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A Tertiary Care Health Institution's Psychiatric Outpatients With Physical Illnesses

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ABTRACT

It is important to identify the physical illnesses in psychiatric patients as part of effective clinical management. The purpose of this research was to explore the type and commonness of physical diseases among psychiatric outpatients. One hundred and twenty five consecutive psychiatric outpatients meeting the inclusion criteria were fully examined with regard to accompanying physical disorders. Clinical history, physical examination, and the results of the investigations permitted a decisive diagnosis. Two related physical illnesses were also considered: the study revealed that a quarter of the patients had related physical illnesses with approximately one-fifth of the diagnoses being new. Among the common physical illnesses were hypertension, respiratory diseases, anaemia, diabetes mellitus and liver diseases. History-taking and physical examination may frequently reveal these conditions. Psychiatrists need to embrace the habit of subjecting their psychiatric patients to regular general physical examination.

Keywords: Pscychiatric, Physical, Anaemia, Outpatients

INTRODUCTION

Mental health conditions are closely linked with various comorbid physical health conditions that may substantially change the nature and treatment of psychiatric disorders. Identification and management of these physical health problems among psychiatric outpatients is important in enhancing the overall patient outcomes because physical conditions that are not treated could worsen their psychiatric symptoms, adherence to treatment and management of both mental and physical health [1]. In spite of the significance of treating comorbid physical illnesses, minimal emphasis has been given to the detection and treatment of physical health problems in the psychiatric facilities [2]. The role of the mental health professional has traditionally focused on identifying and treating psychiatric diseases and conditions with less focus on identifying and treating physical diseases [3]. This discrepancy in care has contributed to the absence of whole-patient, holistic treatment of psychiatric patients which can have an impact on their long-term health and well-being.

The vulnerability of psychiatric patients to physical illness is often increased by a combination of factors including lifestyle behavior (e.g. poor diet, sedentary existence, smoking, substance abuse), medication side effects, and the physiological consequences of mental diseases themselves. As an example, depression, schizophrenia, and bipolar disorder are psychiatric diseases that are often associated with hypertension, diabetes, respiratory diseases, and cardiovascular disorders [4]. Also, the drugs employed in the management of these psychiatric disorders such as antipsychotics, antidepressants, and mood stabilizers come with side effects that promote the development of metabolic and cardiovascular disorders. These drugs including antipsychotics are advised with weight gain, insulin resistance, hyperlipidemia, and cardiovascular diseases risk increase. Hence, it is possible to say that psychiatric population of patients is more susceptible to these comorbid physical conditions, yet they are not diagnosed because of the emphasis on the mental, rather than overall physical health [5].

Various studies have adequately documented the existence of physical illnesses in psychiatric patients. Nonetheless, the nature and extent of comorbid physical conditions among psychiatric outpatients is under-researched in most clinical practices. Mental health professionals must acknowledge that it is seldom that psychiatric disorders occur without any physical health issues. Physical illnesses screening in psychiatric premises is therefore important as a routine [6]. When the physical conditions of such patients are identified and treated early, not only do their physical health conditions get better, their mental health conditions can as well get improved. Treatment of physical illnesses may provide a good chance of lessening the severity of psychiatric symptoms, enhance compliance with treatment, and even thwart psychiatric condition deterioration.

It is essential to have a holistic patient care incorporating mental and physical health concerns. As the first line respondents in the provision of psychiatric care, the psychiatrists should be in a position to spot possible physical health disorders among their patients. This could be done by being careful in taking history, physical tests and constant follow up on the physical condition of psychiatric patients [7]. A screening tool or standardized checklist to be used in the identification of physical illnesses may significantly enhance the rate of detection and timely intervention. Referrals to

other services when more investigations are needed as well as collaboration between mental care professionals and primary care providers could help to make sure that psychiatric patients get optimal care to both their mental and physical wellbeing.
The role of managing comorbid physical illness in the psychiatric setting cannot be over-emphasized. The high rate of physical morbidity in psychiatric patients necessitated the increasing demand of more structured methods of attending to patients which considers the management of the mental and the physical health of the individual. This study intends to describe and determine the prevalence of related physical illnesses in psychiatric outpatients, with an aim of investigating how these diseases are detected, handled and treated [8]. Through this, the study will emphasize the importance of identification and management of physical health conditions in psychiatric hospitals, which will eventually help in providing better patient care and outcome.

MATERIALS AND METHODOLOGY

The present study was carried out in the walk-in clinic, department of psychiatry, Medical College and Hospital, which is a tertiary care healthcare facility. On initial contact, patients are examined by a psychiatrist in the walk-in clinic and a psychiatric diagnosis is made and treatment is commenced.

Sample
The sample of the study included consecutive patients of the walk-in clinic and patients of the general medicine and other OPD services, who were referred to the psychiatry outpatient department (OPD). The participants gave informed consent to the physical examination and to the investigations that were required.The subjects should be psychiatrically diagnosed as per ICD-10.Subjects should be ready to take investigations and procedures needed to specify a physical diagnosis.

Tools
The tools used in this study were as follows:
Semi-structured Sociodemographic Proforma: The subjects were assessed using this tool to obtain a detailed sociodemographic record of the subjects such as age, sex, marital status, occupation, education, family type, locality and source of referral.

Semi-structured Proforma for Physical Diagnosis: This proforma had three parts:
It is a series of seven questions referring to the typical physical health problems with yes/no answers. General Physical Examination Proforma: It is filled in with positive clinical findings during physical examination. Investigations Battery: Contained routine investigations like haemogram and complete urine analysis, and special investigations like renal, liver, thyroid functions tests, ECG, EEG, X-ray, and ultrasonography. Semi-structured Proforma for Psychiatric Diagnosis: This proforma was filled in to record a brief clinical history, and the observations made during the mental status examination.

Procedure
A medical social worker (MSW) initially examined all the subjects to complete proforma no. 1. The senior resident (psychiatrist) then interviewed them, examined them with their informed consent and proforma nos. 2 and 3 were filled. Routine investigations were done on all the subjects. According to the history and physical examination, the necessity of additional investigations was determined in cooperation with specialists. According to the hospital policy , poor people could receive investigations free of charge on the recommendation of both Head of the Department and Medical Superintendent. The psychiatrist made psychiatric and physical diagnosis and referred the subjects to the necessary specialists. The participants were separated into three groups:
Group 1: Physical illness newly diagnosed subjects
Group 2: Patients who had already been diagnosed of having physical illness prior to their referral to the psychiatry OPD
Group 3: Students with no physical disease
The psychiatrists also practiced their skill in clinical examination before enrolling the subjects under experts of different departments. The JandelSigmaStat version 2 statistical software 7 Descriptive statistical analysis, analysis of variance, chisquare and McNemar tests8 were employed in the analysis of the data.

RESULTS

Table 1 provides a summary of the sociodemographic features of the subjects. The participants mainly were male, married, and lived in the urban areas. The subjects were between the ages of 9 and 75 years. Subjects whose physical

illnesses were not diagnosed earlier were notably older, more likely to be married, not employed, less educated, and lower income group. A third of these subjects had been referred by the Medical Outdoor Patient Department (MOPD) meaning that their physical conditions were initially overlooked at the MOPD. About one-fifth of all the sample had been diagnosed with the related physical illness previously (Table 1). Routine investigations on patients were within the normal limits.

Table 2 offers a disaggregation of the psychiatric diagnoses identified in the sample. The predominant diagnosis category was mood disorders, neurotic, stress-related and somatoform disorders, schizophrenia, schizotypal and delusional disorders, and substance use disorders.

The related physical illnesses are provided in Table 3. Associated physical conditions were discovered to be present in 60 subjects out of 125. The common physical illnesses were hypertension (29.1%), respiratory diseases, anaemia, diabetes mellitus, liver diseases, prolapsed intervertebral disc and spinal diseases. In hypertensive patients taking beta-blockers, 6/10 were found to have depression and in hypertensive patients who had not previously been diagnosed or were not on any treatment, were also found to have depression. This difference however was not found to be significant. Among the 11 patients of seizure disorders, one patient had acute psychosis as a consequence of seizure disorder. Moreover, one of the subjects had depression due to hypothyroidism.

Table 1:A description of the subjects' sociodemographic characteristics (n= 125)

Variable	Variants	Group1		Group2		Group3	
		n(%)		*n*(%)		*n*(%)	
		25	(20.4)	35	(27.6)	65	(52)
Age(inyears)	Mean±SD	39±11		38.9±14.2		30.3±10.9	
	Range	13–74		9–70		14–62	
Sex	Male	17	(68.6)	20	(59.4)	41	(63.1)
	Female	8	(31.4)	15	(40.5)	24	(36.9)
Maritalstatus	Single	5	(19.6)	6	(18.8)	25	(38.5)
	Married	19	(78.4)	28	(79.7)	37	(59.2)
	Others[1]	1	(1.9)	1	(1.4)	3	(2.3)
Occupation	Employed	14	(52.9)	14	(39.1)	25	(39.1)
	Unemployed	5	(21.6)	3	(10.1)	8	(11.5)
	Others[2]	6	(25.5)	18	(50.7)	32	(48.4)
Education	Uptomatric	20	(78.4)	20	(58)	34	(51.6)
	Abovematric	5	(21.6)	15	(42)	32	(48.4)
Income(Rupees	0–3500	18	(70.6)	18	(52.2)	40	(61.5)
permonth)	3501–7000	6	(25.5)	9	(26.1)	11	(16.9)
	>7000	1	(3.9)	18	(21.7)	14	(21.6)
Locality	Urban	14	(56.9)	25	(72.5)	34	(52.3)
	Rural	11	(43.1)	10	(27.5)	31	(47.7)
Referredfrom	Direct	11	(43.1)	15	(44.9)	40	(62.3)
	MedicineOPD	9	(33.3)	13	(37.7)	17	(26.9)
	Others[3]	5	(23.5)	7	(17.4)	8	(10.8)

Table 2: Psychological diagnoses of the study participants (n=125)

Diagnosis	n
Mood(affective)disorders	55
Neurotic, stress-related and somatoform disorders	26
Schizophrenia, schizotypal and delusional disorders	17
Mental and behavioural disorders due to psychoactive Substance use	15
Behavioural syndromes associated with physiological Disturbances and physical factors	5
Organic, including symptomatic, mental disorders	4
Others	3

Table 3: Diagnoses of the subjects in the study (*n*=60)

Diagnosis	***N***
Hypertension	18
Bronchialasthma	9
Anaemia	7
Diabetesmellitus	6
Epilepsy	6
Liverdiseases	4
Eyediseases	3
Skindiseases	3
Prolapsedintervertebraldiscandspinaldiseases	3
Hypothyroidism	1

DISCUSSION

The results of the present research indicate the high rate of correlated physical diseases in psychiatric outpatients, and prove that correlated physical diseases are prevalent in patients with psychiatric problems. At least one physical illness was found in 60 out of 125 (48%) psychiatric outpatients in this sample, the most frequent being hypertension (29.1%). Among the other common conditions experienced were respiratory diseases, anaemia, diabetes mellitus, liver diseases and spinal disorders [9, 10]. These results highlight the necessity to focus more attention on the physical health of psychiatric patients since comorbidities may add to the complexity of managing mental health and influence the overall treatment outcomes.

An interesting outcome of the study was that about one-fifth of the sample (20.4 percent) had been diagnosed with a physical illness prior to the study. This indicates that numerous physical ailments among psychiatric patients are not diagnosed perhaps because of the concentration on the mental health challenges instead of thorough physical examinations. Moreover, a third of all patients was referred by the Medical Outdoor Patient Department (MOPD), which means that their physical issues had either been ignored or diagnosed incorrectly within the primary care environment [11]. This highlights the importance of mental health specialists performing adequate physical examination and working closely with other medical specialties to make sure that physical illnesses are not overlooked. The sociodemographic data displayed a number of trends that could possibly affect the presence of a corresponding physical disease. The group having physically ill subjects with undiagnosed illnesses (Group 2) was found to be significantly older, less educated, and belonging to lower income groups. These are the common factors that are related to low access to healthcare which can result in the late identification of physical illnesses [12]. Moreover, the percentage of these subjects married and unemployed was higher, which possibly illustrates the socioeconomic and lifestyle diseases that can influence the mental condition along with the physical one.

Depression was also prevalent among the hypertensive patients and particularly among the beta-blocker users. Nevertheless, the beta-blocker group and the group with no previous knowledge of their hypertension did not differ significantly, which may indicate that other factors are involved in the emergence of depressive symptoms in patients with hypertension besides medicine [13]. The remaining comorbid conditions, which included epilepsy and hypothyroidism, were also found to have associations with psychiatric disorders with one of the patients being found to have depression as a result of hypothyroidism [14]. This study findings highlight the importance of adopting a holistic approach to treating psychiatric patients involving frequent screening to detect physical ailments. Holistic approach will enhance improvement in physical and psychological health, avoiding complications and providing an overall better well-being of patients. With the incorporation of physical health assessment as part of routine psychiatric care, there may be an improved identification and treatment of comorbid conditions, eventually resulting in improved quality of care to such patients.

CONCLUSION

Finally, the study has highlighted the great occurrence rate of comorbid physical illnesses in psychiatric outpatients, which underlines the need of a regular physical health assessment. Physical health issues impact mental health; therefore, a holistic, integrated approach to psychiatric care is vital as physical conditions can be identified and treated early to result in positive physical and mental health outcomes.

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