

Mental Health in Ophthalmic Patients

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Among many aspects of mental health one is the patient's ability to cope with normal stresses of life. We as an ophthalmologist very often encounter patients with some mental illness. Mental illness can be due to some psychiatric disorder per se or it can be the psychological reaction of blindness. Signs like eye movement abnormalities may be associated with specific psychiatric disorders (e.g. schizophrenia) and

could potentially aid in diagnosis to the psychiatrist. Also, there are several eye diseases with unknown causes in which psychological factors are implicated in causation.

Here we have discussed some of the possible psychiatric consequences of ophthalmic diseases like visual hallucinations, depression due to blindness, Psychosis due to steroid and eye patching, Phobias before and during surgery etc.

A significant number of patients with severe (bilateral) visual loss experience visual hallucinations. It is believed that these hallucinations are generated in the visual cortex days or weeks after development of visual loss. It can be temporary or permanent. Visual hallucinations also occur in psychiatric disorders like dementia (where they are usually accompanied by auditory hallucinations), drugs history, alcohol withdrawal. This condition is termed as Charles Bonnet Syndrome.¹ Counseling of the patient regarding the benign nature of the disease is the mainstay of treatment.²

An ophthalmologist's responsibility is to establish the cause for visual hallucination as it can also be observed in neurological disorders like occipital lobe lesions, migraine etc. Neurological symptoms, signs and neuro imaging of brain aid in the diagnosis of these neurological diseases. In such patients, ophthalmic examination is usually completely within normal limits except sometimes migraine attack may simulate subacute angle closure glaucoma.³ Among ocular causes of visual hallucination, patient of posterior vitreous detachment (PVD),⁴ optic neuritis or papilloedema experiencing flashes of lights can also simulate visual hallucination. However proper history & ocular examination can easily rule out the diagnosis. In psychiatric diseases like schizophrenia or functional psychosis, visual and auditory hallucination are treated by psychiatrist doctor. Depression is a common mental disorder. According to a review study prevalence of depressive symptoms seen in ocular diseases was 25%. Among different ocular diseases, dry eye disease patients (DED) observed to have

highest prevalence (29%) of depression. Glaucoma is the second highest cause (25%) followed by Age related macular degeneration (24%) and cataract (23%).⁵ Another study on older patients observed that age-related macular degeneration (AMD), glaucoma, or Fuchs corneal dystrophy are more likely to show signs of depression compared to a control group with good vision.⁶ The sole factor for this depression is increasing dependency on people around them due to vision loss. Apart from depression, anxiety, personality changes, communication problems and emotional distress are the other consequences of vision loss on patient's mind⁷

Often loss of vision occurs as a side effect of psychiatric medication. Once a visually-impaired and mentally ill patient gets dependent into psychiatric medication which in turn can worsen their eyesight further resulting in further deterioration of mental health, thus forming a vicious cycle, especially without a support network, for them to make the necessary lifestyle changes. As an ophthalmologist, we should be able to recognize the mental status of a visually impaired patient refer them to a psychiatrist for proper counseling to adapt to the life style changes to overcome barriers in the daily routine and also to assist in overcoming negative thinking and enhance social supports.

Usage of systemic steroids (as in cases of panuveitis etc) in some patients can induce mental state changes which are termed as steroid induced psychosis. Females and younger patients are more prone to develop this type of psychosis [8]. Features include changes in mood such as depressive or manic disorder. It is usually acute in onset and symptoms generally presents in the first few days of therapy. Phentothiazines and cessation of systemic steroid therapy (or substituting systemic steroids with periocular steroids in purely ocular problems) is the mainstay treatment with resolution of symptoms within six weeks. Psychosis can also develop in some patients who have both eyes patched after traumata or after intraocular surgery. Psychiatric features include restlessness,

hyperactivity, anxiety, irritability, disorientation in time and space. Less frequently mania, delusions, auditory and visual hallucinations may occur. Patients who have impaired other senses like hearing problem etc are more prone to develop this condition. An ophthalmologist should be aware of this condition and can get appropriate consult from psychiatry colleagues when the need arise. Passing through various stages of eye operations can cause a lot of distress, anxiety and fear among patients. Reasons for fear and anxiety can be diverse. As far as local anaesthesia is concerned, the knowledge of needle pricks around the eyes is quite frightening for some people,

while some people with low threshold for pain may be troubled by the prick of needles.⁹ The commonest fear of general anaesthesia is 'not waking up'. Another common cause of apprehension during surgery is the fear of becoming blind by some complication. However, patients who had uneventful and smooth surgeries in one eye earlier are calm generally when being operated upon the second eye.

Most of the studies showed a significant relation between psychiatry and ophthalmology, such as mental problems accompanying eye diseases and significant adverse side effects of psychotropics on the eye. As an ophthalmologists, we should be skilled enough to recognize symptoms of psychiatric disorders in patients. An early recognition of symptoms can help to start an adequate counseling or therapy in these patients to decrease the progression of disease and increase the quality of life of the patients.

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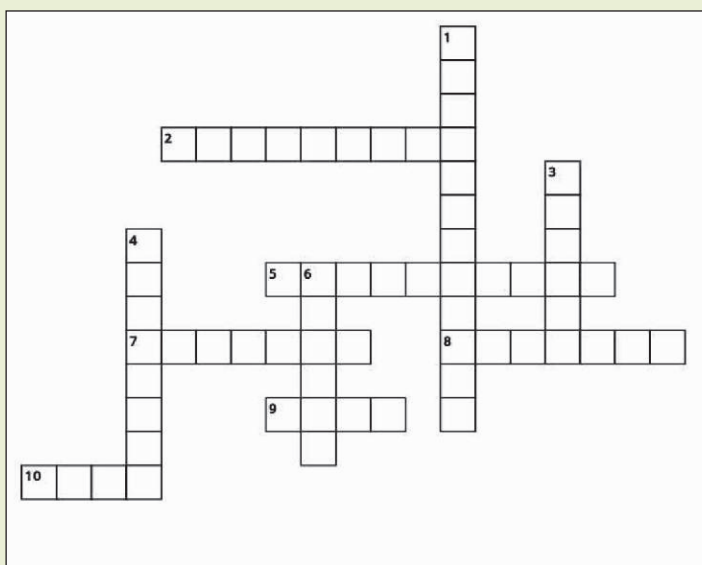
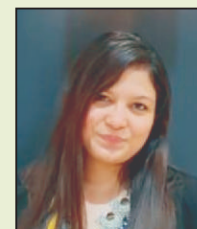
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by : *Dr. Anchal Tripathi*



- Across**
- 2. Pattern formed by folds in ILM overlying microcyst within NFL in foveal schisis
 - 5. Cytokine receptor inhibitor
 - 7. Verteporfin PDT vs Ranibizumab study
 - 8. Pupil expander ring
 - 9. Surgery done for senile entropion
 - 10. Central Retinal artery also known as _ artery
- Down**
- 1. A 26kDA anti-VEGF approved recently for AMD
 - 3. Suprachoroidal based MIGS
 - 4. Rule that states when naevus flammeus involves the upper lid, there is ipsilateral intraocular involvement
 - 6. Hemorrhage in AC in Fuch's

The correct answers can be mailed to editorupsos2018@gmail.com