Healthy Older Schizophrenia Patients: Exceptions to the Rule?

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An unequivocal disquieting picture has emerged from the large amount of research into the physical morbidity and the mortality of individuals diagnosed with schizophrenia. Examples include the high rates of cardiovascular diseases[1] and the substantially shortened lifespan. Lifestyle-related factors (e.g., smoking, poor diet, low exercise levels) most likely account for a large part of these disturbing findings. In late-life schizophrenia, limited research has suggested similar health disparities between older patients and their age peers. For example, the excess mortality found in younger schizophrenia populations persists, although at a somewhat lower level, in later life.[2–4]

Extending this line of research, Brink and colleagues[5] report on the physical health status at age 70 years of a Danish cohort of 667 patients with early-onset schizophrenia. Scandinavian research has a large tradition of high-quality register studies. This thorough case-control study is another example, with access to both inpatient and outpatient data and the inclusion of a large control group. The authors compared physical comorbidity, prescription of medication (both psychotropic and non-psychotropic), and a number of healthcare utilization measures between the schizophrenia patients and their age peers. For the large majority of the variables under investigation, no significant differences could be demonstrated, although there were fewer prescriptions of cardiovascular medications, more prescriptions of analgesics, and fewer general medical outpatient contacts in the schizophrenia group. These are worrisome disparities, but the study suggests that the physical health status of this 70-year-old schizophrenia cohort is by and large quite comparable to that of their age peers.

Of course, this is a welcoming message in a field of research that often finds late-life schizophrenia patients in unfavorable conditions. In the critical appraisal of these findings, however, a number of limitations must be taken into account, some of which are also brought forward by the authors themselves. First, findings from the freely accessible Danish health services cannot be extrapolated straightforwardly to countries with different health care systems or with socioeconomically less favorable profiles. Next, registers by definition will miss physical disorders that have gone undiagnosed. Under-diagnosis of physical disorders is a common pitfall in schizophrenia research. A recent Dutch study reported similar rates of metabolic syndrome in older patients with severe mental illness (about half of them diagnosed with schizophrenia) and age peers, but newly detected metabolic abnormalities were significantly more frequent in the patients.[6] Another uncertainty regards the severity of diagnosed medical disorders. Although two patients both may suffer from diabetes, the intensity and impact of their illness can be very different. It is well conceivable that difference in severity of physical disorders is one of the factors that contribute to the heightened mortality in late life schizophrenia. Register studies are unsuitable to shed more light on this aspect, so other types of research are needed in this field.

Possibly even more relevant than under-diagnosis is the undertreatment of established medical disorders in schizophrenia. Various studies have pinpointed this issue, also in older patients. For example, a North American study of a convenience sample of older community-living schizophrenia patients[7] found that the proportion receiving treatment for four physical

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conditions was significantly lower than in the comparison group. The lower prescription rate of cardiovascular medication in the present study aligns with this finding. In schizophrenia, both individual and systemic factors heighten the risk for inadequately treated medical disorders. Patients may poorly adhere to treatment regimes, or stay away from general healthcare appointments (another finding of the present study). At the same time, doctors may lack communicative abilities in their interaction with schizophrenia patients, or hold a fatalistic view of possibilities to improve their health.

Brink et al. advocate better integration of psychiatric and medical healthcare to overcome shortcomings of segregated delivery of services. Model programs of this kind of collaborative care are available,[8] but the science-to-service gap remains wide. Next, it is important to realize that lifestyle interventions (for example, encouraging physical activity) may not only improve physical condition, but can stimulate cognitive functioning, improve mood, and enhance social interaction as well. Patience and perseverance are crucial elements in motivating patients to adapt their life styles. In this realm, negative countertransference in healthcare providers is another very relevant barrier to overcome. Still too often, older patients with schizophrenia are seen as lost cases, although they should deserve our respect for having survived into old age with an illness as severe and disruptive as schizophrenia.

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