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Though ubiquitous over the ages, dyspepsia is still a vaguely defined and poorly understood clinical phenomenon. The term lacks precision in its meaning, numerous symptoms individually or collectively being subsumed under its rubric (Coghill, 1967; Jones et al, 1968; Thomson, 1969 and Davies, 1977). It is hardly surprising therefore that no satisfactory classification of the conditions presenting with dyspepsia has ever been proposed.

The available literature presents a rather biased picture regarding the aetiological factors, laying more emphasis on the organic ones to the relative neglect of the fact that a vast majority of dyspeptics have nothing structurally wrong in their gastrointestinal tract (Chaudhary and Truelove, 1962). Consequently, the patients are subjected to a battery of painful and expensive investigations and are advised numerous courses of antiamoebic, anthelminthic and other symptomatic agents - all unable to offer any substantial or lasting relief.

That dyspeptic symptoms in many patients could be solely because of psychological factors and that they may be just the overt manifestations of an underlying primary psychiatric illness is being realized only in the
past few years. Thus besides the well known entity of irritable bowel syndrome, dyspeptic symptoms can occur in and at times be the exclusive presenting features of such diverse psychiatric states as depression, hypochondriasis, hysteria, anxiety neurosis, personality disorders and schizophrenia etc. (Alvarez, 1943).

The workers so far have studied one or the other form of non-organic dyspepsia to the exclusion of others, most of the studies being centred around irritable bowel syndrome (Chaudhary and Truelove, 1962 and Hislop, 1971) or hypochondriacal states (Kenyon, 1964; 1976; Burns and Nichols, 1972; Bianchi, 1973 and Dewsbury, 1973). Or else, they have studied individual symptoms like nausea (Swanson et al, 1976), vomiting (Brit. Med. J., 1968) or abdominal pain (Merskey and Spear, 1967 and Apley, 1975). There is hardly any study encompassing various aspects and types of dyspepsias as a whole.

The recent inclination towards sub-specialization has focussed attention on organ systems, with increasing concern for patho-physiological and anatomical changes and a lesser concern for the role of emotional, inter-personal and social issues that come in to play in every instance. It is rather ironic that, despite an increased concern and understanding of psychosomatic illnesses even by laymen, there has been a reduction in the holistic view on the part of the internist (Martin,
1975). Literature is replete with studies relating to the significance of a variety of factors in regard to causation, precipitation or recurrence of psychosomatic disorders (Kroger and Freed, 1951; Shainess, 1961 and Brown, 1967). Nevertheless, failure to recognize emotional factors in an illness is a serious yet common error in medical practice. A considerable number of cases attending a general hospital are undiagnosed, misdiagnosed and inadequately managed, one of the main reasons for which is the neglect of psychological factors in the illness (Bhat et al, 1977).

The interest in the investigations of psychosomatic illnesses from a psycho-social point of view is of recent origin in our country and only a few studies have found their way into the literature (Bagadia et al, 1974; Ramchandran et al, 1974). So far, little is available in the literature about the clinical and psychiatric status of dyspepsia. A perusal of Indian literature reveals a striking paucity of studies on this subject.

In view of the theoretical as well as clinical significance of the problem posed by dyspepsias, particularly of the non-organic origin and the scarcity of literature thereon, it would be worthwhile to study various socio-demographic,
clinico pathological and psychiatric aspects of the patients with non-organic dyspepsia vis-a-vis those of a group of dyspepsias of organic origin. The present work is an attempt in this direction.