Clinics in General Practice

An addiction to drug treatment

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The trainee's problem

This patient has her problems, and one of them is certainly her husband. He is a chronic bronchitic, an alcoholic who is at present in a non-drinking phase, and an occasional unskilled labourer. She—in her early 50s—has herself overcome an alcohol problem but at the expense of her figure. She has been persistently and substantially overweight for some 10 years and sadly is now at least psychologically dependent on appetite suppressants. Nevertheless, she has kept the family home intact against odds and now works part-time as a home help. For several years she has taken a thiazide diuretic to control ankle swelling, diazepam by day, and nitrazepam by night.

Three months ago she was smothered by fellow passengers (but not apparently knocked unconscious) in a train accident, in which she was one of those “taken to hospital suffering from shock and allowed home after treatment.” She has not worked since, generally not sleeping more than two hours a night and having nightmares about the accident with, during the past month, increasing headache present from early morning, dizziness, and some 12 episodes of unconsciousness (none witnessed or accompanied by incontinence). She is clearly deeply depressed, has increased her psychotic medication, and has supplemented it with proprietary analgesics, which do not “touch her headache.” Her weight has fallen by some 25 kg in eight weeks—but she still appears to be generously nourished.

My difficulty is partly in deciding whether referral to hospital will render what may be an acute compensation neurosis into a long-term problem, but equally in assessing whether her current symptoms could just be caused by delayed neurological illness or might forewarn of a suicide attempt. Accepting blame for the iatrogenic problems resulting from her medication, where should we start the repair process?

General practitioner's comments

This case is a good example of how to solve problems in general practice, particularly those that are not easy to fit into the kind of problem-solving models that doctors learn during their hospital training. There are many problems here, some critical, others probably insoluble, some of more concern to the patient and others to the doctor. How can we begin to sort them out in a logical way?

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One useful way of doing so is to construct a problem list. The trainee's chief concern seems to be with the problem of a missed organic diagnosis and the possibility of encouraging a “compensation neurosis.” These are really problems for the doctor but hardly of any concern at all to the patient. The following problem list emerges—in order of appearance, though not, of course, of importance: husband suffering from chronic bronchitis and alcoholism; patient's own drinking problem; obesity; dependence on appetite suppressants; dependence on tranquillisers; not working; nightmares, not sleeping; headaches; reported episodes of “unconsciousness”; depression; loss of weight; risk of compensation neurosis (doctor's problem); risk of missed organic neurological disease (doctor's problem); and iatrogenic problems related to drugs.

One of the most important skills that a doctor in general practice has to learn is what priority to give in a problem list of this kind. Those conditions that are potentially life-threatening and treatable must come first. In this list there is a constellation that should alert us to the seriousness of a problem that the doctor has already noted but has allowed to be displaced from the centre of his attention by his own worries. The patient is depressed, losing weight, not sleeping, unable to work, suffering from obsessional hypochondriacal symptoms, and all too probably drinking as well. I would have to have her sitting with me to confirm or perhaps relieve the sense of urgency that the printed story gives me. But until proved otherwise she must be presumed to be “deeply depressed.” If this is so she needs help quickly. Some possibilities are voluntary admission to hospital, a domiciliary visit with a consultant psychiatrist, or referral as an outpatient. I would favour the second course. It would be invaluable to see the patient at home and if possible also her husband. I suspect that a much clearer picture of the condition of the whole family would emerge. The state of the house would be a useful indicator of the seriousness of her depression. It might also be possible to learn rather more about the present state of her drinking problem. (Look inside the lavatory cistern while performing the statutory after-consultation hand wash—it's a favourite place for women drinkers to keep clandestine bottles.) If she is indeed deeply depressed and drinking she will probably need admission, but this would be best arranged with the consultant on the spot. Alternative management could be discussed and planned.

Let us suppose that the depression is not so severe as to demand admission to hospital. What then? I believe the proper person to treat her is her own general practitioner with the help of his practice team. I would suggest that we can reduce and rationalise our original problem list to depression; blackouts; drug dependencies—alcohol, appetite suppressants, and tranquillisers; and obesity.

The problems that require immediate attention are the first two. If it has been decided that it is reasonable to treat the depression at home then there is no reason why this should not be done by the trainee with the help of his trainer. The patient has several complicated problems that will require a good and trusting relationship between her and her doctor if they are to

be treated. The successful treatment of her depression will be a useful beginning to this therapeutic relationship. If drugs are needed tricyclic antidepressants would seem to be the obvious choice but they must be given in adequate doses for sufficient time. The most likely cause of the headaches, sleeplessness, and weight loss is the depression itself, and the symptoms should respond to the treatment of the primary cause. Certainly there is no need to do anything else about them until there has been time to see the response to the treatment of her depression.

The blackouts are worrying in case serious organic disease is being missed. The trainee is also worried whether he should make a referral for the further investigation of these attacks. I believe he should resist this idea. He is really asking for magic answers. A neurologist would be in even more difficulty than the trainee in assessing the true nature of these attacks. The most essential piece of evidence is to try to find someone who has seen the patient in one of the so-called attacks of unconsciousness. If this cannot be done it is doubtful if they are happening at all. It may be that a careful interview with her will disclose that she and her doctor are talking about quite different things. What is now required is a full history and a careful neurological investigation by the GP. Screening could include a full blood count, measurements of the erythrocyte sedimentation rate and fasting blood sugar, and an x-ray examination of the skull. If all these yield normal results and there are no neurological signs of disease the best course is to continue to see the patient for the management of her depression and to resist the temptation to pay too much attention to these attacks.

Perhaps a word should be said about the fear of encouraging a compensation neurosis. This is really not a disease at all, and I believe it is a concept we should stop talking about. There is, of course, a danger that over-investigation will convince the patient that the symptoms are important; this is a very real problem for general practitioners but it is not about compensation. If the remaining problems are handled properly the worry about compensation neurosis will disappear.

If the patient is drinking again it is probably the result of her depression, and it may be hoped that successful treatment of this will allow her to regain control of her drinking. As she is now losing weight this is a good moment to withdraw the appetite suppressants if indeed she is still using them. Their future use should be discouraged. She may or may not need some support from tranquillisers during the treatment of her depression. Her final medication will have to depend on the doctor's judgment. This new crisis should offer him a chance to renegotiate with the patient her long-term drug treatment. One would hope the successful treatment of her depression and her other problems will allow her to cope without resorting to the long-term use of any drug.

In the background one senses the chronic domestic problem with her ill, alcoholic husband. It may not be possible to do much about this but support from the doctor or a social worker might well improve the functioning of this family.

Finally, I see her work as a central part of her repair process. It seems to me important that she should get back to work. She almost certainly gets a great deal of support for her own threatened sense of self-esteem from this. The co-operation of the home help organiser should be gained at this time. The patient's job should be waiting for her and any potential problems that might interfere with her return to work could well be sorted out with the organiser.

Consultant's comments

The management of the problems presented by this patient include a difficult and in some aspects an impossible challenge to effective treatment. The fact that for many years she has partially controlled her personal problems with some success must indicate that she has hidden reserves of character. It can be no mean feat to maintain a home intact and still live with and

control a personal problem of alcohol abuse; to be also wedded to an alcoholic bronchitic who is an unskilled labourer and obviously adept at using the full benefits of social security to continue his drinking must add up to a formidable problem.

I would think that a modest addiction to appetite suppressants to avoid her previous excess weight is not too large a price to pay, and any formal attempt to deal with this aspect of her problems—for example, by psychotherapy—would probably be ill advised at her time of life even if such facilities were available.

The main problem here, of course, is the development of a whole new spectrum of symptoms as a direct result of the train accident. After this particular type of accident, even though no physical injury was noted at the time, referral to a neurologist in the first instance is probably the correct step, even though most clinical neurologists would not necessarily look forward to the consultation with any great enthusiasm. The reason for referral is the necessity to rule out organic disease. If any lingering doubts remain about this possibility the position of the general practitioner (and possibly later a psychiatrist) may be made extremely difficult. She would not be the first patient in an accident to have relatively trivial physical injury but to be subsequently shown to have a subdural haematoma; nor would she be the first patient to present with apparently florid psychiatric symptoms to be found to have an intracranial lesion. It needs, therefore, a detailed analysis of the history and an expert opinion on the central nervous system designed to rule out such possibilities.

So far as this patient is concerned it can hardly be argued that it was an engaging experience to be in a train accident, to be smothered by her fellow passengers for a time, and, when extricated, to be clearly in a state that prompted the relief organisations to seek hospital examination. Almost certainly her subsequent symptoms are compatible with a depressive illness coupled with anxiety features. The progressive weight loss, her insomnia, and her own general practitioner's observations on the degree of depression would all bear this out. The headache comes into a different category, and while it may be that this is part and parcel of an anxiety state associated with a medicolegal claim, it is equally true that it may be part of the depressive picture, and if no serious abnormality appears in the investigations there would seem to be no reason why she should not be given the benefit of the doubt in the final assessment.

Episodes of unconsciousness always present a problem in this type of patient. The immediate concern is whether they are epileptic or not. The fact that none of the attacks have been witnessed is just one of the hardships of the clinical practice of neurology, and the fact that there has been no incontinence of urine in the attack is irrelevant to the diagnosis. It may be possible, however, if the history is adequate to come to a reasonable assessment of the nature of the attacks of unconsciousness. A prolonged preictal feeling of sickness and a vague awareness of the outside world during the attack are only two of the many features that would be enough to rule out the diagnosis of epilepsy. As against this, a history of sudden onset possibly preceded by brief sensory or motor disturbances in one or other side of the body and soreness of the muscles the day after are some features suggesting epilepsy. If such a diagnosis were made it would affect the type of further investigations and, of course, the difficult problem of the relevance of the epilepsy to the train accident. On the evidence presented most assessors would, I think, believe that there was no association between the two.

So far as investigations are concerned these would include plain x-ray examinations of the chest and skull, a blood Wassermann reaction, and a routine blood count. Subsequent investigations would be dictated entirely by the neurologist's view of the importance of her symptoms. At his discretion an electroencephalogram, and isotope scan, and perhaps even an EMI scan would be considered, but it should be emphasised that in this group of patients this type of investigation is rarely needed unless there is some genuinely suspicious element in the history of the physical signs that hints that organic disease may be present. Nothing will have been achieved if this patient is not

satisfied that "brain damage" has been excluded, always provided, of course, that this is her wish.

The general practitioner is properly concerned with the effects of acute compensation neurosis but he can certainly rest happy in his mind that it will not be the single referral to hospital that will accentuate her present symptoms and cause them to continue in the short term at least. She may have already consulted her solicitor and, if not, the odds are high that she will do so. If she does she will be subjected to the full rigours of a medicolegal claim, and as a result she will also be subjected to two parallel sets of influences. On the one hand, there will be her own practitioner endeavouring to obtain some amelioration of her disabling symptomatology, and, on the other, she will be following the slow and somewhat weary path of a medicolegal claim.

The railways are clearly at fault so the claim will go ahead uncontested, and it will simply be a question of the legal world, aided by their medical experts, deciding on the amount of damages. This in its turn will require a medical examination by a neurologist and perhaps a psychiatrist (or even both) on behalf of the patient's solicitors, and if the amount of damages subsequently claimed is considered excessive the railway company may in their turn seek their own medical opinions. The anxieties engendered by these various interviews and examinations will greatly exceed the one referral to hospital that is uncomplicated by any question of compensation.

The expert opinions obtained may be widely diverse, particularly in a patient such as this when there is no evidence of any physical injury sustained at the time of the accident. There is a view, which is not uncommonly held and sometimes apparent to the patient at the time of the consultation, that the post-traumatic symptoms that she is describing are at best hysterical and at the worst malingering, inspired by the desire to increase the amount of compensation that anyway in this case will be relatively small. There is another view, slightly more charitable, that there are in fact patients who after a highly unpleasant accident become severely depressed, and this is particularly the case in patients whose previous history contains an appreciable psychiatric content. In either case in the medicolegal world the patient will rarely be given any explanation of her symptoms,

nor will her own doctor receive any indication of the opinions held. This is probably for the best, as the general practitioner's burden will be heavy enough without adding to the general confusion of varying opinions on the cause of her symptoms and inspired guesses about the prognosis.

The general practitioner asks where he should start the repair process. If the patient is to be helped at all an antidepressant regimen should be embarked on immediately, and if there is no appreciable response he will undoubtedly soon need the professional help of a psychiatrist. The question of potential suicide will already have been dealt with by the neurologist at the initial consultation, when this possibility will have been explored fully with the patient, and if this were a possibility an immediate referral to a psychiatrist would have been arranged.

The most useful contribution to the relief of her symptoms would be the rapid settlement of her claim against the railways, and this does not necessarily imply that the claim is the sole reason for her symptoms. Experience suggests, however, that this is most unlikely to happen. One thing that is quite certain is that her general practitioner will see a great deal of her in the next few months.

Postscript to the problem

A great deal has indeed been seen of this patient in the six months since this problem was recorded. A neurologist assessed the patient and found no evidence of organic nervous disorder. A profound depression was treated with tricyclic antidepressants, an overdose of which led to admission to a psychiatric unit. Thereupon the husband resumed drinking, and the patient discharged herself from hospital to attend to him. She is much less depressed now—possibly because of her husband's obvious dependence on her—and off psychotropic drugs, though not yet working. We have not heard of the attacks of unconsciousness again. A claim against the railways is making slow progress, partly because of the unwillingness of any of the doctors who have seen her to describe the accident as the main reason for her illness. Her husband says he coughed up some bright red blood last week. . . .

How should one treat atrial fibrillation in the elderly?

In many elderly people atrial fibrillation with a slow ventricular rate, say below 80, needs no treatment unless the patient is in heart failure. If the patient is in heart failure digoxin, diuretics, and potassium supplements are in order. Verapamil (Cordilox), 5 to 10 mg intravenously, may be tried for paroxysmal atrial fibrillation. If it does not work it is reasonable in a case of recent onset to try direct current shock. I do not think that beta-blockers, though helpful for angina, are useful in treating atrial fibrillation. There is no real evidence that any of the more recently introduced beta-blockers are any better than propranolol (Inderal).

There has been an increase in the reporting of anaerobic bacteria (particularly Bacteroides spp) from postoperative wound swabs. Could this be related to the use of non-irritant sutures that produce a minimal local inflammatory response?

Undoubtedly, during the past few years the number of laboratory isolations of anaerobic non-sporing bacteria from various clinical specimens has greatly increased. *Bacteroides* spp and to a lesser extent anaerobic cocci have become prominent, not only in surgical wound exudates but also in blood cultures and specimens from the female genital tract.¹ The main factor underlying this apparently increased incidence is the recent improvement in anaerobic culture techniques coupled with better methods of specimen collection and transport. These have led to a growing awareness of this group of organisms both as the predominant members of the intestinal flora and as pathogens in various conditions. But, of course, intestinal commensals are not always behaving as pathogens when found in a wound or elsewhere. The interesting suggestion that the newer non-

irritant sutures may have encouraged these anaerobes is not supported by their cultivation from sites other than operation wounds or indeed by experimental work on the suture materials.² Two other factors associated with treatment, however, are important. Recent reports of the successful use of clindamycin and metronidazole in treating infections caused by these organisms has increased interest in the group.¹ At the same time, the commonly administered broad-spectrum penicillins, cephalosporins, and aminoglycosides (such as gentamicin) clear most aerobic infections but are less active against *Bacteroides* spp.

¹ Report by a Study Group, *Journal of Antimicrobial Chemotherapy*, 1975, 2, 393.
² Edlich, R F, et al, *Annals of Surgery*, 1973, 177, 680.

Most hospitals supply plastic-covered easy-chairs for inpatients and in a hot summer many patients develop occlusive eruptions that become secondarily infected by Candida, other fungus infections, and bacterial infections—probably aggravated by using plastic mattress covers. We are trying to find a suitable chair for a geriatric upgraded ward. Because many patients are incontinent an ordinary upholstered chair would be unsuitable and perhaps we really require a chair with a removable, washable canvas heat. What would you suggest?

I think the answer to hot and sticky plastic chairs in the summer is for the patient to sit on a natural or synthetic sheepskin. This allows air to circulate around the buttocks and provides some ventilation. Natural sheepskins are best because they absorb moisture, but they do not launder very well. Artificial sheepskins launder much better and last longer, but because they are made of synthetic material they do not absorb moisture. I would suggest that the inquirer conducts a trial of the two kinds in his unit. A canvas-seated geriatric chair would almost certainly be hard, rough, and uncomfortable and would not repel water.