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Editorial
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Editorial

Addressing Mental Health in Persons with IBD

Psychiatric diseases may antedate the diagnosis of inflammatory bowel disease (IBD) by years (1, 2) which may suggest a shared pathobiology. Inflammatory bowel disease is a chronic disease that may be associated with a variety of debilitating symptoms, in addition to the stress associated with an uncertain prognosis. Hence, the increased incidence of psychiatric disorders post-IBD diagnosis compared with matched controls is of little surprise (3). In a recent population-based study from Manitoba using administrative health data, it was reported that the incidence-rate ratio of psychiatric comorbidity was significantly increased in IBD compared with matched controls ranging from 1.27 to 1.82, depending on intestinal disease type (Crohn's disease or ulcerative colitis), psychiatric disease type (depression, anxiety disorder, or bipolar disease), sex, age, urban versus rural residence and socioeconomic status (4). Psychiatric diseases pose unique challenges for persons with IBD, especially since there has been so little research exploring the treatment of these conditions in persons with IBD (5). Addressing psychiatric diseases may improve the health of persons with IBD, but a failure to address these problems may have an important negative impact. An increased risk of disease relapse and a poorer response to treatment have been reported in persons with depression (6–9). An increased risk for surgery, lower adherence to medication and poorer quality of life has been reported in persons with anxiety (6, 10, 11). In a multi-institution cohort study, comorbid depression or anxiety was associated with a 28% increased risk of surgery in Crohn's disease, more colonoscopies and an increased likelihood of using immunomodulators (12).

In this issue of JCAG, a systematic review and meta-analysis of suicide in IBD is reported (13). The analysis was mostly negative. It did not include the only population-based data addressing this issue from Canada (14). In data from 1984 through 2010, there was an increased mortality rate in Crohn's disease, however there was no increased risk of death from suicide compared with controls. However, neither the systematic review nor the Canadian mortality analyses accounted for diagnosed psychiatric comorbidity. In a population-based study from 1984 through 2013 from Manitoba, psychiatric diseases in persons with IBD, multiple sclerosis and rheumatoid arthritis were shown to be associated with an increased mortality risk (15). There was an additive interaction between depression and the chronic immune diseases on mortality risk, such that the effects of depression on mortality risk were greater than the effects of either the chronic immune disease or depression alone. The risk of suicide and suicide attempts was elevated in the three chronic immune diseases collectively, although psychiatric diseases accounted for much of this elevated risk. Hence, psychiatric comorbidity is associated with the most drastic adverse outcome—death.

HOW SHOULD CLINICIANS ADDRESS PSYCHIATRIC COMORBIDITY IN IBD?

A "don't ask, don't tell" approach will spare clinicians from potentially longer clinical interactions with patients or the risk of discerning information they feel they cannot adequately manage. Unfortunately, not inquiring about psychiatric comorbidity is insufficient care. Clinicians can simply ask if depression or anxiety is present or, alternatively, can incorporate brief self-report surveys into office practice. These surveys can provide a numerical score that can be followed over time. A recent study compared several depression and anxiety self-report surveys with a gold standard Structured Clinical Interview for DSM-IV-TR Axis I Disorders (SCID) and found that most performed well (16). Hence, a clinician can incorporate such scales into routine practice. It is important for clinicians to discern if a patient has a psychiatric disease or at least is enduring considerable stress because either may have an impact on physical symptoms. Clinicians must also consider when their interventions may impact mental health. The one drug known to adversely impact mental health is corticosteroid. In another article in this issue of JCAG, authors reported mood changes in approximately half of corticosteroid users (17). Mania or hypomania was the predominant symptom reported. It would have been interesting to have tracked quality of life in this study because the presence of hypomania (or as some refer to it, euphoria) may not be an unpleasant side effect. Few patients enrolled had underlying depression (n=4) or anxiety (n=1), and corticosteroid use in populations with higher rates of underlying psychiatric comorbidity may lead to even higher rates of adverse mental health outcomes. Many corticosteroid users experience

an exacerbation of depression, irritability or sleeplessness, all of which may be very unpleasant.

In summary, psychiatric comorbidity is problematic in persons with IBD because it leads to adverse outcomes and even increases the risk for death. Hence, like other extra-intestinal disorders, it needs to be addressed. Short of primary sclerosing cholangitis, few other extra-intestinal disorders have been associated with death in persons with IBD. Clinicians need to make addressing psychiatric comorbidity in persons with IBD a priority.

Conflicts of Interest

Charles Bernstein has served on advisory boards for Abbvie Canada, Ferring Canada, Janssen Canada, Shire Canada, Takeda Canada, Pfizer Canada and Napo Pharmaceuticals. He has consulted to 4D Pharma and Mylan Pharmaceuticals. He has received educational grants from Abbvie Canada, Shire Canada, Takeda Canada, Janssen Canada. He has been on speaker's panel for Ferring Canada and Shire Canada and has received research funding from Abbvie Canada.

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