

ABSTRACTS

COMORBIDITY OF MENTAL AND PHYSICAL DISORDERS: A CENTRAL PROBLEM FOR MEDICINE IN THE EARLY 21ST CENTURY

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Advances of medicine and the improvement of living conditions contributed to an increase of life expectancy the world over. Longer life offers us more years of work and leisure but it also increases the probability of comorbidity of disorders likely to be more frequent in later years of life. Earlier in life the comorbidity is more likely to involve communicable disorders, particularly in low and middle-income countries; in the years after 1950 comorbidity involves mainly non-communicable diseases. The comorbidity of physical and mental disorders is present throughout life producing high disability, worsening the prognosis of both the mental and the physical disorders, increasing costs of care and reducing the number of disease free years.

The situation is made worse by the current trends of fragmentation of medicine into ever finer specialties. This has been true for branches of medicine dealing with physical disorders over the past four decades: more recently it has emerged as a clear tendency within psychiatry which is splitting into specialties dealing with affective disorders, with neuropsychiatric disorders, with psychosomatic states, with and many others.

The presentation will discuss these tendencies and propose interventions which could respond to problems of management of comorbid mental and physical disorders.

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EPIDEMIOLOGY AND STRUCTURES OF CARE FOR PATIENTS WITH MENTAL AND PHYSICAL COMORBIDITIES

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A huge number of studies have shown that a high proportion of patients with physical illness suffer from coexisting psychiatric disorders. In a study conducted among 993 Austrian inpatients of medical, surgical, gynaecological and rehabilitation departments, 34.6% suffered from some kind of psychiatric disorder. Dementia (13.3%) and minor depression (8.4%) were the most frequent psychiatric conditions, followed by substance abuse (7.2%). The prevalence of all other psychiatric disorders was lower: substance related psychiatric disorders (2.6%), anxiety disorders (2.4%), personality disorders (2.4%), somatoform and eating disorders (2.3%), major depression (2.2%), other organic mental disorders (1.5%), psychoses and bipolar disorders (1.2%).

Nevertheless, in the last 20 years numerous studies and reviews from different countries revealed that people with mental disorders have higher rates of physical illness than the mentally well, and that their risk of premature death due to physical illness is increased. Higher prevalence of cardiovascular disease (e.g. ischemic heart disease, arrhythmia, myocardial infarction), diabetes mellitus, several types of cancer and infectious (e.g. HIV/AIDS) as well as gastrointestinal diseases result in a reduced life expectancy. Overall mortality in patients with a diagnosis of schizophrenia is doubled as compared with mentally well persons.

Causes of "unnatural death" such as suicide and accidents account for only part of this increased mortality; about 60% is due to "natural" causes including physical illness. There are suggestions that almost 50% of patients with schizophrenia may suffer from comorbid physical conditions. Diabetes mellitus, cardiovascular disease, respiratory disease, hypertension, obesity, and the metabolic syndrome are very common conditions in these persons. Schizophrenia has been investigated best, but excess mortality due to physical illness has also been found in other psychiatric disorders, e.g. affective and anxiety disorder.

Recently, a survey among 1008 persons between 18 and 65 years of age from all Austrian provinces using psychiatric expert interviews was finished. The overall 1-year-prevalence was 22.7%. About a quarter of the physically ill also suffered from a psychiatric disorder, while only 14% of the physically well had a psychiatric illness.

In contrast, 86% of persons with psychiatric disorders had a physical comorbidity. This shows that physical and mental disorders frequently co-occur, not only in health services such as primary care, physical hospital departments or psychiatric services, but also in the general population.

The fact that such a high proportion of persons have physical as well as psychiatric illness shows that this is the normal case, but not an exception. Thus, this must be part of the regular treatment and care by psychiatrists. The idea that only some patients have a physical-psychiatric comorbidity needing so-called "psychosomatic" specialists beside psychiatric specialists ignores reality. When such a high proportion of persons have physical as well as psychiatric disorders, this must be part of the training of all psychiatrists as well as of physicians of all medical specialties. This is the basis to meet the patients' needs.

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THERAPY RESISTANT DEPRESSION - A CHALLENGE FOR PSYCHIATRIC SYMPTOMATOLOGY AND UNDERLYING BIOLOGICAL CHARACTERISTICS

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The group for the study of resistant depression (GSRD) is a collaborative project between eight centres in Belgium, France, Greece, Italy, Israel and Austria. A staging model that distinguishes between "non-responders" (patients who failed to respond to one form of treatment, a condition which is now termed "insufficient response" by the (EMA) European Medicines Agency), "treatment resistant depression" (TRD patients that failed to respond to two or more adequate antidepressant trials of different classes of antidepressants), as well as "chronic resistant depression" (CRD, patients being treated with several antidepressants for more than 12 months) have been characterised. Clinical findings of the GSRD provide a set of eleven variables associated with treatment resistance, among them co-morbid anxiety disorders, as well as melancholic features. The group set out not only on clinical variables but also conducted a prospective study that indicated that switching the mechanism of action is less beneficial than continuing the same medication. The GSRD European multicentre project includes now more than 2700 patients that are including clinical, pharmacological as well as molecular biological variables. Genetic findings, combined with clinical characteristics might help to uncover a patient type in the future which is responsive to treatment modalities.

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