Depression in general hospital inpatients: challenges for consultation-liaison psychiatry

Depressão em pacientes internados em hospital geral: desafios para a interconsulta psiquiátrica

Dear Editor,

Nearly one-fourth of medical and surgical inpatients in general hospitals match criteria for depressive disorders[1]. The odds ratio for depression gets higher as the number of chronic diseases increases. Besides, such comorbidities aggravate one another[2].

The Study of Brief Opportunity Intervention (EIBO, in the Portuguese acronym) performed a series of randomized clinical trials with patients admitted to the Clinical Hospital of the State University of Campinas (UNICAMP) in Brazil[3,4]. As part of this research project we screened all patients by means of the Hospital Anxiety and Depression Scale (HAD). The first 50 cases of depressive episode confirmed by the Mini International Neuropsychiatric Interview were given standardized information about depression and referred to a public health service to start treatment for depressive disorder. Because of the naturalistic nature of the present study, there was no interference on the assistant doctors' treatment provided to patients during hospitalization. After six months of hospital discharge, all the patients were reassessed by a telephone interview. In spite of the limitations of this assessment strategy, it made possible to contact (or have news from) all patients, including those living far from the hospital. The criterion used for depression improvement was a decrease of at least 50% on the HAD depression score. Statistical analyses were performed using STATA version 7.0.

Patients' mean age was 49.3 years old (standard deviation: 14.5). Infections, malign neoplasms, renal and gastrointestinal diseases were the major reasons for hospitalization, most of which were associated with underlying diseases (mainly high blood pressure, diabetes and heart diseases).

After six months of discharge, five patients died, six could not be contacted by telephone and one refused to participate in a new interview. Out of 38 reassessed patients, 44.7% received treatment for depression, 58% of whom an antidepressant medication.

Two-thirds continued depressed. In this group there were fewer reports of pain and more previous suicidal behavior at the baseline assessment (see Table 1). It might be that those in pain received more treatment/analgesics for the underlying disease and that the pain relief was followed by fewer reports of depressive symptoms at the follow-up assessment.

The discredit regarding depressive symptoms, the fear of becoming dependent on psychopharmacological medication and the disbelief in antidepressant drugs and psychotherapies were barriers that led 21 patients not to seek treatment for depression. Out of 17 who searched for treatment at public healthcare services, 5 could not get it: "I have been waiting for an appointment for four months", said one patient at the follow-up interview.

Although the patients were assessed by several physicians, only one out of three patients received some treatment for depression; only one, out of five, received an antidepressant medication. Many adverse consequences may occur when depression is not treated such as the increase of morbidity-mortality, costs, non-adherence to proposed treatments and suicidal risk.

Our findings raise the awareness of psychiatrists to create politically effective strategies in order to claim workspaces in general hospitals, in addition to university services. Regarding depressive disorders, there are three challenges for the consultation-liaison psychiatrist: a) to accurately diagnose depressive disorders in comorbidity situations; b) to teach health professionals about how depression is related to other clinical diseases (such as coronary artery disease, diabetes, stroke); and c) to define who treats, and in which way, depressive episodes in comorbid physical diseases[5].

Every person presenting with chronic or severe diseases should be screened for depression. Once diagnosed, this person should be treated with the same attentive care that is given to other pathologies. Equally important is to offer qualified and available mental health services, as well as a pro-active performance of both psychologists and psychiatrists that work in general hospitals.

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Table 1. Profile of the sample of depressive patients

Characteristics		Depression improvement n=13 (%)	No depression improvement n=25 (%)	*p*
BASELINE ASSESSMENT (during hospitalization)				
Sex	Male	6 (46%)	5 (20%)	0.13 *
	Female	7 (54%)	20 (80%)	
Age group (years)	18-35	5 (39%)	7 (28%)	0.45 *
	36-50	2 (15%)	8 (32%)	
	> 50	6 (46%)	10 (40%)	
Marital Status	With stable partner	6 (46%)	18 (72%)	0.6 *
	Without stable partner	7 (54%)	7 (28%)	
Occupation	Housekeeper	4 (31%)	3 (12%)	0.35 *
	Economically active	4 (31%)	8 (32%)	
	Not economically active	5 (39%)	14 (56%)	
Education	0-4 years of study	10 (83%)	17 (68%)	0.68 *
	+ 4 years of study	3 (17%)	8 (32%)	
Pain on the interview day		10 (77%)	9 (36%)	0.01 **
Use of psychotropic medication during hospitalization		0	6 (24%)	0.08 *
Suicidal ideation		2 (15%)	6 (24%)	0.68 *
Suicidal attempt during life-time		0	9 (36%)	0.01 *
Suicidal attempt in the last 30 days		0	6 (24%)	0.07 *
Received psychiatric consultation		2 (15%)	4 (16%)	1.00 *
FOLLOW-UP ASSESSMENT (after 6 months of discharge)				
Needed re-hospitalization		2 (15%)	12 (48%)	0.08 *
Suicidal ideation		0	16 (64%)	0,01 *
Received depression treatment		2 (15%)	10 (40%)	0.16 *

* Fisher test; ** Chi-square test

Disclosures

Writing group member	Employment	Research grant[1]	Other research grant or medical continuous education[2]	Speaker's honoraria	Ownership interest	Consultant/ Advisory board	Other[3]
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** Modest*
*** Significant*
**** Significant: Amounts given to the author's institution or to a colleague for research in which the author has participation, not directly to the author.*
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References

1. Rentsch D, Dumont P, Borgacci S, Carballeira Y, Tonnac N, Archinard M, Andreoli A. Prevalence and treatment of depression in a hospital department of internal medicine. Gen Hosp Psychiatr. 2007;29:25-31.

2. Egede LE. Major depression in individuals with chronic medical disorders: prevalence, correlates and association with health resource utilization, lost productivity and functional disability. Gen Hosp Psychiatr. 2007;29:409-16.

3. Botega NJ, Mitsuuchi GN, Azevedo RCS, Lima DD, Fanger PC, Mauro MLF, Gaspar KC, Silva VF. Depression, alcohol use disorders and nicotine dependence among patients at a general hospital. Rev Bras Psiquiatr. 2010;32(3):250-6.

4. Azevedo RCS, Botega NJ, Mauro MLF, Lima DD, Gaspar KC, Silva VF. General hospital admission as an opportunity for smoking cessation strategies: A clinical trial in Brazil. Gen Hospi Psychiatr. In press 2011.

5. Strain JJ, Blumenfield M. Challenges for Consultation-Liaison Psychiatry in the 21st century. Psychosomatics. 2008;49(2):93-96.