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who has a mental disorder, the psychiatrist must decide whether a medical, surgical, or neurological condition may be the cause. Once satisfied that no disease process can be held accountable, then the diagnosis of mental disorder not attributable to a medical illness can be made. Although psychiatrists do not perform routine physical examinations of their patients, a knowledge and understanding of physical signs and symptoms is part of their training, which enables them to recognize signs and symptoms that may indicate possible medical or surgical illness. For example, palpitations can be associated with mitral valve prolapse, which is diagnosed by cardiac auscultation. Psychiatrists are also able to recognize and treat the adverse effects of psychotropic medications, which are used by an increasing number of patients seen by psychiatrists and nonpsychiatric physicians. Some psychiatrists insist that every patient have a complete medical workup; others may not. Whatever their policy, psychiatrists should consider patients' medical status at the outset of a psychiatric evaluation. Psychiatrists must often decide whether a patient needs a medical examination and, if so, what it should include—most commonly, a

thorough medical history, including a review of systems, a physical examination, and relevant diagnostic laboratory studies. A recent study of 1,000 medical patients found that in 75 percent of cases no cause of symptoms (i.e., subjective complaints) could be found, and a psychological basis was assumed in 10 percent of those cases.

HISTORY OF MEDICAL ILLNESS

In the course of conducting a psychiatric evaluation, information should be gathered about known bodily diseases or dysfunctions, hospitalizations and operative procedures, medications taken recently or at present, personal habits and occupational history, family history of illnesses, and specific physical complaints. Information about medical illnesses should be gathered from the patient, the referring physician, and the family, if necessary. Information about previous episodes of illness may provide valuable clues about the nature of the present disorder. For example, a distinctly delusional disorder in a patient with a history of several similar episodes that responded promptly to diverse forms of treatment strongly suggests the possibility of substance-induced psychotic disorder. To pursue this lead, the psychiatrist should order a drug screen. The history of a surgical procedure may also be useful; for instance, a thyroidectomy suggests hypothyroidism as the cause of depression. Depression is an adverse effect of several medications prescribed for hypertension. Medication taken in a therapeutic dosage occasionally reaches high concentrations in the blood. Digitalis intoxication, for example, can occur under such circumstances and result in impaired mental functioning. Proprietary drugs can cause or contribute to an anticholinergic delirium. The psychiatrist, therefore, must inquire about over-the-counter remedies as well as prescribed medications. A history of herbal intake and alternative therapy is essential in view of their increased use. An occupational history may also provide essential information. Exposure to mercury can result in complaints suggesting a psychosis, and exposure to lead, as in smelting, can produce a cognitive disorder. The latter clinical picture can also result from imbibing moonshine whiskey with a high lead content. In eliciting information about specific symptoms, the psychiatrist brings medical and psychological knowledge into full play. For example, the psychiatrist should elicit sufficient information from the patient complaining of headache to predict whether the pain results from intracranial disease that requires neurological testing. Also, the psychiatrist should be able to recognize that the pain in the right shoulder of a hypochondriacal patient with abdominal discomfort may be the classic referred pain of gallbladder disease.

REVIEW OF SYSTEMS

An inventory by systems should follow the open-ended inquiry. The review can be organized according to organ systems (e.g., liver, pancreas), functional systems (e.g., gastrointestinal), or a

combination of the two, as in the outline presented in the

following subsections. In all cases, the review should be comprehensive and thorough. Even if a psychiatric component is suspected, a complete workup is still indicated. Head Many patients give a history of headache; its duration, frequency, character, location, and severity should be ascertained. Headaches often result from substance abuse, including alcohol, nicotine, and caffeine. Vascular (migraine) headaches are precipitated by stress. Temporal arteritis causes unilateral throbbing headaches and can lead to blindness. Brain tumors are associated with headaches as a result of increased intracranial pressure; but some may be silent, the first signs being a change in personality or cognition. A 63-year-old woman in treatment for depression began to complain of difficulties in concentration. The psychiatrist attributed the complaint to the depressive disorder; however, when the patient began to complain of balance difficulties, a magnetic resonance imaging was obtained, which revealed the presence of meningioma. A head injury can result in subdural hematoma and, in boxers, can cause progressive dementia with extrapyramidal symptoms. The headache of subarachnoid hemorrhage is sudden, severe, and associated with changes in the sensorium. Normal pressure hydrocephalus can follow a head injury or encephalitis and be associated with dementia, shuffling gait, and urinary incontinence. Dizziness occurs in up to 30 percent of persons, and determining its cause is challenging and often difficult. A change in the size or shape of the head may be indicative of Paget's disease. Eye, Ear, Nose, and Throat Visual acuity, diplopia, hearing problems, tinnitus, glossitis, and bad taste are covered in this area. A patient taking antipsychotics who gives a history of twitching about the mouth or disturbing movements of the tongue may be in the early and potentially reversible stage of tardive dyskinesia. Impaired vision can occur with thioridazine (Mellaril) in high doses (over 800 mg a day). A history of glaucoma contraindicates drugs with anticholinergic effects. Complaints of bad odors may be a symptom of temporal lobe epilepsy rather than schizophrenia. Aphonia may be hysterical in nature. The late stage of cocaine abuse can result in perforations of the nasal septum and difficulty breathing. A transitory episode of diplopia may herald multiple sclerosis. Delusional disorder is more common in hearing-impaired persons than in those with normal hearing. Blue-tinged vision can occur transiently when using sildenafil (Viagra) or similar drugs. Respiratory System

Cough, asthma, pleurisy, hemoptysis, dyspnea, and orthopnea are considered in this subsection. Hyperventilation is suggested if the patient's symptoms include all or a few of the following: onset at rest, sighing respirations, apprehension, anxiety, depersonalization, palpitations, inability to swallow, numbness of the feet and hands, and carpopedal spasm. Dyspnea and breathlessness can occur in depression. In pulmonary or obstructive airway disease, the onset of symptoms is usually insidious, whereas in depression, it is sudden. In depression, breathlessness is experienced at rest, shows little change with exertion, and can fluctuate within a matter of minutes; the onset of breathlessness coincides with the onset of a mood disorder and is often accompanied by attacks of dizziness, sweating, palpitations, and paresthesias. In obstructive airway disease, patients with the most advanced respiratory incapacity experience breathlessness at rest. Most striking and of greatest assistance in making a differential diagnosis is the emphasis placed on the difficulty in inspiration experienced by patients with depression and on the difficulty in expiration experienced by patients with pulmonary disease. Bronchial asthma has sometimes been associated with a childhood history of extreme dependence on the mother. Patients with bronchospasm should not receive propranolol (Inderal) because it can block catecholamine-induced bronchodilation;

propranolol is specifically contraindicated for patients with bronchial asthma because epinephrine given to such patients in an emergency will not be effective. Patients taking angiotensin-converting enzyme (ACE) inhibitors can develop a dry cough as an adverse effect of the drug. Cardiovascular System Tachycardia, palpitations, and cardiac arrhythmia are among the most common signs of anxiety about which the patient may complain. Pheochromocytoma usually produces symptoms that mimic anxiety disorders, such as rapid heartbeat, tremors, and pallor. Increased urinary catecholamines are diagnostic of pheochromocytoma. Patients taking guanethidine (Ismelin) for hypertension should not receive tricyclic drugs, which reduce or eliminate the antihypertensive effect of guanethidine. A history of hypertension can preclude the use of monoamine oxidase inhibitors (MAOIs) because of the risk of a hypertensive crisis if such patients with hypertension inadvertently ingest foods high in tyramine. Patients with suspected cardiac disease should have an electrocardiogram before tricyclics or lithium (Eskalith) is prescribed. A history of substernal pain should be evaluated, and the clinician should keep in mind that psychological stress can precipitate angina-type chest pain in the presence of normal coronary arteries. Patients taking opioids should never receive MAOIs; the combination can cause cardiovascular collapse. Gastrointestinal System Such topics as appetite, distress before or after meals, food preferences, diarrhea, vomiting, constipation, laxative use, and abdominal pain relate to the gastrointestinal system. A history of weight loss is common in depressive disorders, but depression can

accompany the weight loss caused by ulcerative colitis, regional enteritis, and cancer. Atypical depression is accompanied by hyperphagia and weight gain. Anorexia nervosa is accompanied by severe weight loss in the presence of normal appetite. Avoidance of certain foods may be a phobic phenomenon or part of an obsessive ritual. Laxative abuse and induced vomiting are common in bulimia nervosa. Constipation can be caused by opioid dependence and by psychotropic drugs with anticholinergic side effects. Cocaine or amphetamine abuse causes a loss of appetite and weight loss. Weight gain can occur under stress or in association with atypical depression. Polyphagia, polyuria, and polydipsia are the triad of diabetes mellitus. Polyuria, polydipsia, and diarrhea are signs of lithium toxicity. Some patients take enemas routinely as part of paraphilic behavior, and anal fissures or recurrent hemorrhoids may indicate anal penetration by foreign objects. Some patients may ingest foreign objects that produce symptoms that can be diagnosed only by X-ray (Fig. 5.9-1). FIGURE 5.9-1 A mentally ill patient who is a habitual swallower of foreign objects. Included in his colonic lumen are 13 thermometers and 8 pennies. The dense, round, almost punctate densities are globules of liberated liquid mercury. (Courtesy of Stephen R. Baker, M.D.,

and Kyunghee C. Cho, M.D.) Genitourinary System Urinary frequency, nocturia, pain or burning on urination, and changes in the size and the force of the stream are some of the signs and symptoms emanating from the genitourinary system. Anticholinergic adverse effects associated with antipsychotics and tricyclic drugs can cause urinary retention in men with prostate hypertrophy. Erectile difficulty and retarded ejaculation are also common adverse effects of these drugs, and retrograde ejaculation occurs with thioridazine. A baseline level of sexual responsiveness before using pharmacological agents should be obtained. A history of sexually transmitted diseases—for example, gonorrheal discharge, chancre, herpes, and pubic lice—may indicate sexual promiscuity or unsafe sexual practices. In some cases, the first symptom of acquired immune deficiency syndrome (AIDS) is the gradual onset of mental confusion leading to dementia. Incontinence should be evaluated carefully, and if it persists, further investigation for more extensive disease should include a workup for human immunodeficiency virus (HIV) infection. Drugs with anticholinergic

adverse effects should be avoided in men with prostatism. Urethral eroticism, in which catheters or other objects are inserted into the urethra, can cause infection or laceration (Fig. 5.92). **FIGURE 5.9-2** A patient brought to the emergency room with lower abdominal pain. X-ray shows a nasogastric tube folded into the bladder. The patient would insert the tube into his urethra as part of a masturbatory ritual (urethral eroticism). (Courtesy of Stephen R. Baker, M.D., and Kyunghye C. Cho, M.D.)

Orgasm causes prostatic contractions, which may artificially raise prostate-specific antigen (PSA) and give a false-positive result for prostatic cancer. Men scheduled to have a PSA test should avoid masturbation or coitus for 7 to 10 days prior to the test.

Menstrual History A menstrual history should include the age of the onset of menarche (and menopause, if applicable); the interval, regularity, duration, and amount of flow of periods; irregular bleeding; dysmenorrhea; and abortions. Amenorrhea is characteristic of anorexia nervosa and also occurs in women who are psychologically stressed. Women who are afraid of becoming pregnant or who have a wish to be pregnant may have delayed periods. Pseudocyesis is false pregnancy with complete cessation of the menses. Perimenstrual mood changes (e.g., irritability, depression, and dysphoria) should be noted. Painful menstruation can result from uterine disease (e.g., myomata), from psychological conflicts about the menses, or from a combination of the two. Some women report a perimenstrual increase in sexual desire. The emotional reaction associated with abortion should be explored, because it can be mild or severe.

GENERAL OBSERVATION An important part of the medical examination is subsumed under the broad heading of general observation—visual, auditory, and olfactory. Such nonverbal clues as posture, facial expression, and mannerisms should also be noted.

Visual Inspection Scrutiny of the patient begins at the first encounter. When the patient goes from the waiting room to the interview room, the psychiatrist should observe the patient's gait. Is the patient unsteady? Ataxia suggests diffuse brain disease, alcohol or other substance intoxication, chorea, spinocerebellar degeneration, weakness based on a debilitating process, and an underlying disorder, such as myotonic dystrophy. Does the patient walk without the usual associated arm movements and turn in a rigid fashion, such as a toy soldier, as is seen in early Parkinson's disease? Does the patient have asymmetry of gait, such as turning one foot outward, dragging a leg, or not swinging one arm, suggesting a focal brain lesion? As soon as the patient is seated, the psychiatrist should direct attention to grooming. Is the patient's hair combed, are the nails clean, and are the teeth brushed? Has clothing been chosen with care and is it appropriate? Although inattention to dress and hygiene is common in mental disorders—in particular, depressive disorders—it is also a hallmark of cognitive disorders. Lapses, such as mismatching socks, stockings, or shoes, may suggest a cognitive disorder. The patient's posture and automatic movements or the lack of them should be noted. A stooped, flexed posture with a paucity of automatic movements may be caused by Parkinson's disease or diffuse cerebral hemispheric disease or be an adverse effect of

antipsychotics. An unusual tilt of the head may be adopted to avoid eye contact, but it can also result from diplopia, a visual field defect, or focal cerebellar dysfunction. Frequent quick, purposeless movements are characteristic of anxiety disorders, but they are equally characteristic of chorea and hyperthyroidism. Tremors, although commonly seen in anxiety disorders, may point to Parkinson's disease, essential tremor, or adverse effects of psychotropic medication. Patients with essential tremor sometimes seek psychiatric treatment because they believe the tremor must be caused by unrecognized fear or anxiety, as others often suggest. Unilateral paucity or excess of

movement suggests focal brain disease. The patient's appearance is then scrutinized to assess general health. Does the patient appear to be robust or is there a sense of ill health? Does looseness of clothing indicate recent weight loss? Is the patient short of breath or coughing? Does the patient's general physiognomy suggest a specific disease? Men with Klinefelter's syndrome have a feminine fat distribution and lack the development of secondary male sex characteristics. Acromegaly is usually immediately recognizable by the large head and jaw. What is the patient's nutritional status? Recent weight loss, although often seen in depressive disorders and schizophrenia, may be caused by gastrointestinal disease, diffuse carcinomatosis, Addison's disease, hyperthyroidism, and many other somatic disorders. Obesity can result from either emotional distress or organic disease. Moon facies, truncal obesity, and buffalo hump are striking findings in Cushing's syndrome. The puffy, bloated appearance seen in hypothyroidism and the massive obesity and periodic respiration seen in Pickwickian syndrome are easily recognized in patients referred for psychiatric help. Hyperthyroidism is indicated by exophthalmos. The skin frequently provides valuable information. The yellow discoloration of hepatic dysfunction and the pallor of anemia are reasonably distinctive. Intense reddening may be caused by carbon monoxide poisoning or by photosensitivity resulting from porphyria or phenothiazines. Eruptions can be manifestations of such disorders as systemic lupus erythematosus (e.g., the butterfly on the face), tuberous sclerosis with adenoma sebaceum, and sensitivity to drugs. A dusky purplish cast to the face, plus telangiectasia, is almost pathognomonic of alcohol abuse. Careful observation may reveal clues that lead to the correct diagnosis in patients who create their own skin lesions. For example, the location and shape of the lesions and the time of their appearance may be characteristic of dermatitis factitia. The patient's face and head should be scanned for evidence of disease. Premature whitening of the hair occurs in pernicious anemia, and thinning and coarseness of the hair occur in myxedema. In alopecia areata, patches of hair are lost, leaving bald spots; hair pulling disorder (trichotillomania) presents a similar picture. Pupillary changes are produced by various drugs—constriction by opioids and dilation by anticholinergic agents and hallucinogens. The combination of dilated and fixed pupils and dry skin and mucous membranes should immediately suggest the likelihood of atropine use or atropine-like toxicity. Diffusion of the conjunctiva suggests alcohol abuse, cannabis abuse, or obstruction of the superior vena cava. Flattening of the nasolabial fold on one

side or weakness of one side of the face—as manifested in speaking, smiling, and grimacing—may be the result of focal dysfunction of the contralateral cerebral hemisphere or of Bell's palsy. A drooping eyelid may be an early sign of myasthenia gravis. The patient's state of alertness and responsiveness should be evaluated carefully. Drowsiness and inattentiveness may be caused by a psychological problem, but they are more likely to result from organic brain dysfunction, whether secondary to an intrinsic brain disease or to an exogenous factor, such as substance intoxication. Listening Listening intently is just as important as looking intently for evidence of somatic disorders. Slowed speech is characteristic not only of depression but also of diffuse brain dysfunction and subcortical dysfunction; unusually rapid speech is characteristic of manic episodes and anxiety disorders and also of hyperthyroidism. A weak voice with monotonous tone may be a clue to Parkinson's disease in patients who complain mainly of depression. A slow, low-pitched, hoarse voice should suggest the possibility of hypothyroidism; this voice quality has been described as sounding like a drowsy, slightly intoxicated person with a bad cold and a plum in the mouth. A soft or tremulous voice accompanies anxiety. Difficulty initiating speech may be owing to anxiety or stuttering or may indicate Parkinson's disease or aphasia. Easy fatigability of speech is

sometimes a manifestation of an emotional problem, but it is also characteristic of myasthenia gravis. Patients with these complaints are likely to be seen by a psychiatrist before the correct diagnosis is made. Word production, as well as the quality of speech, is important. Mispronounced or incorrectly used words suggests a possibility of aphasia caused by a lesion of the dominant hemisphere. The same possibility exists when the patient perseverates, has trouble finding a name or a word, or describes an object or an event in an indirect fashion (paraphasia). When not consonant with patients' socioeconomic and educational levels, coarseness, profanity, or inappropriate disclosures may indicate loss of inhibition caused by dementia. Smell Smell may also provide useful information. The unpleasant odor of a patient who fails to bathe suggests a cognitive or a depressive disorder. The odor of alcohol or of substances used to hide it is revealing in a patient who attempts to conceal a drinking problem. Occasionally, a uriniferous odor calls attention to bladder dysfunction secondary to a nervous system disease. Characteristic odors are also noted in patients with diabetic acidosis, flatulence, uremia, and hepatic coma. Precocious puberty can be associated with the smell of adult sweat produced by mature apocrine glands.

A 23-year-old woman was referred to a psychiatrist for a second opinion. She had been diagnosed 6 months earlier with schizophrenia after complaining of smelling bad odors that were considered to be hallucinatory. She had been placed on an antipsychotic medication (perphenazine) and was compliant in spite of side effects of tremor and lethargy. Although there was some improvement in her symptoms, they did not remit entirely. The consulting psychiatrist obtained an electroencephalogram, which showed abnormal wave forms consistent with a diagnosis of temporal lobe epilepsy. The antipsychotic medication was replaced with an anticonvulsant (phenytoin) after which she no longer experienced olfactory hallucination, nor did she have to endure the unpleasant side effects of the previous medication.

PHYSICAL EXAMINATION

Patient Selection The nature of the patient's complaints is critical in determining whether a complete physical examination is required. Complaints fall into the three categories of body, mind, and social interactions. Bodily symptoms (e.g., headaches and palpitations) call for a thorough medical examination to determine what part, if any, somatic processes play in causing the distress. The same can be said for mental symptoms such as depression, anxiety, hallucinations, and persecutory delusions, which can be expressions of somatic processes. If the problem is clearly limited to the social sphere (e.g., longstanding difficulties in interactions with teachers, employers, parents, or a spouse), there may be no special indication for a physical examination. Personality changes, however, can result from a medical disorder (e.g., early Alzheimer's disease) and cause interpersonal conflicts.

Psychological Factors Even a routine physical examination may evoke adverse reactions; instruments, procedures, and the examining room may be frightening. A simple running account of what is being done can prevent much needless anxiety. Moreover, if the patient is consistently forewarned of what will be done, the dread of being suddenly and painfully surprised recedes. Comments such as "There's nothing to this" and "You don't have to be afraid because this won't hurt" leave the patient in the dark and are much less reassuring than a few words about what actually will be done. Although the physical examination is likely to engender or intensify a reaction of anxiety, it can also stir up sexual feelings. Some women with fears or fantasies of being seduced may misinterpret an ordinary movement in the physical examination as a sexual advance. Similarly, a delusional man with homosexual fears may perceive a rectal examination as a sexual attack. Lingering over the examination of a particular organ because an unusual but normal variation has aroused the physician's scientific

curiosity is likely to raise concern in the patient that a serious pathological process has been discovered. Such a reaction may be profound in an anxious or hypochondriacal patient. The physical examination occasionally serves a psychotherapeutic function. Anxious patients may be relieved to learn that, despite troublesome symptoms, no evidence is found of the serious illness that they fear. The young person who complains of chest pain and is certain that the pain heralds a heart attack can usually be reassured by the report of normal findings after a physical examination and electrocardiogram. The reassurance relieves only the worry occasioned by the immediate episode, however. Unless psychiatric treatment succeeds in dealing with the determinants of the reaction, recurrent episodes are likely. Sending a patient who has a deeply rooted fear of malignancy for still another test that is intended to be reassuring is usually unrewarding. Some patients may have a false fixed belief that a disorder is present. During the performance of the physical examination, an observant physician may note indications of emotional distress. For instance, during genital examinations, a patient's behavior may reveal information about sexual attitudes and problems, and these reactions can be used later to open this area for exploration. Timing of the Physical Examination Circumstances occasionally make it desirable or necessary to defer a complete medical assessment. For example, a delusional or manic patient may be combative, resistive, or both. In this instance, a medical history should be elicited from a family member, if possible, but unless a pressing reason exists to proceed with the examination, it should be deferred until the patient is tractable. For psychological reasons, it may be ill advised to recommend a medical assessment at the time of an initial office visit. In view of today's increased sensitivity and openness about sexual matters and a tendency to turn quickly to psychiatric help, young men may complain about their failure to consummate their first coital attempt. After taking a detailed history, the psychiatrist may conclude that the failure was because of situational anxiety. If so, neither a physical examination nor psychotherapy should be recommended; they would have the undesirable effect of reinforcing the notion of pathology. Should the problem be recurrent, further evaluation would be warranted. Neurological Examination If the psychiatrist suspects that the patient has an underlying somatic disorder, such as diabetes mellitus or Cushing's syndrome, referral is usually made for diagnosis and treatment. The situation is different when a cognitive disorder is suspected. The psychiatrist often chooses to assume responsibility in these cases. At some point, however, a thorough neurological evaluation may be indicated. During the history-taking process in such cases, the patient's level of awareness, attentiveness to the details of the examination, understanding, facial expression, speech,

posture, and gait are noted. It is also assumed that a thorough mental status examination will be performed. The neurological examination is carried out with two objectives in mind: to elicit (1) signs pointing to focal, circumscribed cerebral dysfunction and (2) signs suggesting diffuse, bilateral cerebral disease. The first objective is met by the routine neurological examination, which is designed primarily to reveal asymmetries in the motor, perceptual, and reflex functions of the two sides of the body, caused by focal hemispheric disease. The second objective is met by seeking to elicit signs that have been attributed to diffuse brain dysfunction and to frontal lobe disease. These signs include the sucking, snout, palmomental, and grasp reflexes and the persistence of the glabella tap response. Regrettably, with the exception of the grasp reflex, such signs do not correlate strongly with the presence of underlying brain pathology. Other Findings Psychiatrists should be able to evaluate the significance of findings uncovered by consultants. With a patient who complains of a lump in the throat (globus hystericus) and who is found on examination to have hypertrophied lymphoid tissue, it is tempting to wonder about a causal

relation. How can a clinician be sure that the finding is not incidental? Has the patient been known to have hypertrophied lymphoid tissue at a time when no complaint was made? Do many persons with hypertrophied lymphoid tissue never experience the sensation of a lump in the throat? With a patient with multiple sclerosis who complains of an inability to walk but, on neurological examination, has only mild spasticity and a unilateral Babinski sign, it is tempting to ascribe the symptom to the neurological disorder; but the complaint may be aggravated by emotional distress. The same holds true for a patient with profound dementia in whom a small frontal meningioma is seen on a computed tomography (CT) scan. Dementia is not always correlated with the findings. Significant brain atrophy could cause very mild dementia, and minimal brain atrophy could cause significant dementia. A lesion is often found that can account for a symptom, but the psychiatrist should make every effort to separate an incidental finding from a causative one and to distinguish a lesion merely found in the area of the symptom from a lesion producing the symptom.

PATIENTS UNDERGOING PSYCHIATRIC TREATMENT While patients are being treated for psychiatric disorders, psychiatrists should be alert to the possibility of intercurrent illnesses that call for diagnostic studies. Patients in psychotherapy, particularly those in psychoanalysis, may be all too willing to ascribe their new symptoms to emotional causes. Attention should be given to the possible use of denial, especially if the symptoms seem to be unrelated to the conflicts currently in focus. Not only may patients in psychotherapy be likely to attribute new symptoms to

emotional causes, but sometimes their therapists do so as well. The danger of providing psychodynamic explanations for physical symptoms is ever present. Symptoms such as drowsiness and dizziness and signs such as a skin eruption and a gait disturbance, common adverse effects of psychotropic medication, call for a medical reevaluation if the patient fails to respond in a reasonable time to changes in the dose or the kind of medication prescribed. If patients who are receiving tricyclic or antipsychotic drugs complain of blurred vision (usually an anticholinergic adverse effect) and the condition does not recede with a reduction in dose or a change in medication, they should be evaluated to rule out other causes. In one case, the diagnosis proved to be toxoplasma chorioretinitis. The absence of other anticholinergic adverse effects, such as a dry mouth and constipation, is an additional clue alerting the psychiatrist to the possibility of a concomitant medical illness. Early in an illness, there may be few if any positive physical or laboratory results. In such instances, especially if the evidence of psychic trauma or emotional conflicts is glaring, all symptoms are likely to be regarded as psychosocial in origin, and new symptoms are also seen in this light. Indications for repeating portions of the medical workup may be missed unless the psychiatrist is alert to clues suggesting that some symptoms do not fit the original diagnosis and, instead, point to a medical illness. Occasionally, a patient with an acute illness, such as encephalitis, is hospitalized with the diagnosis of schizophrenia, or a patient with a subacute illness, such as carcinoma of the pancreas, is treated in a private office or clinic with the diagnosis of a depressive disorder. Although it may not be possible to make the correct diagnosis at the time of the initial psychiatric evaluation, continued surveillance and attention to clinical details usually provide clues leading to the recognition of the cause. The likelihood of intercurrent illness is greater with some psychiatric disorders than with others. Substance abusers, for example, because of their life patterns, are susceptible to infection and are likely to suffer from the adverse effects of trauma, dietary deficiencies, and poor hygiene. Depression decreases the immune response. When somatic and psychological dysfunctions are known to coexist, the psychiatrist should be thoroughly conversant with the patient's medical status. In cases of cardiac decompensation, peripheral neuropathy, and other disabling disorders, the nature and degree of

impairment that can be attributed to the physical disorder should be assessed. It is important to answer the question: Does the patient exploit a disability, or is it ignored or denied with resultant overexertion? To answer this question, the psychiatrist must assess the patient's capabilities and limitations, rather than make sweeping judgments based on a diagnostic label. Special vigilance about medical status is required for some patients in treatment for somatoform and eating disorders. Such is the case for patients with ulcerative colitis who are bleeding profusely and for patients with anorexia nervosa who are losing appreciable weight. These disorders can become life-threatening.

Importance of Medical Screening

Numerous articles have called attention to the need for thorough medical screening of patients seen in psychiatric inpatient services and clinics. (A similar need has been demonstrated for the psychiatric evaluation of patients seen in medical inpatient services and clinics.) The concept of medical clearance remains ambiguous and has meaning in the context of psychiatric admission or clearance for transfers from different settings or institutions. It implies that no medical condition exists to account for the patient's condition. Among identified psychiatric patients, from 24 to 60 percent have been shown to suffer from associated physical disorders. In a survey of 2,090 psychiatric clinic patients, 43 percent were found to have associated physical disorders; of these, almost half the physical disorders had not been diagnosed by the referring sources. (In this study, 69 patients were found to have diabetes mellitus, but only 12 of these cases had been diagnosed before referral.) Expecting psychiatrists to be experts in internal medicine is unrealistic, but they should be able to recognize or have high suspicion of physical disorders when they are present. Moreover, they should make appropriate referrals and collaborate in treating patients who have both physical and mental disorders. Psychiatric symptoms are nonspecific; they can herald medical as well as psychiatric illness. They often precede the appearance of definitive medical symptoms. Some psychiatric symptoms (e.g., visual hallucinations, distortions, and illusions) should evoke a high level of suspicion of a medical toxicity. The medical literature abounds with case reports of patients whose disorders were initially considered emotional but ultimately proved to be secondary to medical conditions. The data in most of the reports revealed features pointing toward organicity. Diagnostic errors arose because such features were accorded too little weight.

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