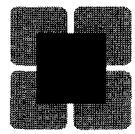

WILLIAM S. WILKE, MD, EDITOR

COMMON PHYSICAL PRESENTATIONS OF PSYCHIATRIC DISORDERS

Most psychiatric conditions that present with medical symptoms are eminently treatable if recognized and managed appropriately. They are remarkably common in the internist's or family physician's office, and may involve as many as a third of patients seen. The disorders are often misdiagnosed, leading to inappropriate and sometimes harmful examinations and treatments, with failure to identify actual pathology. Such patients tend to be high utilizers of health care, and misdiagnosis contributes to their excess utilization of resources.

SOMATOFORM DISORDERS

The somatoform disorders are a group of conditions that includes conversion disorder, somatoform pain disorder, hypochondriasis, and somatization disorder. Patients with somatoform disorders often report having seen numerous physicians whose treatments were either ineffective or actually harmful.

Conversion disorder

The essence of conversion disorder is the psychological production of physical dysfunction. Typical symptoms include hysterical blindness or limb paralysis. In conversion disorder, the physical complaints are not so much a problem as a solution to the patient's internal conflicts. The patients deny stress and tend to idealize parents, spouse, and others. In uncomplicated conversion disorder, the patient has no difficulties with sleep, which is a useful diagnostic sign.

Physical examination may be the most accurate means of diagnosis, as it often discloses non-physiologic signs. For example, Hoover's sign, which helps to rule out organic leg weakness, can be observed by placing the hands under the patient's heels, with the patient supine. When asked to raise the unaffected leg, the patient will press down hard with the "paralyzed" leg in order to lift the other leg. Another example is favoring the affected leg while walking forward, but favoring the opposite leg while walking backward.

Conversion symptoms often begin with organic pathology, and they sometimes mask physical disease. For instance, if viral labyrinthitis rescues the patient from an unpleasant situation, the stage may be set for conversion vertigo. Similarly, pseudoseizures commonly coexist with true epilepsy. From 13–30% of patients initially diagnosed with conversion disorder are later found to have an organic explanation for their condition; thus, caution should be exercised in reaching this diagnosis.

Somatoform pain disorder

Somatoform pain disorder differs from conversion disorder in that pain is the major symptom. In these patients, there has been at least six months' preoccupation with a pain that either has no physiological cause or whose severity is disproportionate to underlying pathology.

In conversion and somatoform pain disorder, it is essential to avoid reinforcing the sick role. Management should start with education. Patients and families should be told that the symptoms are real, but benign, in the sense that they do not indicate serious medical pathology. Thus, recovery should be predicted and healthy behavior encouraged.

Hypochondriasis

Treatment for hypochondriasis is difficult and often fails. One study of patients hospitalized for this condition found that only 21% were much improved after treatment. Patients with hypochondriasis tend to avoid psychiatrists and are more likely to go to internists for treatment. They typically want high-tech, "advanced" interventions. In managing these patients, the physician should look for underlying, treatable psychiatric disorders such as depression, anxiety, and obsessive compulsive disorder.

Somatization disorder

Somatization disorder involves non-organic symptoms affecting virtually all organ systems. It may be genetically based in part. The disorder occurs most frequently in young women. Complaints of physical illness begin before the age of 30 and persist for several years. Symptoms should include conversion-pseudoneurologic phenomena, sexual dysfunction, pain, and problems in the cardiopulmonary, gastrointestinal, and reproductive systems.

These patients rarely fully recover, but can be managed by a physician who provides consistent follow-up, counseling and support, while avoiding unnecessary procedures and evaluations for every new symptom.

OTHER PSYCHIATRIC DISORDERS THAT MAY LEAD TO PHYSICAL SYMPTOMS

Panic disorder

Anxiety disorders affect about 16% of the population, about 10% of whom have "panic attacks" characterized by an overwhelming, unexplained terror. They often lead to fear of places in which they have occurred. Panic attacks are easily misdiagnosed. In one study, 70% of patients had been to 10 or more physicians without obtaining a diagnosis. Panic disorder differs from phobia in that the episodes are unexpected. The symptoms are not the result of being the center of attention, as in the case of stage fright.

Panic disorder usually responds well to antidepressants, especially imipramine. Treatment may be initiated with time- limited benzodiazepines. In addition, patient education and re- exposure to feared situations are essential for full recovery.

Depression

Depression, which affects 8% of the population, often masquerades as physical illness, because many of its symptoms are somatic. Although treatable, depression can be difficult to diagnose in a patient with an underlying disease, such as cancer. In these cases, self-esteem, capacity for pleasure, and sense of humor help to differentiate depression from symptoms of disease.

Substance abuse

Substance abuse affects 17% of the population and alcohol abuse affects 11%. Alcoholics often have many vague somatic complaints, such as anxiety, insomnia, loss of energy, headaches, and gastrointestinal symptoms. Correct diagnosis usually depends on the history, which the patient is generally unwilling to provide. Relatives provide the most accurate history and should be consulted.

Factitious disorder, malingering

Uncommonly, physical symptoms result from intentional, conscious attempts by the patient to feign disease. Patients who have factitious disorder have an obsessive "need" to be sick; they usually have a severe personality disorder. External incentives for their behavior may be absent or minor. In contrast, external incentives are easily recognizable in a malingering patient.

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SEPTIC STERNOCLAVICULAR ARTHRITIS: DIAGNOSTIC CLUES AND MANAGEMENT

Septic arthritis is a common infectious disease with devastating orthopedic and potentially life-threatening complications. Disseminated gonococcal infections continue to account for 50% of all cases of adult septic arthritis. Gonococcal arthritis generally responds well to parenteral penicillin, and severe sequelae are uncommon. Nongonococcal infections of joints have a greater morbidity and occasional mortality. The sternoclavicular (SC) joint is involved in septic arthritis with about the same frequency (5–10%) as the ankle, shoulder, wrist, and elbow. The frequency of involvement as well as several unusual clinical aspects of septic SC arthritis warrant separate consideration.

PATHOPHYSIOLOGY

The SC joint is a true diarthrodial synovial lined joint with a thick interarticular disk. Anatomically, it is close to the thyroid, sternocleidomastoid muscle, first rib, trachea, great vessels, pleura, and mediastinum. It is used very frequently since every movement of the arm is accompanied by rotation at the sternoclavicular joint. These anatomic and physiologic factors may account for many of the clinical aspects of infectious arthritis of the SC joint.

A wide variety of organisms have been reported to infect the SC joint and include mycobacteria, yeast, and most commonly aerobic and anaerobic bacteria. Recent interest has focused on gram-negative infections, predominantly *Pseudomonas* SC arthritis in intravenous