

Commentary to the Paper “Prevalence of the Most Frequent Neuropsychiatric Diagnoses in Hospitalized SARS-CoV-2 Patients Evaluated by Liaison Psychiatry: Cross-Sectional Study”

Comentário ao Artigo “Prevalence of the Most Frequent Neuropsychiatric Diagnoses in Hospitalized SARS-CoV-2 Patients Evaluated by Liaison Psychiatry: Cross-Sectional Study”

Keywords: COVID-19; Delirium; Mental Health Services; Psychiatry; Referral and Consultation

Palavras-chave: COVID-19; Delírio; Encaminhamento e Consulta; Psiquiatria; Serviços de Saúde Mental

Dear Editor,

We have read with great interest the article by Fernandes *et al*¹ recently published in Acta Médica Portuguesa reporting the prevalence of neuropsychiatric diagnoses in hospitalized COVID-19 patients evaluated by a consultant liaison (CL) psychiatry unit. They found delirium to be the most prevalent neuropsychiatric condition in this population, which is in line with what has been described, although lower prevalence rates were reported by other studies.² There are several articles reporting a high prevalence of delirium in COVID-19 patients but there is a lack of studies directly comparing the incidence and prevalence of delirium between COVID-19 and non-COVID-19 hospitalized patients. Therefore, it is still unclear if SARS-CoV-2 infection is specifically associated with delirium leading to a higher risk for this syndrome when compared with other similar diseases.

We recently analyzed the referral pattern to our CL psychiatric unit (March 2020 to March 2021) and delirium was the most prevalent condition (23.8%). Followed by depressive (18.9%) and anxious (16.9%) syndromes. However, the prevalence of delirium was not significantly different when comparing COVID-19 and non-COVID-19 patients. Jäckel *et al* in 2020 and 2021³ evaluated the prevalence of delirium in intensive care units (ICU), and they also found that delirium was not more frequent in COVID-19 patients. In their first study, the prevalence of delirium did not differ between patients with viral acute respiratory distress syndrome due to influenza or SARS-CoV-2,³ being actually lower in COVID-19 patients.³ These findings should be carefully interpreted when compared to our results, since delirium is more prevalent in ICU regardless of the primary health condition.⁴ Nevertheless, the overall prevalence of delirium in hospitalized patients in a 2016 meta-analysis study

was approximately 23%,⁴ which is similar to the reported rates in another meta-analysis of delirium prevalence in COVID-19 patients.²

Moreover, previous authors attempted to determine if there were specific characteristics of delirium associated with COVID-19 infection, namely, if there was a specific subtype or different response profiles to pharmacological interventions.⁵ However, clear evidence of distinct characteristics was not found.

Despite the apparent specificity of the neurological tropism of the virus,² taking all this evidence together, we must admit the possibility that SARS-CoV-2 infection may not be a specific risk factor for delirium. Its high prevalence may be related with the prevalence of other risk factors for delirium, which may be also shared by hospitalized COVID-19 patients. More studies comparing delirium in hospitalized COVID-19 and non-COVID-19 patients should be conducted.

AUTHORS CONTRIBUTION

GA, RS: First author. Data collection, conception of the work, draft of the paper.

LG, CG: Critical review of the manuscript.

FN: Draft and critical review of the manuscript.

PROTECTION OF HUMANS AND ANIMALS

The authors have followed the protocols of their work center on the publication of data. The data was anonymized and none of the authors had access to patient identification. The study was conducted in accordance with the Helsinki Declaration updated in 2013.

DATA CONFIDENTIALITY

The authors declare having followed the protocols in use at their working center regarding patients' data publication.

COMPETING INTERESTS

GA, RS, LG, CG: Declared no competing interests exist.

FN: Received payment or honoraria for lectures, presentations, speakers, bureaus, manuscript writing or educational events from Tecnifar and Lundbeck. Received payment for expert testimony from iQVIA. received support for attending meetings and/or travel from Viatrix and Angellini.

FUNDING SOURCES

The authors received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

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Recebido/Received: 02/07/2022 - Aceite/Accepted: 04/07/2022 - Publicado/Published: 01/09/2022

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<https://doi.org/10.20344/amp.18802>

Comment on: Diffuse Large B-Cell Lymphoma with Axillary Cutaneous Invasion in a HIV Positive Patient

Comentário a: Linfoma Difuso de Grandes Células B com Invasão Cutânea Axilar num Doente com Infecção VIH

Keywords: HIV Infections; Lymphoma, Large B-Cell, Diffuse
Palavras-chave: Infecções por HIV; Linfoma Difuso de Grandes Células B

Dear Editor,

We read with great interest the article published by Dias *et al.*¹ The authors report the case of a 34-year-old man with untreated HIV-1 infection that was admitted to the hospital with obstructive jaundice and progressive swelling of the left axillary region.¹ An imaging study by computed tomography scan revealed an expansive 3.2 cm pancreatic mass and multiple hypodense liver lesions. Hepatic and pancreatic biopsy confirmed the presence of stage IV diffuse large B-cell lymphoma.

Additionally, on dermatological examination, the presence of multiple erythematous papules and nodules of variable size, upon an area of nontender swelling, in the left axillary region was also evident, which the authors identified as cutaneous invasion by diffuse large B-cell lymphoma.

The cutaneous manifestations of systemic lymphomas can be varied and are often non-specific. Their diagnosis relies on correlation with histopathological examination and immunohistochemical staining of an appropriate skin biopsy.² This procedure would be a necessary step to establish a definitive diagnosis of skin infiltration by diffuse large B-cell lymphoma.

Notably, a broad spectrum of infectious, inflammatory, and neoplastic skin conditions may develop in the setting of HIV infection,³ particularly in severely immunosuppressed patients, who often have mixed infections or combined infectious–neoplastic or inflammatory–neoplastic lesions.³ The reported patient had a CD4⁺ T-cell count of 133

cells/mm³ (11.8%), which is classified as WHO clinical stage 4 HIV infection (the severely symptomatic stage) and can encompass all the AIDS-defining illnesses.³ In this setting, the differential diagnosis of multiple erythematous papules and nodules is broad and includes entities such as Kaposi sarcoma, cutaneous tuberculosis and non-tuberculous mycobacterial skin infections, fungal infections (for example, chromoblastomycosis, coccidioidomycosis or histoplasmosis) and cutaneous leishmaniasis.⁴

With this comment, we wish to draw attention to the importance of clinical-histopathological correlation for an accurate diagnosis of cutaneous manifestations of systemic diseases.

AUTHORS CONTRIBUTION

JB: Draft of the paper.

MC: Critical review, approval of the final version.

PROTECTION OF HUMANS AND ANIMALS

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COMPETING INTERESTS

The authors have declared that no competing interests exist.

FUNDING SOURCES

The authors received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

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