CORRESPONDENCE

Mortality and Medical Comorbidity in in the Severely Mentally Ill

A German Registry Study

by Prof. Dr. med. Dr. rer. soc. Frank Schneider, Prof. Dr. P. H. Michael Erhart, Prof. Dr. med. Walter Hewer, Leonie AK Loeffler, M. Sc., and Prof. Dr. rer. nat. habil. Frank Jacobi in issue 23–24/2019

Risk of Rehospitalization can be Reduced

I read the work of my colleagues Schneider et al. (1) with great interest and would like to share the following experience: it is true that psychotropic drugs may increase risk factors for cardiovascular disease, due to adverse effects. However, antipsychotics can reduce the risk of rehospitalization (also of that due to somatic comorbidity). Paradoxically, it has been shown that some combinations of antipsychotics are even superior to monotherapy (2). Furthermore, it was not mentioned that in particular gerontopsychiatric patients can receive an "overtreatment" due to interactions, even though polypharmacy can lead to an increased mortality. Also, the unhealthy lifestyle of patients with psychosis should be highlighted; patients with schizophrenia have a three-fold increased risk of nicotine abuse, are less active, and have a reduced awareness of the treatability of somatic diseases (3). Even with severe somatic diseases, patients often do not let themselves be adequately treated. In turn, this leads to a recommendation of compulsory treatment, in particular for patients who lack insight regarding treatment. However, outstanding bureaucratic efforts make this implementation unsatisfactory: for instance, from my own experience, I can say that it sometimes can take more than eight weeks to get judicial approval for a necessary surgery of a non-consenting patient. In turn, other patients are often "not manageable" in somatic wards, resulting in inadequate care that may increase the rate of morbidity and mortality. Therefore, care of the mentally ill to reduce somatic comorbidity can be optimized and should take into account both preventive and organizational measures.

Unfortunately, anxiety disorders were not mentioned, although these may be associated with a higher prevalence rate for cardiovascular disease than depression (4).

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In Reply:

We thank Dr. Quante for contributing to the discussion and for the possibility to further elaborate on what was perhaps too concisely presented. His remarks show how complex the connections are between mental and somatic illnesses, psychopharmacological treatment, and risks of morbidity and mortality. We have already described that adequate psychopharmacotherapy has protective effects on somatic health: although adverse effects of psychotropic drugs may promote the development of somatic comorbidities, these drugs still significantly reduce mortality (1). We also described polypharmacy, drug interactions, and problematic health and illness behavior (for instance, nicotine abuse, problems of low compliance, and problematic lifestyles) in patients with severe mental illnesses (1, 2). However, routine data do not reveal these factors.

Decreased physical health is also of paramount importance in anxiety disorders, and many other F-group diagnostics not included in our analysis, due to the increased risk of somatic disease. However, we have confined this analysis to patients with severe mental illness, which according to general consensus mainly includes schizophrenia, severe unipolar depression, bipolar affective disorders, and also (well-justified) cases of borderline personality disorder. In these serious cases, direct and indirect health risks are particularly conspicuous, and there are particular problems with respect to the health system and special needs in the care system (2). Furthermore, the restriction to special diagnostic groups in the analysis of administrative data contributes to increased diagnostic validity (1).

Further, we also unequivocally agree with Dr. Quante that care and types of care for this group of

patients must be significantly optimized, and that preventive measures must also be taken into account. As stated, this is the goal of our future work.

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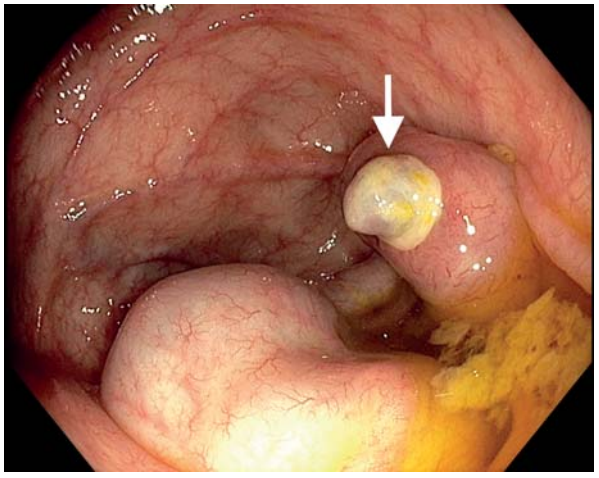
Conflict of interest statement
The authors of both contributions declare that no conflict of interest exists.

CLINICAL SNAPSHOT

Large Cecal Varices as Cause of Lower Gastrointestinal Bleeding



A woman in her early 60s with alcohol-related liver cirrhosis was admitted for investigation of peranal blood loss. Her hemodynamic and respiratory parameters were initially stable, with a serum hemoglobin concentration of 7.2 (normal range: 12.0 to 15.2) g/dL on admission.

Esophagogastroduodenoscopy revealed grade 1 esophageal varices with no signs of hemorrhage. Subsequent colonoscopy showed a large convolute of varicose veins *(Figure)* with a fibrin-covered hemocystic spot (arrow) at the cecal pole. Despite embolization of the varices (cyanoacrylate) and drug treatment (terlipressin) the patient suffered recurring hemorrhagic episodes requiring transfusion.

Because of this refractory variceal bleeding we decided to insert a transjugular intrahepatic portosystemic shunt, which succeeded in lowering the portosystemic pressure gradient to 4 mm Hg. During the course there was renewed massive bleeding with hemorrhagic shock. The interdisciplinary treatment team opted for surgical treatment. Right hemicolectomy with creation of an ileostomy put an end to the hemorrhages.

Gastrointestinal bleeding from ectopic varices is rare, but represents a challenging diagnostic and therapeutic conundrum. The various treatment options should be evaluated by a team including specialists in gastroenterology, interventional radiology, and visceral surgery.

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