Intersection of Psychiatric Patients with Additional Comorbidities

Lauren Strange, MS ; Nasra Ahmed, MD; Nita Bhatt, MD, MPH

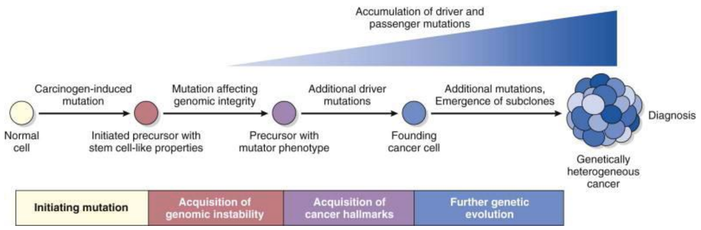
Department of Psychiatry, Boonshoft School of Medicine, Wright State University

Purpose

To present a unique case demonstrating the importance of evaluating acute psychiatric patients for additional comorbidities aside from their mental illness

Background

Cancer is the second leading cause of death among the United States population. Development of cancer occurs when normal cells within the body lose their ability to be regulated and avoid cell death or apoptosis. There have been eight proposed hallmarks of cancer that are present in all cells that have transformed to cancerous cells. These hallmarks are introduced to cells through a multitude of both genetic and epigenetic changes within the genome.[1]



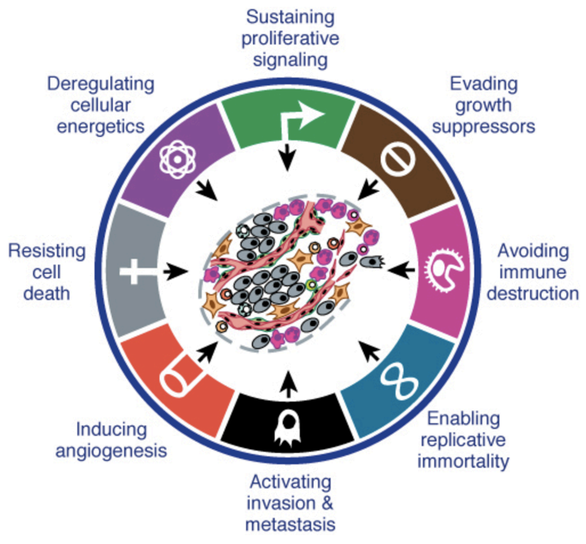


Figure 1 and 2: Robbins and Cotran textbook [1]

While cancer continues to be the second leading cause of mortality in the US, research has shown a disproportionate number of deaths within psychiatric patients compared to non-psychiatric patients. The increase in mortality has not been associated with an overall increase in incidence. There has been a variety of suggestions as to what has caused this variation between groups. Studies have proposed a delay in seeking care for cancer-like symptoms or being lost to follow up after the initial diagnosis. [2,3] Therefore, this topic brings up the discussion on how the healthcare field can better support psychiatric patients throughout diagnosis, treatment and their follow up cancer care.

Case Presentation

63-year-old Filipino male admitted to a state psychiatric hospital due to recent threats made to others, disorganized thoughts and delusions.

History of Present Illness at Admission:

- Patient was admitted via order of detention after threatening a nurse at a 24 hour community mental health. Was originally seeking care due to excessive neighbor noise. Speech was noted to be pressured.
- During a probate screening, patient stated that his neighbor had been purposefully flooding their house and was stealing from them. Continued to have pressured and disorganized speech
- At the time of admission, patient was noted to have a cough which in the past was attributed to a substantial tobacco history.

Psychiatric History:

- Documented as bipolar I disorder vs. schizoaffective disorder bipolar type. Difficult to discern due to poor patient history
- Multiple inpatient psychiatric hospitalizations; 11 previous admissions at hospital of current admission and at least 5 other admissions at other hospitals in the area

Past Medical/Surgical History:

- COPD
- Hypothyroidism
- Essential hypertension
- Hyperlipidemia

Psychosocial History:

- Originally born in the Philippines, moved to the United States at age 14
- Previous CNA and hospital technician
- Homeless at time of admission
- State-appointed legal guardian
- Significant smoking history, past cocaine, methamphetamine, alcohol and cannabis use

Brief Hospital Course:

- Patient initially placed on Haldol and then later Depakote with improvement of delusions and manic episodes
- Patient continued to have cough that was present at admission
- CXR was completed and showed small effusion with left basilar airspace disease
- Episode of acute SOB and was taken to near by hospital for acute respiratory distress. Additionally endorsed recent weight loss and loss of appetite. Given symptoms and history of tobacco use, CT chest ordered
- CT showed 0.4cm lung nodule, near complete opacification of LLL and a large left pleural effusion
- Thoracentesis was recommended at this time. Patient refused and ethics committee stated they could not force procedure unless his situation worsened or patient consented. Patient was discharged back to psychiatric facility on antibiotics for bacterial pneumonia coverage
- 3 weeks later, patient experienced acute labored breathing and was sent back to an outside hospital. Patient was discharged from the psychiatric facility and admitted to a nearby ICU after patient consented to thoracentesis. Cytology suspicious for carcinoma
- Healthcare team from the psychiatric hospital continued to advocate for the patient after discharge to ensure they were set up with a safe and steady living arrangement

Intervention

- Patient assessed during each shortness of breath episode, transferred to outside facility for further medical evaluation
- Chest CT completed secondary to acute shortness of breath, weight loss, loss of appetite and history of tobacco use concerning for malignancy
- Treated bacterial pneumonia with Levofloxacin
- Continued Haldol and Depakote for psychiatric symptoms and placed orders to maintain the same regimen while admitted to outside hospital
- Eventually admitted to ECF post discharge to ensure stable housing and healthcare

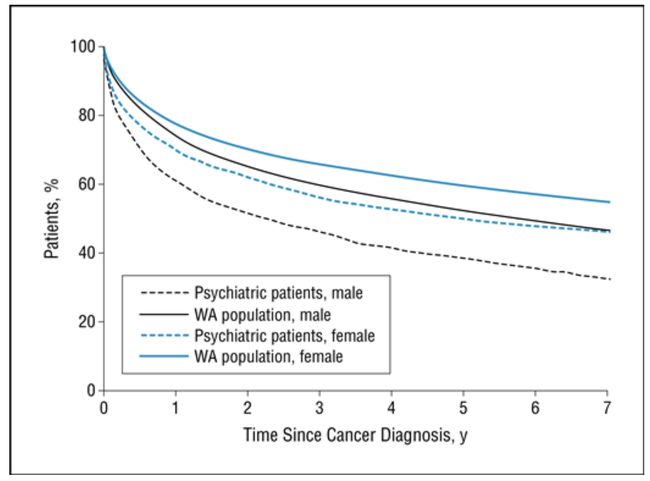


Figure 3: "Survival since diagnosis of all cancers by contact with mental health services" Kisely et al 2013 [2]

Conclusions

This case report re-iterates the importance of holistically evaluating psychiatric patients and advocating on their behalf. Clinical symptoms experienced by a patient with mental illness can frequently be misattributed to factitious disorder, malingering or other psychiatric conditions. However, this case shows the significance of evaluating the whole patient and not solely their chief complaint. This is further exemplified in multiple research studies that showed higher mortality rates of cancer patients with psychiatric disorder backgrounds. One plausible explanation for this discrepancy is the delayed diagnosis of cancer within patients with psychiatric history. This could simply be secondary to dismissed concerns voiced by patients solely due to their mental illness background. While this patient was screened and went through diagnostics, there is still the large challenge ahead of treating and maintaining continual care. Advocating for patients and ensuring they are provided with stable follow up and housing may provide the answer we need to solve the increased mortality rate.

References

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3. Guan NC, Termorshuizen F, Laan W, et al. Cancer mortality in patients with psychiatric diagnoses: A higher hazard of cancer death does not lead to a higher cumulative risk of dying from cancer. *Soc Psychiatry Psychiatr Epidemiol*. 2013;48(8):1289-1295.

Boonshoft School of Medicine
WRIGHT STATE UNIVERSITY