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CASE REPORT

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Long-term stays in hospitals: a case report

Abstract: Inpatients experience frequent psychiatric disorders. Long-term stays in hospitals increase this risk of having a psychiatric disorder and cause negative effects on their ongoing treatments. Several studies emphasized that physicians should be careful for psychiatric disorders affecting the treatment process of inpatients as well as the period of stay in the hospital. This study is a case report. Psychodynamic formulation has been made evaluating the psychiatric disease history and psychodynamic and psychosocial history as well as through psychological tests.

Key Words: Inpatients, general hospitals, long-term stays, psychiatric disorders

Hastanede uzun süreli yatış: bir olgu sunumu

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Özet: Hastanelerde yatarak tedavi gören hastaların ruhsal belirtileri oldukça sıktır. Uzun süreli hastanelerde yatarak tedavi görme ruhsal belirtiler açısından riski attırmakta ve hastaların mevcut tedavilerini olumsuz yönde etkilemektedir. Çok sayıdaki çalışmada hastaların tedavi uyumunu ve hastanelerdeki yatış süresini etkileyen ruhsal belirtiler konusunda hekimlerin dikkatli olması gerektiği vurgulanmıştır. Bu çalışma bir olgu sunumudur. Psikiyatrik hastalık öyküsü, psikodinamik ve psikososyal öyküsü ile psikolojik testleri değerlendirilerek psikodinamik formülasyon yapılmıştır.

Anahtar Sözcükler: Yatan hasta, genel hastaneler, uzun süreli yatış, psikiyatrik bozukluklar

Introduction

Inpatients experience frequent mental disorders. Long-term stays in hospitals increase the risk and cause negative effects on ongoing treatments of inpatients. Several studies emphasized that physicians should be careful for mental disorders affecting the treatment process of inpatients as well as the period of stay in the hospital (1,2).

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Case Report

Miss T is a 22 year-old single lady, who is a graduate of a vocational school. The patient was met in a training hospital while she was having treatment as an inpatient in the surgical clinic where she was referred to psychiatric consultation because "she was unable to define her complaints". The patient was staying in a single-bed room at the General Surgical Clinic for 5 years (except for short-term home discharges) with the diagnosis of Weber-Christian Disease, which is a very rare condition, resulting from the characterization of painful panniculitis at different parts of the body (3). The patient had approximately 100 surgeries during the period of 5 years. Because she was not informed about the treatment process, she refused the psychiatric consultation in the early minutes claiming that the doctors did not trust the authenticity of her pain complaints. She

reported that the doctors think that she took pills for her pains secretly in the clinic, and that she was an addict. On the other hand, the treatment team of the patient reported that she has been staying in the hospital for a long time. She did not have a good communication with them. She did not talk. She did not have a regular sleep. She often cried. She asked for pills claiming that she had frequent pains. Having graduated from a vocational school with a high degree 5 years before, Miss T went to holiday with her family in the summer. Then, Miss T started to have a urine incontinence problem. The first physician they saw at the location they were on holiday diagnosed it as an ordinary urethra infection, and advised her to stay out of the sea. Although she took antibiotics and analgesics for a period of time, her complaints did not decline. In addition to her urinary complaints, Miss T had painful abscesses at her legs, and then the family took her to a University Hospital in the city they lived. They could not find any solutions through serum and urine tests. She was transferred to another University Hospital in another city, and she was diagnosed with Weber-Christian Disease, a very rare condition. Presently, Miss T experiences difficulties in walking and carrying out daily activities due to about 100 operations she had so far, and lastly the left mastectomy she had 2 months ago. During first few months in the hospital in which she stayed for 5 years, the patient's treatment costs were met by her family's social security; however, for some reasons, such as the prolongation of the treatment and her suffering from a rarely observed condition, she was accepted as a teaching case by the university hospital. In addition, certain non-governmental organizations and associations helped with the hospital expenses.

The first psychiatric consultation interview was carried out the patient's room. As she was not informed about the psychiatric consultation, Miss T refused the interview in the early minutes. She asked who sent them there and for what reason. After explaining the purpose of the interview, she presented a temperate attitude. Miss T's hospital room looked like the room of her home with a TV, a small fridge, a bookcase, and some personal belongings. Miss T was sitting on her bed. Her clothing was slipshod but clean. There was an IV drip attached to her arm, and a bandage up to her elbow due to an abscess recently developed on the other arm. She was talking with a low tone, hesitatingly, and unwillingly. She complained that the treatment team has often changed in the last 5 years; the residents completed their residency left, and the newcomers did not know her disease well. Therefore, she was able to explain her complaints only to the Department Chair, who was the only one who, she thought, understood her best, and she felt particularly close to him. The first interview was like a warm-up session.

During the first psychiatric consultation session, the patient was anxious, and somewhat depressive. It looked like her feelings about her sickness and treatment affected her very much. The Hospital Anxiety and Depression Questionnaire, comprised 14 items, was applied to the patient. Amitriptyline treatment (50 mg/g) was applied to the patient with the diagnosis of depressive character adaptation disorder. The dose was gradually increased in order to carry on weekly interviews. Detailed information on the patient and her sickness was obtained from the treatment team. The patient's family and the treatment team were informed about the psychology of the patient. In the successive interviews following the first interview, it was observed that the participation of Miss T increased, her communication with the treatment team got better, her sleeps and appetite became regular, and even she started to make jokes about her sickness. Her mother reported that this was the first time in the previous five years she witnessed that she talked with someone and unburdened her heart. She looked forward to seeing your coming here. Miss T's father was also invited to one of the weekly interviews. However, he did not accept this invitation claiming that he was not ready for this. In one of the weekly interviews in the second month of the consultation, it was seen that she was not at her room because she had high fever and irregular heart beat 1 night before, so she was urgently taken to the intensive care unit. Her physician said that she was taken to the intensive care due to the myocardium related to the internal organs. When she turned back to her room after 20 days, Miss T commented on what

happened with a joke: "they did not accept me to the other world for now!" Presently, the medical and psychiatric treatments of the patient still continue with the current diagnosis. During her short home discharges, Miss T visits some web sites related to her sickness and exchange email with few people with same disease.

Discussion

It is obvious that inpatients cannot be treated successfully by only medical care. Psychological aspects that negatively affect the sickness or treatment should also be carefully examined (1,2). Psychological symptoms that make negative effect on the medical treatment and the period of hospital stays of inpatients would also require psychiatric care and therapy (4,5). Therefore, physicians should be sensitive for the mental disorders of their patients, and recommend psychiatric consultation on time. Especially, the patients with unexplained physical complaints should be suspected for depression, and examined as soon as possible. Moreover, chronic pains are 30% related with depression; therefore, other depression symptoms should be investigated before making a diagnosis on pain disorder (6-8). Besides, it is obvious that the current diagnosis classification of the patients with physical disorders as well as with mental disorders is not sufficient; therefore, different diagnosis classifications are required.

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