Management of Schizophrenia with Medical Disorders: Cardiovascular, Pulmonary, and Gastrointestinal

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KEYWORDS

• Atypical antipsychotic • QT prolongation • Anticholinergic

Medical illnesses are particularly common in patients who have schizophrenia and pose challenges for the treatment of these patients in our health care systems, specifically in choosing the most appropriate antipsychotic medications. Patients who have schizophrenia have up to a 20% shorter life span than the general population, with the leading cause of death being cardiovascular disease.[1] A recent review[2] noted that there may be a 15-year decrease in life expectancy in patients who have schizophrenia compared with the general population. Patients who have schizophrenia have increased prevalence of the metabolic syndrome, which includes obesity, insulin resistance, diabetes, dyslipidemia, and hypertension (discussed in another article of this publication). The higher rates of morbidity and mortality in patients who have schizophrenia result in significant problems for these individuals and a high socioeconomic cost.[3] Patients who have schizophrenia also face barriers to receiving prompt and appropriate medical health care.[3] These barriers include difficulties in negotiating

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Psychiatr Clin N Am 32 (2009) 759–773
doi:10.1016/j.psc.2009.09.005 **psych.theclinics.com**
0193-953X/09/$ – see front matter. Published by Elsevier Inc.

the health care system. Also, primary care doctors often do not have sufficient time to deal with their multiple complex issues and communication problems.

According to Newcomer,[1] "Considerable evidence indicates that mentally ill patients often do not receive adequate recognition of, monitoring of, or care for their medical illnesses." He continues to note that there is a critical need for psychiatrists and primary care professionals to increase their awareness of the physical health problems of persons who have mental illness, especially as it relates to metabolic adverse events associated with psychiatric medications (discussed elsewhere in this publication). Kane and colleagues[4] did a survey that included 60 questions with 994 options to an expert panel. These experts stressed the importance of monitoring for health problems, especially obesity, diabetes, cardiovascular problems, HIV risk behaviors, medical complications of substance abuse, heavy smoking and its effects, hypertension, and amenorrhea in patients being treated with antipsychotics. This problem needs increased attention by psychiatrists and primary care professionals. Establishment of comprehensive programs of care that can address this need is recommended.[3]

Because the authors have had a major focus in affiliation with University of Virginia at the Salem VA Medical Center, and some of our psychiatrists have also been trained in internal medicine, they developed a primary care psychiatry clinic in 1996. This clinic was under the supervision of double-boarded psychiatrists, with residents in the authors' general psychiatry and medicine-psychiatry residencies seeing patients under supervision. The authors showed a significant cost savings as a result of this model primarily because of decreased costs of subsequent inpatient psychiatric care.[5] This differs from a major current focus in the VA at this time in having consultative-collaborative sorts of models or co-located models of mental health in primary care. That model addresses a larger population of patients who have less severe mental illnesses that are able to access care for their medical illnesses through primary care clinics. Although this is also an important issue, it is not the focus of this article.

The prevalence of diabetes (discussed elsewhere in this publication), lung disease, and liver problems are particularly increased[6] in patients who have serious mental illness. The odds of having respiratory illnesses are also increased in seriously mentally ill patient groups, even after controlling for smoking.[6] Patients who have schizophrenia and other mental illnesses have several risk factors that are preventable, including smoking, high alcohol consumption, poor diet, and lack of exercise.[7] This comorbidity accounts for 60% of premature deaths not related to suicide.[7] The causes of high rates of physical illness seem to be varied, including shared vulnerability, genetic factors, and rates of smoking.

Cardiovascular risk factors are becoming of particular concern with the newer atypical antipsychotics.[8] Other authors[9] suggest routine assessment in monitoring the physical health needs of patients who have serious mental illness. These authors[9] note the odds ratio for eight medical disorders in Medicaid beneficiaries who have psychiatric disorders compared with those without psychiatric disorders. Diabetes, hypertension, heart disease, asthma, gastrointestinal illnesses, cancer, acute respiratory disorders, and skin infections are all increased relative to the comparison group.

Some differences of opinion exist regarding whether these results would be the same if the data were adjusted for various health and lifestyle issues. For example, when controlling for smoking, the debate is whether certain illnesses (eg, cancer) remain elevated. Compared with those without a mental illness, those with a serious mental illness have more than twice the likelihood of smoking cigarettes and a 50% increase in the likelihood of being overweight or obese.[10] "Various biological, iatrogenic, and social factors" may lead to these increased risks.[10] The same preventive