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When "Psychiatric" Symptoms Are Not

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The Case

A 70-year-old man without documented past psychiatric history was placed on an involuntary hold as a danger to others and for grave disability because of his belief that his neighbors were shocking him with low-voltage electricity.

The patient had been seen for many years through a local HMO and his records indicated no psychiatric or medical disorders other than a remote GI bleed. A friend of the patient's reported the patient had believed for the past 5 to 7 years that the "shockers" had been after him. In the 2 weeks prior to hospitalization, the patient reported they had somehow "upped the current."

At a local ER, the patient had normal labs and physical examination, with a confirming non-focal neurologic exam on admission to the psychiatric inpatient unit. The patient used a walker for ambulation "because of pain." He was diagnosed as Psychosis NOS (not otherwise specified) with a note in the plan to defer starting anti-psychotic medications and rule out medical etiologies for his acute symptoms.

The treating team began low dose haloperidol. On the first day of hospitalization, the patient complained that he couldn't move because he was shocked by something in his room. Although he felt paralyzed, he was able to lift both legs off the bed and move his toes. On day 2, he was incontinent of urine. He was placed on an extended involuntary hold on day 3. By day 4, he reported continued difficulty moving, continued incontinence of urine, decreased sensation below the waist, and constipation.

Neurology was then consulted. They found his history and findings on exam to be concerning for spinal cord pathology of advanced severity. They ordered an MRI of the spine, which demonstrated an infiltrating mass between T8 and T10 with well-preserved disc space, thought most likely to be either lymphoma or metastasis. Brain metastases were also present.

The patient was transferred to the inpatient medical unit for CT-guided biopsy and other indicated procedures.

The consensus was that the patient's prognosis was not affected by the several-day delay. His neurological status improved after radiation treatment for his cord compression, but the mistake could have resulted in permanent loss of neurological function.

The Commentary

This case addresses the medical error of neglecting to assess possible underlying medical causes for symptoms in a psychotic patient. Medical symptoms in patients with psychiatric disorders are often ascribed to the psychiatric disorder. Unfortunately, patients with chronic psychiatric disorders are as likely as anyone else to develop new medical conditions. In this particular case, a 70-year-old man presented with delusional thinking. The presence of "normal labs" and a cursory non-focal neurologic examination led to "medical clearance" prior to a psychiatric admission. Once the medical system "decided" that this patient had a psychiatric disorder, many physical symptoms were then ascribed to that disorder rather than to a concurrent or underlying medical illness. New medical symptoms in psychiatric patients should be listed as separate problems rather than being "lumped" under the assumption that the psychiatric disorder explains everything.

Some background literature (mostly more than 10 years old) confirms that medical disorders are often overlooked in psychiatric patients. Koran and colleagues (1) found that 39% of community mental health center patients had a medical disorder and that only 58% of those with important disease had been recognized. Reports of the incidence of overlooked important medical issues in psychiatric patients range from 8.8% to 71%.(2-8) A number of medical problems are particularly problematic to diagnose because of the non-specificity of symptoms, which overlap with psychiatric symptoms.(Table) (9) The dilemma for the clinician is often how to conduct a cost-effective evaluation of symptoms without entering into an unnecessary, expensive work-up. As with most medical care, the best practice continues to rely on a careful history and physical examination guided by epidemiological risk factors.(10)

This case illustrates a number of mistakes that led to delayed diagnosis of an underlying medical disorder.

> #1: The mistake of neglecting the medical risks associated with older age. The emergence of medical symptoms (or change in psychiatric symptoms) in a 70-year-old should prompt suspicion of underlying medical disease. Recent evidence suggests that primary psychotic disorders (which may present with somatic features and preoccupations) in elderly patients may occur more commonly than previously thought.(11,12) Nevertheless, the emergence of new onset psychotic symptoms in patients older than age 60 should prompt careful assessment for underlying medical causes of psychosis.

> #2: The mistake of ascribing all symptoms to a chronic psychiatric disorder. The presence of delusions in this patient for several years would lead most clinicians to the conclusion that any underlying medical disease is unlikely because it would have declared itself over that duration of time. The presence of chronic psychiatric symptoms often leads clinicians to be less assiduous in their evaluation of emerging physical symptoms such as (in this case) the otherwise unexplained use of a walker and complaint of pain.

#3: The mistake of “medical clearance.” Since medical symptom presentations are so diverse, it is not possible to delineate a “standard guideline” for medical clearance beyond an expectation of complete and pertinent history, physical examination, and laboratory studies. However, there is often lack of acknowledgment that a careful neurologic examination is difficult to conduct in a psychotic patient, which often leads to charting of a “normal PE with non-focal neurologic examination.” Such patients may be better served by recording some uncertainty over the adequacy of the examination’s validity and completeness. Clinicians are likely to be biased by the recorded impression of a prior examination, especially from another specialty. The notation of “normal labs” (specific tests not specified in this case) also may create a false sense of security in clinicians. Widespread use of extensive laboratory screening does not seem indicated in the majority of psychiatric patients. Instead, laboratory evaluations should be targeted for certain sub-groups such as the elderly, those with low socioeconomic status who may have neglected health care, patients with substance abuse histories, and patients with self-neglect, delirium or dementia.(13,14) The issue of “non-focality” may also be misleading since the presence of psychiatric symptoms is, in a sense, a focal neurologic abnormality, which if not explained by a confirmed psychiatric disorder such as chronic schizophrenia, warrants neuroimaging as a basic aspect of the initial evaluation.

#4: The mistake of neglecting a patient’s symptom reports. This patient was treated with haloperidol for psychotic symptoms, and continued to complain of symptoms that are not typical side effects of that medication - paralysis, incontinence, and impaired sensation. While objective neurologic findings such as reflex abnormalities or strength testing would be important, it can be difficult to obtain such data on some psychotic patients. In such cases, ongoing efforts to record an objective and complete neurologic examination need to be made. Eventually, the clinical team realized how atypical such complaints would be as haloperidol side effects and consulted neurology. In this case, the delay was not damaging, but represents how difficult it can be for the psychiatric team to overcome the bias associated with psychiatric patients’ complaints.

Psychiatric patients whose symptoms are worsening rather than improving with treatment warrant careful and prompt diagnostic re-assessment. Mistakes such as this can be minimized by:

What providers can do:

- Use a problem list that highlights the presence of unexplained physical symptoms (in this case pain, ambulation problems) without automatically clustering them as part of a primary psychiatric diagnosis.
- Maintain an open, questioning mind—this is the clinician’s final line of defense for the errors seen in this case.

What systems can do:

- Use “M&M” conferences to highlight the “myth of medical clearance,” grapple more openly with the difficulties of medical assessment of chronic psychiatric patients, and improve awareness of the poor medical care for this population.
- Continue to assure adequate medical/neurologic training for psychiatrists, and adequate psychiatric training for medical staff. More support (and board requirement) for such cross-training may be necessary.
- Offer ongoing teaching on the value of and indications for admission diagnostic neuroimaging.

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Table

Table. Selected Medical Disorders That May Present with Puzzling Symptoms Often Ascribed to a Psychiatric Disorder

Metabolic:	Hyponatremia, porphyria, hypercalcemia
Neurologic:	Complex partial seizures; multiple sclerosis; neurodegenerative disorders; CNS tumors (primary or metastatic); paraneoplastic disorders; vascular disease (TIA, stroke, cranial vascular inflammation); chronic subdural hematoma; CNS infection
Nutritional:	Vitamin deficiencies
Medication:	Unrecognized adverse effects of numerous medications

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