

# Correspondence

## Collaborative care for depression in diabetes: Challenges, opportunities and strategies

Depression, a major public health problem, is gradually climbing up the list of the global burden of disease to the second place.<sup>1</sup> Depression has incremental effect on the disability caused by the non-communicable disease (NCD) itself. With diabetes, it has the most incapacitating impact, resultant disability being more than the summative disability.<sup>2</sup> Coexistence of depression with diabetes results in poor glycaemic control and more complications due to poor self-care and lack of adherence to treatment. Depression often hinders diagnosis and management of diabetes due to delayed help-seeking and excessive concern about side-effects of medication.<sup>3</sup>

People with diabetes are two times more likely to be depressed as compared to the general population. Compared to the west, one-fourth to one-third higher proportion of people with diabetes have depression in low- and middle-income countries.<sup>4</sup> India has the second largest population with diabetes in the world with about a third having comorbid depression. Low socioeconomic status, education, unemployment, female gender and high body mass index are risk factors for depression in India. The synergistic effect of socioeconomic risk factors for NCDs and mental disorders is termed as 'syndemic approach', which is useful for developing and implementing integrated intervention programmes.

Collaborative care of depression and diabetes improves both glycaemic control and depression. By definition, collaborative care is management of psychiatric disorders in medical settings. The core components include systematic identification of patients with psychiatric disorders, working of physicians and psychiatrists as a team and stepped up approach of treatment as per patient needs. International guidelines recommend this approach for meeting the complex needs of this vulnerable population.<sup>4</sup> Systematic reviews report significant improvement in reduction of symptoms, glycaemic control, improved functionality and cost-effectiveness.

Collaborative care is feasible and cost-effective in low-income populations and primary care settings. Non-specialist health workers have been employed for providing mental healthcare in the community. Implementation of collaborative care approach is labelled as 'grand challenges in global health'. The difficulty lies in training the workforce in delivering interventions and coordinating service delivery.

A district mental health programme is currently operational in about 50% of the districts where mental healthcare can be integrated at the subcentre, primary and community health centre levels. Community health workers, nurses and doctors can be trained in identifying and treating depression in patients with diabetes. The prescribed doctor's manual under the National Mental Health Programme (NMHP) can be used for training depression while Patient Health Questionnaire 9 can be used as a screening instrument. On-going supervision at the community level can be provided by specialists through the nodal centres.

There is a need to integrate the National Programme for Prevention and Control of Diabetes, Cancer and Stroke and NMHP, which are currently working in separate compartments.<sup>5</sup> Local-level solutions by using the existing community resources in terms of workforce, logistics and indigenous service providers and integrating them into the health system can help in establishing collaborative care. This system level integration can provide solution to this public health challenge.

*Conflicts of interest.* None declared

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Suravi Patra

Department of Psychiatry

Binod Kumar Patro

Department of Community Medicine and Family Medicine

AIIMS Bhubaneswar

Odisha

India

patrasuravi@gmail.com

## ***Burkholderia cepacia*: An uncommon cause of bilateral primary psoas abscesses in a patient with a Pott spine that cannot be ignored**

*Burkholderia cepacia* is a Gram-negative, non-fermentative, aerobic, motile, non-spore-forming bacillus.<sup>1</sup> It is frequently found as a saprophyte in soil, water and other damp environments and is an opportunistic pathogen in patients with underlying medical disorders.<sup>2,3</sup> Extrapulmonary manifestations are rare and small number of cases of abscess due to this organism have been described in the 'at-risk' group.<sup>1,4–7</sup> Infections are difficult to treat as this pathogen is inherently resistant to multiple antibiotics. Till date, there are no reports of psoas abscess caused by *B. cepacia* from India. We report a rare case of primary, bilateral large psoas abscesses due to *B. cepacia* in a patient with tuberculosis of the spine.

A 60-year-old man with diabetes and hypertension presented to the neurosurgical outpatient department of our hospital for evaluation of fever of unknown origin. A detailed history revealed tuberculosis of the spine and that he was on antitubercular treatment for 4 months. He had a history of bilateral lower limb weakness for 4 months and bladder/bowel dysfunction for 1 month prior to his present complaint, following which he was started on antitubercular therapy. He had been complaining of fever for 3 weeks before the referral despite receiving intravenous antibiotics at a private hospital. His physical examination at our institute showed that he was febrile (101 °F) and had a pulse rate of 100/minute. Laboratory data revealed a total leukocyte count of 16 000/cmm with 80% polymorphonuclear leucocytes. A blood culture done at this time was sterile. No inflammatory diseases in the bowel were identified by radiographic and endoscopic examination. Contrast-enhanced magnetic resonance imaging (MRI) of the lumbosacral spine showed large bilateral psoas