

Reflections on Mental Life and Medical Illnesses

Just as the brain and the rest of the body are intertwined, so too are mental life and general medical illnesses. General medical conditions can have profound effects on the mental lives of our patients, and disturbances in mental life can affect the course of general medical illnesses. A few patients come to mind that illustrate these principles, and I would like to share their stories with you.¹

Mrs. R was a patient I admitted during my psychiatry sub-internship on the geriatric psychiatry service. She was a 70-year-old woman with no past psychiatric history who came to us for evaluation of recent cognitive decline and low mood. Her story resonates with me as I reflect on the connections between medical illnesses and mental life because of how dramatically her general medical condition impacted her mental life.

Before I go further, a brief description of her mental life seems apt. At her baseline a spunky, independent senior citizen, Mrs. R had not been able to care for herself for the past month. Her mental status exam on admission was notable for psychomotor retardation, marked latency of speech, and minimal, brief responses to questions. She endorsed low mood and appeared dysphoric. She was also no longer able to remember how to crochet, one of her favorite pastimes. Finally, she was not able to state the date, the name of the hospital, or the name of the president, and she scored a 19/30 on the Mini-Mental State Exam (MMSE).

The night she was admitted, Mrs. R was found to have a urinary tract infection and we began to treat her with antibiotics. During her second night on our service, her temperature spiked to over forty degrees Celsius and she went into atrial fibrillation with rapid ventricular rate. She was then transferred to the medicine service, where she was treated for urosepsis.

After about a week on the medicine service, Mrs. R returned to our floor and I conducted a second admission interview. It was striking to see how different her mental status exam was compared to her first admission interview one week earlier. Prior to being treated for urosepsis, Mrs. R had shown considerable cognitive impairment – she had not known where she was or what year it was. She had also forgotten how to crochet and how to take care of herself. On her return to our service, she was oriented to person, place, and time, and her MMSE score jumped nine points, from a 19/30 to a 28/30. While she still appeared dysphoric at times and continued to endorse low mood, Mrs. R now brightened from time to time, and was even crocheting a scarf while waiting for our interview to begin.

Mrs. R's story reminds us of the important role that general medical conditions can play in the mental lives of our patients. In her case, sepsis resulted in a delirium that manifested in disorientation and cognitive impairment. Treating the underlying cause of the delirium with antibiotics and fluids led to an improvement in her cognitive functioning. The clearing of Mrs. R's delirium then allowed us to assess her underlying

mental life – in particular, the low mood, decreased self-attitude, and anhedonia – and we were able to identify and treat her major depression.

Recognizing the contribution of Mrs. R's general medical condition to her mental life was of critical importance. If we had not discovered her urinary tract infection and ensuing urosepsis, we could have mistakenly attributed her cognitive decline to dementia or depression. Even worse, in the absence of helpful information from family and other loved ones, we could have made the error of taking her present cognitively-impaired state for her baseline. This would have been a great disservice to our patient, as we would not have been able to improve her cognitive picture without addressing her delirium.

While Mrs. R's story reminds us of the profound impact that general medical conditions can have on our patients' mental lives, another patient illustrates the other side of the coin – how disturbances in mental life can affect the course of general medical illnesses. This second patient was a patient I met during my OB/GYN rotation. Ms. C was a 63-year-old woman with a history of schizophrenia who came to the gynecology outpatient clinic with post-menopausal uterine bleeding that had been going on for many years. Seven years ago, she had an abnormal pap smear that was concerning for endometrial cancer. In particular, her pap smear had showed atypical glandular cells of undetermined significance, or AGUS, a finding that portends endometrial cancer in over 20% of women over the age of 35. Upon receiving the abnormal pap smear results, Ms. C needed to come back in for follow-up – colposcopy and biopsy to determine if she had cancer, and surgery if it did turn out to be cancer.

Unfortunately, Ms. C had not returned to the gynecology clinic for seven years – today was her first clinic visit since the abnormal pap smear. She was also not receiving treatment for her schizophrenia – she did not have a psychiatrist and was not taking any psychiatric medication. During our clinic visit, Ms. C had poor eye contact and appeared to be responding to external stimuli. Her responses were also tangential, and it was very difficult to communicate with her.

We were finally able to do the colposcopy and biopsy that day at clinic, and there was ultimately bad news upon more bad news. Not only did Ms. C have endometrial cancer, but she also had a type of endometrial cancer, papillary serous endometrial cancer, that was particularly aggressive. While most endometrial cancers have a 5-year survival of greater than 85%, papillary serous endometrial cancer is a rare form of the disease with a 5-year survival of only about 20%. This dismal survival rate is due in part to the fact that the majority of patients with this type of endometrial cancer present with disease that has already spread beyond the uterus. Given the aggressive nature of her disease, the seven-year delay in Ms. C's work-up was particularly unfortunate, and did not bode well for her prognosis.

Ms. C's story is unfortunately one that is altogether too common – we know that psychiatric patients with cancer are often diagnosed at a later stage of the disease compared to cancer patients without psychiatric illnesses.² We also know that cancer mortality rates among psychiatric patients are 30% higher than cancer mortality rates in

the general population.³ What are the reasons for these disparities? Taking a closer look at Ms. C's story lends itself to some possible answers.

Ms. C's mental illness was the very reason that I ended up meeting her that day in clinic. My OB/GYN resident had initially gone to see Ms. C by herself, and I was to go see the next patient on the clinic schedule. However, after a few short minutes, the resident emerged from the exam room with an exasperated look on her face. She sputtered, "Janet, you're going into psych. This patient is crazy and was spitting out hot dogs all over me! Go talk to her."

This brief exchange with my resident was a vivid reminder of the stigma of mental illness and the negative impact that it can have on patient care. Going through medical school as a future psychiatrist, one is bombarded by complaints from fellow medical students, residents, attendings, and nurses who have great difficulty and distaste for dealing with patients with psychiatric illnesses, and who, as a result, spend less time with them or avoid them altogether if they can. Although Ms. C was not able to tell us why it had taken her seven years to return to clinic, one reason may be that she was not treated well at previous clinic visits. Another reason, of course, is that her psychosis and disorganized thinking prevented her from taking care of her basic needs, including making health care appointments.

Although Ms. C's story does not lend itself to a rosy-hued ending, it was not without positive developments. We made an appointment for her to see a gynecologic oncology

specialist, who would surgically remove as much of the cancer as possible. However, Ms. C did not come to her appointment at the GYN-ONC clinic, which by chance was scheduled to take place during the two weeks that I was on the GYN-ONC portion of my OB/GYN rotation. At first it looked like Ms. C would be lost to follow-up yet again, but fate looked kindly upon us. The resident asked the GYN-ONC clinic receptionist to call Ms. C and to try to get her to come to the hospital to be directly admitted for surgery without the clinic visit, given her dire clinical situation. When the receptionist made the telephone call to Ms. C, I happened by chance to be in the reception area, assembling pre-operative paperwork for the cases for the coming week, and overheard the phone conversation. The receptionist was on the phone with Ms. C for a good twenty minutes, trying to convince her to come into the hospital. The receptionist was extraordinarily kind, patiently repeating to Ms. C how important it was for her to come in, how to get to the hospital, and so on. Her efforts turned out to be a success – Ms. C came to the hospital that evening and got the operation she so desperately needed.

As future and current psychiatrists, we must be aware of our patients' general medical illnesses. As in the case of Mrs. R, general medical illnesses may be contributing to the disturbances in our patients' mental life, and only by addressing the contributory medical illnesses as well as the psychiatric illnesses will we be able to fully help our patients. As in the case of Ms. C, we must be aware of the barriers that keep patients with mental illnesses from getting general medical care, and we must make the time, like the kindly receptionist at the GYN-ONC clinic, to facilitate our patients' access to general medical care. We must also try to educate others about mental illness. When the frustrated

internist complains to us about “that crazy patient,” we must try to help him/her distinguish the patient from the mental illness. Though these tasks are not simple, our work is made just a little easier because we work alongside the waves of progress. Every year we learn more about the links between medical illnesses and psychiatric illnesses, and we also uncover more about the basic science mechanisms that underlie psychiatric illness. One day, we will understand mental illness in terms of pathophysiology, just as we do today with diseases like coronary artery disease. The connections between mental life and medical illnesses, while strong now, will thus only grow stronger with future advances in psychiatry.

¹ Names and other identifying details have been changed to protect patient confidentiality.

² Kisely, S., Crowe, E., Lawrence, D., 2013. Cancer-Related Mortality in People With Mental Illness. *JAMA Psychiatry* 70(2):209-217.

³ See note 2, above.