Somatic assessment of one hundred inpatients in a psychiatric crisis unit: A retrospective observational study

G. Choron, F.-X. Lesage, L. Picy, P. Courtet, E. Olié

Evaluation somatique de cent patients hospitalisés en unité de crise psychiatrique : une étude observationnelle rétrospective

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CHORON Guillaume[1], LESAGE François-Xavier[1,2], PICY Laurence[3], COURTET Philippe[3,4], OLIE Emilie[3,4]*

[1] Univ Montpellier, CHU, Montpellier, France

[2] Epsylon, Univ Montpellier, Univ Paul Valéry Montpellier 3, CHU, Montpellier, France

[3] Psychiatric emergency and post-acute care, CHU, Montpellier, France

[4] Unité INSERM U1061, Montpellier, France

* **Corresponding author**: OLIE Emilie

Département Urgences et Post-Urgences psychiatriques Hôpital Lapeyronie 191 avenue Doyen Gaston Giraud 34295 Montpellier cedex 5

E-mail: e-olie@chu-montpellier.fr

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ABSTRACT

Objectives: Compared to the general population, psychiatric patients are more exposed to physical illness but have reduced access to care. **Methods:** We conducted a descriptive study in Montpellier between November 2011,2nd and December 2012, 21st. Every Wednesday and Friday, the last two inpatients admitted in the psychiatric post-emergency unit of the University-Hospital of Montpellier were assessed by a general practitioner and included in the study. This unit takes care of suicidal patients suffering from mood and / or personality disorders. The general practitioner assessed lifetime somatic history, current somatic comorbidities and medical follow-up for non-psychiatric issues. **Results:** One hundred patients were included. The sample consisted of 81% women with a mean age of 43 years (18-79 years). The majority of patients had a lifetime history of somatic disease (96%) and was followed by a general practitioner (99%). Six patients had no met general practitioner for at least one year. Dyslipidemia was reported in 32 patients, among those only one patient was on lipid-lowering drug (96.88%). Among patients with impaired dental condition, 29 (55.77%) had not met a dentist for at least one year. Among those with impaired near visual acuity and/or impaired distance visual acuity, 19 (65.52%) had not met an ophthalmologist for at least one year. **Conclusion:** Although detected, somatic comorbidities seem outsourced in psychiatric patients. Greater awareness among different health professionals about the medical care of such patients could improve healthcare management and life expectancy.

Key-words: Mental disorders, Mortality, Comorbidity, Health status, Cardiovascular risk

RESUME

Intérêt : En comparaison de la population générale, les personnes souffrant de troubles psychiatriques sont en moins bonne santé et ont un accès aux soins réduits. **Méthodes** : Nous avons réalisé une étude descriptive au CHU de Montpellier entre le 2 novembre 2011 et le 21 décembre 2012. Chaque mercredi et vendredi, les deux derniers patients hospitalisés dans le service de post-urgences psychiatriques du CHRU de Montpellier étaient évalués par un médecin généraliste et inclus dans l'étude. Ce service accueille principalement des patients en crise suicidaire dans le cadre d'un trouble de l'humeur et/ou d'un trouble de personnalité. L'évaluation informait sur les antécédents somatiques, les comorbidités somatiques actuelles et le suivi médical pour des raisons non psychiatriques. **Résultats** : Cents patients ont été inclus. La population était principalement composée de femmes (81%) et l'âge moyen était de

43 ans (18 à 79 ans). Quasiment tous les patients avaient un antécédent somatique (96%) et un suivi par un médecin généraliste (99%). Six patients n'avaient pas vu leur médecin généraliste depuis plus d'un an. Une dyslipidémie était retrouvée chez 32 patients, parmi lesquels seul un patient était traité par un médicament hypolipémiant. Parmi les patients présentant une altération de l'état dentaire, 29 (55,77%) n'avait pas consulté de dentiste depuis plus d'un an. Parmi ceux présentant une baisse d'acuité visuelle de loin ou de près, 19 (65,52%) n'avaient pas consulté d'ophtalmologue depuis plus d'un an. **Perspectives** : Les comorbidités somatiques, bien que dépistées, semblent sous-traitées chez ces patients. Une sensibilisation des différents professionnels de santé sur leur prise en charge pourrait améliorer leur couverture thérapeutique et leur survie.

Mots-clés : Troubles mentaux, Mortalité, Comorbidité, Etat de santé, Risque cardiovasculaire

INTRODUCTION

Compared to the general population, psychiatric patients are more exposed to physical illness because of: (i) general risk factors (genetic, environmental, occupational…), (ii) psychotropic side-effects, (iii) risk factors related to the patient psychopathology and (iv) risk factors related to psychiatric comorbidities (addiction…). Hence, psychiatric patients have a higher premature mortality rate, an unhealthy lifestyle and poorer access to health care services (1–3). The main risk identified is cardiovascular risk which increases the overall mortality of psychiatric patients (4). We need to have a comprehensive approach and enhance the dialogue between general practitioner and other specialists. General practitioners are the first doctors consulted by patient suffering from psychological distress: more than 60% patient suffer from psychological distress would see a general practitioner versus 10% who would see a psychiatrist (5). Furthermore, general practitioners are often the gateway to the health care system for psychiatric patients (6). Nevertheless, studies showed that the quality of communication between psychiatrists and general practitioners needs improvement (2,7,8). Fleury et al. showed that collaboration between general practitioner and psychiatrists was a key factor for accurate management of mental disorders whereas limited access to specialist was impediment (9). The medical care of patient suffering from severe mental disorders has been the subject in France of « Haute Autorité de Santé » (HAS) recommendations, recently

proposed by the FFP-CNPP (Fédération Française de Psychiatrie – Conseil National Professionnel de Psychiatrie (10) . Thus, we aimed at describing the general health status of inpatients in a psychiatric post-emergency unit in order to identify the elements of monitoring that could be improved.

METHODS

A random sample of 100 inpatients were analyzed retrospectively between November 2011, 2nd and December 2012, 21st. The department of Psychiatric Emergency and Post-acute Care mainly takes care of patients in suicidal crisis in the context of a mood disorder and / or borderline personality disorder.

Two days a week (Wednesday and Friday), a standardized assessment of the two last admitted inpatients was performed by a general practitioner. This assessment included a full clinical examination that provided information on (i) somatic personal history, (ii) current somatic comorbidities (including cardiovascular comorbidities), (iii) follow-up by a general practitioner (frequency, date of last visit) and (iv) follow-up by a specialist (gynecologist, ophthalmologist and dentist). A biological sample was performed in order to detect metabolic disorders.

Qualitative variables were described according to frequency and percentage. Quantitative variables were described by the mean and standard deviation or median and interquartile range when graphical distribution was normal or not respectively. Descriptive analysis of the data was be performed using the R software for Windows version 3.3.0.

STROBE guidelines were followed (11).

RESULTS

In total, one hundred inpatients were included (Table1). Most of the patients were women (81%), middle-aged (mean age = 41 years; SD = 14.75), single (60%) and had children (65%). Half of the patients were working full-time job (50%) and 17% were student. The mean age at onset of psychiatric disorder was 18.5 years (SD = 9.5) while the mean age at first medical contact for psychiatric reasons was 24.5 years (SD = 10.3). Only half of the patients had a consultation with a psychiatrist within the year following psychiatric disorder onset. The mean-age at first psychiatric hospitalization was 30 years (SD = 12.66).

The most frequent comorbidities were cardiovascular, including hypertension (17%), orthostatic hypotension (19%), cardiac murmur (11%), dyspnea (16%) and lower extremity oedema (9%). Half of patients (45%) were smokers. Two third of patients did not practice physical activity. Thirteen patients were underweight (body mass index < 18.5 kg/m²), 20 were overweight (body mass index between 25.0 and 29.9 kg/m²) and 9 were obese (body mass index > 30 kg/m²). One third of patients (36%) had a high waist-to-hip ratio (> 0.85 for females or > 1 for males). Over one third of patients (39%) had a high waist size (> 80 cm for females or > 94 cm for males). A sixth of patients (14%) had an excessive consumption of alcohol defined by > 14 units per week for females and > 21 units per week for males. Among eight patients with low blood sugar, 3 patients were on anti-diabetic drugs. One fifth of patients had hyperglycemia and/or were treated with antidiabetic drugs. One third of patients (32%) had dyslipidemia (hypercholesterolemia or hypertriglyceridemia). Nine patients were on lipid-lowering drugs among those one had uncontrolled hyperlipidemia. Nineteen patients had a metabolic syndrome according to the International Diabetes Federation criteria (12,13) .

Most of patients (96%) had a health insurance. Almost all patients (99%) reported having a regular general practitioner. But six patients had not visited their general practitioner for more than one year.

Oral examination revealed moderate to severe alterations in 52 patients, among those, half had not visited dentist within the past year. Five patients have never been to a dentist. Two thirds of patient suffering from low visual acuity (65.52%) had not visited an ophthalmologist within the past year.

Among the 81 females, 14 had not visited a gynecologist for more than 3 years. Five had never been to a gynecologist. Half of non-menopausal women did not use contraception (57.81%).

DISCUSSION

We show (i) almost all patients had a regular general practitioner, (ii) prescription rate of lipid-lowering drug was low despite high rate of dyslipidemia, (iii) visits to specialists was less frequent in psychiatric sample than in the general population.

In our sample, the prevalence of metabolic syndrome was higher than in the general population (14). Moreover, we may have underestimated the frequency of metabolic syndrome as thirteen patients did not have a blood test. Presence of metabolic syndrome is associated with an increase mortality in psychiatric patients (15). Intriguingly, most of patients with dyslipidemia did not receive adequate pharmacological treatments. This result is consistent with a previous observation done in Fondamental Advanced Centers of Expertise in Bipolar Disorders (FACE-BD) (16). It suggests that metabolic disorders are enough screened in primary care even if psychiatric disorder are at high metabolic risk. Recommendations (17) highlight the necessity to realize regular clinical, biological and electrocardiographical examinations in subjects suffering from psychiatric disorder. Furthermore, many psychotropic drugs participate to metabolic disorders, imposing annual biological monitoring. Several studies showed general practitioners have difficulties to take care of patients suffering from psychiatric disorders. Emergency care practitioners feel insufficiently trained to manage suicidal patients (18). Some general practitioners declare to feel so much uncomfortable with

the psychiatric patients that they “avoid” them. Some others general practitioners would doubt about the quality of delivered medical care. These difficulties, which may have prognostic consequences, were well reported in a report by French Senat in 2009: "Delayed diagnosis of psychiatric disorders and overconsumption of psychotropic drugs are partly due to the lack of psychiatry information delivered to the general practitioners" (19). Somatic management of psychiatric patients needs to be integrated in training of general practitioner. On the contrary, some psychiatrists underestimate the cardiovascular risks of their patients. European Society of Cardiology listed the recommendations for the lipid-lowering drug treatments of patients suffering from mental disorders: (i) major psychiatric disorders are modifiers for estimating total cardiovascular risk, (ii) the management of total cardiovascular risk in patients with a psychiatric disorder is not different from what is recommended in patient at high/very high cardiovascular risk, (iii) in patients with psychiatric disorders particular attention has to be paid to adherence to lifestyle changes and compliance with drug treatment (20). The European Society of Cardiology proposed different interventions according to cardiovascular status and level of low-density lipoprotein cholesterol (20). Systemic prescription of statins should be considered in psychiatric patients with dyslipidemia to manage cardiovascular risk (21).

The rate of visits to general practitioner is similar in our sample and in general population (21), but psychiatric patients had a less frequent access to specialists (gynecologists, ophthalmologist and dentists) than general population. For example, 29% patients had not visited a dentist within the two last years vs 18% in the general population. We propose two explanations: depressive symptomatology of depression and precariousness (22).

Most of the patients were women (81%), middle-aged from the South of France. This selection bias impact the generalizability of our results.

CONCLUSION

Although detected, somatic comorbidities seem outsourced in psychiatric patients. Greater awareness among different health professionals about the medical care of psychiatric patients could improve healthcare management and life expectancy.

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Conflit d'intérêt : aucun

Table I. Baseline characteristics of the study population.

Patients characteristics (n=100)	%
Women	81
Age (mean (range))	43 (18-79)
Civil status	
Single	34
Married	25
Divorced	25
Couple	15
Widowed	1
No child	35
Health insurance	96
Workers	47
Student	17
Unemployed	36
Lack of physical activity	64
Smoking (active)	48