Family Practice Grand Rounds

Gastric Cancer

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Hospital inpatients under the care of residents and faculty of the University of Wisconsin–Madison, Department of Family Medicine and Practice, are discussed at morning rounds three times a week. These sessions are attended by family practice residents, faculty, nurse clinicians, social workers, medical students, and other health care related students, staff, and guests. The primary purpose is educational: to provide an opportunity for learning from family practice patients by all residents. Secondary purposes include quality assurance through peer review and "sign-out" to persons on call. Dr. Sternburg will present today's case.

DR. JON STERNBURG *(Assistant Professor, Department of Family Medicine and Practice)*: I have two reasons for presentation today: (1) to review issues related to the diagnosis and treatment of gastric cancer, and (2) to foster discussion of the role of the family physician in the care of patients requiring subspecialty consultation.

The patient, Mr. C., is a retired dairy farmer who first came to the Northeast Family Practice Clinic three months prior to being hospitalized. He is of Scandinavian descent and has lived the past 50 years in southeastern Wisconsin.

This hospital admission is the second in the past two months for this 70-year-old white married male who entered after a three-week history of increasing burning epigastric pain, a ten-pound weight loss, and persistent nausea and vomiting. Three months prior to admission the patient saw me for the first time, complaining initially of diarrhea and excessive belching which persisted despite the antispasmodic and tranquilizer medi-

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cations prescribed by another physician. These medications were discontinued, and antacids were begun along with dietary restriction of excessive milk intake. The diarrhea decreased and the belching subsided. Two months prior to this admission I saw the patient to confirm a right inguinal hernia he had noticed for the previous two days. He was admitted to the hospital for surgical repair of this hernia.

During the hospital course to repair this right inguinal hernia, an upper GI series showed retained fluid and food in the stomach and very slow peristalsis. An abdominal x-ray film 24 hours later showed a large amount of retained barium in the stomach. A 3.5 cm antral wall ulcer was found on gastroscopy. Multiple biopsies and brushings were negative for malignancy. On recommendation of the gastroenterologist, the patient was discharged on cimetidine and antacids, and was scheduled to have gastroscopy after eight weeks of treatment. He did well for five weeks and then developed increasing burning in the mid epigastrium, relieved by meals and antacids. He discontinued cimetidine because of "stomach upset" two weeks prior to admission. One week later he began having several episodes of nausea and vomiting which became persistent on the day prior to admission.

For the preceding ten years he had suffered from chronic bronchitis, which is related to his 50-year history of smoking about ten self-rolled cigarettes a day. Six years ago a diagnosis of hiatal hernia was made by x-ray films which showed no signs of ulcer disease. His family history is significant in that he has a 74-year-old brother who was successfully treated for rectal cancer 11 years ago. His 48-year-old son began medical treatment for gastric ulcer five years ago and is now asymptomatic.

The patient denied drinking coffee, quit occasional drinking of alcohol one year ago, and denied taking medications, including aspirin, other than cimetidine and antacids. He sold his dairy farm five years ago when he retired. He remains active and especially enjoys fishing, driving the car with his wife, spending time with his grandchildren, and making model cars.

Physical examination revealed a well-developed 6 ft 1 in 162-pound, fair skinned man with moderate epigastric distress. His vital signs were normal.

Significant findings included absence of icterus, increased anterior-posterior chest diameter, absence of supraclavicular or cervical lymphadenopathy, mid epigastric discomfort on deep palpation without evidence of a mass, a liver span of 9 cm to percussion in the right mid clavicular line, no evidence of enlargement of the left lobe of the liver, normal umbilicus, and normal rectal examination without evidence of a shelf.

Diagnostic studies demonstrated retained food in the stomach on an upper GI series and a 3.5 cm antral malignant gastric ulcer on endoscopy with biopsies. Liver function studies and a liver scan were normal. An antrectomy with Billroth II anastamosis was performed, removing a 4.5 cm well-differentiated adenocarcinoma which extended into omental fat without evidence of spread to regional lymph nodes. The liver was grossly normal at surgery.

DR. RICHARD R. LOVE *(Assistant Professor, Departments of Family Medicine and Practice, Human Oncology, and Medicine)*: I will focus my remarks on three issues: radiologic diagnosis of benign gastric ulcer, the use of nonradiologic diagnostic studies in patients with gastric ulcer, and the current status of therapy for patients with clinically resected gastric cancer.

A careful history of symptoms is not particularly helpful in distinguishing malignant from benign gastric ulcers and, thus, the first decision point in such patients comes with the radiologic demonstration of a gastric ulcer. If the radiologist says that the ulcer is benign, he will be correct in 93 to 99 percent of cases.[1-5] The Veterans Administration (VA) study,[1] despite its male population, offers a representative standard of what we all might encounter in routine medical practice. In that study 3.3 percent of gastric ulcers diagnosed as radiologically benign subsequently proved to be malignant.[1] Spiro has an excellent summary of the radiologic features of benign gastric ulcers in his textbook.[2]

Subsequent investigation of patients with gastric ulcer should be selective. Gastric analysis can be important if achlorhydria is found. Gastric cytology is an excellent study when the interest and facilities permit a careful examination. Probably the most definitive and widely available procedure of choice is gastroscopy with multiple biopsies and brush cytology of the ulcer margin. There are six categories of patients with a radiologic diagnosis of gastric ulcer who should have further studies.

1. Patients with radiologically uncertain gastric ulcers—The patient under discussion falls into this category. In the Veterans Administration study, almost ten percent of patients with an ulcer of uncertain benignity were subsequently found to have malignant ulcers.[1]

2. Patients with large ulcers, greater than 20 mm across—For a long time we thought that giant ulcers were always malignant. It appears that this is not true; however, the larger an ulcer is, the more likely it is to be malignant.[1]

3. Patients with an antral gastric ulcer or a nondistensible antrum—The antral portion of the stomach can be very difficult for the radiologist to examine adequately. When pathological conditions develop in this area, scarring and spasms may prevent the normal passage of food and barium, as in the patient under discussion, and definitive radiologic diagnosis is impossible.

4. Patients who fail a healing test *or patients with recurrent gastric ulcer*[1]

5. Patients suspected of having gastric malignancy because of signs or symptoms other than those associated with gastric ulcer—for example, patients with supraclavicular lymphadenopathy, acanthosis nigricans, or a rectal shelf.

6. Patients with risk factors for cancer—These include family history of cancer, or personal history of gastric polyps, pernicious anemia, or achlorhydria.

Three other categories of patients should be mentioned. Patients with greater curvature gastric ulcers were thought to be significantly more likely to harbor gastric cancer. In the Veterans Administration study none of 29 greater curvature ulcers were malignant.[1] Age should play little role in assessing risk of cancer. Finally, older literature suggests that if both gastric and duodenal ulcers are found simultaneously, gastric malignancy is very unlikely.[6]

Patients who do not require immediate further investigation after a diagnosis of gastric ulcer should be followed closely, mentioned in point 4 above as a *healing test*. In the VA study, researchers define healing of 50 percent of the diameter of an ulcer in three weeks as successfully passing the healing test, and beyond that, 90 percent in six weeks. Initial ulcer size should be taken into account because the bigger an ulcer is, the longer it will take to heal. What is significant is that some healing should have occurred at three weeks, and at six weeks, and by six to eight weeks all ulcers should be healed.[1]

DR. ANNE GRIFFITHS *(Third year resident in family practice):* Did the VA study use x-ray films to demonstrate the ulcers?

DR. LOVE: Yes. An ulcer demonstrated radiologically should be followed radiologically at 2 to 3 weeks, and at 6 and 12 weeks after diagnosis. Patients who completely heal their ulcers do not have malignant ulcers. Partial healing under medical management does occur with cancerous ulcers.

Finally, I wanted to comment on the current status of therapy for patients with completely resected gastric cancer. This man had a transmural lesion extending through the serosa and into the surrounding fat. Lymph nodes removed in association with this tumor did not show evidence of metastatic cancer. Unfortunately, however, such patients do not have a good prognosis: current data indicate five-year survival rates of 15 to 20 percent. In the Eastern Cooperative Oncology Group, advanced carcinoma of the stomach treated with combination chemotherapy has shown response rates as high as 40 percent with modest improvement in survival.[7] The Cooperative Group experience is genuinely reflective of what physicians in community hospitals might expect to achieve with their patients. At present there are four studies underway seeking to learn whether combination chemotherapy given as an adjuvant therapy following resection of gastric cancer is of benefit.[8] Our patient has agreed to participate in one of these studies.

DR. STERNBURG: The second reason for presenting this case is to foster discussion of the family physician's role in caring for patients needing subspecialty consultation. What is the role of the family physician in caring for this patient?

DR. ELLEN FLANNERY *(Second year resident in family practice)*: I think that any patient who has a diagnosis of carcinoma is going to be exposed to numerous specialists, consultations, and therapies. In these cases the family physician plays an essential role. I think successful management of such a complicated medical problem requires coordination so that everyone involved knows what medical direction is being taken and also what support exists for the family. The family physician knows the medical situation, is available, and is the person on whom the family de-

pends to relate information clearly and to develop a plan of action. The family physician knows the patient, his style of handling previous successes and problems, his likes and dislikes, his skills and weaknesses, and is also committed to the patient as a person. This commitment is different from that of other medical specialists because it goes beyond managing a particular organ system or diagnosis. Family physicians encourage patients and their families to call on them regardless of the reason. Furthermore, patients can count on family physicians *never* to bow out of their care.

DR. WILLIAM SCHECKLER *(Associate Professor, Departments of Family Medicine and Practice, and Internal Medicine)*: I agree with everything that Dr. Flannery has said. One of the things you have to be sure of is that you are in a system that allows the family physician to be central.

DR. STERNBURG: One of our problems was that when the patient was admitted I was not informed right away. He had called the gastroenterologist, and was admitted by one of the specialist's partners; I was not informed for two days.

DR. SCHECKLER: I would be interested in the specific things that you told the patient, negotiated with him, or agreed to with him prior to his decision to call the consultant about the worsening of his ulcer. How do you do that in relation to any consultant?

DR. STERNBURG: I think I would do it differently now. I would more clearly spell out to the patient after the first admission to the hospital what type of follow-up I anticipated, that is, I would request that he call the Family Practice Clinic at the first sign of any medical problems, rather than calling the consultant. Furthermore, I would be more specific with my consultant regarding my involvement in the patient's care. Our departmental consultation policy is one format that comes to mind.[9]

DR. LYNN PHELPS *(Associate Professor, Department of Family Medicine and Practice)*: I am chairman of the Family Practice Subcommittee dealing with consultations at St. Mary's Hospital. In addition to family physicians, we have an internist and a pediatrician involved, and we are addressing the problem of how the primary physician discovers when patients are admitted by a consultant. One of our recommendations is that the admitting personnel ask the patient, or patient's relatives, who their primary physician is. If they had asked this patient he probably would have said Dr. Sternburg. Then they would put Dr. Sternburg's name on the plastic plate along with the admitting physician's name, so that when the patient reached his room the nurses could contact Dr. Sternburg. This procedure would change the hospital's way of doing things and is our recommendation. Advising the patient directly about follow-up plans is another way of making certain the patient's family physician is notified immediately.

SECOND YEAR FAMILY PRACTICE RESIDENT: One of the roles of the family physician is answering the questions of the patient's family. I am curious about the fact that the son had a gastric ulcer. Has the patient or family asked for your advice to the son?

DR. STERNBURG: Not yet, and the son does not live in the area. Apparently they feel his problem is completely cured, but my intention is to talk about it after we get through addressing the patient's own immediate needs and concerns.

SECOND YEAR FAMILY PRACTICE RESIDENT: That would seem to be an important contribution by the family physician. As another example, in the case of the man who has had a myocardial infarction at 35 years of age, one of the important issues is to intervene with his children early, that is, assess his children's risk factors for heart disease and begin a plan of management for them. The family physician is in a unique position to deal with these other aspects of the patient's disease.

DR. GRIFFITHS: The family physician is also in a unique position to offer patient education about the role of the family physician as well as about medical problems. I think we could take a couple of minutes when we see new patients to explain that family physicians are the center of care, facilitators for patients to get into the secondary and tertiary health care system, and partners with the other medical specialists in caring for complicated problems. Because I often do not take the time to provide that education, I think that some of my patients may be confused about what a family physician is. We can do a better job with this kind of patient education.

DR. GEORGE ROENNING *(Third year family practice resident)*: When I take care of someone like this, one thing I try to do early in our relation-

ship is to find out the patient's goal after hearing this terrible diagnosis, ie, what he or she wants from medical care and his desired goals for the future. Then I try to individually tailor each patient's care. Perhaps this man has always wanted to return to his homeland or to take an extended fishing trip with some of his friends.

DR. STERNBURG: I addressed that, and he said, "Well, what do *you* think I should do?" This patient is relying on me quite a bit to let him know all he should know about this particular illness. That is a heavy responsibility.

DR. ROENNING: It is also hard to understand how he has projected his future, that is, how he wants to spend the next months and years. He may never have seen himself as a retired or sick person.

DR. STERNBURG: Clearly he wants to continue his activity of the past several years such as fishing, and being with his wife and grandchildren. In addition to answering many of his medical questions, I am becoming much better acquainted with this man and his family since his diagnosis. Thank you for your comments and I will keep you informed about his future course.

Acknowledgements

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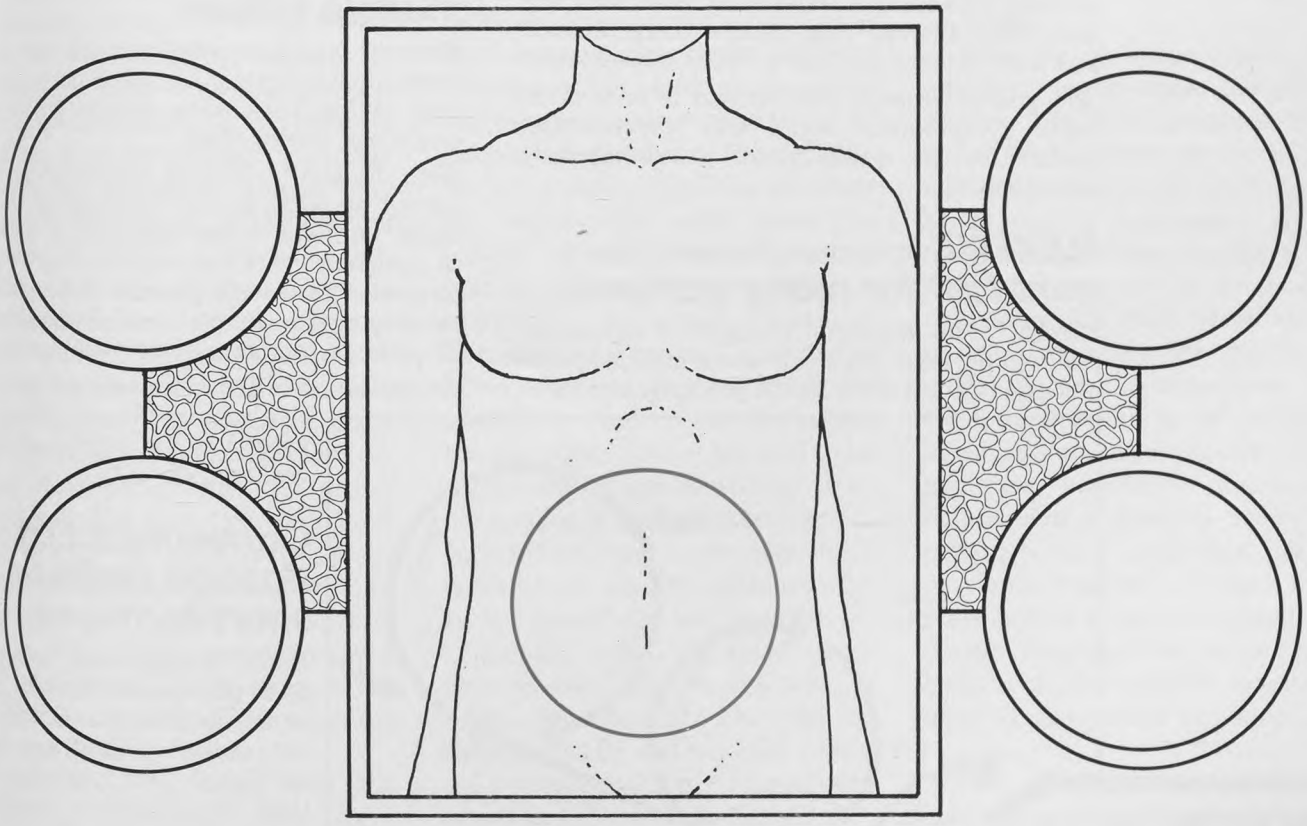

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period of years. In this setting, the departure of her youngest child has left the patient feeling virtually roleless and unneeded. The patient may or may not require an antidepressant medicine but, in any event, drug treatment alone is doomed to failure in the long run, for she will require support, thoughtful assistance, and perhaps the cooperation of her spouse in order to develop new roles for herself, necessary to the restoration and maintenance of her self-esteem.

Personal Assets and Resources

Physicians generally tend to focus much of their attention on pathology, on "what is wrong" with their patients. This is hardly surprising in view of the fact that, in the overwhelming majority of instances, patients visit physicians only when they are having troubles of one kind or another. Nonetheless, the physician utilizes and engages that part of the patient which is healthy when he undertakes treatment of any condition, although he may do this more or less automatically or unconsciously. In our view, it is just as advisable deliberately to assess the areas of psychologic health and other assets of the patient when the physician is dealing with a person who is emotionally ill, as it is to assess cardiopulmonary function prior to surgery. In setting therapeutic goals, it is helpful to know how well the patient was getting along in the various areas of his life prior to the present illness.

At a very elementary level, the physician obviously must have some notion of the patient's general level of intelligence, mastery of the language, and memory, for without this he will not know if the patient is able to comprehend and cooperate with the plan of treatment. Less obvious, but equally important, are the patient's desire to get well, his ability to place trust in the physician and others, his ability to make relevant observations about himself and others and his willingness to report these observations to his physician.

Often, in the course of treatment of emotional illness, the patient's values, goals, and commitments to significant other people in his life become key foundation stones on which recovery is constructed. In this connection, it is noteworthy that sometimes an attitude or value system which was implicated in the genesis of emotional illness may also be utilized in recovery from it. The empty-nest-syndrome patient mentioned previously, who had too narrowly based her raison d'être on the care of her children, obviously places great value on relating to people who need her. This fact can be put to use in reviewing the marital relationship with both the patient and her husband, and in helping the patient to seek opportunities for the personal gratification of "being needed" outside the home; further, it may be useful tactfully to explore with the patient the possibility that in her zeal to be a good mother she unwittingly may have made it difficult for others to reciprocate, and thus may have contributed to the distance between herself and her husband.

Family, social, and financial resources must also be evaluated in order for them to be utilized therapeutically and to avoid imposing upon the patient a plan of care which is impossible to carry out.

Methods

The principal method of psychiatric evaluation consists of history taking and mental status examination by means of interviewing the patient.[3,5,6] Interviewing includes observations of the patient's behavior and verbal exchanges that occur during the physical examination. In addition to the interview, the physician may arrange for the administration and interpretation of special tests or procedures if these are required to complete the examination in selected cases.[1,4]

The Psychiatric Interview

In conducting the interview, the physician is in the roles of both participant and observer.[5,6] In practice, these two activities of participation and observation are so interrelated as to be virtually inseparable.

What the physician observes or otherwise learns about the patient as the interview proceeds influences his approach to the patient and the particular areas of inquiry he chooses to emphasize. A particular historic item or observation stimulates a train of associations in the physician's mind which may in turn lead him to make specific inquiries to test a hypothesis. For example, anorexia or refusal to eat in an adolescent female brings to mind the possibility of anorexia nervosa; in a guarded suspicious person, the possibility of a paranoid delusion of food being poisoned; in a histrionic, seductive person, the possibility of a neurotic basis with the appetite loss being used to manipulate someone; in a

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person of any age, but particularly middle age and older, the possibility of depression. Various physical possibilities, such as hepatitis or carcinoma of the colon or pancreas, may also occur to the interviewer even when the anorexia appears to be part of a depressive syndrome. The interviewer may elect to postpone the pursuit of a particular hypothesis until some later point in the interview, if in his judgment the patient's spontaneous speech is currently centered upon other relevant topics or on issues which are important to the patient (and therefore also to the interviewer); the physician will also postpone a particular line of inquiry if he feels that the patient's sensitivity or defensiveness makes such a course wise for the time being.

In addition, the interviewer's attitudes, manner, and phraseology affect how the patient feels and therefore influence what he chooses to reveal verbally and in nonverbal behavior.

Principles and Techniques

To gain the most information from the patient and to be of the most help, the clinician must arrange a setting in which the patient is at ease and is assured of the interviewer's complete attention. Privacy must be assured, when possible, by a separate room; a busy public ward is paradoxically more private than is a shared double room. Interruptions destroy the continuity of the patient's story and his sense that the clinician deems this story important. Therefore, phone calls, paging, and other disturbances should be held or delayed. A certain length of time is also necessary to establish a working relationship. An hour is generally necessary to conduct a full psychiatric interview. To ensure hearing the patient's story rather than what the patient thinks the examiner wants to hear, one should maintain a free-ranging approach, beginning with what the patient is most ready to tell. Open-ended questions instead of those which can be answered "Yes" or "No" yield more complete information.

The interviewer strives to establish rapport with the patient. His effort is frequently complicated by the fact that patients with emotional problems or illnesses often tend to suffer from loss of self-esteem. This, in part, stems from the patient's notion that mental illness itself indicates personal failure or inadequacy. Further, the illness is sometimes the surface manifestation of underlying problems and conflicts which are associated with painful feelings that are partially allayed, avoided, and revealed by specific symptoms. Therefore, in developing rapport with the patient, the physician needs to be mindful of these two related issues of self-esteem and defensiveness.

Self-Esteem. The interviewer proceeds in a manner that conveys respect, interest, and, if possible, intellectual and empathic understanding. He conducts the interview with an attitude that he and the patient are engaged in a collaborative undertaking which has as its goal (1) a better understanding of the patient's problems, (2) an understanding of the patient himself, and (3) assistance in returning him to a state of well-being. The deliberate adoption of this attitude carries the message that the patient's role is an active one in which he works with the physician and not a merely passive one of receiving advice and pills.

Not uncommonly, a distressed person who is seeking help will tend to idealize the physician, perceiving him as a person of exceptional wisdom, knowledge, understanding, and skill. This idealization is often manifest even though the patient has had virtually no experience with the physician. This in part stems from the patient's need to feel confidence and trust in his doctor. As the patient gains more experience with the physician, this initial, illusory idealization is gradually replaced by a more realistically based appraisal of the physician's reliability, competence, and therapeutic intent.

Defenses. One of the most common defenses encountered by the general physician is that of somatization, in which the patient simultaneously avoids and reveals emotional problems by focusing on one or more physical complaints. The depressed patient, for example, may complain of fatigue or of some bodily pain for which no organic basis can be found. He may tend to minimize feelings of depression or dismiss such feelings as secondary to one or another physical symptom.

It is a useful technique to respect the patient's somatization of his problems by encouraging him to recount fully his complaints and their chronologic development. During this phase of the interview, the physician listens for spontaneous references to feelings and experiences which may provide openings for inquiry into personal and emotional issues that are related to the problems underlying

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the somatic defenses. In proceeding in this fashion, the interviewer is taking advantage of the patient's associative processes to get clues to feelings, fantasies, and experiences relevant to the present illness. If the pursuit of a given line of inquiry arouses discomfort, the patient may temporarily return to somatic symptoms or some other psychologically safe area. The physician should be attuned to these defensive shifts in the conversation, for they enable the interviewer to develop hypotheses about what may be troubling the patient. These may be confirmed or refuted as he gets more data.[2,5]

It is often revealing to ask the patient for his own theories about what is causing his physical (or other) complaints, and to elicit from him the consequences of his somatic symptoms. The usefulness of the latter inquiry was exemplified by a patient who explained that the numbness and weakness of her hands, for which no organic basis could be found, would make it impossible for her to hold and otherwise care for a baby. It was learned that the patient wanted out of her marriage and that her physical symptoms developed a day or two after she first suspected that she was pregnant.

Tact. In conducting the mental status examination, the interviewer includes an assessment of intellectual functions such as memory, concentration, and orientation. In carrying out this part of the interview, it is important to be aware that most people are uncomfortable if they feel their mental functioning is being tested. It is, therefore, helpful to soften the impact of an otherwise jarring question by tactfully giving it a rationale in the context of the interview. For example, one may comment to the patient that, in view of certain symptoms or problems with which he has been suffering, it would seem likely that he has been preoccupied and perhaps has found it difficult to concentrate and keep track of the details of daily life. This can be followed by stating that the examiner would, therefore, like to ask several questions which will help him to assess these aspects of the patient's functioning.

Verbal and Nonverbal Behavior. During the interview, the physician is interested not only in what the patient says but in how he says it: the structure or form of his speech and accompanying affect as well as its content. He will also take note of topics which the patient completely avoids or, as mentioned previously, those which prompt the patient to change the subject. The interviewer will also observe nonverbal aspects of behavior as revealed in facial expression, gestures, and posture, or as implied by the patient's general appearance, including neatness, appropriateness of attire, and nutritional status.

Collateral Interviews

It is often advisable to interview one or more members of the patient's family or, occasionally, a friend of the patient. This is particularly the case when the patient's illness has seriously impaired his ability to give historic data that are important in diagnosis, or when the cooperation of the family is necessary in order to proceed with further evaluation or treatment. In addition, the patient's emotional difficulties may be so interwined with the attitudes and behavior of key members of the family that the interviewer must include family members in the evaluation in order to achieve comprehensive diagnosis and to plan treatment. Collateral interviews are, in a way, the psychiatric equivalent of laboratory examinations, since they can yield new information from a different source.

As a general rule, it is strongly advisable to interview relatives or other interested persons only after the reasons for doing so have been discussed with the patient and his consent obtained. Rarely, an exception to this must be made, as with an acutely psychotic or self-destructive patient who does not give the physician permission to talk with responsible next of kin.

Sometimes, a well-intentioned relative will offer to give the physician information about the patient with the provision that the physician keep the information or the source of it secret. When this occurs, the physician should explain that such information would be useless to him unless he is at liberty to use his own discretion about discussing the information with the patient and revealing its source. In the great majority of instances, the relative sees the sense in this policy and withdraws his insistence upon secrecy. The physician should, in most situations, freely discuss with the patient the content of interviews with other informants. In fact, it is often quite appropriate to invite the patient to be present and to participate when relatives or others are interviewed.

Physical Examination

The general physical and neurologic examinations afford the clinician an excellent opportunity

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to make observations and inquiries relevant to the patient's emotional or mental condition. For example, observations of weight loss, fine tremor, moist palms, constricted pupils, dilated pupils, or skin excoriations provide important clues to further investigation.

Psychologic Testing

Psychologic testing is a valuable adjunct to the psychiatric examination in several circumstances.[1,4]

1. Determination of intelligence level. This may be useful in cases of school failure, apparent inadequacy at work, or when one suspects that the patient is seriously underchallenged by his occupation.

2. Psychologic testing may be helpful when the clinical picture is equivocal. For example, standardized tests of higher cerebral function are useful when one suspects organic brain damage resulting in changes too slight or subtle to be detected by the conventional mental status examination.

3. Certain psychologic tests may reveal psychodynamic themes or personality traits which were not discerned clearly during the interview.

4. Symptom inventories and other types of clinical "scales" are sometimes used to establish a quantitative estimate of the patient's illness or symptomatic status, and may be repeated one or more times in order to observe the effect of therapeutic intervention.

There are a variety of psychologic tests available. Some, such as the Rorschach, Wechsler Adult Intelligence Scale, and the Thematic Apperception Test, are administered by trained psychologists. Others, such as the Minnesota Multiphasic Personality Inventory and a variety of clinical "scales" to assess symptomatic states, are self-administered but are scored by the physician or the psychologist.

Special Diagnostic Procedures

It is apparent that thorough psychiatric evaluation of the patient cannot be separated from the total medical evaluation. It would be folly, for example, to assume that a particular somatic complaint is without an organic basis because the patient happens to be depressed or because the symptom appeared at a time when the patient was experiencing emotional stress. While it is true that the physician cannot prove a negative, ie, that organic disease is absent, it is also true that both he and the patient need to be assured that all reasonable diagnostic tests for physical illness have been done. What constitutes "reasonable" depends upon the physician's judgment in a particular clinical situation. There is no quicker way to alienate a patient than by giving him the impression that his complaints have not been taken seriously or that the physician jumped to the conclusion that they are "psychologic."

Because of the frequency with which emotionally disturbed patients have symptoms referable to the nervous system (headaches, giddiness, tremor, weakness, tingling sensations, difficulties in concentrating, etc), careful neurologic evaluation is always indicated and may, in selected cases, include neurologic consultations and special diagnostic studies such as an electroencephalogram, skull x-ray, or more elaborate procedures.

Specific steps useful in confirming the diagnosis of addiction to hypnotic drugs and opiates are discussed in Part 10.

Continued Observations

More often than not, thorough evaluation and comprehension of the patient's problems require a number of contacts over a period of time. Occasionally, a brief period of hospitalization, in which the patient can be observed by a trained staff, is necessary for adequate diagnostic evaluation.

Organization of Data

Although the actual order in which data are collected depends upon a number of factors, the clinician should have a mental outline of key areas of the history and the present mental status that are to be covered in carrying out a psychiatric evaluation.

History

The organization of historic information does not differ essentially from that usually obtained in general medical evaluation of the patient. In the case of psychiatric illness, somewhat more emphasis is placed upon a detailed psychosocial history because this is often crucial to understanding the development of the presenting problem, the present illness, previous episodes of illness and remissions from illness, the preillness level of adaptation, and the patient's personality and development. It is useful to organize psychosocial data temporally and topically.

Temporally, psychosocial data can be organized as follows: (1) present life situation; (2) life situation concurrent with the present illness; (3) in the case of previous episodes of illness, life situation concurrent with onset of the first episode of illness and its remission; and (4) psychosocial history prior

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to the illness. The interviewer is particularly interested in events or circumstances in the patient's life, such as those involving family, friends, and work, which may have contributed to emotional disturbances, which may be secondary to maladaptive behavior, or which may be indicative of resources and strengths potentially useful in management and recovery.

Within these temporal groups, psychosocial data can be further organized topically. The major topics to be covered are included in the history outline given below.

Outline of History

1. Identifying Data

Name, age, sex, race, marital status, and occupation.

2. Presenting Problems.

These should be recorded in the patient's own words.

3. Present Illness

This consists of a detailed chronologic reconstruction of the present illness (or present episode of illness) from its inception to the present. While obtaining the present illness history, it is important to ascertain why the patient decided to consult the physician at this time. This is particularly relevant if the presenting problems have existed for some time. It is important to know if the patient seeks help because of his own concern or at the behest of some other person or agency; did he select the physician or was he referred by someone?

In the case of psychiatric illness, it is not uncommon for the patient to report aspects of his life situation that are temporally associated with features of the illness. He may or may not regard these aspects of his life situation as causally related to his problems but the fact that they are associatively linked to his problems is worthy of note.

4. Past Psychiatric History

Previous episodes of psychiatric illness similar to or different from the present illness are noted. Approximate dates of onsets and remissions should be recorded as these may be of significance when a chronologically parallel psychosocial history is obtained; type of treatment obtained for previous illnesses also gives clues in planning management.

Has the patient had a history of mood swings, history of symptoms suggestive of episodes of anxiety or of chronic tension, phobias, obsessions, compulsions, somatic symptoms suggestive of conversion hysteria, and other symptoms indicative of neurosis; psychophysiologic symptoms; maladaptive patterns of recent change in attitudes or customary ways of behaving?

5. Past Medical History

This includes any history of significant illnesses, surgical procedures, accidents, injuries, and review of systems.

6. History of Alcohol and Drug Intake

The amount, type of substance, regularity and duration of use, and route of administration are recorded. A patient's defensiveness may pose a barrier to obtaining an accurate history; this may be reduced if one begins by inquiring about the more acceptable substances such as coffee and tobacco. In addition, one can engage the patient's interest and often form judgments about the actual amounts consumed by inquiring about the effects the patient experiences from his use of substances.

7. Present Household and Family History

It is often convenient to initiate inquiry into this area by asking the patient to name persons who presently live in his home and their kinship or relationship to him. This inquiry usually provides a natural opening for obtaining information about the patient's spouse, his children, and other relatives who are involved in the patient's current and past life, including parents and siblings.

It is particularly important to obtain the patient's description of the personalities of the important people in his current family or household and the family of origin, and his relationship with them. The interviewer is particularly alert to important or disturbing events in the patient's family life which are temporally associated with illnesses in the present or past; this includes events such as marital separation, divorce, departure of children from the home, illnesses, and deaths. The incidence of psychiatric or other illness in the family not only provides data relevant to hereditary predisposition, but may also provide a clue about the patient's fears regarding the health of himself or his children.

8. Occupation and Economic Status

This includes the type of work in which the patient is engaged, job

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