

Outpatient Referrals to Psychiatry II: From Neurosurgery

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Abstract

In this part of the prospective controlled study patients referred from neurosurgery to psychiatry outpatient (n=27) were evaluated regarding their sociodemographic features, reasons for referral, psychiatric signs and symptoms, nature of chief complaints and diagnosis. Referred patients differed significantly from non-referred random patients (control group) as regards chief complaints and diagnostic pattern. Multiple somatic complaints and anxiety features were the main chief complaints and neurotic illnesses were the commonest psychiatric diagnosis in patients referred from neurosurgery.

Key words -

**Referrals,
Neurosurgery,
Psychiatry,
Consultation,
Liaison psychiatry**

The need of consultation-liaison services is probably more in patients attending neurological and neurosurgical services because of

- (a) common presenting symptoms like pain, headache, memory problems, paraesthesia, weakness, numbness etc.
- (b) high psychiatric morbidity in neurological inpatients [1], [2], [3]
- (c) and high incidence of primary psychiatric morbidity in patients attending neurology outpatient [4].

The pattern of referrals from neurosurgery to psychiatry outpatient has so far received little attention., The combined rate of referrals from both neurology and neurosurgery to psychiatry outpatients were reported to be 7% in a general hospital [5]. In the present study we have described the sociodemographic characteristics, reasons for referral, the nature of chief presenting complaint(s) and the diagnostic pattern in patients referred from neurosurgery outpatient to psychiatry outpatient department. These parameters were compared with those of patients who were not referred, but were attending the same psychiatric clinic during the same period as the index group.

Methods

The methods have already been elaborated in the first part of this paper.

Here the characteristics of neurosurgical referrals to the psychiatry outpatients have been described. Details regarding identification data, sociodemographic factors, reasons for referral, chief complaints, neurological and psychiatric examination were recorded systematically. Psychiatric and medical diagnosis were given to these patients according to ICD 9 [6]. All details mentioned above were also recorded for the control group patients. The index and control groups were compared and significance of differences computed using chi square test.

Results

The total number of patients seen in psychiatry outpatient during the study period were 518, of which 85 patients (16%) were referred from neurology, neurosurgery and outside. Out of these 85 patients 27 (32%) were referred from neurosurgery outpatient. These form the index group in this part of the report. The mean age of patients in the index group was 33.7 years and for the control group was 33.8 years.

Fifty-five per cent of the referred patients were in age group of 26-45 years and only 15% were above 45 years of age. Referred patients were more often male (67%) and from urban areas (63%). Majority of index group patients were married, illiterate labourers and came from lower socioeconomic status. The sociodemographic characteristics of index group however were similar to those of the control group.

Reasons for which the patients were referred from neurosurgery were that either these patients did not have any neurosurgical problems (37%) or were sent for the assessment of psychiatric problems in those who had multiple vague somatic complaints including headache (22%). In 30% of patients presence of psychiatric symptoms like anxiety and depression were the reasons for referral.

In many patients (81%) multiple somatic complaints and headache were the chief presenting complaints and none of the referred patients reported sadness as complaint. The index group patients differed from the control group patients significantly regarding their chief presenting complaints (Table 1).

Table I - Presenting complaints in neurosurgical referred patients

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On psychiatric examination, common symptoms in the index group patients were found to be those of anxiety (44%), or depression (26%); only one patient had psychotic features and was found to be suffering from major depression. None of the patients had disturbed cognitive functions. Most referred patients had less than 2 years of duration of illness (55%). In 27% of patients duration of illness was between 2-5 years.

None of the patients in index group had organic psychosis but three patients had functional psychosis (manic depressive psychosis, depressed phase). None of the index group patients had schizophrenia

and one patient did not have any psychiatric illness. Majority of the referred subjects had neurotic illness ((77%) like neurotic depression (33%), anxiety neurosis (26%), hysterical neurosis (8%). Other problems like hypochondriasis (4%), adjustment reaction (4%), psychalgia (4%), psychosexual dysfunction (4%), were also noted. The index group patients differed significantly from the control group regarding the diagnosis ($p < 0.001$). None of the patients required inpatient care. The treatment modalities employed were pharmacotherapy and psychotherapy, alone or in combination.

Table II - Diagnostic comparison

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Four per cent of control group subjects had organic psychosis, compared to none in the Index group.
Chi square 24.24, df 3, $p < 0.01$

Discussion

Presenting symptoms like difficulty in attention-concentration, weakness, paralysis, memory disturbance, aches and pains can present to any specialty-psychiatry, neurology or neurosurgery. The possible cause of these symptoms would determine the pathway of referral from one specialty to another. The referral rate from neurosurgery to psychiatry in this study is nearly 5% of all the psychiatric cases and 32% of all the referred cases. The demographic features were same as for other psychiatric patients in the control group.

It is difficult to compare our results with other studies because they were conducted either in general hospital or in consultation-liaison units. Somatic symptoms were the commonest presenting feature, as noted in most other studies [7], [8], [9], [10]. That schizophrenia is rarely diagnosed in patients referred from other specialties [11], [12] is also noted in our study. The commonest psychiatric disorders observed in referred cases were depression and anxiety neurosis as in other studies [4], [11]. The significant difference between the distribution of psychiatric diagnosis between the index and control groups are mainly due to low frequency of psychosis in the Index group, and higher prevalence of neurotic disorders amongst the index group, who mainly because of the nature of their presenting complaints, like headache or giddiness, perceived their problems as physical. the presentation of patients to any specialty depends on the patients' own perception of his problem e.g., headache is likely to make him seek a neurosurgeon's opinion. Moreover patients tend to deny (underplay) emotional problems which may be presenting with somatization. This study also highlights the sensitivity of neurosurgeons in picking up psychiatric morbidity and referring for psychiatric help in their patients. The extent and nature of psychiatric morbidity in the neurosurgical referred patients emphasises the need for exposing neurosurgeons to some experience in mental health issues.

- 1.Lipowski Z J, Review of consultation psychiatry and psychosomatic medicine. II. Clinical aspects
Psychological Medicine Page: 29; 210-224, 1967
- 2.De Paulo J R, Foilstein M F & Gordon B, Psychiatric screening on a neurological ward
Psychological Medicine Page: 10: 125-132, 1980
- 3.Schiffer R B, Psychiatric aspects of clinical neurology
American Journal of Psychiatry Page: 140: 205-207, 1983
- 4.Kirk C & Saunders M, Primary psychiatric illness in a neurological outpatient department in North

East England

Acta Psychiatrica Scandinavica Page: 56: 294-302, 1977

5.Jindal R C & Hema Rajani, Study of psychiatric referrals in a general hospital

Indian Journal of Psychiatry Page: 22: 168-170, 1980

6.World Health Organisation, *Mental disorders, glossary and guide to their classification in accordance with the 9th revision of the International Classification of Diseases, Geneva*1978

7.Katon W, Ries R K & Kleinman A, A prospective study of 100 consecutive somatization patients

Comprehensive Psychiatry Page: 25: 305-314, 1987

8.Bridges K W & Goldberg D P, Somatic presentation of DSM III psychiatric disorders in primary care

Journal of Psychosomatic Research Page: 29: 563-569, 1985

9.Chaturvedi S K, Michael A & Sarmukaddam S, Somatizers in psychiatric care

Indian Journal of Psychiatry Page: 29: 337-342, 1987

10.Teja J S, Narang R L & Aggarwal A K, Depression across cultures

British Journal of Psychiatry Page: 119: 253-260, 1971

11.Schofield A & Daune M M A, Neurologic referrals to a psychiatric consultation liaison service

General Hospital Psychiatry Page: 9: 280-286, 1987

12.Srinivasan K, Babu R K, Appayya P & Subrahmanyam H S, A study of inpatients referral patterns to a general hospital psychiatry unit in India

General Hospital Psychiatry Page: 9: 372-375, 1987
