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"Patient knows best"—detection of common mental disorders in Santiago, Chile: cross sectional study

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Depression and anxiety are common in primary care but about half of patients with these disorders are not identified by primary care physicians.^{1,2} Mental disorder is more likely to be diagnosed in patients who present with or attribute physical symptoms to psychological causes.³⁻⁴ We investigated how patients' ways of understanding their health problems influenced the detection of common mental disorder by primary care physicians in Santiago, Chile.

Methods and results

We studied 815 consecutive patients seen by 11 primary care physicians from five randomly selected clinics in northern Santiago, Chile. Patients with a chronic illness or patients aged over 50 were excluded because these patients are better known by doctors. Most doctors in Chile and in this study have less than four years' experience in primary care.

Before the patient saw the doctor, a lay interviewer asked the patient's reason for consultation and whether it was because of a physical or psychological problem. The interviewer inquired about other potential confounders: physical illness, disability, common somatic symptoms, and whether patients tended to interpret common somatic symptoms by using psychological, physical, or normalising explanations.

A psychiatrist administered the clinical interview schedule—revised, and patients scoring 12 or more were classified as having a common mental disorder.⁵

After the patient had seen the primary care physician, the doctor rated blindly whether the patient had a mental disorder using a five-point scale. Patients with a rating of "mild or greater" severity were considered to have a mental disorder.

The prevalence of mental disorders was 49% (396 of 802; 95% confidence interval 46% to 53%) according to the clinical interview schedule—revised and 35% (276 of 796; 31% to 38%) according to the doctors' ratings. Agreement of doctors' ratings was 48% (186 of 385; 43% to 53%) with the psychiatric assessment ($\kappa=0.27$), so 52% (199 of 385; 47% to 57%) of the cases identified by the clinical interview schedule went undetected. As a whole, 34% (269 of 795; 30% to 37%) of the patients chose a psychological explanation for their reason for consultation but only 69% (185 of 269; 63% to 74%) of them were psychiatric cases according to the psychiatric interviewer.

When analysis was restricted to psychiatric cases, almost half (48%) (186 of 389; 43% to 53%) of these patients attributed their reason for consultation to psychological causes. Among psychiatric cases, doctors identified correctly 34% (70 of 204; 28% to 41%) of those who attributed their reason for consultation to physical causes and 63% (116 of 185; 55% to 70%) of those who attributed their presenting problems to a psychological cause. After adjustment for confounders three variables showed significant independent associations with detection (table): a spontaneous

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The association between patients' causal attribution (physical or psychological) of the reason for consultation and the detection of common mental disorders by primary care doctors. Only cases diagnosed according to psychiatric interview are included

	No*	Crude odds ratio (95% CI)	Adjusted odds ratio† (95% CI)
Reason for consultation‡:			
Physical	168	1	1
Ambiguous	136	2.20 (1.31 to 3.69)	1.33 (0.72 to 2.48)
Psychological	26	22.9 (5.7 to 92.2)	6.24 (1.27 to 30.6)
Patients' causal attribution:			
Physical	206	1	1
Psychological	181	3.22 (2.12 to 4.87)	2.31 (1.43 to 3.74)
Physical illness:			
Absent	274	1	1
Present	108	0.73 (0.46 to 1.15)	0.54 (0.28 to 1.05)
Disability:			
Absent	245	1	1
Present	150	1.05 (0.77 to 1.42)	0.91 (0.55 to 1.46)
Common somatic symptoms:			
Below median	118	1	1
Above median	262	2.45 (1.50 to 3.98)	1.30 (0.74 to 2.28)
Symptom interpretation questionnaire:			
Psychologising:			
Below median	149	1	1
Above median	233	1.57 (1.04 to 2.37)	0.81 (0.36 to 1.79)
Somatising:			
Below median	182	1	1
Above median	200	0.95 (0.63 to 1.42)	1.10 (0.67 to 1.80)
Normalising:			
Below median	247	1	1
Above median	135	0.53 (0.34 to 0.81)	0.75 (0.37 to 1.52)
Clinical interview schedule—revised score:			
12-20 points	186	1	1
>20 points	210	2.04 (1.22 to 3.39)	2.00 (1.15 to 3.50)

*Number of subjects included in the calculation of crude odds ratios.

†Logistic regression involved 291 subjects only, because cases with missing data are automatically omitted from the procedure. Using Huber White Robust Estimator for clustering of doctors and adjusted for all study variables.

‡Fifteen cases are missing and 55 cases are not included because reasons for consultation were unclear or patients were consulting primarily for administrative reasons (for example, physical check ups, to obtain a sickness note, and so on).

psychological reason for consultation, a psychological causal attribution for the presenting problems, and an increased severity of the mental disorder.

Commentary: Clinical practice is as important as diagnosis

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For decades the relative roles of primary care and secondary care in mental illness have been debated, as has the capacity of primary care practitioners to detect and effectively treat mental illness.¹ Araya et al have shown again that patients' attributions influence the detection of mental health problems in primary care. Doctors were twice as likely to detect a psychiatric problem if the patient attributed his or her reason for consultation to psychological rather than physical causes, although the doctors still missed a third of true cases, having a sensitivity of 67%. An important part of psychiatric practice is the "formulation," where, in addition to making a diagnosis, the psychiatrist pulls together relevant information to answer the question,

Comment

Patients in primary care with mental disorders usually consult with doctors for physical problems and this can make it difficult for primary care physicians to identify mental disorder. However, our study has found that a substantial proportion of patients presenting with physical problems readily acknowledge that there is a psychological component to their physical problems. Doctors were more likely to identify patients with mental disorder who attributed their symptoms to a psychological cause than to a physical cause. Asking the patient directly about possible causes of their symptoms might be a simple way of improving the identification of mental disorder in primary care.

Learning how best to clarify patients' presenting complaints should be an important objective of communication skills programmes for clinicians. This could help improve detection rates of mental disorders, compliance, and patients' satisfaction with management. Patients' views are even more important when evidence based knowledge is difficult to come by and clinical uncertainty more common.

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"Why this person with this illness at this time?" This process includes asking the patient what he or she considers to be the basis of the problem. Thus, the proposal that general practitioners should ask their patients a similar question fits with what is regarded as good practice in the mental health field and perhaps goes some way to providing that elusive quick screening test for mental disorder in primary care. It must be remembered, however, that under-recognition of psychiatric disorder may be due to patient, doctor, and factors in the system of health care,^{2,3} and the exact nature and relative importance of these are likely to differ between cultures and countries.

This work also points to another aspect of the debate about mental health in primary care. What about those patients who had no mental health problem according to the clinical interview schedule, but considered that there was a psychological basis to their presenting problem? These were a considerable proportion (a third) of those who chose a psychological explanation for their consultation. Such patients would probably expect some attention to be paid to their psychological problem, and even if they did not have a specific psychiatric illness they might well have a degree of psychological unease or distress, and attention to this might improve their mental and physical wellbeing.

This brings us to the heart of the matter. The need is not simply to improve general practitioners' detection of true psychiatric cases (the increase in sensitivity that most studies focus on), although this is important. Primary care doctors need to be able to deal with the psychological components of what is presented to them, even if it is a "physical" illness. Of the psychological problems present in patients who attend primary care doctors, diagnosable mental illness is only an important subset. Furthermore, general practitioners may recognise and respond to psychological distress in ways other than the "standard" psychiatric treatments, but in ways that are therapeutic none the less. We need to be asking not only how we can improve general practitioners' detection of psychiatric

illness but also what organising principles general practitioners use to classify possible psychological problems and how these influence their clinical practice. Exploration of questions such as these has begun recently and has shown that general practitioners probably do use conceptual models other than classification systems such as the *Diagnostic and Statistical Manual of Mental Disorders* and *International Classification of Diseases* (MaGPIe research group, unpublished results, 1999).⁴ Until we all have a better appreciation of the variety of factors influencing general practitioners' decision making, general practitioners and psychiatrists will continue to talk past each other and our patients will suffer.

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Drug points

Pancreatitis associated with hydroxyurea in combination with didanosine

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Hydroxyurea is a popular, but unlicensed, means of intensifying treatment in patients receiving didanosine, an inhibitor of nucleoside reverse transcriptase (a "nucleoside analogue") used in combination with other retroviral drugs for the treatment of HIV infection. We report on a patient who developed pancreatitis after hydroxyurea was added to didanosine.

In January 1998 a 26 year old man who was HIV positive started taking stavudine 40 mg twice daily (Zerit, Bristol-Myers Squibb), didanosine 400 mg daily (Videx, Bristol-Myers Squibb), and nevirapine 200 mg twice daily (Viramune, Boehringer Ingelheim) because of a falling CD4 count ($250 \times 10^6/l$), high viral load (81 747 copies/ml), and symptoms related to HIV. He was receiving no other treatment. He had no additional risk factors for pancreatitis. Response to treatment was good: the viral load decreased to undetectable levels, the CD4 count increased to $470 \times 10^6/l$, and the symptoms improved, enabling the patient to resume full time employment. In June 1999 the viral load increased to 1390 copies/ml despite the patient's adherence to treatment, so treatment was intensified with hydroxyurea 500 mg twice daily (Hydrea, Bristol-Myers Squibb). The viral load decreased to 237 copies/ml. The patient began to experience malaise and pain in the upper abdomen. This was attributed to the hydroxyurea, which was stopped after 42 days. The symptoms worsened, and three weeks later he was admitted to hospital with severe pain, vomiting, fever, tenderness of the upper abdomen, and guarding. Amylase concentration was 746 units

(normal range < 300), with neutrophil leucocytosis ($18.1 \times 10^9/l$). Computed tomography showed changes consistent with pancreatitis. All drugs were stopped. The patient made an uneventful recovery with conservative treatment. He is no longer taking antiretroviral drugs.

Hydroxyurea potentiates the action of nucleoside analogues by depletion of the deoxyribonucleoside triphosphate pool, particularly deoxyadenosine triphosphate.¹ This increases viral uptake of nucleoside analogues, especially didanosine, which competes against deoxyadenosine triphosphate. Few side effects have been reported with hydroxyurea used in conjunction with didanosine.¹ Pancreatitis is a dose dependent adverse event of didanosine, occurring in 0.7-5.5% of patients receiving doses between 200 mg and 750 mg per day, almost always within the first nine months.^{2,3} Thus, adding hydroxyurea to our patient's treatment may have precipitated didanosine induced pancreatitis, perhaps by potentiating the intracellular toxicity of didanosine. Precipitating serious side effects of previously well tolerated drugs is a newly recognised hazard of hydroxyurea.

This adverse event has been reported to the Medicines Control Agency and Bristol-Myers Squibb. It has not been reported previously.

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