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Original Research Article

A Descriptive Study of the Clinical Profile of Psychiatric Referrals from the Dermatology Unit in a Tertiary Care Center

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Abstract

Objective: To study and examine the clinical profile of psychiatry referrals to tertiary care dermatology units.

Methodology: The medical records of dermatology patients transferred to the psychiatric department were evaluated retrospectively. Assessing demographics, mental diagnoses, comorbidities, and skin conditions. There was a total of 200 people included in the sample; 60% of them were women and 40% were men.

Results: The study analysed all patients who were referred. The characteristics of the patients dominated the caseload. Most referrals had mental diagnoses. Patients suffer from multiple comorbidities. Dermatological conditions were also associated with mental referrals.

Conclusion: The results of this study cast light on the clinical profile of dermatology-based referrals to psychiatry from tertiary care centers. The high prevalence of comorbidities and the association between certain dermatological conditions and psychiatric disorders emphasise the need for integrated dermatology and psychiatry care. These findings can be used to enhance patient care and referral systems and inform the development of collaborative treatment methods. The underlying mechanisms in this population should be investigated further, and patient care should be optimized.

Categories: Healthcare Technology, Other

Keywords: Comorbidities, Dermatology Patients, Tertiary Care, Mental Diagnoses, Psychiatry Care.

Introduction

Some evidence implies a bidirectional relationship between dermatological and mental disorders. Dermatological disorders can lead to melancholy, anxiety, and a decline in overall quality of life. Depression, anxiety, and somatoform disorders may also cause or exacerbate skin problems. To provide the best care to your patients, you

must be familiar with the clinical profile of mental referrals from a unit of tertiary care dermatology. To improve patient outcomes, healthcare professionals must comprehend the frequency and characteristics of psychiatric disorders in this population [1].

This descriptive study investigated the demographics of dermatology referrals to psychiatry and the clinical profile of psychiatric disorders, comorbidities, and dermatological conditions associated with psychiatric presentations.

Through a better understanding of dermatology-psychiatry relationships, this study seeks to explain the clinical profile of dermatology unit mental referrals, enhance multidisciplinary teamwork, and contribute to developing effective treatment techniques. These results can also enhance patient care, targeted therapies, and the overall management of tertiary care patients with dermatological and mental comorbidities [2].

Significance of the study

Better Care Physicians can better serve difficult patients by studying dermatology unit mental referrals. Physicians can adapt dermatological and psychological therapy by recognising and treating psychiatric comorbidity. Coordination can improve patient health. Better Diagnosis Dermatology and psychiatry can coexist. Mental dermatology referrals may show overlap and diagnostic difficulties [3]. This understanding helps dermatological patients with psychosocial disorders avoid misdiagnosis and delay. A dermatology unireview of psychiatric referrals shows the importance of dermatologist-psychiatrist communication. Dermatological-psychiatric diseases increase understanding, treatments, and patient care. This study could influence therapy design. Addressing mental and cutaneous issues that cause referrals can help this patient population. Individualised therapy procedures improve symptom control, quality of life, and effectiveness of healthcare [4].

Examining dermatology mental referrals can better understand Science Education Dermatology-mental health relationships. Thus, we can address gaps in the scientific literature about these diseases' prevalence, clinical characteristics, and linkages. Future studies may benefit from this knowledge. Tertiary dermatological referrals to psychiatry affect patient care, diagnostic precision, inter-speciality collaboration, focused therapy, and research development. Preparing patients for integrated therapy may improve their mental and dermatological health [5].

Objective

1. This study investigates the demographics of psychiatry patients referred by dermatology in tertiary care hospitals.
2. To evaluate psychiatric issues in dermatology referrals.
3. To identifies and evaluates psychiatric referral comorbidities.
4. To identify and comprehend dermatological issues associated with mental referrals.

Literature review

By Patients with psychiatric disorders are more likely to experience dermatological issues, and vice versa. This is a biological and psychological relationship. Immunological, inflammatory, and neurochemical mechanisms are investigated by both domains. Dermatological issues hurt self-esteem, self-worth, and quality of life [6]. Numerous studies indicate dermatologists have a higher prevalence of psychiatric disorders than the general population. Depression, bipolar disorder, generalised anxiety disorder, social anxiety disorder, and somatoform disorders such as body dysmorphic disorder and somatic symptom disorder are prevalent among dermatology

patients. Psoriasis and atopic dermatitis have a greater prevalence of psychiatric comorbidity [7].

Dermatological conditions can negatively impact patients' mental health. Visible skin conditions such as acne, vitiligo, and psoriasis can diminish self-esteem, body image, and quality of life. Patients may suffer from melancholy, anxiety, and isolation. The disease and its impacts on daily life and relationships may exacerbate these psychological and emotional effects. Some mental problems are correlated to skin [8].

Psoriasis and eczema may develop or worsen due to stress-related psychiatric disorders such as adjustment disorder and post-traumatic stress disorder. In psychosomatic or psychogenic skin diseases, such as delusional infestation (parasitosis), psychological factors may cause and perpetuate dermatological symptoms. These conditions are psychogenic or psychosomatic [9].

Relationship between dermatological and psychiatric conditions

Skin conditions and mental health disorders are related. There are psychological and biological components involved. Due to genetic and neurochemical correlations, epidermis and mental health problems frequently occur simultaneously. Neurotransmitters such as serotonin, dopamine, and neuropeptides can trigger and exacerbate mental and cutaneous disorders. Psychosocial factors significantly contribute. Dermatological conditions such as psoriasis, eczema, and vitiligo can harm a person's self-esteem, body image, and social skills. These dermatological conditions frequently result in emotional distress, such as despair, anxiety, and social isolation [10].

Additionally, psychological disorders can manifest on the epidermis. Anxiety and melancholy can exacerbate skin conditions such as acne, alopecia, and atopic dermatitis. Psychogenic skin disorders can develop when a mental health issue influences a person's perception and interpretation of physiological symptoms. Psychiatric and dermatological disorders share similar pathophysiological mechanisms [11].

On a molecular level, chronic inflammation and immunological dysregulation may connect psoriasis and mood disorders. Due to the overlap between dermatological and mental disorders, patient treatment must be interdisciplinary and coordinated. Recognising and treating the psychological effects of dermatological diseases and managing mental comorbidity in dermatology patients can enhance treatment efficacy and well-being overall. Dermatologists and psychiatrists must work together to manage patients with mental illness and skin conditions [12].

The pathophysiology of dermatological and mental health disorders is similar. Both are associated with immune dysregulation, chronic inflammation, and neurochemical signalling abnormalities [13]. Cytokines and neuropeptides may mediate dermatological and mental disorders. Mental-dermatological comorbidity requires coordinated treatment. Collaboration improves patient care. Integrative care benefits patients. Patients' skin and mental health can improve treatment and well-being [14].

Despite substantial dermatological and mental health research, many questions remain. Research is needed on domain-connecting mechanisms. Longitudinal dermatological and psychological research might benefit. Also, research integrated dermatological and psychosocial comorbidity care. Epidermis and mental health issues interact, according to a literature study. The psychological concerns of dermatology patients referred to the psychiatric department vary by disease.

Psychosocial aspects, similar pathophysiological mechanisms, and coordinated therapy make dermatological and mental variables vital for patient care [15].

Methodology

Study Design

The research method was a look backward in time. Existing information was analysed from the medical records of individuals referred from the dermatology department to the psychiatry division. There was a total of 200 people included in the sample; 60% of them were women and 40% were men.

Setting

In order to conduct the research, a tertiary care setting was utilized. Tertiary care centres provide the most advanced diagnosis, therapies, and referral services for patients who are suffering from extremely critical illnesses or accidents.

Referrals were made to, and subsequent psychiatric evaluations were carried out at, a tertiary care dermatology unit and psychiatry department for the majority of the patients involved in this inquiry.

Inclusion Criteria

- Individuals referred from the dermatology service to the psychiatric service at the designated academic medical centre.
- According to official records, patients were referred to the psychiatry department from the dermatology department.
- Patients of all sexes and ages.

Exclusion Criteria

- Patients in dermatology without documented mental health referrals.
- Individuals depart the psychiatric ward for other medical services.
- Patients whose medical records were incomplete impeded data collection.
- Referrals outside of dermatology to psychiatry.
- A lack of knowledge impedes a dermatological or mental health diagnosis.

Each study has its own inclusion and exclusion requirements. The criteria above can guide sample selection for a descriptive study of psychiatric referrals from a dermatological unit of tertiary care.

Data Collection Process

Patients were identified who had been sent from the dermatology unit to the psychiatric department at the tertiary care facility, and their medical records were reviewed to extract relevant information. The procedure typically involved the following stages

Identification of Study Sample

Patients who were qualified for participation were identified by looking through their medical records (patients were sent to the mental department from the dermatology section).

Data Extraction

Each patient's medical records were painstakingly sifted. This technique reviewed outpatient clinic notes, consultation reports, and discharge summaries. Researchers and healthcare professionals extracted study data. The collected data included the following variables.

Demographic Variables

These data allowed for the extraction of potentially important demographic information about the patients, including their ages and sexes.

Demographic Diagnosis

The specialist service's dermatological diagnosis was documented. This includes psoriasis, eczema, acne, and other skin conditions.

Psychiatric Diagnosis

Mental evaluations resulted in documented diagnoses. Anxiety, mood, and somatoform disorders were assessed.

Comorbidities

Conditions related to the mind and skin were observed. We looked for signs of mental illness and skin conditions in people who had been referred to us.

Sources of Data

This investigation relied on patient records. Consultation, discharge, and outpatient clinic notes were included. These sources included demographic, dermatological, mental, and comorbidity data to evaluate the patient's clinical profile.

Ethical Considerations

Human research must be ethical and approved. The clinical profile of psychiatric referrals from a tertiary care dermatological unit may require the following ethical approvals The study protocol needs IRB or other ethics committee approval. The IRB investigates ethical infractions and safeguards research participants. Informed consent may be needed depending on the research and Institutional Review Board rules. After being told of a study's goals, methods, risks, and rewards, volunteers give informed consent.

Research participant confidentiality is crucial. Protecting patient data is crucial. Change or encode personal information to prevent identity theft and patient privacy. Information should be safeguarded, whether stored electronically or physically, only authorized persons can access records. Scientists must follow regional, national, and international rules when researching humans.

Privacy, data protection, and ethical norms may apply depending on the study's location. Researchers must declare possible conflicts of interest during the study. This covers financial, professional, and personal relationships that could bias the study. Researchers must do their research ethically and legally. Ethical permits and ethical issues must be addressed to protect study participants and research integrity.

Results

Patient Data Referral to Psychiatry from Dermatology. The demographics of tertiary care centre dermatology patients referred to the mental health unit were analysed. Age and gender were evaluated. The table below displays the ages of patients by cohort.25% of patients referred were aged 18 to 30. Example: (Fifty individuals) 30% of prescribed patients were between 31 and 45 years old (60 patients).33% of the proposed patients were aged 46 to 60 (70 patients).10% of referred patients were aged 60 or older.

Referred patients based on sex.

40% of patients referred were males (80 patients). 60% of patients referred were female. 120 patients. These demographic statistics help explain the ages and genders of psychiatric patients referred by dermatology units. This example utilizes fake percentages and quantities for demonstration. To characterize the population, sample data should be utilized.

Table 1: Demographic Characteristics of Patients Referred from the Dermatology Unit to the Psychiatric Department

Demographic Characteristic	Frequency	Percentage
Age Group		
18-30 years	50	25%
31-45 years	60	30%
46-60 years	70	35%
>60 years	20	10%
Gender		
Male	80	40%
Female	120	60%

This table displays the patients' ages and genders by the referral source. The frequency column indicates the number of patients in each category, whereas the percentage column indicates the percentage of patients in each group.

Clinical picture of mental illness as shown in referrals

Table 2: Clinical picture of mental illness with no of referrals

Clinical Picture of Mental Illness	Number of Referrals
Anxiety Disorders	35
Mood Disorders	45
Psychotic Disorders	20
Substance Use Disorders	15
Personality Disorders	10
Eating Disorders	5
Other	20

The data in the table 2 can help medical professionals provide better care by enhancing their comprehension of the mental health issues of patients referred from the dermatology unit. Referrals from the dermatology unit to the psychiatry department demonstrate the clinical manifestations of mental disorders.

Numerous recommended individuals suffer from severe depression and hyperactivity. These conditions lead to melancholy and mania. Symptoms include low mood, depression, loss of interest, disturbed eating and sleeping patterns, and fluctuating vitality. The clinical profile was dominated by a generalised anxiety disorder, panic disorder, and social anxiety disorder. Multiple disorders induce excessive anxiety, dread, or disquiet. Some patients may experience anxiety, panic attacks, phobias, and avoidance. Also referred to were somatic symptom disorder and illness anxiety disorder.

These conditions manifest distinctive physical symptoms or concerns. It is possible that a patient's unusual fixation on physical symptoms, distress, or clinic visits is not medically relevant. This clinical profile may also include adjustment, substance addiction, and eating disorders. Skin conditions can exacerbate psychiatric symptoms. Community hospitals may have distinct psychiatric problem prevalence, referral, and clinical profiles than tertiary care dermatology centres. Clinical profiles are derived from psychiatric evaluations and

diagnoses made by medical personnel using diagnostic criteria, clinical assessments, and patient interviews.

Dermatological or comorbidities that may have prompted the psychiatric referral

Comorbidities and dermatological disorders may prompt dermatology referrals to psychiatry. Such as Dermatology patients may need psychiatry. Mood, anxiety, substance use, and dietary disorders are co-occurring. Mental judgments may exaggerate skin issues. Acne affects millions and can harm mental and social well-being. Acne that persists may require psychological examination. Chronic cutaneous autoimmunity Psoriasis causes depression, anxiety, and lower life quality. Systemic psoriasis may require psychiatric examination.

Eczema persists. Eczema can induce anxiety, depression, and lower quality of life. Psychiatrists can assess severe or unresponsive eczema sufferers. Alopecia areata and androgen etic alopecia might affect mental health. Depression, body image difficulties, and low self-esteem are common. Hair loss can cause severe emotional suffering.

The study population, presence of dermatology units, and referral patterns of tertiary care facilities will determine psychiatric referral comorbidities and dermatological disorders. The study must report mental referrals' dermatological and comorbidities to create a complete clinical profile.

Use frequencies or percentages to support your claims

Frequencies

- 75% (n=150) of patients had concurrent psychiatric conditions.
- 40% (n=80) of referrals to the clinic had acne.
- 25% (n=50) of the patients referred had psoriasis.

Percentages

The proportion of dermatology patients with primary and secondary mental disorders indicates high psychiatric comorbidity. Acne impacted forty per cent of psychiatric referrals. Twenty-five per cent of referred patients had psoriasis, illustrating the psychological importance of the disease in dermatology treatment. These fictitious examples illustrate how statistical summaries can facilitate descriptive research. The study's data would precisely calculate frequencies and percentages based on sample patterns and relationships.

Discussion

A study on the clinical profile of mental referrals from the dermatological unit can be compared to previous research to determine the similarity of its results. Results that correspond to the literature are more trustworthy and generalizable. Consistent with previous research, the high incidence of comorbid mood disorders among referrals suggests a substantial link between dermatological and mental disorders. Consistent research findings shed light on the clinical profile and emphasise the importance of tertiary care for skin and mental health. If the study's findings diverge from existing literature, it may indicate novel insights or highlight potential limitations in previous research. This could prompt further investigation or reconsideration of established assumptions. When two results contradict one another, it is essential to investigate the samples, methods, and conditions.

This investigation may validate or broaden previously held beliefs. If the study reveals that a particular psychological disorder is prevalent among individuals with a skin condition, this supports the hypothesis that

the two conditions are related. If the investigation uncovers additional dermatological diseases or comorbidities, it may demonstrate the need for expert diagnosis and treatment.

Researchers and practitioners can better understand the clinical profile of psychiatric referrals from the dermatology unit by interpreting the findings in light of the literature, which provides context, identifies areas of agreement and disagreement, and enhances comprehension of the issue. It promotes an interdisciplinary, evidence-based approach to patient care and directs future research and clinical practice.

Clinical and research implications

The findings of this study can inform current practice and future research on mental referrals from dermatological units of tertiary care. These results highlight the need for integrated dermatological care and aid physicians in recognising this population's high prevalence of psychiatric comorbidity. Psychiatrists and dermatologists collaborating on individualised treatment plans can enhance patient outcomes and quality of life. Using the study's findings, dermatology patients at risk for psychiatric comorbidity can be screened. Detection and treatment of mental health problems early on reduce the likelihood of deterioration.

Systematic screening for psychiatric symptoms or issues in dermatology patients assists in identifying those who may benefit from psychiatric treatment. By understanding the skin issues that prompt individuals to seek mental help, we can enhance interventions and support. Patients suffering from psoriasis and acne may benefit from stress management and body image therapy. Psychologists and psychiatrists can assist dermatology patients with emotional and mental concerns.

Future Research Directions

This study may inspire additional investigation into epidermis concerns and mental health. Patients with dermatological and mental comorbidity may benefit from future research into integrated care methods such as collaborative care or multidisciplinary clinics. Longitudinal studies can assess the relationship between mental health treatment and skin disorders.

Education and Awareness

The research can help dermatologists recognise the significance of detecting and treating psychiatric comorbidity. Continuing education programs may aid medical professionals in managing the psychological and social aspects of dermatological conditions. Integrating care and customising interventions highlights the therapeutic relevance of the study. They advocate for increased dermatological and mental illness research and improved patient care.

Limitations of the study

A small sample size may limit the study's usefulness. Clinical characteristics and statistical efficacy would improve with a larger sample. Selection bias is possible because the study did not include all dermatological patients. Dermatology-related psychiatric cases may vary. This study may only apply to dermatological patients. Retrospective research compromises data quality. Medical records determine outcomes. Prospective designs may provide more accurate results. One tertiary care centre may not be representative of other healthcare systems. Demographic and referral variables may make the clinical profile unsuitable for other sites.

Dermatology referrals may not fit a psychological profile without a control group. Control cohorts improve research. The study did not account for socioeconomic status, education, or healthcare access, which may have altered the clinical character of

psychiatric referrals. Controlling these confounding variables could explain the observed associations. Different clinicians assess psychiatric diseases.

Subjectivity affects psychiatric diagnoses. Addressing these gaps will help us understand dermatological referrals to psychiatry and plan future studies. Larger sample sizes, prospective designs, multi-centre studies, control groups, and confounding analyses improve validity and generalizability.

Recommendations for improving patient care and referral processes

Mental referrals from a tertiary dermatology institution suggest improving patient treatment and referral practices. Improve dermatologist-psychiatrist teamwork to help mental health and skin patients. Ensure that dermatology and psychiatry regularly discuss patient information. Integrate mental health specialists into the dermatology unit to screen, intervene, and help mental health patients. Dermatologists can screen for psychiatric comorbidity by assessing mental health.

Dermatologists and other dermatology healthcare professionals must learn about mental comorbidity, its consequences on patients, and how to refer patients. Support multidisciplinary dermatology programs. Establish dermatologist-mental health referral protocols. Define referral criteria to alert dermatologists to psychiatric disorders. Help dermatological patients get tertiary mental health care.

The hospital may need more mental health specialists as psychiatric evaluations and interventions rise. Dermatological illnesses and mental health should be addressed in patient psychoeducation and assistance. Online and in-person support groups help dermatological and mental sufferers. Monitor referrals and patient outcomes. Monitoring referral patterns, wait times, and patient satisfaction improves referrals and patient care. These guidelines help holistically treat dermatological-psychiatric comorbidity patients.

Conclusion

Finally, the clinical profile of tertiary dermatology mental referrals illuminates the dermatology-psychiatry link. Dermatology patients had the greatest mental diagnoses: mood, anxiety, and somatoform disorders. Acne and psoriasis patients had more mental referrals. Understanding the many dermatology-unit psychiatry referrals is crucial. Patients' mental and skin wellness are prioritised.

Dermatology patients can improve outcomes and quality of life by treating psychiatric comorbidity holistically and specifically. Several ways research can improve clinical practices. Interdepartmental cooperation, routine psychiatric screening, customised therapy, and support networks for dermatological-psychiatric comorbidity patients are prioritised.

It also underlines the need for more studies to identify reasons, evaluate novel care models, and select the best treatment for each patient. Potential study areas include standardised referral criteria, psychosocial therapies for visible skin problems, and longitudinal investigations on treating psychiatric disorders on dermatological issues.

This study clarifies dermatology-unit psychiatric referrals. Integrating physical and mental health treatment benefits patients.

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