

COMMENTARY

Uncertainty is an important symptom in patients awaiting revascularisation procedures

An epidemiological study in western Sweden by Bengtson *et al*¹ in this issue of *Heart* clearly shows that patients with ischaemic heart disease awaiting revascularisation surgery are anxious and depressed and that these aspects of wellbeing are related to the severity of pain and dyspnoea. These and other mood disturbances in patients surviving identified myocardial infarction have also been reported in epidemiological studies in the United States² and the United Kingdom³ and also in clinic populations.⁴

Bengtson *et al* identified "uncertainty" rather than pain as the most distressing symptom in their patients—uncertainty and fear about survival, about whether they would get treatment soon enough, and about the future of their families. Such distress was not related to how long they waited for surgery. This finding accords with the common clinical experience that many patients begin to breathe more freely again a year or two after myocardial infarction (and may start smoking again and regain lost weight). But there is indirect evidence that in the short term such initial distress can increase the risks of further damage to the heart. For instance it seems that distress from related adverse life events can precipitate death from myocardial infarction.^{5,6} Crisp *et al*² showed that emotional distress, independently of pain, characterised those in whom myocardial infarction was imminent, and when this factor was taken into account in addition to the other principal physical risk factors the overall predictive power for infarction during the next six months was enhanced from 50% to 83%.⁷ More recently Kawachi *et al*⁸ showed high levels of phobic anxiety in a large general population in the two years preceding myocardial infarction. Thus it may be that, if the stage is set by constitutional factors, then the more immediate mental state itself can be a powerful determinant of exactly when infarction occurs—for instance, significantly often it may bring forward death from infarction. In the light of these findings in populations that overlap with that reported on by Bengtson *et al*, there is a case for testing the effectiveness of psychological interventions under such circumstances and including all those hoping to survive until revascularisation surgery is undertaken.

The first task must then be to identify such psychopathology when it exists. This may be difficult, especially if there is any substance in published reports suggesting a link between personality type (for example, perfectionism and denial of distress) and myocardial infarction. Denial of distress characterises many such patients in the clinic.⁹ Nonetheless, Bengtson *et al* identified considerable distress simply by the use of a questionnaire.

Recently a combined report from the Royal Colleges of Physicians and Psychiatrists¹⁰ recommended increased staff training and liaison psychiatry resources to deal more

effectively with these psychological issues. The *BMJ* quoted the president of the Royal College of Physicians as saying "The main message we wanted to get across in the report is that treatment and management of psychological elements do have a considerable impact on the patient's wellbeing, health, length of stay in hospital, and even the need for investigation".¹¹

Helping an individual with such distress requires considerable skill. The patient must be allowed to talk about how they feel and their distress must be diffused or resolved psychotherapeutically when this is appropriate or possible. Such distress must be taken into account when emotional support is given and when their position on the waiting list is considered. Such approaches, properly applied, might not only relieve uncertainty and distress but also reduce other morbidity and mortality in patients waiting for surgical intervention. One major but not randomised study of patients referred with anxiety and depression after myocardial infarction showed that expert psychological intervention was associated with a significantly lower mortality over the next 15 months or so.¹²

Thus the principal advantage of reporting Bengtson's study may be that it highlights the distress of these patients on a nationwide scale. Published reports on the relation of stress to the precipitation of (further) myocardial infarction also invite the hope that any such interventions may improve the prognosis overall.

A H CRISP

Psychiatric Research Unit,
Atkinson Morley's Hospital,
Wimbledon, London SW20 0NE

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