EDITORIAL

Mental disease, alcoholism and XDR-TB: loss to follow-up and resistance, the cost of an inadequate approach

Ignacio Monedero, MD, MPH, PhD

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"They were all very happy, except for the ugly duckling, who was sad because the others in the yard laughed at the sight of him. So, one day, the ugly duckling decided to escape the farmyard."

The Ugly Duckling. Hans Christian Andersen.

Alcoholism, mental disease and other social determinants are known risk factors both for tuberculosis (TB) and for negative treatment outcomes.¹ Among others, the emergence of TB resistance is associated with problems in adherence. Even without mental disease or problems with alcohol, remaining adherent to the interminable treatment regimens for multidrug-resistant TB (MDR-TB), with the high number of pills, the injections and the unpleasant side effects, is challenging.²

Alcoholism, mental disease and TB are part of the daily routine in clinical TB management, particularly in big cities, but this remains hidden in academic literature. Clinicians and nurses usually know when things are not well with their patients, but due to the stigma around alcoholism patients and their families usually tend to try to conceal or minimise it. In the case of mental disease, especially in high-burden countries, in addition to the associated stigma, there are few psychiatrists or physicians available to diagnose or treat cases.

As these are not routinely recorded as risk factors, little has been published on mental disease, alcoholism and drug-resistant (DR) TB. However, a lack of written evidence does not mean that the problem does not exist. Despite the small sample size, the study by Scuffell et al. in this issue of *Public Health Action*³ alerts us to the potential magnitude of the problem and its serious implications: untreated mental disease and alcohol abuse can be underreported and unaddressed causes and effects of both MDR- and extensively resistant (XDR) TB. The size of the problem remains unmeasured but can be unexpectedly high in big cities, especially among those with inconsistent adherence presenting lower cure rates or complicated patterns of resistance.

These are not easy patients. The crude reality is that nobody wants them at regular hospitals due to the difficulties they present. There are no guidelines on how to manage TB and alcoholism,⁴ and in many sites the use of common psychiatric medications is highly regu-

lated and/or unavailable. Treating only the TB disease would not suffice to cure these patients, while treating only the mental disease or alcoholism will not cure the TB. Unfortunately, other clinical and social conditions such as hepatitis, human immunodeficiency virus (HIV), other substance abuse, extreme poverty, lack of family and social support and problems with the law exist and align to make adherence more difficult. The usual approach (tertiary hospitals and directly observed treatment), swells the ranks of 'defaulters' and may increase the transmission of resistant forms of TB in the community. It is unlikely that even the current new regimens and drugs will help much to improve adherence in these population groups.

If high rates of substance abuse, mental disease and other comorbidities exist among MDR- and XDR-TB patients in big cities, the current approach should be shifted into a more social, holistic and flexible approach comprising specialised health care workers and halfway houses or new sanatoria where patients have access to food, shelter and plans for social protection and reintegration, linked to clinical care (TB, HIV, alcoholism, psychiatric disorders).

It is naïve to believe that drugs and doctors alone will end TB. All TB patients deserve a patient-centred approach. But in these particularly vulnerable populations it is a neglected must.⁵ Countries, national TB programmes and municipalities need to take on this socio-clinical responsibility together.

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AFFILIATION

TB-HIV Department
International Union Against
Tuberculosis and Lung
Disease
Paris, France

CORRESPONDENCE

Ignacio Monedero
TB-HIV Department
International Union Against
Tuberculosis and Lung
Disease
Paris, France
e-mail: imonedero@
theunion.org

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