The search for a disease

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A professor of psychiatry at Harvard Medical School raised interesting issues in a discussion article in the *New England Journal of Medicine*[1] that were summed up in an interview on the ABC.

> *'The point was that fundamentally most of us have symptoms much of the time. Perfectly healthy people have all sorts of bodily aches and pains and the wear and tear of daily life, and that if we become too focussed on it and too convinced that everything we have is a disease that's treatable, we really get caught in a cycle, the more you believe that, that everything that's bothering you is really abnormal and can be treated away, the more frustrated you become when in fact it can't be, when in fact a lot of this is just part of life and has to be acknowledged as such. Social stress is an important factor, environmental events, all kinds of other factors ... I think without any question we are leading people to believe that everything that bothers them is treatable. Just take it to your doctor and your doctor will have some new miracle treatment to relieve it, and in fact that's not the case'.*[2]
>
> *Arthur Barsky*

There seems to be a new occupation emerging in modern medical practice that is having more than its fair share of influence in Australia as it is elsewhere in the world. It is the occupation of creating new 'diseases'. Not unexpectedly, a 'disease' – having been created – needs to be treated. The more common the 'disease' the better; but the best diseases to create are of course the ones that everyone has, and the longer they have them, the better. But are some of these modern diseases really illnesses, or are they a natural part of living? Are some conditions being overdiagnosed?

The growing incidence of attention deficit and hyperactivity disorder (ADHD) is a concern to many people. It is undoubted that some children have biologically measurable changes in their neurochemistry and the behavioural sequelae that easily classify them as having a treatable condition. But it is highly likely, especially in the USA where the condition is diagnosed with incredible frequency, that many children with behavioural problems are being inappropriately labelled with ADHD. Attention deficit and hyperactivity disorder is a complex medical and social phenomenon with many grey areas and it would be unfair to say it is a disease created out of nothing; although the extent and management of it raises many questions. Is the rise in incidence actual or imagined? Is it a renaming or reclassification of old behavioural problems? Is it a symptom of other social dilemmas? Is it a problem which is to some extent being driven by industry in terms of the number of children being medicated?

Is this new 'diseases' movement to 'identify' or 'create' more diseases (depending on which way you look at it) part of a subtle marketing exercise with enormous financial potential taking advantage of unrealistic expectations and fears?

Menopause, aging, and related phenomena such as loss of libido are possible examples. In one view, aging is seen less as a natural part of the lifecycle and is labelled a pathological process for which the pharmaceutical and biomedicine industry sees endless potential avenues of 'cure'.

Some of our more recent attempts to treat aging have not been too successful. A recent topical example is treating menopause with hormone replacement therapy (HRT) as if menopause, in itself, was an illness. This has come to be seen as an expensive and harmful exercise. Risks that were downplayed such as the risk of breast cancer are now seen to be more significant than originally thought. Hormone replacement therapy was even thought to be protective against cardiovascular disease, but is now considered a risk factor. Originally HRT was to be offered to women with the most severe menopausal symptoms or highest risk of osteoporosis, but over time the threshold for prescribing was lowered to the point that many advocated that HRT should be prescribed for all menopausal and postmenopausal women.

Reason might have instructed us that treating a natural part of the lifecycle as a disease was always going to be a flawed policy. Nature must surely have many reasons for shutting down the ability to procreate at the age it does, but why didn't the same amount of attention and resources go toward things that promote healthy aging, improved function and mental health, as well as reducing osteoporosis and other menopausal symptoms? Exercise, moderate

sunlight, good nutrition, and productive social roles have good side effects no matter what condition they are prescribed for, and at no or low cost.

An important step in the creation of a new disease may be to create the perception in people's minds that things are not the way they should be. The natural diminution in libido as one ages was always likely to attract particular attention especially as there are so many unrealistic media messages and images about sex. It is not surprising that many people feel inadequate about this aspect of their life even if, in reality, they might be functioning well for their age. Perhaps, at least in part, this concern is also driven by the increased number of people seeking new partners in their middle and later years because of divorce rates and longer life expectancy.

Whatever the cause and contributing factors, it seems that much of the responsibility for dealing with these problems falls on the shoulders of the general practitioner. In response, there have been an increasing number of pharmaceutical 'treatments' put into the GPs armamentarium for both men and women. It would be unwise to suggest there are no indications for these treatments, but what tends to happen is that such treatments become too widely used and attention shifts from more pressing matters that do need attention. Possibly, the use of a pill will obscure attention from being directed to the more important underlying issues that might be contributing to the problem. Libido, again, is strongly tied to lifestyle issues[3] including alcohol, smoking, coexisting health problems (eg. medications, diabetes) and perhaps even more importantly, they are affected by relationships, attitudes and mental health.

The other way to create a disease and treat more people is to lower the threshold for prescribing until virtually everyone will qualify for treatment. To illustrate, an area that may loom as a future concern is the lowering threshold for prescribing medications such as cholesterol lowering drugs and antihypertensives until people with normal cholesterol and blood pressure are being encouraged to receive treatment? Even if we do prove they lower the incidence of cardiac events, will they reduce all cause morbidity and mortality? Will we simply be transferring harm from one illness to another? Does this improve or prolong people's lives or is it an expensive and potentially harmful process driven by industry? Is this going to prove a mistake of the magnitude of HRT?

As with everything in life, time will answer all questions. In the meantime, common sense might be one of the best guides we have.

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References

1. Barsky AJ. Clinical practice. The patient with hypochondriasis. N Engl J Med 2001;345:1395–1399.
2. http://www.abc.net.au/rn/talks/8.30/helthrpt/stories/s1083259.htm.
3. Fung MM, Bettencourt R, Barrett-Connor E. Heart disease risk factors predict erectile dysfunction 25 years later: the Rancho Bernardo Study. J Am Coll Cardiol 2004;43:1405–1411.

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