'Lolo Mai' syndrome

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Since most or all of us do take turns as OP Officers, how many times do we come across people saying that they have these 'lolo mai' attacks. More often, one is bound to see at least one or more such patients in one week.

Before going further it is now essential for us to define the word 'lolo'. It is a multimeaning word. It can mean:

1. Oil.
2. Space underneath a tree.
3. To push or dip underwater.

However, the meaning we are interested at is often referred Firstly to the wind (i.e. to bear down, to press or exert pressure), and secondarily to the rain (i.e. to fall heavily or come in torrents).

Clinical features

These people describe this feeling or sensation in different ways. Most describe it as a feeling of generalised weakness, some experience it as numbers, others say that it is "death" still others refer to it as loss of power or energy.

Whatever the feeling might be, it gradually crawls upwards (from lower limbs or lower abdominal region) and tightens the chest. She feels that her respiratory passage is being obstructed there is palpitation and patient looks pale. She is also sweating and has shortness of breath. She may feel faint and fall but there is neither loss of consciousness nor convulsions. There is marked diminished muscular tone with cold clammy extremities.

The frequency of the attack varies. It may occur daily or ever once a week. Most do not give a precipitating or aggravating cause. The attack may appear during light work or even at rest. The duration of the attack also varies. It may disappear after a short rest, or lasts up to hours. (I have seen one patient being bedridden for days after an attack).

These patients also have multiple physical complaints epigastric pain not unlike that of Peptic ulcer, headache - simulating Migraine, etc. They try to see different doctors and are very fond of saying how badly they have been treated by Drs X & Y etc. (I often shudder to think of what they would say about me to the next doctor they go to). In addition, the patient would almost always complain of sleep disturbances, which could either be initial or delayed insomnia. Her appetite is always poor but she "Force herself to eat. This *self-forcing* must be very effective because she is almost always obese and mild to moderate Hypertension is not an uncommon finding.

The sex and age affected are middle aged females. A typical patient would be an obese married middle aged female. All kids have left home for school (or work). The husband is a "professional" worker in rather than being a grower.

Differential diagnosis

With such features as above, they are so *non specific* that they could very well be those of any disease one could think of. However, particular attention should be paid to the following:

1. Diabetes - I once had such a patient. After being firmly reassured that everything was alright, she went to another doctor who tested her urine and found it to be brick red.
2. Heart Failure - However, other features of CCF would be present.
3. Thyroid Disturbances (Hypo and Hyper -) Bear in mind that the symptoms could very well be the first clues to this glands malfunction.
4. Anaemia - from any cause would give a similar picture.
5. Epilepsy (Temporal lobe) but there are unconsciousness and convulsions.

**Reprinted with permission from Tonga Public Health Newsletter 1979; 3(3):19-23. The late Dr Palu Lasalo was in charge of Psychiatry, Ministry of Health, Tonga Islands.*

Management

This is very difficult as can be seen by some patients still being followed up at the Psychiatric Clinic for the last 2-3 years:

- Exercises and recreations should be encouraged.
- Rest should be avoided.
- Repeated physical examination should be minimal - or the patient would be convinced that there must be something physically wrong.
- Symptomatics - e.g. hypnotics if there is sleep disturbances.

Reassurance

A patient with psychiatric symptoms is often told by her doctor that there is nothing wrong with her. More often than not, this makes the patient more frightened and more anxious. She feels that there is something wrong which has not been found or diagnosed.

The doctors should make the patient understand there is something wrong but the trouble is not due to a physical illness but rather his symptoms are manifestation of an emotional illness. (Unfortunately, a Tongan would find it hard to see how has emotion (ongo 'ae loto) got to do with her illness.

Whether one is using the work emotional or mental, at least it is something for the patient to think about rather than *physical.*

Discussion

I cannot help but feel that this "lolo mai" syndrome or neurosis, (whatever one would call it) is peculiar to Tongans. As it has been seen it was hard to put a definite diagnosis, for it includes a number of neurotic entities such as Depression, anxiety, hypochondriacs and not to forget, of course, the malingerers. No wonder then that this condition is (as in most neurotic disorders) very difficult to manage.

I have never met a Tongan who would outwardly say 'I am anxious' or 'I am depressed'. (mafasia).

The way a European handles a stress - he intellectualises it and says to himself, 'I am depressed'. A Tongan, on the other hand, tends to internalise the concept and is dealt with as a somatic (physical) feeling and says "I have a pain in the chest" rather than "I am so depressed my heart aches".

The closest expression a Tongan uses to "I am depressed" would probably be "I am sad (Mamahi)". However, there is always an OBVIOUS external stimulus e.g. death of or separation from, a loved one. Only when the cause is obscure to the patient's conscious mind, would she say "I have this lolo mai attack".

Comment on "Lolo Mai" Syndrome: Tonga Public Health Newsletter 1979, 3(4):6

Sudden acute or subacute onset of mixture of symptoms including general weakness, feeling of fainting attack, may be sweating and a little chilly, palpitations, loss of interest and partial loss of appetite.

These symptoms usually last between 1 hour to a day or having short frequent attacks or even last for some days.

Cause:

1. Unknown.
2. Neurosis.
3. Infection: Renal - kidneys or others.
4. Diabetes.
5. Others mentioned by Dr P. Lasalo.

I wish to congratulate Dr P. Lasalo for his interest and keeness to write about this rather common "syndrome".

Anecdotes from Vaiola Hospital Medical Ward 1979

there was the Pink Nurse who could not find one litre bottles of intravenous fluid to run at 30 drops per minute as the doctor prescribed. She found 500 ml bottles instead and ran it at 15 drops per minute to fill the prescription!

... then there was the not so Pink Nurse who could not find any Vitamin B12, so she gave the patient a double dose of Vitamin B6!

... and then there is the MSU form for the patient with urinary frequency, hanging on the wall next to faeces form for the patient with diarrhoea. Five days later no specimen has been sent because none has been caught, even on the run!