Letter to the Editor

Challenges in the Transition from In-Patient to Out-Patient Treatment in Depression

An Analysis of Administrative Health Care Data From a Large German Health Insurer

by Hauke Felix Wiegand, MD/PhD, Joachim Saam, Dr. med. Ursula Marschall, Prof. Dr. rer. biol. hum. Andrea Chmitorz, PD Dr. phil. Levente Kriston, Prof. Dr. med. Mathias Berger, Prof. Dr. med. Klaus Lieb, and Dr. phil. Lars P. Hölzel in Issue 27–28/2020

Breaking Down Barriers in Outpatient Treatment

This very well researched article (1) unfortunately fails to address one essential issue: The ratio of medical psychotherapists (who can prescribe drugs) to psychological psychotherapists (who are not licensed to do so) registered with the Association of Statutory Health Insurance Physicians for North Saxony has shifted from 90:10 to 50:50 and then to 10:90.

As severe depression is almost always associated with intensive, expensive medication, patients first treated by psychologists are sent to their primary care physicians when they require medication. Primary care physicians fear legal claims as this is outside their area of expertise (my own experience as a primary care physician in Lower Saxony from 2001 to 2005) and refer patients to psychiatrists/medical psychotherapists, of whom there are no longer enough. The ordeals of patients with severe depression end in this cul-de-sac.

My own practice for psychosomatic medicine and psychotherapy, which has existed since 2013 (I was formerly a primary care physician with a special interest in psychotherapy), was threatened with a large claim for damages in 2015 in connection with taking on responsibilities for such medication. The medical review board has only now, in 2020 (after 5 years of uncertainty), declared the claim unfounded due to increased demand.

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References

1. Wiegand HF, Saam J, Marschall U, et al.: Challenges in the transition from in-patient to out-patient treatment in depression—an analysis of administrative health care data from a large German health insurer. Dtsch Arztebl Int 2020; 117: 472–9.

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Alarming Figures for Severe and Moderate-to-Severe Depression

The transition to outpatient care is insufficiently well organized for 92% of patients discharged from a psychiatric hospital or hospital for psychosomatic medicine. This transition, however, is an essential factor in a patient's condition becoming stable. Patients' relatively long hospital stays and thus the possibility of becoming familiar with patients' home situations would form a sound basis for preparing for discharge.

This also affects patients' relatives, who in most cases have already had to tackle feelings of helplessness. Children and young people, in particular, would benefit from a smooth transition, as they especially see changes in their mother, their father, and therefore their whole life. It is not enough to refer the family to the Internet to find a family coach or the like. Regular, personal conversations between the family and the team of treating professionals are part of a well-planned transition.

Help in finding outpatient psychotherapy is also part of a good discharge plan.

What a positive move that the authors (1) draw attention to this problem. Hopefully, many hospitals will be driven by this analysis to rethink and make changes.

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In Reply:

We appreciate these important points and comments on our article (1). We also believe that mental illness should be addressed in its global psychosocial context. Relatives of those with mental illness are often also heavily impacted and require information and support to enable them to cope satisfactorily with the consequences of their relative's illness (2, 3). However, friends and family also have a major effect on the further progress of a patient with mental illness (4). Critical friends and family constitute an additional stressor and can have a negative effect on the development of the illness, whereas supportive ones can be an important factor in resilience. For this reason, the S3 Guideline on Unipolar Depression recommends psychoeducation for relatives (www.awmf.org/leitlinien/detail/ll/nvl-005.html, English version at https://www.leitlinien.de/mdb/downloads/nvl/depression/archiv/unipolare-depression-kurz-engl-1.3.pdf).

We also believe that future follow-up treatment should be considered and arranged during longer inpatient treatment. In the current, compartmentalized health care system, too much thought has been given to individual interventions and too little to continuous therapeutic chains. Both hospitals and associations of statutory health insurance physicians should be enabled to arrange guideline-compliant therapeutic chains, in collaboration with each other.

Primary care physicians, of course, play a key role in caring for people with depression; the majority of people with depression are treated by primary care physicians, after all. It is essential to prevent fears of claims for damages from contributing to insufficient care for those who are severely ill. Instead, in the future consideration should be given to how barriers to guideline-compliant treatment can be removed and how scientific incentives for such treatment can be created.

In summary, going forward, patients with depression should be cared for in structures that provide incentives allowing for integrated, phase-appropriate, guideline-compliant treatment; the effects of structural realities and economic incentives, which may be inappropriate, should be addressed more by scientists and politicians.

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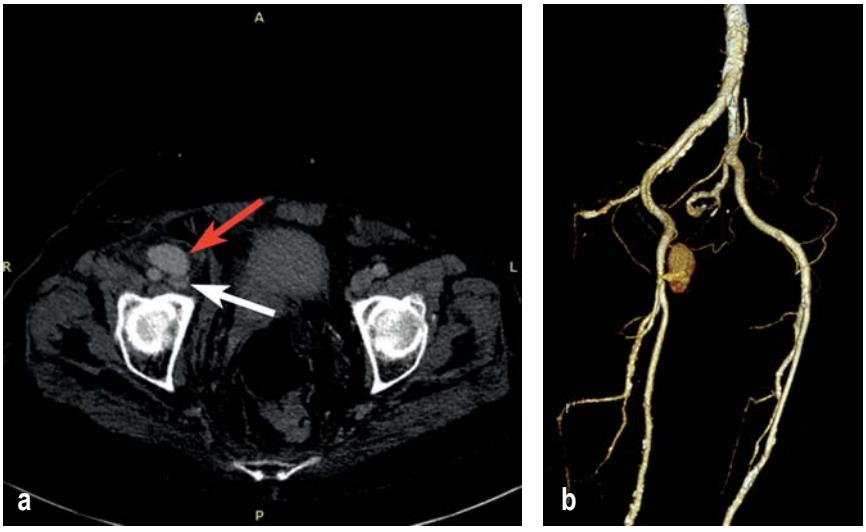
CLINICAL SNAPSHOT

Pseudoaneurysm Following Transfemoral Percutaneous Aortic Valve Replacement

An 86-year-old female patient developed acute swelling and bulging varicose veins on the right leg. The patient had undergone transfemoral percutaneous aortic valve replacement via a 9-F sheath 2 days previously due to high-grade aortic stenosis. Clinical examination revealed swelling of the right thigh as well as prominent varicose veins on the right great saphenous vein and its side branches. Ultrasound ruled out deep and superficial vein thrombosis; however, a pseudoaneurysm causing venous reflux in the saphenous vein was suspected. Subsequent computed tomography angiography *(Figure a, b)* confirmed a pseudoaneurysm of the right common femoral artery measuring 3.5 × 2.0 × 3.0 cm *(Figure a, red arrow)*, which was compressing the right common femoral vein *(Figure a, white arrow)*. Following surgical removal of the pseudoaneurysm, the patient was discharged 10 days postoperatively. Pseudoaneurysms occur in up to 7.9% of cases following transfemoral percutaneous aortic valve replacement. Predisposing factors include inadequate postinterventional compression, large sheath diameter, and multiple arterial punctures.



Figures: a) Computed tomography angiography of the lower limb arteries (transverse section) with evidence of a pseudoaneurysm (red arrow) that is compressing the right common femoral vein (white arrow). In addition, a medially located infraperitoneal postinterventional hematoma in the pelvic region could be seen displacing the urinary bladder to the contralateral side; b) computed tomography angiography of the pelvic and lower limb arteries in the volume rendering technique showing evidence of a pseudoaneurysm of the right common femoral artery, including aneurysmal neck.

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