Everything you need to know about Psychiatry and GI in 20 minutes…. Or less

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Disclosures

- **Faculty:** Melanie Marsh-Joyal
- **Relationships with commercial interests:**
  - **None**

Learning Objectives

- 1. To gain an appreciation for the psychiatric comorbidities of gastrointestinal disease
- 2. To develop skills in accurately assessing and diagnosing common psychiatric illness' in persons with gastrointestinal disease
- 3. To become aware of the different treatment options available from a biopsychosocial perspective
- 4. To become aware of community psychiatric resources available

Managing the Mind & the Gut

- Four Essential Rules:

1. Our mind and our gut are intimately connected
   - Just think about that for a minute
2. Our patient is more than just an illness:
   - Context is EVERYTHING
3. When in doubt-
   - SCREEN IT OUT
4. Not everyone requires medications
   - But some do

Rule #1: Our mind and our gut are intimately connected

- IBD Facts:
  - Any Anxiety Dx (moderate to severe)
    - 1 yr prev- 12%
    - 1 yr prev in persons with IBD= **17.9%***
  - MDD (moderate- severe)
    - 1 yr prev= 4.8%
    - 1 yr prev in persons with IBD= **27%***

*Walker, J et al. The Manitoba IBD Cohort Study: A population based study of the prevalence of lifetime and 12 month anxiety and mood disorders. Am J Gastroenterol 2008; 103; 1989-1997

Rule #1: Our mind and our gut are intimately connected

- Chronic Liver Disease Facts:
  - 20% of the CLD population will complain of FATIGUE
  - Mortality in those with transplant-stage CLD + MDD than in those with transplant-stage CLD alone
  - Severity of liver disease α severity of psychiatric symptom
  - Patients wait list for liver transplant show ↑symptoms of depression and anxiety
  - Course of illness & response to treatment are impacted when depression, ETOH abuse, & anxiety are present
  - Quality of life ↑ & psychiatric symptoms ↓ with treatment & enhanced coping skills

Rule #1: Our mind and our gut are intimately connected

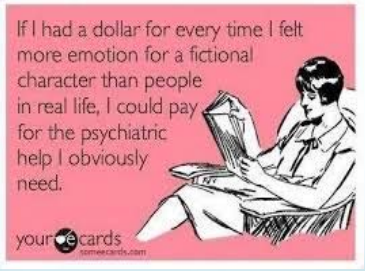
- European Consensus Statement on HCV (2012):
  - 6.7-8.5% prevalence in persons with psychiatric illness
  - IV drug use – 61% of infections
- Psychiatric co-morbidity in IBS (Folks, 2004)
  - 20-60% will have psychiatric symptoms
  - Most common dx include Anxiety Dx (GAD, PD); Depressive Dx (MDD, Dysthymia); Somatic Symptom Dx
  - Psychiatric intervention → ↓IBS sx & ↑ Function

Rule #1: Our mind and our gut are intimately connected

- Patients with chronic GI illness, and let's face it, acute GI symptoms:
  - ↑incidence of-
    - Depressive sx
    - Anxiety sx
    - Fatigue
    - Cognitive impairment
    - Problem etoh use
    - Problem illicit substance use (primarily with HCV)
    - Treatment non-compliance (can be result of or result in)

Rule #1: Our mind and our gut are intimately connected

- ↑ psychiatric sx for many reasons:
  - Preexisting mental illness (ie: major depressive disorder)
  - Treatment related (IFNα induced depression; prednisone induced psychosis, mania, anxiety, depression)
  - Infection and inflammation → changes in CNS (ie: w/HCV virus may replicate in cns; △serotonin & dopamine binding)
  - Acute and chronic illness → psychological distress (stigmatization, worry, ↓ QOL)
    - Consider implications of HCV, Crohn's, UC, PUD, CLD

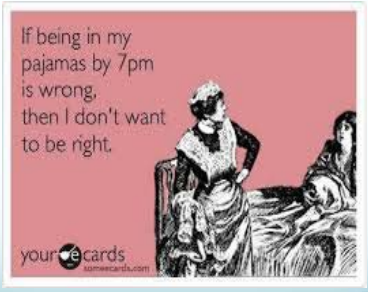


Rule #2: Our patient is more than just an illness

- Nothing beats a complete history and physical
  - past & current ψ history (prev. hospitalizations, prev. suicide attempts, prev. diagnosis, current psychiatrist)
  - past & current substance use history (prev. detox, prev. rehab, types of substances used, method of use)
  - relationship history (current status, stability of relationships, abuse)
  - work history
  - Growth and development; relationship with family (what was life like growing up?); education

Rule #2: Our patient is more than just an illness

- In preparation for a flare or in the midst of the illness:
  - assess coping skills
  - assess current supports
  - provide basic psychoeducation wrt Rx, Dx, Ix
- Optimizing above can:
  - mitigate severity of symptoms
  - mitigate side effects from treatment
  - enhance both the therapeutic relationship and the patient's perceived QOL



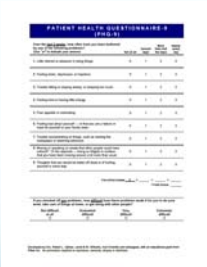
Rule #3: When in Doubt- Screen it out

- Validated screening tools can help in several ways:
  - Identify the presence of a co-morbid illness
  - Guide treatment decisions
  - Monitor progress and response to treatment
- Helpful screening tools are:
  - Easy to administer and quick
  - Sensitive to change
  - Validated

Rule#3: When in Doubt- Screen it out

- PHQ-9
  - Quick screen
  - Self administered
  - Validated w/high specificity & sensitivity
  - Scoring:
    - 5 mild
    - 10 moderate*
    - 15 mod-severe*
    - 20 severe*

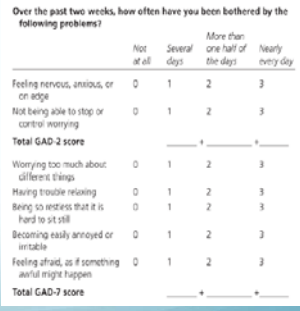
  * recommend referral


PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Rule #3: When in Doubt- Screen it Out

- GAD-7
  - self administered
  - quick and easy
  - Specific for GAD but also can detect unspecified anxiety dx in comorbid illness
  - Scoring:
    - 0-4 Minimal
    - 5-9 Mild
    - 10-14 Moderate
    - 15-21 Severe*

  *recommend referral

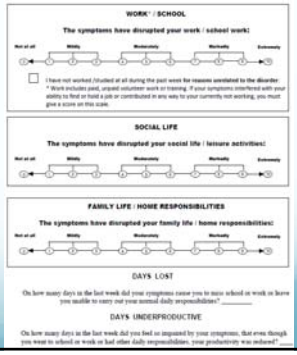


Over the past two weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than one half of the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Total GAD-2 score		____ +	____ +	____
Worrying too much about different things	0	1	2	3
Having trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid, as if something awful might happen	0	1	2	3
Total GAD-7 score		____ +	____ +	____

Rule #3: When in Doubt- Screen it Out

- Sheehan Disability Scale (SDS)
  - Again, easy and quick to admin
  - Self admin
  - Gives clinician snapshot of function
  - Reflects change over time with effective treatment
  - Scores > 5 in any domain = red flag



WORK* / SCHOOL

The symptoms have disrupted your work / school work:

Not at all — Mildly — Moderately — Markedly — Extremely

0 1 2 3 4 5 6 7 8 9 10

☐ I have not worked / studied at all during the past week for reasons unrelated to the disorder.

* Work includes paid, unpaid volunteer work or training. If your symptoms interfered with your ability to find or hold a job or contributed in any way to your currently not working, you must give a score on this scale.

SOCIAL LIFE

The symptoms have disrupted your social life / leisure activities:

Not at all — Mildly — Moderately — Markedly — Extremely

0 1 2 3 4 5 6 7 8 9 10

FAMILY LIFE / HOME RESPONSIBILITIES

The symptoms have disrupted your family life / home responsibilities:

Not at all — Mildly — Moderately — Markedly — Extremely

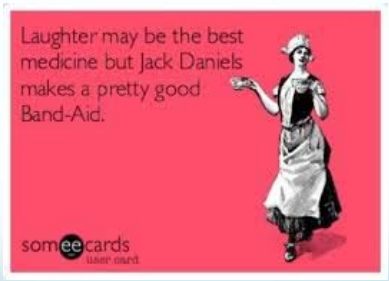
0 1 2 3 4 5 6 7 8 9 10

DAYS LOST

On how many days in the last week did your symptoms cause you to miss school or work or leave you unable to carry out your normal daily responsibilities? _____

DAYS UNDERPRODUCTIVE

On how many days in the last week did you feel or impaired by your symptoms, that even though you went to school or work or had other daily responsibilities, your productivity was reduced? ____



Rule #4: Not everyone needs medication… but some do

Psychotherapy is usually the first step:

- Goal of psychotherapy:
  - Understand impact of illness on life
  - Develop effective coping skills
  - Diminish symptoms
  - Enhance quality of life
- Success of psychotherapy depends on:
  - goodness of fit btwn patient and clinician
  - willingness to be open & explore feelings

Rule #4: Not everyone needs medication… but some do

- Supportive Psychotherapy
  - Easily administered in the office, no referral required- you already do this in your practice!
  - Essential in helping patients who are struggling
    - Provision of empathy, validation of feelings, reassurance
    - Provision of a safe space for patient to express feelings of hopelessness, helplessness over illness
    - Provision of education by answering questions about symptoms, explaining procedures and investigation results, explaining MEDICATION SIDE EFFECTS
    - Supporting patient in problem solving and identifying inner strengths

Rule #4: Not everyone needs medication… but some do

- Cognitive Behavioral Therapy:
  - Evidence based treatment for mild to moderate major depressive disorder, GAD, SAD, OCD, PD and Agoraphobia
  - Time limited, 12-20 sessions
  - Access via AHS resources or via Private Psychologists
- 2014 RCT in Children with IBD*
  - Grp 1- CBT
  - Grp 2- Weekly Support
  - Grp 1 showed overall reduction in IBD sx and on Depression rating scale after 3mos compared to Grp2

*Szigethy, E. Randomized efficacy trial of two psychotherapies for depression in youth with inflammatory bowel disease. J Acad Child & Adolescent Psychiatry 2014; 53(7): 726-735

Rule #4: Not everyone needs medication… but some do

- First- the SSRI & GI Bleed Issue:
  - Suggested pathophysiology:
    - Serotonin required in clotting cascade
    - Released by platelets
    - When blocked by SSRI, clotting ability of platelets impacted
  - Few case studies and one study in 2014*-
    - Development of uncomplicated PUD was associated with SSRI use, finding not robust
    - NO evidence to suggest SSRI's should not be used in persons with GI illness

*Gonzalez-Perez, A. Risk factors associated with uncomplicated peptic ulcer and changes in medication use after diagnosis. 2014

Rule #4: Not everyone needs medication… but some do

- Clinical Bottom line:
  - Use with caution in those with hx PUD & hx upper GI bleed
  - Educate re: ↓ other risk factors (smoking, NSAID use..)
  - Multiple other studies have demonstrated SSRI's as beneficial in mgmt Functional Dyspepsia, IBS, Interferon induced depression

Rule #4: Not everyone needs medication… but some do

- Treatment of MDD and Anxiety Disorders in persons with comorbid GI illness follow same rules:
  - Arm pt with info prior to initiating-
    - ALL SSRI's & SNRI's will ↑ anxiety sx and SI in first 2 weeks of treatment
    - ALL SSRI & SNRI will have GI side effects- make sure your pt knows this!
    - Provide with crisis # in case sx unbearable
    - Allow 6-8 weeks for meds to take full effect
  - Zoloft & Citalopram have the least drug-drug interactions
  - Zoloft is most likely to cause GI distress

Rule #4: Not everyone needs medication… but some do

- In addition to managing a full blown disorder, do not forget about:
  - Sleep disturbance (independent of other neuropsychiatric△)-
    - Rx with hypnotics like imovane, zoplidem (ambien), trazodone, temazepam
    - New HC warning re: imovane
      - Recommend start dose of 3.75mg
  - Fatigue- can be Rx safely with stimulants such as dexedrine & modafanil

Rule #4: Not everyone needs medication… but some do

- Little Clinical Pearls:
  - If absorption an issue-
    - Remeron Rapid Dissolve
  - On immunosuppressive Rx?
    - Paxil and Prozac can have adverse interactions, AVOID
  - Remember LOT when considering benzo's in those with CLD
  - Evidence is limited wrt treating ETOH induced depressive illness- medication is unlikely to help
  - Max Celexa is 20mg in those >60 and those with hepatic impairment
  - Start low and go slow ESPECIALLY in those with anxiety!

Ultimately…

- Identifying & treating neuropsychiatric symptoms:
  - Enhance therapeutic relationship
  - Enhance quality of life
  - Improve compliance with treatment

The End

Extra Bonus Slides: Bibliotherapy

- For patients who are more psychologically minded and motivated:
  - Mind Over Mood: Change How You Feel by Changing the way you Think (Greenberger & Padesky)
  - Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness (Kabat-Zinn)
  - Anxiety and Phobia Workbook (Bourne)

Extra Bonus Slides: Essential Websites

- Mood Gym- https://**moodgym.anu.edu.au/**
- Anxiety BC- www.**anxietybc.com**
- Support network 211- www.**211edmonton.com/resources.html**

Resources

For Urgent Situations:

- Adult Mental Health Crisis Response Team

  780-342-7777 (ANYONE can call)

- Call the 'on-call' Psychiatrist at any of the 4 Tertiary Hospitals in Edmonton- we are here to help and advise if questions arise….
  - RAH 780-735-4111
  - UAH 780-407-8822
  - MCH 780-735-2000
  - GNCH 780-735-7000

Resources

To Access Psychiatry in Edmonton (Hospital Based):

- Royal Alexandra Outpatient Psychiatry 780-735-4181
  - Requires physician referral
- University of Alberta PTC 780-407-6501
  - Patients can self refer
- Grey Nuns Community Hospital 780-735-7292
  - Phone for information
- Misericordia Community Hospital 780-735-2000
  - Phone for information

Resources

To Access Psychiatry in the Edmonton (Community Based):

- Northgate Clinic 780-342-2700
- East Edmonton Health Center 780-342-4908
- Northeast Community Health Center 780-342-4027
- Edmonton Mental Health Clinic 780-342-7700

**Patients can self refer to all of the above clinics!

Of course, patients affiliated with a Primary Care Network may have access to a Psychiatrist through a referral from their family doctor

Resources

To Access Psychiatry around Edmonton:

- St Albert Mental Health 780-342-1410
- Leduc Mental Health 780-986-2660
- Fort Saskatchewan Mental Health 780-342-2388

** Patients can self refer to all of the above clinics!