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Perspective

Psychiatric Complications (Depression, Anxiety Disorders, Post-traumatic stress Disorder) of ARDS

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ABOUT THE STUDY

ARSDS requires extensive resuscitation and has major physical sequelae. We evaluated the psychiatric sequelae by conducting a systematic review to determine prevalence of symptoms of depression, anxiety disorders and post-traumatic stress disorder (PTSD) following ARDS, as well as their risk factors. It is known that there can be psychiatric consequences following a stay in ICU and it seems likely that ARDS, which requires long and invasive management in ICU, can also be the cause of significant psychiatric comorbidities, of equal or greater frequency, especially as many of the physical sequelae of ARDS can be disabling in the long term.

The link between depression and chronic pathologies has also been demonstrated. Although many studies have evaluated the prevalence of co-morbidities following ARDS, there is to date no recent systematic review of the psychiatric complications (depression, anxiety disorders, post-traumatic stress disorder (PTSD)) of ARDS. However, a better understanding of the psychiatric sequelae of these patients would be valuable for psychiatrists, whether in current practice or in a context where we are regularly affected by new infectious diseases that generate ARDS, such as SARS ten years ago or COVID-19, more recently.

We searched for studies assessing the prevalence of the symptomatology of depression and/or anxiety disorders and/or PTSD following ARDS management. They could be longitudinal studies, prospective cohort studies, retrospective case-control studies. Randomized controlled trials that looked for the influence of a therapeutic parameter or component on depression and/or anxiety disorders and/or PTSD were also included if they looked for the prevalence of depression and/or anxiety disorders and/or PTSD in their population.

The search initially returned 382 studies, 30 studies met the inclusion and exclusion criteria and were therefore read in full. Of these, 23 were selected for the final qualitative analysis. Most studies assess the presence or absence of psychiatric symptoms using psychometric scales, but not a clinical diagnosis by a psychiatrist. Therefore our study referred to the symptoms of a given pathology and not to the pathology itself. Indeed, studies with diagnosis made by psychiatrists are difficult to conduct. We included only studies using validated scales in the diagnosis of depression, anxiety disorders and PTSD.

The population of ARDS survivors therefore appears to be at greater risk than the general population developing depressive disorder. Similarly, the estimated global prevalence of anxiety disorders ranges worldwide ranges from 3.8% to 25%) and the prevalence of PTSD has been estimated at 3.9%. Our results are therefore higher than those for the general population, but are comparable to those found in studies of populations that have been managed in intensive care units.

People with a history of mental illness are at greater risk of developing after ARDS depression, anxiety disorders or PTSD. Certain factors associated with the patient such as female gender, young age (for anxiety disorders), low socio educational level (for depression), unemployment or disability, high BMI (for both depression and anxiety disorders), co-morbidities (for anxiety disorders) or a history of addictions also appear to induce greater risk of developing mental illness.

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