Assessment Of The Incidence Of Psycho-Emotional Disorders In The General Somatic Hospital

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ABSTRACT

The article provides data from real studies on the prevalence of psycho-emotional disorders in the general somatic network. The analysis showed that the incidence of psycho-emotional disorders is very high among patients with somatic diseases. Namely, anxiety disorders are characteristic of patients with a gastroenterological profile, depressive disorders are characteristic of neurological; for cardiological patients - depression and anxiety, respectively.

KEYWORDS

Psychosomatic disorders, anxiety, depression, general somatic pathology, psychometric tests.

INTRODUCTION

According to the data of Russian and foreign epidemiological studies of recent decades, a significant proportion of patients with mental disorders are detected outside the psychiatric network [1], most of them accumulate in general medical institutions [2]. At the same time, a small number of patients with associated disorders seek help from the institutions of the psychiatric network [3]. This contingent is not considered by the statistical services in official reports as in need of psychological assistance, which distorts clinical and epidemiological trends. Psychosomatic disorders multiply the severity of the course of somatic illness, increase the threat to life, increase the burden of the disease [4], while the relationship between mental and somatic disorders remains the least developed in psychiatry, neuropsychology and psychology [5].

Among the psychopathological syndromes identified in the general medical network as high-frequency, depressive, anxious, somatoform are identified - up to 20-30% of

the total number of mental disorders [6]. According to the trends established until 2020, their further growth is predicted. At the same time, there is insufficient information about the prevalence of these disorders in different profiles of somatic pathology [7]. Especially our region.

As is known, no research in the field of psychosomatics has previously been conducted in Uzbekistan, therefore, the frequency of occurrence of psychosomatic disorders in hospitals of the republic has not been established. This, in turn, is extremely important for establishing the influence of psychosomatic disorders on the course of the underlying disease, patient adherence to treatment, from which the impact on the patient's quality of life as a whole follows. The high prevalence and typological diversity of psychosomatic relationships revealed in these studies determine the need for modernization of treatment and diagnostic approaches, traditionally focused on the study of a narrow range of disorders in the general somatic network.

Our goal is to identify the incidence and ratio of psychosomatic disorders among patients with a general somatic profile.

Materials and methods: we examined 272 patients at the general somatic hospital, which were divided into three groups depending on the profile of the somatic disease: the first group - 92 patients from the craniological department; the second group - 90 patients from the department of gastroenterology; the third group - 90 patients from the neurological department. All patients were correlated depending on age, which averaged 55.4 ± 7.7, and gender (145 women and 127 men), as well as the duration of somatic illness (more than 3 years), while the presence of complaints of anxiety, irritability, sleep disturbance and emotional instability.

To verify the diagnoses, general clinical, neurological, instrumental and laboratory research methods were carried out. Patients of the cardiology department underwent a general blood test and a general urine analysis, electrocardiography, Holter blood pressure monitoring, echocardiography, veloergometry; for patients of the gastroenterological department - a general blood test, a general urine analysis, a general analysis of feces, an ultrasound examination of the abdominal organs, an analysis for pancreatic enzymes, an analysis for cholesterol and bile acids; patients of the neurology department - general blood test, general urine analysis, magnetic resonance imaging of the brain, duplex of cerebral vessels, echoencephalography. Diagnoses among all patients were ranked as follows (Table 1).

Table # 1.
Sample of diagnoses in each group

№	Diagnoses	Number of patients	%
First group (n=92)			
1.	Essential hypertension stage 2 AHII. CHF IIB	40	43,5%
2.	Ischemic heart disease, stable exertional angina FC3. PEAKS (2005-2009). CHF IIB	30	32,6%
3.	Ischemic heart disease, arrhythmic form, ventricular extrasystole II class according to Lown. CHF IIA.	22	23,9%
Second group (n=90)			
1.	Peptic ulcer and duodenal ulcer in the stage of scarring	39	43,4%
2.	Irritable bowel syndrome	30	33,4%
3.	Chronic erosive gastritis in remission	21	23,2%
Third group (n=90)			
1.	Consequence of acute cerebrovascular accident	37	41,2%
2.	CVD is a widespread atherosclerosis of the brain. NK II.	33	36,6%
3.	Dyscirculatory encephalopathy stage 2	20	22,2%

* - the difference from the initial indicator is reliable, $\rho \leq 0.05$

All patients received the necessary basic therapy in accordance with the existing somatic disease and standards of therapy.

To assess psycho-emotional disorders, the subjective data of patients (complaints) were analyzed with the following psychometric tests: the subjective HADS test (hospital scale for depression and anxiety), which is filled in by the patient, as well as the Hamilton objective test for determining anxiety and depression, which is completed by a specialist in compliance with their observations.

Research results.

In the course of our research, according to the HADS questionnaire, the severity of anxiety-depressive disorder in three groups showed the following results (Table 2).

Table 2.

Comparison of data on the HADS scale among those studied.

Criteria:	1st group (n=92)	2nd group (n=90)	3rd group (n=90)
Clinically significant ADD	48 (52%) (17±1,5) *	35 (38,9%) (16±0,5) *	32 (35,5%) (14±0,8) *
Subclinical course of ADD	23 (25%) (10±1,52) *	39 (43,4%) (10±1,8) *	24 (26,7%) (10±1,3) *
Clinically significant depression without anxiety	10 (11%) (10,2±1,73)*	7 (7,8%) (12±1,67) *	26 (28,8%) (11,2±2,3) *
Absence of significant symptoms	11 (12%) (5±1,2) *	9 (9,9%) (6±0,5) *	8 (9%) (5±0,9) *

* - the difference from the initial indicator is reliable, $\rho \leq 0.05$

In patients of the cardiological spectrum, in high numbers, there is a clinically pronounced TDR (52%), with a high level of intensity of the disorder (mean score 17 ± 1.5). However, in patients of the neurological spectrum, clinically expressed TDR was also noted in high numbers, but with a lower intensity of psycho-emotional disorder (mean score 14 ± 0.8), while this category of patients, relative to other groups, the level of clinically expressed depression without anxiety was noted in most cases (28.8%). Patients with a gastroenterological profile were characterized by subclinical TDR (43.4%), with a high intensity of the disorder (mean score 10 ± 1.8).

Based on this analysis, we can pretend to conclude that patients with the cardiological spectrum are more characterized by a clinically expressed TDR, patients with a gastroenterological profile are characterized by subclinical TDR, while patients with a neurological profile note in high numbers depressive disorder without anxiety.

For a more reliable analysis of the level of TDR in all three groups, we also evaluated the Hamilton test for detecting anxiety and depression (Table 3).

Table #3

Comparison of the results of the Hamilton test among those studied

	1st group (n=92)	2nd group (n=90)	3d group (n=90)
Severe ADD	37 (40,2%) (35±2,5) *	19 (21%) (31±1,8) *	33 (36,6%) (33±1,8) *
Moderate degree of ADD	30 (38%) (26±1,5) *	37 (41%) (24±1,7) *	25 (27,7%) (22±1,8) *
Easy degree of ADD	15 (16,3%) (17±1,3) *	27 (30%) (16±2,5) *	24 (26,7%) (16±1,9) *
No signs of ADD	10 (5,5%) (6±0,5) *	7 (8%) (5±0,5) *	8 (9%) (5±0,8) *

* - the difference from the initial indicator is reliable, $\rho \leq 0.05$

As can be seen from the table, a severe degree of TAD is noted to a greater extent in patients with a cardiac profile (40.2%); moderate degree of TDR corresponds to patients with gastroenterological profile (41%). Patients with a neurological profile also have a high degree of TDR (36.6%), more due to the severity of depression (1: 2.3).

When correlating the results of HADS and Hamilton's test, we can conclude that subjective data correspond to objective data.

TDR is more pronounced among patients with cardiological profile, and the percentage of depression is higher in patients with the neurological spectrum. Patients of the gastroenterological department correspond to the mean values of TDR and depression among all studied. Nevertheless, the frequency of occurrence of psycho-emotional disorders is relatively high, namely, a higher level of subjective data, based on the average points scored by patients.

The data obtained indicate that psycho-emotional disorders have a high prevalence in hospitals of the general somatic network. This, in turn, adversely affects the patient's quality of life and prevents the effective treatment of somatic pathology, by reducing the patient's compliance and mutually burdening pathophysiological mechanisms between the patient's psycho-emotional state and his underlying disease. And also a comparison of the data on the prevalence of psycho-emotional disorders in various somatic pathologies speaks of selective affinity at the level of statistically significant indicators. The high prevalence and typological diversity of psycho-emotional relationships revealed in these studies determine the need to modernize treatment and diagnostic approaches, traditionally focused on studying a narrow range of disorders in the general somatic network.

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