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Short Communication Open Access

Mental Disorder or Untreated Pneumonia

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Short Communication

A classic autopsy case scenario that is encountered by pathologists in hospitals with overworked psychiatric wards or hospice care is an elderly patient who was admitted for mental status change reported by relatives or close encounters, given a quick diagnosis of some form of psychosis (paranoid schizophrenia; bipolar disease etc), hospitalized for days or weeks under treatment with neuroleptic drugs with little assessment of his or her physical health (cursory physical exams and few laboratory tests) until it is reported that "the patient mental status had deteriorated significantly and the patient one day was found dead by the attending nurse".

Not every one of such cases ends up with an autopsy but of those who do get an autopsy, the most frequent cause of death (more than 50% in the author's experience) is bronchopneumonia that is often bilateral or severe [1]. Neuropathological examination in most of those cases shows nothing more than hypoxic encephalopathy. Some of these patients are in their late fifties or sixties with a relatively substantial productivity time left if their lives could have been saved and "fixed" with the simple use of an "antibiotic" to treat their respiratory tract infection!

Elderly individuals, because of age or poor nutrition-related, less than optimal functioning of the immune system, are more susceptible to respiratory infections [2, 3]. The latter may start as a simple cold or flu but if not properly cared for with supportive measures (often lacking in the case of the homeless or a resident of low-quality hospice or a patient in a poorly managed psychiatric ward) can quickly progress from a simple viral infection to a superimposed severe bacterial pneumonia. The destruction of lung parenchyma by the inflammatory process (pneumonia) may significantly impact the total lung capacity for air exchange which results in reduction of vital organ oxygenation or tissue hypoxia. Brain hypoxia (hypoxic encephalopathy) almost always manifests itself in transient or permanent mental status change which can easily mimic many psychotic disorders. It takes a good physician (literally!), who obtains a good medical history and performs a discerning physical examination and even runs a few general health-related laboratory tests, to arrive at the more accurate diagnosis of pneumonia that is easily treatable then with an antibiotic [4, 5].

In the current literature, pneumonia is one of the most frequently reported causes of death among mentally ill patients above 65 years of age with or without dementia who are being treated with antipsychotic medications. The mortality rate among such patients is 15-30% or 1.5-2 times higher than in the general age-matched population [6,7]. These statistics are based on documented (pre-mortem) diagnosis and likely to be much higher if the post-mortem discovered cases are added. A large research project is probably needed to look at this overlooked group of patients. Clinicians treating mentally ill patients are strongly advised to closely monitor those patients, particularly at the early phases of antipsychotic therapy and with high doses. If pneumonia-related signs and symptoms are identified, the withdrawal and or dose-adjustment of antipsychotic treatment should be considered.

Unfortunately, it is by far much easier for an overworked health care provider, especially in a public facility with limited resources, to take the "short cut" of conducting a psychiatric evaluation and declaring the case a mental disorder. Such a "working diagnosis" typically means no more physicals, labs tests or antibiotic treatment of a simmering pneumonia from which the only remaining exit is death!

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