%) des médecins qui ont répondu ont fait les bons choix la moitié du temps. Ces résultats indiquent fortement la nécessité parmi les médecins de se familiariser davantage avec les manifestations psychiatriques des affections d'ordre médical ou chirurgical.

Many physicians do not recognize the etiologic importance of systemic factors in the onset or perpetuation of psychiatric symptoms.[1,2] After depression, organic mental disorder is the diagnosis psychiatric consultation teams most frequently make among medical–surgical patients referred to them. Many of these patients suffer from delirium, which is almost always the result of a systemic disorder.[3,4] Certain psychiatric symptoms, such as confusion, disorientation, memory impairment and visual hallucinations, are also more often due to systemic than to functional conditions.

The prompt recognition and appropriate management of organic mental disorders are critical to their reversal. The administration of large doses of antipsychotic drugs, especially phenothiazines, for long periods may actually prolong or aggravate the symptoms of organic mental disorder through increased anticholinergic effects. In addition, such drugs can cause extrapyramidal side effects, including tardive dyskinesia.

To test the level of knowledge concerning organic mental disorders among nonpsychiatrist physicians I sent out 90 copies of a three-page multiple-choice questionnaire that was based on six brief case histories that involved temporal lobe epilepsy, hypokalemia, pernicious anemia, frontal lobe syndrome, chronic subdural hematoma and postoperative alcohol withdrawal. Thirty-one responses were received. The six patients had originally been referred to or treated by me. There was enough laboratory and historical information with each of the six to make a diagnosis immediately possible. The questionnaire was accompanied by a letter in which the physicians were requested to choose the most appropriate diagnoses out of the following: schizophrenia, affective disorder (manic–depressive illness), organic mental disorder, personality disorder, generalized anxiety disorder and hysteria. The questionnaire had earlier been answered independently by two other psychiatrists, and there was 100% concordance between the three of us. The correct diagnosis in all six cases was the third choice, organic mental disorder.

Presented here are two of the case histories as examples:

- A 65-year-old widow who lived alone was brought to hospital by a public health nurse at the request of neighbours because she secluded herself at home; the house was unkept except for the occupied rooms. At admission a large amount of money and uncashed cheques were discovered on her; she was dishevelled and suspicious, thinking people were after her money, and her memory, especially for recent events, was impaired. There was no previous personal or family history of psychiatric illness and no evidence of physical illness. The results of laboratory tests were essentially normal except that the serum vitamin B_{12} level was less than 200 pg/ml (150 pmol/l) and the hematologic findings suggested macrocytic anemia.
- A 50-year-old man, a successful business executive, became restless, tremulous and disoriented with respect to time and had excessive sweating and visual hallucinations about 5 days postoperatively and 7 days after admission to hospital. There was no previous personal or

*Now assistant professor, department of psychiatry, University of Manitoba; at the time of the study, senior psychiatrist, psychiatric centre, Union Hospital, Moose Jaw, Sask.

Reprint requests to: Dr. M. Oluwafemi Agbayewa, 770 Bannatyne Ave., Winnipeg, Man. R3E 0W3

family history of psychiatric illness. The results of laboratory tests were essentially normal. The patient was in the habit of drinking alcoholic beverages at meals and business luncheons but did not abuse drugs.

It is true that multiple-choice and case-history questionnaires may not be a true measure of individual knowledge in any field and that specialists tend to concentrate on their areas of interest at the expense of other possibilities. However, the performance of surgical specialists and family physicians here (Table I) does suggest a need for improved or increased acquaintance with the psychiatric manifestations of medical–surgical conditions. The surgical specialists, for instance, least often recognized postoperative alcohol withdrawal, a condition they are quite likely to encounter. The consultation process can provide opportunities for such continuing education.

Table I—Performance of physicians and surgeons in diagnosing organic mental disorders from six brief case histories

Specialty (no. of physicians)	No. (and %) of physicians with at least three correct diagnoses
Medicine (7)	6 (86)
Surgery (10)	4 (40)
Family practice (14)	7 (50)
Total (31)	17 (55)

Quick and easy-to-administer tests that are good indicators of cerebral dysfunction include the Number Connection Test,[5] the Cognitive Capacity Screening Examination,[6] serial subtraction from 100 by 7s or 3s, recalling days of the week or months of the year backwards and tests of orientation to time, place and person.

I thank my colleagues and the staff of the psychiatric centre who helped with the questionnaires, and especially those colleagues who responded.

This study was supported through grants from the psychiatric centre and Union Hospital, Moose Jaw, Sask.

References

1. KORANYI EK: Morbidity and rate of undiagnosed physical illnesses in a psychiatric clinic population. *Arch Gen Psychiatry* 1979; 36: 414–419

2. ENGEL GL, ROMANO J: Delirium, a syndrome of cerebral insufficiency. *J Chronic Dis* 1959; 9: 260–277

3. TAYLOR G, DOODY K: Psychiatric consultations in a Canadian general hospital. *Can J Psychiatry* 1979; 24: 717–723

4. KARASU TB, PLUTCHIK R, STEINMULLER RI, CONTE H, SIEGEL B: Patterns of psychiatric consultation in a general hospital. *Hosp Community Psychiatry* 1977; 28: 291–294

5. ZEEGEN R, DRINKWATER JE, DAWSON AM: Method for measuring cerebral dysfunction in patients with liver disease. *Br Med J* 1970; 2: 633–636

6. JACOBS JW, BERNHARD MR, DELGADO A, STRAIN JJ: Screening for organic mental syndromes in the medically ill. *Ann Intern Med* 1977; 86: 40–46