Cardiometabolic Conditions in Patients with Schizophrenia

To the Editor:

I read the recent Jerrell et al. article on cardiometabolic conditions in patients with schizophrenia with great interest (1). Jerrell et al. found that cardiometabolic conditions were common. There are some points for discussion. First, it is still not possible to exclude the possibility that the detected cardiometabolic conditions in this retrospective study are a direct effect of antipsychotic medications or the co-medical findings. In general, those cardiometabolic conditions can be found with considerably high prevalence among the general population. Another interesting observation by Jerrell et al. is "a widening gap in access to needed services for conditions that are known mortality risk factors." Indeed, the treatment of the cardiometabolic conditions might have been handled by other medical personnel, not the psychiatrists, and the medical records might not be complete in this review. However, I agree that the concern for the co-presentation of cardiometabolic conditions is important for both psychiatrists and general practitioners. Morden et al. proposed that "primary care physicians' understanding of the problem, involvement in the solutions, and collaboration with psychiatrists" is the tool for success in healthcare for any patients with serious mental problems.

References

1. Jerrell JM, McIntyre RS, Tripathi A. Incidence and costs of cardiometabolic conditions in patients with schizophrenia treated with antipsychotic medications. Clin Schizophr Relat Psychoses 2010;4(3):161-168.

2. Morden NE, Mistler LA, Weeks WB, Bartels SJ. Health care for patients with serious mental illness: family medicine's role. J Am Board Fam Med 2009;22(2):187-195

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Dr. Jerrell and Colleagues Reply

To the Editor:

The authors would like to thank Dr. Wiwanitkit for his comments. Although we tried to "control for" pre-existing cardiometabolic conditions in this analysis, we cannot determine whether the incident conditions developed as comorbid conditions or as the direct result of an antipsychotic medication. Therefore, the associations reported cannot be used to infer causality, as noted in the Limitations section of the Discussion. The Medicaid data set used in this analysis contains *all* of the service visits (medical and psychiatric) and pharmacy claims for each patient, so the research records are complete. As noted in the Discussion, many patients were receiving less medical care over time from primary care physicians (PCPs), while their psychiatric services were essentially unchanged. We agree that the involvement in, and collaboration of, the PCPs in the healthcare of patients with serious mental illness is a critical element of success.

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