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POSTTRAUMATIC STRESS DISORDER AFTER MYOCARDIAL INFARCTION; STILL A NEGLECTED ENTITY IN DAILY CARDIOLOGY PRACTICE

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Dear Editor,

Posttraumatic stress disorder (PTSD) is common entity in psychiatry defined as complex somatic, cognitive, affective, and behavioral disorder that develops in some people who have experienced a shocking, scary, or dangerous event (van der Kolk et al. 1996). The lifetime prevalence of PTSD ranges from 6 to 9 percent in adult population in the United States (Goldstein et al. 2016). Lower prevalence rates of PTSD have been found outside of North America, in upper- and lower-middle income countries of 2 percent (Koenen et al. 2017). Many different types of trauma may result with PTSD like sexual relationship violence, interpersonal-network traumatic experiences, combat and war trauma etc. The diagnosis of PTSD can be challenging because of the heterogenity of the presentation and resistance on the part of the patient to discuss past trauma (van der Kolk et al. 1996).

It is known that patients with chronic stress, anxiety and especially patients with diagnosed depression are more likely to suffer from cardiovascular diseases. Also, depressed patients after a heart attack or cardiac surgery have impaired quality of life, increased risk of recurrent cardiovascular events, worse outcome and higher mortality than those without depression (Lichtman et al. 2008). In addition, it is known from the literature that approximately 15% of patients may develop PTSD symptoms after acute coronary syndrome (ACS), which often remain unidentified and untreated (Edmondson et al. 2011). A meta-analysis of 24 observational studies with patients who experienced ACS found a prevalence rate of ACS-induced PTSD of 12 percent (Edmondson et al. 2012). Furthermore, patients experiencing ACS-induced PTSD had a twofold risk of subsequent mortality or ACS recurrence compared with ACS patients who did not experience PTSD symptoms (Edmondson et al. 2012).

Our experience in treating and rehabilitation of patients who had myocardial infarction or have undergone cardiac surgery shows that despite the above mentioned facts and literature data, at least some patients with symptoms of ACS-related PTSD remain unrecognized and untreated in the acute, subacute and chronic phase of the disease leading to a cascade of previously mention adverse events. In our rehabilitation center a psychologist is an important and unavoidable part of the team, so we often succesfully detect PTSD elements after ACS or heart surgery. Unfortunately, there is no regular consultative psychiatric service available in our hospital. After completion of cardiac rehabilitation, we refer these patients to a psychiatrist.

Taking all this into account, the purpose of this letter is to raise the awareness of the clinician, especially cardiologists, to this problem and to suggest that the integrative and routine part of any serious heart team, besides cardiologists, anesthesiologists and cardiac surgeons, should be a psychologist and a psychiatrist. Such a comprehensive approach would achieve the desired effect not only on the somatic but also on the full psychological stability of these serious patients, which would ultimately improve the quality of life, reduce adverse cardiovascular effects and mortality of these patients.

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