

CONSULTATION-LIASON PSYCHIATRY PRACTICE IN A NIGERIAN TEACHING HOSPITAL

A. O. OYEWOLE

Department of Psychiatry, Ladoke Akintola University Teaching Hospital, Osogbo, Nigeria

ABSTRACT

Background

Much psychiatric co-morbidity still go un-noticed or unrecognized by the attending physician and referral seemed to be related to the severity of illness or previous history of psychiatric illness.

Objective

This study therefore attempts to examine various issues of consultation- liaison psychiatry in a Nigerian Teaching

Materials and Methods

A proforma was used to record issues such as referral pattern, communication process and intervention by the referring team and final disposal. Subjects were all inpatients in non-psychiatric wards of Ladoke Akintola University of Technology Teaching Hospital, Osogbo, Nigeria for which consultation was sought over a 6-month period. A detailed psychiatry interview was done by using the structured clinical interview according to DSM IV to generate AXIS I diagnosis.

Results

A total of seventeen patients were referred over the 6 months study period. This gives a referral rate of 1.8%. The mean age was 39.5+19.3yrs and more females 10 (58.8) were seen during the study period than males 7 (41.2%). The commonest diagnosis made was organic brain syndrome in 11 (64.7%). Most of the patients, 11 (64.7%), were seen within 24 hours. Three (17.3%) were actually transferred to the psychiatry ward, 4(23.5%) died on admission while final disposal of other patients were not known.

Conclusion

There is need for earlier detection of psychiatric morbidity associated with physical illness so that referral in the early stage can be undertaken.

KEYWORDS: Consultation-Liaison Psychiatry, Co-Morbidity, Organic Brain Syndrome, Traditional Mental Health Practitioners

INTRODUCTION

Consultation- liaison psychiatry is defined as an area of psychiatric practice which involves consultation to and collaboration with non-psychiatric physicians and other health workers in all types of medical care settings^{1,2}. Psychiatric

disorders attributable to physical conditions have been estimated at 15-25% of all mental disorders encountered in Africa^{3,4}. Much psychiatric co-morbidity still go unnoticed or unrecognized by the attending physicians and referral seemed to be related to the severity of illness or previous history of psychiatric illness.⁵⁻⁹

A number of studies had been conducted on psychiatric referrals in Nigeria, which range from outpatients clinic referral studies¹⁰⁻¹⁵ to inpatient referral studies.¹⁶⁻¹⁷ Compared to situations in developed countries, the problems of infectious diseases and malnutrition^{18,19} make the morbidity worse, and unlike in the developed countries where the predominant diagnosis is that of depression and anxiety disorders in the medical inpatients,^{20,21,25} the predominant diagnosis in Nigeria seems to be a mixture of three disorders- acute organic Brain Syndrome, Depression and Anxiety Disorders^{8,22}

Very few systematic studies had been done on consultation- liaison psychiatry in West Africa because the practice itself had been adversely affected by the scarcity of qualified psychiatric manpower in the sub-region. This present study attempts to examine the various issues of consultation – liaison psychiatry in a Nigerian Teaching Hospital.

METHODS

The subjects in this study were all inpatients in this non-psychiatric wards of ladoke akintola university of technology teaching hospital for which consultation was sought over the six month period.

Psychiatric clinical services had been available as a sub-unit in the Department until 2 years ago when it assumed the status of a full-fledged clinical department with three consultants, four residents doctors and a clinical psychologist in a twelve bedded ward.

A proforma questionnaire designed by the author was used to record all data collected on each patient including socio-demographic characteristics, referral pattern, communication process, intervention by the referring team, intervention by the psychiatrist and final disposal of the patient. Each referral letter was critically reviewed for essential information such as list of symptoms patient presented with, physical examination findings, mental state examination findings, list of investigations and urgency attached to the referral. Patients' case notes were reviewed by the author to find out about relevant information that have previously been obtained from the patient such as the medical or surgical diagnosis, management instituted and other important information that may not be included in the referral letter. A detailed psychiatric assessment was done by obtaining a psychiatric history of such patient and mental state assessed using the structure for clinical interview according to DSM-IV, DSMIV AXIS I diagnosis were generated. Interventions initiated by the referring team as well as the psychiatric team were recorded and followed up after discharge at the psychiatric clinic. All data were analyzed using the Epi info version 6.0 computer software.

RESULTS

Seventeen in- patients were seen over the 6 month study period. The total number of admission into the medical, surgical, pediatric, obstetric and gynecology wards during the study period was nine hundred and forty. The mean age was 39±19.3 yrs. This gives a referral rate of 1.8%. Majority of the patients 4(23.5%) were in the age range 10-20 yrs. The socio-demographic characteristic of the patients is shown in Table 1. There were more females referred, and majority were had either primary or secondary educations. They were equally distributed with regards to religion into either Christianity or Islam, and most are single.

The commonest reason for referral was the presence of psychiatric symptoms in 15(88.22%) and 2 (11.8%) for previous contact with the psychiatrist. These 2 cases had previous history of psychoactive substance abuse with psychiatric manifestations and one was managed for acute appendicitis in the surgical unit

Table 2: shows the distribution of mental health diagnoses among the referred patients. Most had an organic brain syndrome. The sources of referrals is shown in Table 3. A greater percentage of the patients were referred from internal medicine and surgery, with fewer referrals from pediatrics and obstetrics and gynecology.

The Psychosocial stressor preceding Patient's mental illness were such that only 8(47.1%) patients of the 17 experienced stressful life events preceding their illnesses. Breakdown of psychosocial stressors are as follow: (1) chronic medical illness-5 (2) issues of childbirth-1 (3) job loss-2

The physical diagnosis made by the referring team is distributed as follows

- **Infections: 5**
 - Immuno-suppression secondary to Acquired Immune Deficiency syndrome-4
 - Perforated Enteric fever-1
- **Neurological Disorders: 4-**
 - Paraplegia-1
 - Dementia-1
 - CVD-1,
 - Parkinson's disease-1
- **Obstetric/Gynaecological Disorders:**
 - Choriocarcinoma-1
 - METABOLIC DISEASES:
 - Chronic Renal Failure-1
 - SURGICAL CONDITIONS : 6-
 - Basal- skull fracture-1
 - Corrosive oesophagitis-3.
 - Acute appendicitis-1,
 - Head injury-1.

Eleven (64.7%) of the patients were seen within the first 24hrs of referral; 2(11.8%) were seen immediately because of the sense of urgency indicated and the remaining 4(23.5%) were seen after 24hrs.

Regarding final disposal of patients three cases were actually transferred to the Psychiatric unit of the hospital for inpatient admission. Two had associated febrile illness which was already treated but supported laboratory result showed no evidence of pathology but persistent psychiatric symptoms, the other one is a case of relapse of paranoid schizophrenia. One actually discharged self against medical advice. It was a case of deliberate self harm with depressive symptoms (corrosive oesophagitis). The event was perceived by the patients and the relatives as a 'spiritual attack' from the devil. The remaining 13(76.5%) patients were mostly cases of delirium or dementia. There were 3 cases of dementia, 6 cases of delirium (2 of them secondary to AIDS), 2 cases of RTA (Basal skull fracture & Concussion). The other 2-cases were that of Choriocarcinoma and chronic renal failure. Four cases (23.5%) died on admission-2 cases of head injury and 2 cases of HIV/AIDS. Details of final disposal of other patients were not known.

DISCUSSIONS

There referral rate in this study was 1.8 per 100 admissions. This rate is in keeping with a previous study done in a similar setting ¹. The mean age of 39.5+19 yrs falls within the age range of 16-45 yrs illustrated by previous Nigerian studies ^{8,13,17}.

The bulk of the referral is from internal medicine 8 (47.1%) which is in keeping with the previous studies ^{8,17,23}. The only referral from paediatrics departments in this study was a 12yr old boy who had perforated bowel enteric fever and had laparotomy complicated with delirium. The paucity of referral from both the pediatrics and Obstetric and Gynecology may not be unconnected with the volume of patients in these units because there are alternative cheaper government general hospitals in the town which handle the bulk of Obstetric and paediatric cases under a free medical treatment programme of the state government. These hospitals have no consultation-liaison referral culture especially for psychiatric cases or psychiatric complications of medical problems. Most of the patients' relatives would also prefer traditional medical health practitioners to orthodox medicine especially when there is no psychiatry unit in such hospitals.

A number of reasons have been proffered as being responsible for the bulk of referral from internal medicine.

- The fact that infective disorders which constitute the commonest condition encountered in the topics are managed by the internal physicians ¹⁰.
- Neurological disorders which are usually complicated by neuropsychiatric features are also within the domain of internal medicine ⁸.

The commonest reason for consultation was the presence of psychiatric symptoms in 15 (88.2%) and in 2 (11.8%) because of previous contact with the psychiatrists.

The findings are not surprising since the need to refer to a psychiatrist will be determined more or less by the presence of symptoms. No patient was outright referred for disposition although after assessment by the psychiatrist, three patients were referred to the psychiatric ward. This finding is in contrast to what was reported by Aghanwa et al. ⁸ who observed that the immediate concern of the attending physician or surgeon in most cases is immediate transfer of patient to psychiatric ward. The commonest psychiatric disorder referred to the psychiatrists during the study period was organic brain syndrome 11(64.7%). This finding of predominance of organic brain syndrome as the commonest psychiatric diagnosis is similar to the findings of some other studies ^{8,17,23}.

This study found that infective conditions constitute about 5(29.4%) of all physical diagnosis made; 4 of which were due to HIV infection and 1 was due to enteric fever. This is in keeping with previous studies that have reported the preponderance of infective agents as major pathways for organic brain syndrome in Africa^{3,4}. The rising incidence of acute organic brain syndrome in medical wards as a result of increase in the number of cases of Acquired Immune Deficiency Syndrome (A.I.D.S.) is worth mentioning because of the challenges to management of dramatic behavioral changes that accompany terminal stages of this illness.

The implication of this findings is that the training of medical doctors especially at the postgraduate level should continue to emphasize the development of clinical skills in the detection and management of psychiatric disorders complicating physical disorders.

Three cases (17.6%) were transferred to the psychiatric ward for admission after investigations showed no infection but there was persistence of symptoms. One of the patients discharged self against medical advice because he felt his case was spiritual. He is a 60 year old Deacon in a Pentecostal church who attempted suicide by ingesting caustic soda and was managed on the otorhinolaryngology unit as a case of corrosive oesophagitis. The remaining 13 cases of organic brain syndromes were co-managed in the medical and surgical units.

Quite a number of those who were discharged without having psychiatric follow up could be explained on the premise that the patients probably preferred to seek traditional psychiatric help outside of the hospital setting. This is a plausible reason as patients have been reported in previous studies to patronize traditional mental health practitioners (TMHPs) in line with their belief in the supernatural causation of their mental symptoms and illness^{28,29}. This therefore calls for public enlightenment programme on the aetiology and treatment of psychiatric disorders.

The study has a few limitations namely the lack of control group such that conclusions on psychiatric intervention on referred patients could not be drawn. The time frame of 6 months may appear inadequate for appreciable number of patients to be studied.

Although the referral rate of 1.8% is comparable to other studies, departments such as obstetric/Gynaecology and Paediatrics having only 1 patients referred within 6 months appear surprising in the study though reasons had been given for the lower rate of referral. Other forms of psychiatric management such as joint consultation/seminar or case conference in patients should be fully utilized.

CONCLUSIONS

There were evidences to suggest that patients that were discharged and lost to follow up might probably be patronizing traditional mental health practitioners in line with their belief in the supernatural causation of mental symptoms and illness. This implies that there is the need for public enlightenment programme on the aetiology and treatment of psychiatric disorders.

Table 1: Socio-Demographic Characteristics Of

Sex	10	58.8
Female	7	41.2
Male		
Occupational Group		
Major group 1	1	5.9
Major group 2	1	5.9
Major group 3	-	-
Major group 4	1	5.9
Major group 5	1	5.9
Major group 6	-	-
Major group 7	-	-
Major group 8	7	41.2
Major group 9	6	35.3
Others		
Educational		
Primary	6	35.3
Secondary	6	11.8
Tertiary	2	17.6
None	3	
Religion		
Christianity	8	47.1
Muslim	8	47.1
Others	1	5.9
Marital status		
Single	8	47.1
Married	7	41.2
Separated	1	5.9
Widowed	1	5.9

Table 2: Diagnoses distribution based on DSM IV

Diagnosis	N = 17	% N
Organic Brain syndrome	11	64.7%
Deliberate self-harm	3	17.6%
Adjustment Disorder	2	11.8%
Relapse of paranoid Schizophrenia	1	5.9%

Table 3: Psychosocial Stressors Proceeding Patient's Mental Illness

Type of Stressors	No of Patients N =8	% of N
Childbirth	1	5.9%
Health related-	5	23.5%
Job lost	2	11.8%

Table 4: Final Disposal of Patients

Disposal	N	%
Admission in psychiatry ward	3	17.6
Discharge against medical advise	1	5.9
Died on admission	4	23.5

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