

# The crisis of poor physical health and early mortality of psychiatric patients

**It is well established that general medical conditions can be associated with various psychiatric disorders. But the reverse is less recognized: That serious mental illness is associated with many physical maladies, often leading to early mortality. Thus, it is a bidirectional medical reality.**

The multisystem adverse effects of psychotropic medications, such as metabolic dysregulation, often are blamed for the serious medical problems afflicting psychiatrically ill patients. However, evidence is mounting that while iatrogenic effects play a role, the larger effect appears to be due to a genetic link between psychiatric disorders and cardiovascular risk.<sup>1</sup> Unhealthy lifestyles, including sedentary living, poor dietary habits, smoking, and alcohol/substance use, also play a role in the rapid deterioration of physical health and early mortality of individuals afflicted by mood disorders, psychotic disorders, and anxiety disorders. The mantra of “healthy body, healthy mind” is well known, but “unhealthy mind, unhealthy body” should be equally emphasized as a reason for high morbidity and premature mortality in patients with serious mental disorders.

Consider the following alarming findings:

- A recent study revealed that even before the onset of the first psychotic episode, young patients with schizophrenia already suffer from a wide variety of medical conditions.<sup>2</sup> In a large sample of 954,351 Danish persons followed from birth to adulthood, of whom 4,371 developed schizophrenia, 95.6% of patients with schizophrenia had a history of hospitalization for somatic problems, including gastrointestinal, endocrine, genitourinary, metabolic, and circulatory system diseases; cancer; and epilepsy. Those findings suggest genetic, physiological, immunological, or developmental overlap between schizophrenia and medical conditions.

- A survey of 67,609 individuals with mood, anxiety, eating, impulse control, or substance use disorders followed for 10 years found that persons with those psychiatric disorders had a significantly higher risk of chronic medical conditions, including heart disease, stroke, hypertension, diabetes, asthma, arthritis, lung disease, peptic ulcer, and cancer.<sup>3</sup>

- A 7-year follow-up study of 1,138,853 individuals with schizophrenia in the United States found a 350% increase in mortality among this group of patients, who ranged in age from 20 to 64 years, compared with the general population, matched for age, sex, race,



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**To prevent premature death, collaborative care with a primary care provider is a must, not an option, for every psychiatric patient**

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ethnicity, and geographic regions.<sup>4</sup> An editorial accompanying this study urged psychiatrists to urgently address the “deadly consequences” of major psychiatric disorders.<sup>5</sup>

- A study of 18,380 individuals with schizophrenia, schizoaffective disorder, or bipolar disorder in London found that these patients were frequently hospitalized for general medical conditions, most commonly urinary, digestive, respiratory, endocrine/metabolic, hematologic, neurologic, dermatologic, and infectious disorders, neoplasm, and poisoning.<sup>6</sup> The authors attributed those nonpsychiatric hospitalizations to self-neglect, self-harm, and poor health care access, as well as to “medically unexplained” causes.

- An extremely elevated mortality rate (24-fold higher than the general population) was reported in a 12-month study of young individuals (age 16 to 30 years) diagnosed with psychosis.<sup>7</sup> The investigators also found that 61% of the cohort did not fill their antipsychotic prescriptions during that year, and 62% had  $\geq 1$  hospitalizations and/or emergency room visits during that year. The relationship between high mortality and lack of treatment with antipsychotics in schizophrenia was confirmed by another recent study,<sup>8</sup> a 7-year follow-up of 29,823 persons with schizophrenia in Sweden that measured all-cause mortality. These researchers found the highest mortality among patients not receiving any antipsychotics, while the lowest mortality was among those receiving a long-acting injectable second-generation antipsychotic.

- A recent systematic review of 16 studies that examined glucose homeostasis in first-episode psychosis<sup>9</sup> revealed that even at the onset of schizophrenia, glucose homeostasis was already altered, suggesting that predisposition to type 2 diabetes mellitus is a medical condition associated

with schizophrenia, and not simply an iatrogenic effect of antipsychotic pharmacotherapy. This adds fodder to the possibility of a genetic overlap between schizophrenia and somatic disorders, including diabetes.<sup>10</sup>

- In a meta-analysis of 47 studies of young people at “ultra-high risk” for schizophrenia, cardiovascular risk was found to be high, mostly as a result of lifestyle factors such as low levels of physical activity and high rates of smoking and alcohol use, even before the onset of psychosis.<sup>11</sup>

- The risk of stroke was found to be higher in 80,569 patients with schizophrenia compared with 241,707 age- and sex-matched control subjects.<sup>12</sup>

- A meta-analysis of the risk of stroke in 6 cohorts with schizophrenia found that there is a higher risk for stroke in schizophrenia, and that this may be related to natural history of the illness itself, not just due to comorbid metabolic risk factors.<sup>13</sup>

- The high rate of cardiovascular disease in depression has been attributed to neuroinflammation<sup>14</sup> or possibly to increased platelet reactivity.<sup>15</sup>

As psychiatric physicians, we always screen our patients for past and current medical conditions that are comorbid with their psychiatric disorders. We are aware of the lifestyle factors that increase these patients’ physical morbidity and mortality, above and beyond their suicide-related mortality. Our patients with schizophrenia and mood disorders have triple the smoking rates of the general population, and they tend to be sedentary with poor eating habits that lead to obesity, obstructive sleep apnea, diabetes, hypertension, and dyslipidemia, which increases their risk for heart attack, stroke, and cancer. Self-neglect during acute episodes of depression or psychosis increases the risk of infection, malnutrition, and

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tooth decay. We also see skin damage in obsessive-compulsive disorder patients who are compelled to wash their hands numerous times a day, the life-threatening effects of anorexia nervosa, and various types of medical ailments caused by incomplete suicidal attempts. Poverty and substance use among chronically mentally ill patients also increase the odds of physical ailments.

So we need to act diligently to reduce the alarming medical morbidity and mortality of the psychiatric population. Collaborative care with a primary care provider is a must, not an option, for every patient, because studies indicate that without collaborative care, patients receive inadequate primary care.<sup>16</sup> Providing rapid access to standard medical care is the single most critical step for the prevention or amelioration of physical disorders in our psychiatric patients, concurrently with stabilizing their ailing brains and minds. If we focus only on treating psychopathology, then we will win the battle against mental illness, but lose the war of life and death.



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