



Accuracy of self-reported medical problems in patients with alcohol dependence and co-occurring schizophrenia or schizoaffective disorder

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ABSTRACT

Background: Schizophrenia and alcohol dependence (AD) are both major risk factors for a variety of medical problems, yet little is known about the medical status of patients in whom both conditions coexist.

Objective: The objectives of this study are to assess accuracy of self-reported medical problems and to compare the accuracy reports in patients with schizophrenia or schizoaffective disorder and co-occurring AD compared to patients with AD only and to controls. Our hypothesis was that medical problems are under-reported in patients with co-occurring disorders, possibly due to the combination of alcohol use and symptoms of schizophrenia.

Methods: Self-reported medical diagnoses were recorded and compared to medical records obtained from all area hospitals in 42 patients with schizophrenia and AD, 44 patients with schizoaffective disorder and AD, 41 patients with AD alone or in controls. The most commonly underreported diagnoses included coronary artery disease, chronic renal failure, seizure disorder, hyperlipidemia, asthma and hypertension.

Results: Patients with schizophrenia or schizoaffective disorder and co-occurring AD underreported their medical problems significantly more than patients with AD only and controls. Accuracy of self report was significantly lower in patients with schizophrenia-spectrum disorders plus co-occurring alcohol dependence than in AD alone or in controls. The most commonly underreported diagnoses included coronary artery disease, chronic renal failure, seizure disorder, hyperlipidemia, asthma and hypertension.

Discussion: In order to detect potentially unreported medical conditions in patients with co-occurring schizophrenia/schizoaffective disorder and alcohol dependence, the use of targeted screening questionnaires is recommended in addition to physical examination and thorough review of medical records.

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1. Introduction

Schizophrenia has been described as a “life-shortening disease” (Lambert et al., 2003; Colton and Manderscheid, 2006; Capasso et al., 2008). In the United States life expectancy is significantly shorter and mortality rates are significantly higher for patients with schizophrenia, compared to the general population. Over one-third of patients with schizophrenia meet criteria for an alcohol use disorder (AUD) — over three times the prevalence in the general population (Regier et al., 1990; Jeste et al., 1996; D'Souza et al., 2006; Green and Brown, 2006). Excluding nicotine, AUDs are the most common co-occurring substance use disorders (SUDs) in schizophrenia (Drake and Mueser, 2002).

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It has been estimated that more than 50% of patients with schizophrenia have another medical diagnosis (Mitchell and Malone, 2006). The most prevalent medical problems in this population include diabetes (Dixon et al., 1999; Muir-Cochrane, 2006), hyperlipidemia (Lambert et al., 2003), obesity (Lambert et al., 2003; Goff et al., 2005), COPD (Carney et al., 2006), cardiovascular disease (notably hypertension) (Lambert et al., 2003; McCreadie and Scottish Schizophrenia Lifestyle Group, 2003), and hepatitis (Lambert et al., 2003; Nasrallah, 2005; Carney et al., 2006). Shorter life expectancy is due mainly to cardiovascular disease (CVD) (Fleischhacker et al., 2008) associated with the frequent occurrence of low HDL, high triglyceride levels (Nasrallah et al., 2006), smoking and substance abuse (Graham et al., 2007; Green and Brown, 2006).

AUDs increase the likelihood of developing a wide range of medical problems (Liskow et al., 2000; De Alba et al., 2004). Excessive alcohol use affects numerous body systems including the nervous, gastrointestinal, hematopoietic, cardiovascular, and endocrine systems. Heavy alcohol use is also associated with an increased risk of cancer.

Schizophrenia and alcohol use disorders are therefore both independent major risk factors for a variety of medical problems. Patients with schizophrenia and co-occurring SUDs have higher morbidity than patients with schizophrenia alone (Dickey et al., 2002; Batki et al., 2009a, 2009b). Medical conditions may go unrecognized and undertreated, placing this patient population at a higher risk. General health care may be neglected in these patients (Liskow et al., 2000; De Alba et al., 2004; Nasrallah et al., 2006) because of barriers between mental health and general health services, stigma, cognitive problems due both to substance use and to schizophrenia, and problems with adherence (Druss and Rosenheck, 1998; Druss, 2002; Meyer and Nasrallah, 2003). Inadequate recognition of medical illness and poor access to care may contribute to the high morbidity and mortality of patients with schizophrenia and AUD, compared to the general population (Dixon et al., 1999; Nasrallah et al., 2006; Batki et al., 2009a, 2009b).

The aims of the present study were to assess and compare accuracy of self reported medical problems in patients with schizophrenia or schizoaffective disorder plus AD, patients with AD and in control subjects. We also aimed to identify the most commonly under-reported medical diagnoses. We examined possible relationships between accuracy of self report and demographic variables, alcohol and other substance use severity, psychiatric symptom severity, and number of verified medical diagnoses. Our hypothesis was that self-report of medical history is less accurate in patients with co-occurring alcohol dependence and schizophrenia/schizoaffective disorder compared to those with alcohol dependence only or to controls.

2. Methods

2.1. Participants

We obtained data from a total of 142 participants enrolled in two NIAAA-funded parent studies. The *first study* was a double-blind, placebo controlled trial of directly monitored naltrexone treatment for alcohol dependence in schizophrenia (Batki et al., 2009a, 2009b). Participants were 86 patients with schizophrenia or schizoaffective disorder, and co-occurring alcohol dependence, recruited from community mental health clinics in Syracuse, New York. Forty-four had schizoaffective disorder and 42 had schizophrenia. We analyzed baseline data collected during the screening phase. The *second study* was designed to examine genetic biomarkers of ethanol-induced brain damage in non-treatment seeking patients with alcohol dependence (N=41), and controls recruited from the community (N=15). All patients in both parent studies provided informed consent.

2.2. Accuracy of self-report

All patients underwent a detailed structured medical history, physical examination, and review of all available medical records. Medical records were requested going back 6 months prior to the time of enrollment in the two parent studies. Self-reported medical problems were documented and compared to problems obtained from medical records (outpatient clinic charts, inpatient discharge summaries, and emergency room visit records) requested from all local hospitals in the Syracuse metropolitan area. Accuracy was calculated as percent of verified medical conditions reported in patients who had at least one medical condition. The numerical difference between verified and self reported medical diagnoses was determined for each subject as a measure of underreporting of medical problems.

2.3. Demographic variables

Baseline demographic data included age, gender, race, level of education, and employment status.

2.4. Measures of alcohol and substance use

Alcohol and substance use and diagnoses were assessed with the Timeline Follow-Back (TLFB) interview (Sobell et al., 1985) and the Structured Clinical Interview for DSM-IV (SCID) (First et al., 2001).

2.5. Measures of psychiatric severity

Schizophrenia symptoms were assessed by the Positive and Negative Syndrome Scale (PANSS) (Kay et al., 1987). Interviewers were certified by the PANSS Institute. Diagnosis of schizophrenia vs. schizoaffective disorder was determined using the SCID. Severity of depression was assessed with the Calgary Depression Scale for Schizophrenia [CDSS] in patients with schizophrenia or schizoaffective disorder (Addington et al., 1993).

2.6. Statistical analyses

Statistical analyses were performed using IBM SPSS (Statistical Package for Social Sciences), version 18 software (IBM Co., Somers, NY). All tests employed two-tailed alpha to reject the null of 0.05. Wilcoxon signed ranks test was applied to compare number of medical diagnoses reported vs. number of verified medical diagnoses in each subject (measure of underreporting). Kruskal–Wallis test was used to compare accuracy of self report between groups (schizophrenia/AD vs. schizoaffective/AD vs. AD vs. control patients). Mann–Whitney *U*-test was used to compare underreporting in each group. Pairwise association (Spearman's rho coefficient) was performed using the data of 142 subjects to assess the association between accuracy of self report and the following measures:

- (1) demographic variables: age, gender, years of education, and employment status
- (2) alcohol and other substance use variables: number of drinking days/month, number of standard drinks/week, number of cigarettes/week, cocaine use (number of days/moth), and cannabis use (number of days/moth)
- (3) variables describing severity of psychiatric symptoms: PANSS positive, negative, and general scores, the PANSS composite index (positive minus negative scale score) and Calgary Depression Scale for Schizophrenia
- (4) number of total verified medical diagnoses.

3. Results

Demographic data, number of verified and reported medical diagnoses, psychiatric symptom severity and alcohol and substance use are summarized in Table 1. The majority of patients with schizophrenia, schizoaffective disorder, and alcohol dependence were middle-aged, male, Caucasian, single, unemployed and supported on welfare or disability payments. Control patients included a higher proportion of women, were more likely to be employed and smoked less. PANSS positive and negative scores were moderately low in the schizophrenia/schizoaffective disorder patients as compared to the inpatient standard used as a normative group in PANSS manual (Kay et al., 2006). Patients with alcohol dependence drank significantly more than controls and patients with schizophrenia/AD. Schizoaffective patients drank significantly more than patients with schizophrenia. There was no significant difference in drinking severity between schizoaffective/AD vs. AD patients.

Patients with schizoaffective disorder and AD had significantly more verified medical problems (on average, 3.3) compared to controls, patients with schizophrenia/AD, and patients with alcohol dependence only (Table 1).

Subjects with alcohol dependence, schizophrenia/AD or schizoaffective disorder/AD underreported their medical problems. The

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