Psychiatric aspects of chronic physical disease

Ana Miorelli
Anne Marie Abe

Abstract

Nearly one-third of people with a long-term physical condition have a co-morbid mental health disorder such as depression or anxiety. It is important to look into this group of patients to understand how to improve our daily practice to benefit both patients and the health service. Co-morbidity of physical and mental illness such as major depression is well known to increase impairment of functioning levels. Here, we summarize recent findings on the prevalence of co-morbid mental and chronic physical health and the impact on overall health.

Keywords Chronic physical illness; functional disorder; mental health; psychiatry

Key points

- The prevalence of mental illness in people with chronic physical illness is higher than in the general population
- The challenges of managing co-morbid physical and mental illness require close collaboration between mental and physical health services
- In patients with functional disorders, a physician-led collaborative stepped-care approach is important for optimizing clinical outcomes

Introduction

Nearly one-third of people with long-term physical conditions have a co-morbid mental health problem such as depression or anxiety disorder. These mental health conditions raise the costs of physical healthcare by 45% or more for a wide range of conditions including cardiovascular disease (CVD), diabetes mellitus and chronic obstructive pulmonary disease (COPD) at each level of severity (costing the UK at least £8 billion a year). Therefore, it is important that we look into how to alter and improve our daily practice to benefit both these patients and the health service.

Co-morbidity of physical and mental illness such as major depression is well documented to increase impairment of functioning levels. In addition, people presenting with mental illness are more likely to have decreased adherence to prescribed regimens (see Further reading). Depression and schizophrenia are associated with adverse health behaviours (diet, exercise, smoking) leading to earlier death from medical conditions. Finally, major mental illnesses are related to increased mortality.

This review examines the relationship between common chronic physical illness and co-morbid mental illness, severe mental illness with co-morbid physical illness and the overlap between physical illness and functional disorders.

Common chronic physical illness with co-morbid mental illness

The prevalence of major depression in people with chronic physical illness is higher than in the general population. The lifetime prevalence of major depression is higher in individuals with cardiovascular conditions, diabetes mellitus and COPD. Depression adversely affects the course, complications and management of chronic physical illness and is a risk factor for the development of common chronic physical illness (Figure 1).

Cardiovascular disease and depression CVD is the leading cause of mortality worldwide: in 2008, an estimated 17.3 million people died from CVD — approximately 30% of all deaths. By 2030, it is estimated that the number will increase to 23.6 million, largely through increases in low- and middle-income countries. Cardiovascular morbidity remains a substantial clinical and economic burden as more people survive with CVD. Depression is one of the most common mental health problems, affecting between 3% and 5% of the population at any time; almost one in five individuals can expect to experience a depressive disorder at some point. The World Health Organization has estimated that depression will be the second leading cause of global disability (after heart disease) by 2020. Given the high prevalence of both CVD and depression, a degree of co-morbidity is to be expected. The relationship between CVD and depression appears to be bi-directional, as depression can be both a cause and a consequence of CVD. A previous meta-analysis of 21 studies, including 124,509 participants free of CVD at baseline and 4016 cardiovascular events, found an 81% increased risk of incident coronary heart disease events in people with depression at baseline during the mean follow-up of 10.8 years, although there was considerable heterogeneity between studies.[1] Another meta-analysis of 28 studies found that depressed mood increased risk of myocardial infarction, coronary heart disease, cerebrovascular diseases and other CVDs by 43–63%.[2] Considerable heterogeneity between studies was reported, the most consistent result being a 60% increased risk in myocardial infarction in individuals with depression.

Diabetes mellitus and depression

Significant depressive symptoms are present in approximately one in four adults with type 1 and type 2 diabetes, while a formal diagnosis of depressive disorders is made in approximately 10–15% of people with diabetes. A recent meta-analysis of 11 studies including nearly 50,000 individuals with type 2 diabetes

Ana Miorelli *MB BS MRCPsych PhD is a Consultant Liaison Psychiatrist at the Department of Psychological Medicine, Southampton General Hospital, UK. Competing interests: none declared.*

Anne Marie Abe *MRCPsych is a Consultant Liaison Psychiatrist at the Department of Psychological Medicine, Southampton General Hospital, UK. Competing interests: none declared.*

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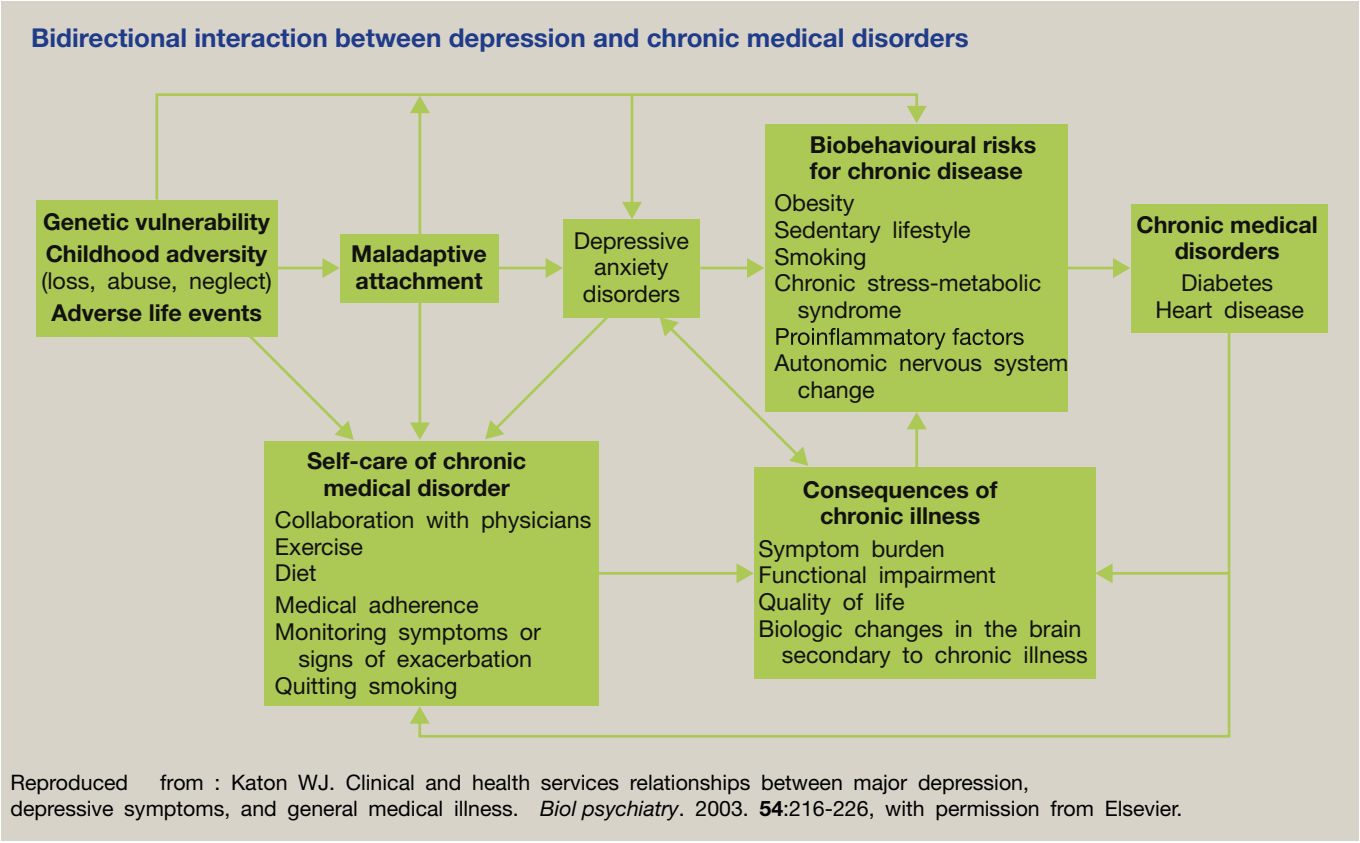

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Figure 1

but without depression at baseline indicated that the incidence of depression is also 24% higher in people with diabetes.

Chronic obstructive pulmonary disease and depression

The prevalence of clinically significant depression is significantly higher in patients with COPD. This association worsens respiratory-specific and overall physical health-related quality of life.[3] In addition, patients with COPD have a higher prevalence of anxiety disorders, and this has been associated with higher rates of re-admission to hospital. Both anxiety and depression increase the risk of relapse and admission to the emergency department in patients with asthma and COPD. There is increasing evidence that stressful life events are more strongly associated with depressive symptoms and poor quality of life in patients with COPD than in controls without COPD.

Although more research is needed, stress and anxiety management seem to be possible strategies to address quality of life and life expectancy in people with COPD. Treating depression and other mental illness in individuals with a chronic physical health problem has the potential to increase their quality of life and life expectancy. National Institute for Health and Care Excellence (NICE) Clinical Guideline No. 91 aims to support clinicians in their clinical practice with people with co-morbid chronic physical illness and depression. The stepped-care model is summarized in Table 1.

Other chronic physical health diseases with high prevalence of depression

Neurological conditions also have a higher prevalence of co-morbid mental disorders. In epilepsy, it is estimated that 20–30% of patients have psychiatric disturbances: some studies have shown that patients with epilepsy are about twice as likely to present with lifetime anxiety disorders or suicidal thoughts. Another common neurological co-morbid presentation is psychiatric symptoms coexisting with idiopathic Parkinson's disease. Depression and anxiety are the most common psychiatric conditions that accompany Parkinson's disease, but they tend to be underdiagnosed and poorly treated, partly due to being misinterpreted as reactive to the illness rather than representing the well-described non-motor symptoms of Parkinson's disease.

Finally, there is an increasing body of research confirming that rheumatoid arthritis (RA) is associated with depression: the prevalence of depression in patients with RA is approximately 13–20%. It is described that patients with coexisting depression and RA have increased levels of reported pain. It is still unclear if depression is a reaction to the pain of RA or if depression can contribute directly to the pain experience: however investigations in other groups with chronic musculoskeletal pain indicate that the causal relationship between pain and depression seems to be bidirectional, with pain increasing depression and depression increasing pain. This might be also applicable for RA for although longitudinal studies have not described causal relationships between pain and depression, other

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