Neurology

Psychiatric disorders in neurology patients

John Moriarty

Psychiatric disorders

A high incidence of psychiatric disorders is found in patients attending neurologists. Among new outpatients, the prevalence of all disorders has been estimated at >50%.¹ Mood and anxiety disorders are present in 40% of patients, are associated with greater disability and are persistent.² Functional neurological symptoms or somatoform disorders may be present to some degree in up to one third of patients and these are the patients neurologists find more difficult to help.³ In the paper by Jeffries *et al*⁴ (see p 414), similarly high rates of psychiatric disorder are shown to occur among inpatients, with just over half of all patients having some form of disorder.

Often, these disorders are not formally recognised by neurologists and a minority of patients are referred for psychiatric intervention.⁵ Jeffries *et al* suggest a batch of relatively easy-to-administer questionnaires as a screening instrument with good sensitivity for the detection of psychiatric disorders.

Neurologists may find it implausible that they could be failing to diagnose psychiatric disorders in such a high proportion of their cases. Clinicians may be reluctant to give half of their patients an additional diagnosis when the implications for treatment are unclear to them. Patients may feel stigmatised. Caseness in psychiatry means exceeding a certain

threshold of symptomatology rather than implying any disease process, and some patients experience distress and fear of illness, which could be unhelpful to pathologise as disorder. The real challenge is to identify patients who have symptoms amenable to treatment and whose outcome is improved by psychiatric or psychological intervention. Psychosocial intervention such as explanation, education or problem solving may be what is required in many cases, whereas more definitive psychiatric or psychotherapeutic treatment may be needed in others.

At present, there are likely to be more than clinical factors at play in determining who is diagnosed and who is referred to psychiatry. Psychiatric disorder in neurology patients may be seen as beyond the expertise or remit of overburdened mental health services, with their focus on severe and enduring mental illness. Consultation-liaison services or specialist neuropsychiatry liaison services, if they exist, may be patchy and under-resourced. What services are available may differ from place to place as to whether they think it appropriate to take on the management of the whole range of psychiatric disorders, including dementia, mood disorder, psychosis, substance misuse as well as conversion or dissociative disorders.

There are implications from the increasing recognition of the prevalence and burden of psychiatric and psychological disorders among patients with neurological disease for training, service provision and research. Training of both neurologists and psychiatrists will need to include knowledge and skills in the recognition and treatment of common disorders. Service providers will need to look towards the provision of at least good enough psychological and psychiatric treatment services for this group of patients. Clinicians must aim to identify those patients or patient groups most likely to benefit from interventions and develop strategies for their cost-effective delivery. The gap between this aspiration and the current service is considerable.

J Neurol Neurosurg Psychiatry 2007;**78**:331.
doi: 10.1136/jnnp.2006.109058

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Received 23 October 2006

Revised 23 October 2006

Accepted 23 October 2006

Published Online First 10 November 2006

Competing interests: None declared.

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Narcolepsy and RBD

Towards a common pathway for narcolepsy and rapid eye movement sleep behaviour disorder

Rainer Dzierwas

Robust association between narcolepsy and RBD

Following the pioneering work of Schenk and Mahowald,¹ a robust association of idiopathic narcolepsy

and rapid eye movement (REM) sleep behaviour disorder (RBD) has recently been confirmed, suggesting that around

one third of patients with narcolepsy have concomitant RBD.² Although particularly severe cases with frequently occurring cataplexies and other associated symptoms of narcolepsy seem to be affected, the pathophysiological link between narcolepsy and RBD remains to be elucidated.

Contributing to this topic, in this issue, Mathis *et al*³ (see p 427) report on a HLA DR2-negative patient who developed both narcolepsy and RBD due to an isolated inflammatory lesion of the dorsomedial pontine tegmentum. Their finding is very interesting as it suggests a common pathway for narcolepsy and RBD at the level where REM muscle atonia is regulated. Apart from a conclusive neuroanatomical and pathophysiological survey,