

Primed by prevalence

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It is a truth universally acknowledged that a researcher seeking psychiatric comorbidity in a general hospital will find it in abundance. The accompanying paper by Weichert¹ adds to the copious literature that has demonstrated this over decades,² reporting the findings of a cross-sectional survey in a large English general hospital, as a first step in an ambitious aim to develop an evidence-based liaison psychiatry service.

Research has also demonstrated that the prevalence of psychiatric comorbidity varies by subsetting (emergency department, high dependency, general medical ward, specialist unit, outpatient clinic, etc.) and by patient population, especially when broken down by age. It is perhaps less explicit that the *nature* of that comorbidity varies widely too. In high-dependency units rates of delirium are high, while in medical outpatient clinics they are close to zero.³ Alcohol use disorders are common in all settings,⁴ but full-blown delirium tremens is more likely to be seen in acute admission units, and alcohol dependence most prevalent in gastrointestinal and hepatology wards. Somatisation also occurs in most settings but is most prevalent in outpatient clinics, while the specific subtype will vary according to specialty (e.g. anxiety-based noncardiac chest pain in cardiac clinics).⁵

All this is so well known that there is no pressing need to continue demonstrating it: the question of course is what to *do* about it – and here the answers are much less clear cut. The issue can only be addressed by considering the nature, severity and acuity of any psychiatric comorbidity; its relationship to the presenting physical problems; its potential to interfere with treatment of physical problems; and the locus of responsibility for responding to it.

Classifying comorbidity by *severity* (mild, moderate and severe) and *acuity* (acute, subacute and chronic) is relatively

straightforward. Classifying it by its *nature* is more difficult, and raises further questions: screening within clinical practice (and for research purposes) can only find what it looks for, and there may well be psychiatric morbidity that is significant but which remains unidentified if decisions are not taken to seek it out, or to count it as psychiatric or relevant. For example, nicotine dependence is considered a mental disorder in both ICD-11⁶ and DSM-V⁷ and yet smoking is not normally considered a psychiatric problem, and smoking cessation treatment is not an arm of the mental health service.

In this regard, medical services may only screen for comorbidity that they see as relevant, which clearly requires intervention and where there is agreement about whose role it is to intervene. For example, the screening of acute medical admissions for alcohol use is intended to identify those at risk of acute alcohol withdrawal and Wernicke's encephalopathy, where prophylactic treatment with benzodiazepines and B vitamins is clearly the duty of the medical team primarily responsible for treating the presenting physical problem.

More problematic still is the task of classifying the *relationship* between psychiatric comorbidity and presenting physical problems. In broad terms, this could be considered coincidental, causal (where the physical problem has caused the psychiatric comorbidity, as in depression after myocardial infarction), reverse causality (where the psychiatric problem causes the physical, as in alcoholic liver disease), epiphenomenal (where both physical and psychiatric problems arise from the same underlying cause) or inherent (where the physical and psychiatric problems are both manifestations of the same condition). Weichert has confirmed the findings of much previous research, namely an association between psychiatric comorbidity and adverse physical outcomes. His use of the term 'impact' implies he sees a causal relationship

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between the two, which justifies intervention addressing the comorbidity. He may well be right, but cross-sectional research alone cannot demonstrate causality.

Delirium is the best acute example and dementia the best chronic example of inherent comorbidity, in that these diagnoses are, by their very nature, *both* physical and psychiatric, with clear organic physical causes and manifestations in experience, cognition and behaviour. Acute delirium is a medical emergency with significant impacts on mortality, morbidity, length of stay and discharge destination. It requires urgent intervention in a medical inpatient setting, in parallel with identifying and treating the underlying physical causes: liaison psychiatrists may have a role in assisting with diagnosis and management in a subgroup of cases (particularly those whose behaviour poses risks requiring resort to mental health or incapacity legislation) but there is little role for community psychiatric services.

By contrast, intervention for dementia (which is of course highly prevalent in any acute medical units with many elderly patients) will require coordination between primary care, psychiatry and acute medical teams, with agreed areas of responsibility for provision. Yet even here agreement may not be easy to come by: in a patient whose acute delirium due to urinary tract infection heralds a previously unidentified diagnosis of dementia, where lies the responsibility for confirming the diagnosis, relaying it to the patient and relatives, and offering intervention, follow up and support?


However it might be related to the presenting physical problem, psychiatric comorbidity could *interfere* with its treatment, and thereby have an indirect effect on outcomes and prognosis. For example, specific phobias are often chronic and can be severe, but are unlikely to be related to accompanying physical morbidity: so a longstanding phobic avoidance of spiders will have little bearing on a patient's treatment for diabetes, but a specific phobia of needles can pose potentially life-threatening obstacles in the treatment of chronic renal failure, where renal biopsy and needling of a fistula for haemodialysis may be required. Simply demonstrating that a comorbid phobic anxiety exists will not, of itself, capture the acuity, severity or need for treatment arising in such cases.

It might be instructive to consider an analogous investigation of the levels of physical comorbidity in psychiatric settings. These will vary, from chronic ingrowing toenails unrelated to the presenting psychiatric problem, to acute chest pain misinterpreted as a panic attack, when in fact it heralds a myocardial infarction and requires urgent transfer to a coronary care unit. For much of this hypothetical physical comorbidity, the answers to questions about intervention are self-evident

or so widely accepted on the basis of custom and practice that disagreements are limited: the same is not true for psychiatric comorbidity in medical settings. Also, it is unlikely that clinicians would lump together, under the unhelpfully vague portmanteau term 'physical health issues', such disparate forms of medical problems. The persistence of such terms reveals our continued propensity to dualistic thinking, made concrete by dualistic practice, where mental and physical illnesses are treated in separate places by different teams.

Some of the questions posed above can be answered by further focused research, but the last question (whose responsibility is it to respond?) *cannot* be answered by evidence alone. It requires agreement among physicians, surgeons and other specialists in acute medical settings, liaison psychiatrists working with them there, psychiatrists based elsewhere and primary care clinicians. This agreement, in turn, depends on the type of intervention proposed, and whether it is possible, necessary, desired by the patient, deliverable in the medical setting, and appropriate to the salience of the comorbidity as compared with the presenting medical problem: someone undergoing chemotherapy for metastatic cancer may well be bemused by a proposal to treat her spider phobia between infusions.

Intervention for psychiatric comorbidity may take the form of acute, urgent treatment in the medical setting by the primary medical team – as in the case of delirium. In other cases, intervention within the same medical setting by liaison psychiatric services may be appropriate (e.g. treatment of severe comorbid depression in an oncology ward). In others still, the patient may require transfer to a psychiatric inpatient service (e.g. for treatment of a severe paranoid psychosis once acute surgical needs are met) or referral to a community-based mental health service (e.g. to treat moderate depression in a patient with stable cystic fibrosis). Some patients may require referral back to primary care, or signposting to nonmedical community services, and others may need no intervention at all.

The theme is clear: it is no longer enough simply to demonstrate psychiatric comorbidity in medical settings, the fact of its presence is not sufficient to determine what response is required. Assigning patients to categories of intervention for psychiatric comorbidity cannot be carried out simply by measuring prevalence: it requires assessment of the nature, severity and acuity of the comorbidity, judgement about its relationship with physical problems, awareness of the range of interventions available, and working agreements across the interfaces between medical, psychiatric and primary care services. In other words it requires medical care that is patient-centred, holistic, realistic and integrated, as Weichert concludes. 

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