

The medical care of people with psychosis

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Early detection and prevention applies to medical comorbidity as well as psychiatric symptoms

Having a psychotic illness has been and remains a barrier to all forms of effective medical care. All serious mental illness is associated with undue medical morbidity and mortality.^{1,2} Such morbidity stems from a complex web of interactions between the illness itself, various aspects of the patient's environment, the nature of the antipsychotic medication and, most worryingly, barriers to the acceptance within the wider medical profession of adequate screening and treatment for comorbidity.³ As 70% of patients with persistent psychoses receive some or all of their treatment from non-psychiatric physicians,⁴ this is an important issue for the broader profession.

Severe mental illness is chronic, typically involves progressive neuropsychiatric impairment, and reduces the ability of individuals to independently manage their own care, both medically and socioeconomically. Psychosis lies at the centre of the illness, and its management depends on the use of antipsychotic drugs. These medications are the bedrock on which psychosocial interventions can then be brought into play to aid recovery. Yet, despite the centrality of antipsychotics in treatment, their therapeutic and non-therapeutic effects on the individual patient are by no means predictable. The adage that therapy must be individualised is as true today as it was in the 1950s, when these agents were first introduced. Reported efficacy is moderated by adverse effects, as well as patient-specific factors that influence adherence. These include patients' own consideration of their susceptibility to the illness, their judgement of its severity, and their personal evaluation of the benefits and risks of treatment.⁵

The antipsychotic agent clozapine best illustrates the medication issues. Clozapine remains unique in its ability to alleviate the symptoms of patients with refractory illness (30%–40% of patients appear to be "resistant" to other antipsychotics). However, potential toxic side effects of clozapine include agranulocytosis; metabolic disorder (particularly hyperglycaemia, hyperlipidaemia and obesity); seizures; potent sedation; hypotension; hypersialorrhoea; central and peripheral anticholinergia; life-threatening gastric hypomotility; sudden death in elderly patients; and, of recent interest, cardiac complications such as myocarditis, cardiomyopathy and pericarditis.⁶

Articles by Layland et al (*page 190*)⁷ and Borovik et al (*page 210*)⁸ in this issue of the Journal discuss critical adverse effects of clozapine treatment. These reports are timely, as they serve to remind us that uncommon side effects may lead to considerable morbidity and mortality and that vigilance for all potential adverse events is critical in people with mental illness. The metabolic syndrome, along with other cardiometabolic risks such as smoking and inadequate exercise, is more prevalent in people with schizophrenia than in population controls and is a predictor of early coronary heart disease and mortality (with up to 25 years of life lost prematurely).³ Indeed, as the study by John et al (*page 176*)⁹ demonstrates, the metabolic syndrome appears highly prevalent in several other groups with serious mental illness such as bipolar disorder or schizoaffective disorder.

Waterreus and Laugharne (*page 185*)¹⁰ propose a data entry form for metabolic risks, based on an earlier algorithm developed as a follow-on to a consensus document on diabetes and antipsychotics.^{11,12} The items on which their system is based are the five criteria proposed by the International Diabetes Federation to diagnose the metabolic syndrome.

However, other factors that contribute to overall cardiometabolic risk should also be considered when monitoring and reviewing patients with enduring psychotic disorders.¹³ Ageing, family history, ethnicity, obesity, current smoking status, diet, and exercise/lifestyle are all currently being tested for significance in a study being conducted through the Concord Centre for Cardiometabolic Health in Psychosis in Sydney.¹⁴ Schizophrenia and bipolar illnesses are also independent risk factors for developing metabolic dysregulation.¹⁵ Finally, the issue of non-adherence cannot be ignored. Side effects in general may be important factors leading patients to less than full compliance with medication schedules. When this occurs, the bedrock of their treatment is lost.

Thus the causes of the metabolic syndrome, while often laid at the feet of antipsychotic and other orexigenic agents, are more complex. These agents may be seen as forming the tip of the risk iceberg, while a plethora of independent factors associated with psychotic illness form the often unrecognised body of the problem.¹⁶ The alarming rates of premature death in this population confirm the need to closely monitor cardiometabolic risks for *all* patients with psychosis. In particular, although in the short term there may be differences in the incidence of metabolic risk associated with different antipsychotics, limits should not be imposed based on the specific antipsychotic the patient is receiving at any particular time.¹¹

Clearly, the mantra of first-episode psychosis services ("early detection and prevention") applies to comorbid physical health as well as psychosis itself. The paucity of long-term data in the global literature provided the impetus for a multicentre study currently underway in Australia to examine cardiometabolic risks in first-episode psychosis patients. The study exploits the strong signal of obesity and hyperlipidaemia often seen in clinical settings. Its aim is to determine the time to the development of key cardiometabolic risks from onset of treatment.

The relationship between psychotic illness and metabolic illness is not a new one. Maudsley noted in 1895 that "diabetes is a disease which often shows itself in families in which insanity prevails",¹⁷ and Hippocrates observed over two millennia ago that "persons who are naturally fat are apt to die earlier than those who are slender". Although clinicians acknowledge the need for improved monitoring and management of comorbid and iatrogenic conditions, much needs to be done before outcomes are improved. A clearer understanding of medication side effects, of the metabolic syndrome and of compliance issues is needed. In addition, barriers to screening and management need to be identified and removed.³

EDITORIALS

Competing interests

I have been a speaker/advisory board member for Hospira, one of the manufacturers of clozapine, in the past 2 years.

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