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Comparative Approach to the Administration of Patients with Alcohol Dependence in Generalized Schizophrenia and Schizoaffective Disorder

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Abstract: Goal of this study of the relationship between alcohol use, severity of psychiatric symptoms and the number of verified medical diagnoses. The study was that self-reporting of medical history is less accurate in patients with comorbid alcohol dependence and schizophrenia compared with patients with alcohol dependence only or with control. 46 patients with schizophrenia or schizoaffective disorder and concomitant alcohol dependence recruited from the Bukhara Regional Psych neurological Dispensary. 27 patients suffered from schizophrenia, and 19 patients from schizoaffective disorder.

Keywords: Alcohol addiction, medical problems, schizophrenia, schizoaffective psychosis.

Introduction

Excessive alcohol consumption affects many body systems, including the nervous, gastrointestinal, hematopoietic, cardiovascular, and endocrine systems. Schizophrenia and alcohol use disorders are independent major risk factors for various medical problems. Patients with schizophrenia and associated foam have a higher morbidity than patients with schizophrenia alone [1,2]. Most often, schizophrenia precedes alcoholism, although another sequence in the development of these two diseases is possible [2]. Medical conditions can go unrecognized and poorly understood, placing this group of patients at higher risk.

These patients may neglect general health care [1,4] because of barriers between mental health and general health services, stigma, cognitive problems associated with both substance use and schizophrenia, and adherence problems [2,4]. A study of medical problems with schizophrenia or schizoaffective disorder and concomitant alcohol dependence was carried out in 46 patients.

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Research Methods

46 patients with schizophrenia or schizoaffective disorder and concomitant alcohol dependence recruited from the Bukhara Regional Psych neurological Dispensary. 27 patients suffered from schizophrenia, and 19 patients from schizoaffective disorder.

All patients underwent a detailed structured history, physical examination and review of all available medical records. Self-proclaimed medical problems were documented and compared with problems obtained from medical records (outpatient records, hospital discharge summaries, and emergency department visit records). Baseline demographic data included age, gender, race, educational attainment, and employment status. Alcohol and substance use as well as diagnoses were assessed using a structured clinical interview for DSM-IV [SCID]. Symptoms of schizophrenia were assessed

on the Positive and Negative Syndrome Scale [PANSS]. The diagnosis of schizophrenia versus schizoaffective disorder was assessed using SCID. The severity of depression was assessed using the Calgary Depression Scale for Schizophrenia [CDSS] in patients with schizophrenia or schizoaffective disorder. Spearman's RO coefficient was carried out using data from 46 subjects to assess the relationship between self-report accuracy and the following indicators:

1. Demographic variables: age, gender, years of schooling and employment status
2. Alcohol and other substance use variables: number of days drunk, month, number of standard drinks per week, number of cigarettes, week
3. Variables describing the severity of psychiatric symptoms: positive, negative and overall PANSS scores, PANSS composite score [positive minus negative scale score] Calgary Depression Scale for Schizophrenia
4. The total number of verified medical diagnoses

Research Results and Discussion

Demographic data, the number of verified and registered medical diagnoses, the severity of psychiatric symptoms, alcohol and psychoactive substance use are summarized in Table 1. The majority of patients with schizophrenia, schizoaffective disorder and alcohol dependence were middle-aged, male, and disabled. Control patients included a lower proportion of women.

Table 1. Socio-demographic and clinical characteristics

	Control N=8	Alcohol dependence N=47	Schizophrenia N=27	Schizoaffective N=19	Kruskal-Wallis ANOVA
Age [years]	33±13	40±13	42±7	31±7	NS
Gender	3/5	2/8	25/2	12/6	0.011
Marital status	7/0/0/1	12/16/12/6	10/9/3/5	8/5/3/3	NS
Employment [Yes /	2/6	5/41	2/25	7/12	<0.001
No, not	0.1±0.2	2±23*	17±10*	8±11*	<0.001
No, not	0±0	0±7*	7±3*	7±6*	<0.001
calgary Depression	N/A	N / A	3.3±3.4	6.9±3.2	<0.001
Positive PANSS	N/A	N/A	12.1±4.4	15.0±6.1	NS
Negative rating of	N/A	N/A	14.9±4.9	10.7±2.7	0.002
Overall rating	N/A	N/A	21.5±4.0	12.9±6.6	NS
PANSS composite	N/A	N/A	-1.2±7.6	3.9±5.6	0.001

Patients with alcohol dependence drank significantly more than controlpatients and patients with schizophrenia. Schizoaffective patients drank significantly morethan patients with schizophrenia. There was no significant difference in the severity of alcohol use between schizoaffective and schizophrenic patients. Patients with schizoaffective disorder and schizophrenia had significantly more verified medical problems [an average of 2.7] compared to controls, patients with schizophrenia, and patients with alcohol dependence only . Subjects with alcoholdependence, schizophrenia, or schizoaffective disorder недооценииunderestimated their medical problems. The number of self-reported medical problems was significantly lower than the actual verified numberof diagnoses in subjects with schizophrenia [тест Wilcoxon test P=0.001], schizoaffective disorder/BA [Wilcoxon test POn the contrary, control subjects accurately reported almost all of them [89% about their medical problems. The results of associative analysis are summarized in table 2.Correlation analysis between underreporting of medical diagnoses and demographics, alcoholism severity, and psychiatric severity.

	Control	Alcohol dependence [AD]	Schizophrenia	Schizoaffective
N	8	46	27	19
Age [Years]	0.210 [NS]	0.202 [NS]	0.070 [NS]	0.101 [NS]
Gender [Male/Female]	0.327 [NS]	0.086 [NS]	-0.247 [NS]	0.248 [NS]
Education [years]	0.263 [NS]	0.098 [NS]	0.168 [NS]	0.075 [NS]
Employment [Yes / no]	0.189 [NS]	-0.121 [NS]	-0.072 [NS]	-0.064 [NS]
Number of verified medical diagnoses	0.348 [NS]	0.448 [0.003]	0.609 [<0.001]	0.655 [<0.001]
Number of days / month consumed	N / A	0.032 [NS]	-0.039 [NS]	0,131 [NS]
Number of standard drinks per week	N/A	-0.176 [NS]	-0.020 [NS]	0.172 [NS]
Positive PANSS rating	N/A	N/A	-0.028 [NS]	-0.063 [NS]
Negative rating PANSS	N/A	N/A	-0.058 [NS]	-0.081 [NS]
Overall rating PANSS	N/A	N/A	-0.174 [NS]	0.002 [NS]
PANSS composite index	N/A	N/A	0.012 [NS]	-0.039 [NS]

The most commonly underreported medical diagnosis of AMI in patients with schizophrenia and schizoaffective disorder would be whether the coronary heart disease [2 from 1, 100% not reported], chronic renal failure [2 of 2 100% not reported], gastroesofageoLina reflux disease [4 11, 29% ne was reported], hyperlipidemia [3of 8, 22% were not reported], asthma [2 17, 14%not reported] and hypertension [4 35, 12% not reported]

Discussion

The aim of this study was to study the problems in patients with schizophrenia or schizoaffective disorder and concomitant alcohol dependence compared to patients with only alcohol dependence and control. In contrast to the previously reported high accuracy of self-reporting of drug and alcohol use in research settings, self-reporting of medical problems had limited accuracy only in patients with alcohol dependence and was significantly less accurate in patients with concomitant schizophrenia and schizoaffective disorder. While patients with concomitant schizophrenic spectrum disorders were more inaccurate in reporting medical problems, the accuracy of self-reporting did not significantly correlate with rates of alcohol use and severity of psychosis, but negatively correlated with the number of medical diagnoses. The absence of a significant correlation between the accuracy of self-reporting and the selected indicators of severity of psychosis and substance use in this small cohort does not exclude the potential impact of severity of psychosis and substance use on accuracy. The results of this study are that medical problems and disorders associated with substance use have been carefully assessed using various methods: physical examination, laboratory tests, self-reporting, diagnostic interviews, and a comprehensive review of medical records. Doctors are often unaware of the many chronic diseases that are present in patients with schizophrenic spectrum disorders and alcohol dependence.

Conclusions

Our results show that a combination of these disorders is associated with less accurate reporting of medical problems than controls and even alcohol-dependent patients alone. In the treatment of

patients with schizophrenic spectrum disorders and concomitant alcohol dependence, we recommend a physical examination and careful analysis of existing medical records in the CEC. Using targeted screening forms that include questions about common medical conditions found in this patients area can help improve the health care of these vulnerable patients.

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