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Extent Of Depression Among Gastrointestinal Tract Symptoms In Medical Outpatient Clinic Of Al-Hussein Teaching Hospital In Al-Nasiriya City In 2018

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Abstract

Background: Depression is one of the most common mental health conditions in the general population as well as in clinical practice. In clinical studies, there is a strong relationship between gastrointestinal symptoms and depression and the gastrointestinal symptoms remain for longer time and are more serious than in patients without depression.
Objective: To estimate the extent of depression in gastrointestinal tract symptoms in medical outpatient clinic attendees.
methods: The study was a cross-sectional analytical study for 154 adult population in the Al-Hussein teaching hospital in Nasiriya city , conducted at first March 2018 and completed at end of September 2018. Tools of the method were questioner and for diagnosis of depression was used Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM- IV) criteria. the refusal rate was zero and for statistical the analysis was used SPSS version 22.
Result: The study showed that 43.5 % of subjects with gastrointestinal symptoms suffer from depression. depression was found in 40.7% of females and 47.1% of males. 50.0% of depressed patients were in two age groups of 20 -44 years and ≥ 65 years.
Most depressed patients were suffering constipation (51.3%), change in appetite (51.3%), and change in weight(50.7%), where only change in appetite had a significant association with depression, were p-value=0.001. More depressed subjects had GI symptoms with one-month duration and ≥7 numbers of GIT symptoms.
Recommendation: Raising awareness of the general population about the depression and relation of that with GIT symptoms.

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Introduction

In the majority of patients with gastrointestinal (GIT) symptoms(40–80%), no pathological cause for their symptoms can be found,[1] and some patients may suffer from several GIT symptoms that have been present for many years.[2] When these symptoms are related to disturbance of motility, hypersensitivity of visceral, change in function of mucosal and immunity, altered gut microbiota and change in central nervous system(CNS) processing define as functional disorders.[3] FGIDs are often associated with affective disorders, such as depression, anxiety, panic, and posttraumatic stress disorder (PTSD).[4]

In patients affected by GIT diseases, depression represents a common recurrent and serious disorder which leads to diminished functioning and quality of life, medical morbidity, and mortality. [2,5,6] Psychological factors commonly influence onset, severity, and outcome in the functional GIT disorders,[7] which cause the patients often have worse somatic symptoms, need more time for recovery and worse prognosis, so need to consume more medication.[8-10]

Depression is the fourth leading cause of disease burden, accounting for 4.4% in the year 2000, and it causes the largest amount of non-fatal burden, for almost 12% of all total years lived with disability worldwide. [6] Previous studies (Chinese 14.39% and Italian 27% studies) showed that the prevalence of depressive disorders in patients with GIT disorders was high.[11,12]

Sustained and acute life-threatening stressors play an important role in the onset and modulation of GI symptoms as well as in the development of affective disorders and PTSD. [4] Although GIT diseases are related to mood disorders like depression and anxiety, “40%-90% of patients with depressive disorders” do not receive suitable medical and health services and treatment because the majority of patients cannot be identified by gastroenterologists,[13-15] so knowledge about the psychosocial aspects of the functional gastrointestinal disorders (FGIDs) is fundamental and critical to the understanding of the FGIDs and their effective treatment. [2]

Methodology

1. Study design

A hospital based cross sectional analytical study. The study was

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started in March 2018 and completed end of September 2018.

2. Population

The study included adult patients with gastrointestinal symptoms who attended the GIT outpatient clinic in Al-Hussein teaching hospital in Al-Nasiriya city, during the study period.

3.Inclusion criteria: participants with age ≥18, of either sex presenting with GIT symptoms as abdominal pain , heartburn, reflux, dyspepsia, dysphagia, constipation, diarrhea, vomiting and nausea in a stable state. [1]

4.Exclusion criteria: patients who were under 18 years, patients with any cognitive or physical impairment, patients with a history of any major systemic disorder (involving any system apart from GIT), Pregnancy, Malignancy, Drug dependency, Seizure disorders, patient with severe GIT disease and in unstable state.

5.Response rate

No subject refused to participate in the study, so the response rate was 100%.

6.Sample size calculation

The size of sample was calculated according to the simple formula: [16]

"$n= (z^2pq) /d^2$

n= sample size

z= z statistic for a level of significance

p= estimated prevalence rate in WHO which was(3.7%) in Iraq.[17]

q= (1-p)

d= precision

$$N = \frac{(1.96)2*p(1-p)}{(0.04)2} *1.8"$$

N=153.9~154

7.Sampling procedure: For collecting the population of study I went to the clinic for 5 days per week and use systematically random way and was selected as every 2 attendants to the outpatient clinic and then take the third one if had the inclusion criteria. We select the participants after diagnosis of symptoms was related to GIT system by the doctor. We gave the

questionnaires to them for self-answering because there is an Arabic version of CIDI questionnaire, but if there was illiterate, their relative or me road the questionnaire without any difference for them.

Period of collection of data last for 2 months due to low number of attendants to the clinic.

8.The study tools:

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The data collected through two questionnaire forms, the first one consist of two sections:

Section 1:
This includes questions about the name, age, sex, number of family members, number of children, occupation, marital status, monthly income, education level, and address.

Section 2:
It includes the GIT symptoms that participants suffer from and the duration of symptoms. It also includes a history of a psychiatric visits if present and drug history.

Second questionnaire

The second questionnaire is the depression modules of the CIDI to MDD. The CIDI interview includes three screening (known as STEM) questions about sadness/depressed mood, feelings of discouragement, and loss of interest lasting several days or longer. Participants who select any of the three questions will give the depression module. Those who failed to endorse any of the three STEM questions will be skipped out of the depression modu**le".** [18]

In accordance with DSM-IV criteria,[19] can diagnose depression with the presence of "five (or more) from following symptoms during the same 2-week period; at least one of the key symptoms is either (1) loss of interest or pleasure or (2)depressed mood.

(1) depressed mood indicated by either subjective report or observation made by
others most of the day, nearly every day.
(2) markedly diminished pleasure or interest in all, or almost all, activities most of
the day, nearly every day
(3) significant weight change when not dieting (e.g., a change of more than 5% of
body weight in a month), or change in appetite nearly every day.
(4) hypersomnia or insomnia nearly every day
(5) psychomotor retardation or agitation nearly every day
(6) loss of energy or fatigue nearly every day
(7) feelings of worthlessness or excessive or inappropriate guilt nearly every day
(8) indecisiveness, or diminished ability to think or concentrate
(9) recurrent thoughts of death, recurrent suicidal ideation, or a suicide plan or
attempt for committing suicide

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The severity of depressive episode [19]

The severity of depressive episode can be divided into mild, moderate and severe

according to several symptoms (criterion A and B) and functional impairment.

A:

Depressive mood
Loss of interest and enjoyment in activities
decrease activities and reduced energy

B:

Reduce confidence and self-esteem
Unworthiness and feelings of guilt
Negative thought
Disturbed sleep
Diminished appetite
Ideas of self-harm

mild: 5-6 symptoms but mild in severity and functional impairment or >1 from
column A plus 1-2 from column B.

Moderate: 7-8 symptoms but moderate functional impairment or >1 from A plus
2-3 from B.

Severe : All 3 from A plus >3 from B. or fewer symptoms but any of severe functional impairment, psychotic symptoms, recent suicide attempt, specific suicide plan."

In this study, the current MDD was defined in the past 12 months and there were no organic causes,and for diagnosis and detection of severity I take help from my supervisor .

9.Pilot study:

the pilot study was performed on the first of March 2018 on fifteen participants to
know time, cost and feasibility that required for the final study and also to know the refusal rate. At end of this study, results were discussed with the supervisor for modified and managed .

10.Definition of variables

Age: last birthday in years and all ≥18 years were involved in the study.

Sex (male or female)

Marital status: classified as:

Married
single (unmarried)

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Widow
Divorced

Socioeconomic status:
It was measured depending on the following scoring system [20]:
Living in owned or rented/illegal house scored as 1 or 0.
Having or not having a private car scored as 1 or 0.
The number of electrical appliances in the household is scored as:
presence of up to 2 electrical appliances scored as (1).
#presence of 3-5 electrical appliances scored as (2).
presence of 6 or more electrical appliances scored as (3).
The overall socioeconomic status was calculated for each subject as follows:
#scoring of ≤ 2 was considered as low socioeconomic status,
#scoring of 3-4 was considered as moderate socioeconomic status,
#scoring of > 4 was considered as high socioeconomic status.

Education level measurement
It was classified as: [21]
Illiterate means a person who is unable to read or write.

primary schools are typically the first stage of formal education, coming after preschool and before secondary education include 6-12 years.
Intermediate present or middle school is an educational stage which exists in some countries, providing education between primary school and secondary school.
secondary schools is both an organization that provides secondary education and the building where this takes place. Some secondary schools can provide both lower secondary education and upper secondary education (levels 2 and 3 of the ISCED scale), but these can also be provided in separate schools, as in the American middle school- high school system.

College is an educational institution or a constituent part of one.

Occupation level measurement: classified as:
Employed (governmental)
Non-employed
Self-employed
House-wife
Student
Retired

residency: urban, rural, semi-urban

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11. ethical consideration

Ethical clearance was obtained from Al- Hussein teaching hospital management to perform the study. Informed consent also was taken from all participants.

12. Statistical analysis: SPSS version 23 was used for data analysis. Descriptive statistics, frequencies, percentages, association, tests of significance were used for the analysis of categorical variables. Chi-square was used for categorical variables and Fisher's exact test was used when more than 20% of the expected variable was less

than 5**.** P-value <0.05 was considered statistically significant.

Result

A total of one hundred and fifty four (154) participants included in this cross
sectional study with mean age 37.74 ± 14 years with a male to female ratio
(0.7:1).More than half of the participants (55.9 % of males and 51.2 % of females) were falling within the age group 20-44 years old and a minority of them (1.6 % of males and 3.5 % of females) were falling within the age group ≥ 65 years. Nearly 2/3 of them (65.6%) lived in an urban area and 11.7% lived in a rural area. Regarding the occupation, there were significant differences between the two sexes, nearly one-third of males either employed(29.4 %) or self-employed(39.7 %), majority of females(81.4 %) were housewives. The educational level shows significant differences between the two sexes, nearly a third of the females either illiterate (34.9%) or primary (29.1 %), and nearly third of the males were primary level (30. 9%). About ¾ of the participants (79.2%) at a moderate socioeconomic status and 11.7% of them were at high socioeconomic status. More than 2/3 of them belong to family with more than6 members. Most of them were married (70.1 %) as shown in table 1.

Table 2 shows the distribution of the participants according to the depression state and sociodemographic characteristics. There was no significant association between the depression state and each of the following; age, sex, residency, occupation, educational level, socioeconomic status, family member and marital status, where the p-value more than 0.05. It was observed two age group with high prevalence, 50.0% of a depressed patient located at 20-44years, and 50.0% of ≥65 years. The 40.7% were from females and 47.1% from males, more than half (66.7%) were from a rural area, 55.9% students, 56.5% from secondary education, 50.0% from high social class, 43.3% of

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the family with 4-6 members and 43.6% of family >6 members and 87.5% of widow participants.

Table 3 shows the relationship between symptoms of the studied population and depression. It showed an association between prevalence of depression and change in appetite (p=0.001), where p-value less than 0.05, but there was

no significant association with each of the following abdominal pain, heartburn, dyspepsia, dysphagia, nausea or vomiting, abdominal distention, diarrhea, and constipation, where p-value more than 0.05. This table also shows that more than half (57.1%) of depressed participants had a history of psychological disease.

Table1: socio-demographic characteristics of the studied participant according to the gender.

variables	Males no.%	Females no.%	Total no. (%)	x^2	P
Age *				4.740	.186
15-19 years	3(4.2)	12(13.9)	15(9.7)		
20 -44 years	38(55.9)	44(51.2)	82(53.2)		
45 -64 years	26(38.3)	27(31.4)	53(34.5)		
≥ 65 years	1(1.6)	3(3.5)	4(2.6)		
Residency				4.342	.114
Urban	46(67.5)	55(63.9)	101(65.6)		
Semi urban	18(26.6)	17(19.8)	35(22.7)		
Rural	4(5.9)	14(16.3)	18(11.7)		
Occupation*				105.858	.000
Employed	20(29.4)	7(8.1)	27(17.5)		
Non-employed	7(10.3)	0(0.0)	7(4.5)		
Self-employed	27(39.7)	0(0.0)	27(17.5)		
House-wife	0(0.0)	70(81.4)	70(45.5)		

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Student	9(13.2)	9(10.5)	18(11.7)		
Retired	5(7.4)	0(0.0)	5(3.3)		
Educational level				13.458	.009
Illiterate	11(16.2)	30(34.9)	41(26.6)		
Primary	21(30.9)	25(29.1)	46(29.9)		
Elementary	8(11.8)	14(16.3)	22(14.3)		
Secondary	12(17.6)	11(12.8)	23(14.9)		
College	16(23.5)	6(6.9)	22(14.3)		
Socioeconomic state				1.416	.493
Low	10(14.7)	8(9.3)	18(11.7)		
Medium	51(75.0)	71(82.6)	122(79.2)		
High	7(10.3)	7(8.1)	14(9.1)		
Family member*				5.570	.065
<4	3(4.4)	4(4.7)	7(4.5)		
4-6	19(27.9)	11(12.8)	30(19.5)		
≥ 6	46(67.7)	71(82.5)	117(76.0)		
Marital state*				4.684	.182
Married	50(73.5)	58(67.4)	108(70.1)		
Single	16(23.5)	17(19.8)	33(21.4)		
Divorced	2(3.0)	3(3.5)	5(3.2)		
Widow	0(0.0)	8(9.3)	8(5.3)		
Total	68(100)	86(100)	154(100)		

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Table 2: Distribution of socio-demographic characteristics of the studied population according to their depression state.

Variables	Depression no.%	No depression no.%	Total no. (%)	x^2	P
Age*				4.525	0.201
20 < years	7(46.7)	8(53.3)	15(100)		
20 -44 years	41(50.0)	41(50.0)	82(100)		
45 -64 years	17(32.1)	36(67.9)	53(100)		
≥ 65 years	2(50.0)	2(50.0)	4(100)		
Sex				.625	0.429
Male	32(47.1)	36(52.9)	68(100)		
Female	35(40.7)	51(59.3)	86(100)		
Residency				4.549	0.102
Urban	40(39.6)	61(60.4)	101(100)		
Semiurban	15(42.9)	20(57.1)	35(100)		
Rural	12(66.7)	6(33.3)	18(100)		
Occupation*				5.287	0.386
Employed	9(33.3)	18(66.7)	27(100)		
non-employed	3(42.9)	4(57.1)	7(100)		
self-employed	14(51.9)	13(48.1)	27(100)		
house-wife	30(42.9)	40(57.1)	70(100)		
Student	10(55.9)	8(44.4)	18(100)		
Retired	1(20.0)	4(80.0)	5(100)		
Educational level				2.524	0.640
Illiterate	16(39.0)	25(61.0)	41(100)		
Primary	21(45.7)	25(54.3)	46(100)		
Intermediate	9(40.9)	13(59.1)	22(100)		
Secondary	13(56.5)	10(43.5)	23(100)		
College	8(36.4)	14(63.6)	22(100)		
Socioeconomic state				1.026	0.599
Low	6(33.3)	12(66.7)	18(100)		
Medium	54(44.3)	68(55.7)	122(100)		
High	7(50.0)	7(8.0)	14(100)		

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Family member*				0.089	0.999
<4	3(42.9)	4(57.1)	7(100)		
4-6	13(43.3)	17(56.7)	30(100)		
≥6	51(43.6)	66(56.4)	117(100)		
Marital state*				5.748	0.104
Married	48(44.4)	60(55.6)	108(100)		
Single	11(33.3)	22(66.7)	33(100)		
Divorced	1(20.0)	4(80.0)	5(100)		
Widow	7(87.5)	1(12.5)	8(100)		
Total	67(43.5)	87(56.5)	154(100)		

**Exact fisher test.*

Table 3: the relationship between GIT symptoms of the studied population and depression.

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Variables	Depression no.%	No depression no.%	Total no. (%)	x^2	P
Abdominal pain*				0.794	0.373
Yes	64(44.4)	80(55.6)	144(100)		
No	3(30.0)	7(70.0)	10(100)		
Heart burn				0.238	0.626
Yes	32(41.6)	45(54.8)	77(100)		
No	35(45.5)	42(54.5)	77(100)		
Dyspepsia				0.245	0.620
Yes	12(48.0)	13(52.0)	25(100)		
No	55(42.6)	74(57.4)	129(100)		
Dysphagia				0.618	0.432
Yes	7(53.8)	6(46.2)	13(100)		
No	60(42.6)	81(57.4)	141(100)		
Nausea or vomiting				0.638	0.424
Yes	45(45.9)	53(54.1)	98(100)		
No	22(39.3)	34(60.7)	56(100)		
Abdominal distention				2.722	0.099
Yes	50(48.1)	54(51.9)	104(100)		
No	17(34.0)	33(66.0)	50(100)		
Change of appetite				1.979	0.001
Yes	60(51.3)	57(48.7)	117(100)		
No	7(18.9)	30(81.1)	37(100)		
Change of weight				2.529	0.112
Yes	34(50.7)	33(49.3)	67(100)		
No	33(37.9)	56(62.1)	87(100)		
Diarrhea				0.000	0.993
Yes	27(43.5)	35(56.5)	62(100)		
No	40(43.5)	52(56.5)	92(100)		

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Constipation				1.285	0.257
Yes	20(51.3)	19(48.7)	39(100)		
No	47(40.9)	68(59.1)	115(100)		
Psychological disease*				0.555	0.456
Yes	4(57.1)	3(42.9)	7(100)		
No	63(42.9)	84(57.1)	147(100)		
Total	67(43.5)	87(56.5)	154(100)		

***Exact fisher test.*

Discussion

A hospital based observational, cross-sectional study extended over 7 months to include (154) attendants to a gastrointestinal outpatient clinic in Al-Hussein teaching hospital in Al-Nasiriya city to study the prevalence of depression in subjects suffering from gastrointestinal symptoms**.** The current study showed that the high prevalence of depression distributed in participants was 43.5%, like the Indian studies [22,23] were 43.1 %, 37.1 %. The factors that caused high prevalence in our study were may be due to methods or tools, population, the setting of population, and season. The unstable condition of Iraq, where included successive wars in the previous years and absence of security in recent years, also may affect the people psychologically, and the state of unemployment and loss of suitable services had left people desperate, which also can play an important role in appearing of MDD. Regarding the severity of depression, participants with mild (30(44.8%)members) severity had a higher prevalence than other degrees, followed by moderate (19(28.4.4%) members) and severe (18 (26.8 %)members). These differences in severity may be returns to going of the patient who with severs degree to specialist and subjects which suffers from mild degree come to the clinic due to mild symptoms or not aware of their depressed condition.

In the current study, 50.0% of participants with age 20-44 and ≥65 had depression, that this high prevalence is similar to Korean study [24] 57% for 18-44 and Indian study [22] that were 52.8% for age 20-29.

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Regarding the sex, 47.1% of males had depression in the current study that is similar to the Indian study (47.2%), [16] but regarding the females, 40.7% and 52.9% were results for our study and Indian[22] study respectively, that are no similar. The current study shows no significant association between occupational state and depression and the highest percentage was found with those who were students (55.9%), while in the Iranian study,[25] participants that have a job included more prevalent of depression. And regarding the educational state, were secondary school level (56.5%) had a high percentage, where was similar to Pakistan study (57.0%),[26] where the secondary school level. Regarding the socio-economic state, the percentage of depression was higher in participants with high socioeconomic level (50.0 %) were not similar findings reported from the Indian study (low level= (47.1).[22] In the current study seen the prevalence of depression was high in widow participants (87.5%), but there was no significant association, like to another study in which the Widow (66.7%) was more prevalent. [22] The distribution of depression in a rural area were (66.7%) in the current study,where in the Indian study [22] also the rural area had a higher level (44.4%).[22] In the present study, the most frequent GIT symptoms were abdominal pain (95.5 %), change in appetite (89.6 %), abdominal distention (74.6%), nausea and vomiting (67.2 %) and change in weight (50.7%), while the more frequent symptoms in depressive participants were constipation (51.3%), change in appetite (51.3%), change in weight (50.7%) and abdominal distention (48.7%), and there was the significant association between depression and change in appetite, where p-value =0.001. In other studies [27]. Regarding the GIT symptoms, more depressive participants were suffering from ≥7 symptoms (55.9%) like Saudi study[27] that (43.9Z%) from participants were suffering from multiple complaints. In this study (63.3%) of participants had 1month duration of symptoms, while in the Saudi study[96] 51.7% of subjects had suffered from complaints for 6-30 years.

Conclusion :

1.The study findings revealed that depression was high in the Al-Nasiriya population.
2. Most of the participants with depression were in two age groups 20-44 years and ≥ 65 years.
3.In this population study, more

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of depressive participants had more than 7 GIT symptoms. 4.In this study 57.1% of participants were with a history of psychiatric disease, that this result shows the importance of psychological history for the incidence of depression.

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مدى أنتشار الأكتئاب بين أعراض الجهاز الهضمي في العيادة الخارجية للأمراض الباطنية في مستشفى الامام الحسين التعليمي في مدينة الناصرية لعام 2018 .

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الخلاصة:
واحد من أكثر حالات الصحة العقلية شيوعا في الممارسة السريرية وفي عموم السكان هو الاكتئاب. في الدراسات السريرية، هناك علاقة قوية بين أعراض الجهاز الهضمي والاكتئاب وتبقى الأعراض المعوية لفترة أطول وأكثر خطورة في المرضى الذين يعانون من الاكتئاب.
الهدف: دراسة مدى انتشار الاكتئاب لدى مراجعي عيادة الجهاز الهضمي.
المواد والأساليب: كانت الدراسة مقطعية للبالغين في مستشفى الحسين التعليمي في مدينة الناصرية، أجريت في أول مارس 2018 وانتهت في نهاية سبتمبر 2018. جمع البيانات تم من خلال استبانة معدة لهذا الغرض وذلك بأجراء مقابلة مع المراجعين الموافقين على المشاركة بالدراسة حسب معايير DSM-IV التي طبقت على 154 مشارك. كان معدل الرفض صفر ولأغراض التحليل الإحصائي أستخدم البرنامج SPSSالإصدار 22.
النتائج: أظهرت الدراسة أن 43.5% من الأشخاص الذين يعانون من أعراض الجهاز الهضمي يعانون أيضا من الاكتئاب. وقد وجد في 40.7% من الأناث، 47.1 % من الذكور.
خمسون بالمئة 50% من المرضى المصابين بالاكتئاب كانوا من الفئتين العمريتين 20-44 سنة، أكثر من 65 سنة. معظم المرضى المصابين بالاكتئاب يعانون من الإمساك (51.3%), وتغير في الشهية (51.3%)، وتغير في الوزن (50.7%) حيث كان التغيير في الشهية يرتبط ارتباطا كبيرا مع الاكتئاب، كانت قيمة P= 0.001.
معظم الأشخاص المكتئبين يعانون من مشاكل صحية في الجهاز الهضمي لمدة شهر واحد وكان لديهم أكثر من 7 أعراض.
توصية: رفع الوعي العام حول الاكتئاب وعلاقة ذلك مع اعراض الجهاز الهضمي.
الكلمات المفتاحية: الاكتئاب، اعراض الجهاز الهضمي، الانتشار، الناصرية, 2018.