LETTER TO THE EDITOR

Rates of physical illness in patients with mental disorders seen at Nnewi Nigeria: rejoinder

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REPORT

We write to react to an interesting article with the above title that appeared in the Volume 25 January - June 2013 issue of this journal concerning medical co-morbidities encountered in psychiatric practice at the Nnamdi Azikiwe University Teaching Hospital (NAUTH) Nnewi, Nigeria.[1]

It was a scholarly article describing the size of the problems and some idea of the spectrum, but the authors, unfortunately, did not suggest their approach in the management of such problems. It also, did not recommend any standard operating procedure for other practitioners to follow when they suspect that a mental health problem co-exists with other diseases.

The problem of concurrently occurring diseases is encountered in all branches of medicine. Management of co-morbidities is frequently complex and challenging, calling for prioritization. The diseases may be such as can be resolved in the same specialty, or may require the services of other medical specialists.

The co-morbidity could be minor, non-urgent, or life-threatening, needing immediate and more urgent attention than the primary condition which brought the patient to the hospital.

Drugs used in treating the different diseases may interact, adverse effects may be more intolerable, or a drug needed for treatment of one condition may be contra-indicated in the presence of the co-occurring condition.[2] The dilemma in management of co-morbidities includes deciding on their relative severity, whether, and when to suspend, temporarily, further proceedings on minor presenting disease, and treat or refer the patient to get attention for a more serious illness.

A questionnaire survey (by one of the authors but, yet to be published) of 127 medical doctors of different specialties belonging to the Nigerian Medical Association (NMA) in 2012 regarding how they manage ocular co-morbidity in their practice revealed that some ignored the condition, some treated minor diseases, but most referred ocular trauma and conditions they considered serious.

At the Guinness Eye Centre Onitsha (GEC), an eye care facility of Nnamdi Azikiwe University Teaching Hospital (NAUTH) Nnewi where the authors practice, blood pressure measurements, dip-stick urinalysis and HIV-screening test are done in all adult patients going for eye surgery. In a study of 100 such patients obtained from systematic sampling from 2009 to 2012, it was discovered that in 17 (17%), hypertension was so severe that surgery was suspended pending control to acceptable 140/90mmHg.[3] Our standard operating procedure is a referral to a physician for control of severe hypertension or hyperglycaemia before eye surgery.

In another study of 167 patients who were diagnosed as having chronic simple glaucoma (CSG) from 2009 to 2011 at GEC, systemic co-morbidities were discovered in 42 (25.1%), mostly hypertension, diabetes mellitus, asthma, congestive cardiac failure, and benign prostatic hypertrophy.[4] These resulted in modifying medicines that ordinarily would have been given. In these patients, also, ocular co-morbidities were found in 121 (72.5%).

Although the symptoms of these other diseases were often the cause of the patient presenting to hospital, the CSG, was subsequently, discovered on examination. And, CSG being a blinding disease, was usually the primary focus.

Our algorithm for ocular diseases occurring with systemic conditions is that control of life-threatening systemic conditions takes precedence if severity is such that it poses substantial and urgent threat to life or multiple-organs damage; and for ocular co-morbidities: sight-threatening and severely painful conditions take precedence over less serious or merely inconvenient co-occurring eye diseases.

Similar guidelines, we urge, should be adopted by all doctors in differing specialties in managing concurrently occurring diseases. Finally, researchers should regard it as imperative to build service provision into the framework of their research from the outset. The dearth of healthcare resource in sub-Saharan-Africa and emerging concept of translational research make this mandatory.

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