Incongruence between Clinicians' Assessment and Self-Reported Functioning Is Related to Psychopathology among Patients Diagnosed with Gastrointestinal Disorders

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In a previous exploratory study we observed no relevant differences in psychopathology, personality and functioning between inpatients diagnosed with gastrointestinal motor disorders (GMDs) or functional gastrointestinal disorders (FGDs) [1]. However, we observed higher levels of incongruence between clinician-assessed performance status and patients’ self-reported levels of functioning among patients diagnosed with FGDs. Likewise, research in other medical conditions has shown incongruence between self-reported and clinician-reported or objective measures [2]. Furthermore, in a study on chronic depression, the authors found that discrepancies between patients’ and physicians’ assessments of medical comorbidities were related to higher levels of depressive symptomatology [3]. In this line, the aim of this study was to explore whether the inconsistencies between clinician-assessed and patient self-reported levels of functioning could be related to psychopathology among patients admitted for evaluation of gastrointestinal motility.

Patients with chronic, severe and unexplained gastrointestinal symptoms admitted to a highly specialized digestive unit of a public university hospital were included in the study after the exclusion of organic lesions and mechanical obstruction by a thorough work-up. The protocol of the study was approved by the Institutional Ethics Committee, and all participants gave their written informed consent.

All patients underwent body mass index (BMI) measurement, evaluation of small bowel motility by manometry, Rome III criteria and psychiatric assessment. Patients with suspected gastroparesis underwent a scintigraphic gastric emptying test. The Karnofsky Performance Status (KPS) [4] was used by gastroenterologists to assess levels of functioning. This clinician-administered scale covers a range running from 0 (death) to 100 (full level of functioning).

In the first 72 h after hospital admission, psychiatric assessment covering the main psychopathological domains according to the DSM-IV-TR [5] was performed, and a battery of psychometric tests was administered. The battery of self-administered questionnaires included perceived levels of functioning (assessed with the Short Form Health Survey, SF-36) [6] and psychopathology (using the multidimensional revised version of the Symptom Checklist, SCL-90-R [7]).

During the study period, 119 patients were enrolled; 8 patients were excluded after the assessment, as they did not meet the criteria for GMDs or FGDs. Among the 111 patients included, 8 were not able to fill the psychometric tests given their delicate medical situation and were also excluded from the study.

According to the manometric assessment, 21 patients fulfilled the criteria for intestinal dysmotility. They presented either (a) relapsing acute episodes of intestinal pseudo-obstruction with radiological evidence of intestinal air fluid levels interspersed with relatively symptom-free intervals (n = 15) or (b) chronic (>6 months) postprandial symptoms such as nausea, vomiting, poor satiation, postprandial fullness, abdominal discomfort/pain or distension (n = 6), with reduced feeding tolerance and inability to maintain normal body weight (BMI below 18.7 in women and 20.1 in men). Among these patients, 12 fulfilled the criteria for irritable bowel syndrome (IBS) as a secondary diagnosis. The latter exhibited acute episodes of intestinal pseudo-obstruction without symptoms in between.

Twenty-nine patients presented clinical features compatible with gastroparesis (3 of them had also fulfilled the criteria for intestinal dysmotility). These patients presented early satiation, postprandial fullness and epigastric discomfort/pain, and all fulfilled Rome III criteria for functional dyspepsia. In all of them gastroparesis was ruled out by evaluation of gastric motor function (scintigraphic gastric emptying test). Finally, 22 of them received a primary diagnosis of functional dyspepsia and 7 of gastroparesis. From the 56 remaining patients, 39 presented recurrent abdominal pain or discomfort with constipation, diarrhoea or both, fulfilling Rome III criteria for IBS. The remaining 17 presented persistent or recurrent regurgitation of recently ingested food into the mouth, fulfilling the criteria for rumination syndrome. Finally, 25 patients were primarily diagnosed with GMDs (dysmotility = 18, gastroparesis = 7) and 78 with FGDs (dyspepsia = 22, IBS = 39, rumination = 17).

For this study we defined incongruence as the difference between KPS and the SF-36 physical functioning subscale scores (both with a range of 0–100). Scores close to 0 indicated absolute congruence between the clinician’s and the patient’s perception of functioning; negative scores signified a higher perception of the patient and positive scores the opposite.

SCL-90-R scores were on average half a standard deviation above the local population mean. As in our pilot study [1], differences between GMDs and FGDs in SCL-90-R scores, duration of illness and BMI did not yield statistically significant differences. However, we found a statistically significant difference in KPS...
Incongruence: difference between KPS and the SF-36 physical functioning subscale scores (both with a range of 0–100). Scores close to 0 mean absolute congruence between the clinician’s and the patient’s perception of functioning; negative scores indicate higher perception of the patient and positive scores the opposite. *p < 0.05, **p < 0.01, ***p < 0.001.

1 Excluding item 40: ‘nausea or upset stomach’.

| SCL-90-R                   | Total     | GMD       | FGD       |
|----------------------------|-----------|-----------|-----------|
| Somatization               | 0.404***  | 0.394*    | 0.380***  |
| Somatization excluding     |           |           |           |
| digestive item*            | 0.411***  | 0.361     | 0.400***  |
| Obsessive-compulsive       | 0.351***  | 0.259     | 0.383***  |
| Interpersonal sensitivity  | 0.287**   | 0.069     | 0.393***  |
| Anxiety                    | 0.216*    | 0.206     | 0.272**   |
| Depression                 | 0.318**   | 0.249     | 0.422***  |
| Hostility                  | 0.207*    | 0.003     | 0.282*    |
| Phobic anxiety             | 0.260**   | −0.113    | 0.407***  |
| Psychoticism               | 0.300**   | 0.104     | 0.401***  |
| Paranoid ideation          | 0.271**   | 0.050     | 0.361***  |

Psychopathology seems to co-occur with a different view of functioning by clinicians and patients. Relatedly, it has been reported that gastroenterologists tend to misattribute FGD diagnoses among patients with psychopathology, highlighting a need for improved psychosocial assessment in gastroenterological practice [8]. The concept of illness behaviour may help in understanding the complex interactions that patients and doctors have in relation to gastrointestinal disorders, helping practitioners to develop an integrated vision of these patients [9].

This study had several limitations related to its design and methods. The research was conducted in a tertiary care setting, including exclusively inpatients currently suffering from severe gastrointestinal symptoms. The instruments used in this study are not specially adapted to the characteristics of digestive patients. However, the use of universal instruments, like the SCL-90, SF-36 or KPS, allowed us to compare different types of digestive patients with a highly different range of symptoms. Furthermore, the nature of the SCL-90 scale does not allow us to deepen our theoretical explanations about the origin of somatization or its differentiation from physical comorbidities. Future research with more accurate and specific tools is needed. The Diagnostic Criteria for Psychosomatic Research could be a way of improving psychosomatic and psychosocial evaluation in medical settings [10].

In this study we have seen how the presence of incongruence between patient- and clinician-reported levels of functioning could be a better proxy for psychopathology than having received a functional or a motor gastrointestinal disorder diagnosis. These results highlight the importance of considering the contrasts between subjective and clinical evaluations in digestive patients.

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