Editorial

Dry eye and mental health☆

Ojo seco y salud mental

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Chronic ocular discomfort (COD) is one of the main reasons for ophthalmological consultations, mostly due to the broad concept of dry eyes. Frequently, symptoms are not related to clinical findings, which makes its diagnosis difficult and does not enable ophthalmologists to understand the cause of the discomfort. In addition, if the treatment is not sufficient, the patient will become a frequent visitor to the practice, which will give rise to growing frustration both for the patient and ophthalmologist, the end result of which is that dissatisfied patients will blame ophthalmologists and will become unwelcome at the practice, not to mention the considerable impact caused by frequent visits.

COD is one of the many issues to be resolved in ophthalmology, which at present is vaguely classified within the broad range of dry eye. In the quest for new diagnostic methods, clinical tests based on biomarkers have been developed and have made some progress but still lack precision. Over a decade ago it was demonstrated that the dry eye has an immunological basis. On the other hand, several recently published articles related COD with psychiatric disorders, 1–4 even though this association was known previously and could be due to the ocular dryness produced by many of the drugs prescribed for said disorders. In addition, the perception of discomfort is greater in these patients 5 and has a significant impact on their quality of life.

The finding of highly inflammatory marker levels in several psychiatric disorders seems to be of greater interest. Even though most of the studies have focused on major depression, similar results were observed in other disorders such as anxiety or fibromyalgia. In fact, one of the effects of antidepressants is to reduce the effects of inflammatory cytokines in the brain. 6

Anxiety and stress are considered to be risk factors for the worsening of epidemic inflammatory diseases, including psoriasis. 7 The free edge disease (blepharitis or Meibomium disease) is frequently associated to several forms of dermatitis and it is almost a norm that worsening is associated to cycles of emotional instability. These fluctuations make the assessment of free edge and its relation with COD more difficult. It has been documented that patients with blepharitis are at greater risk of suffering anxiety and depression. 8 Accordingly, the situation is rather complicated because ocular surface diseases frequently are difficult to assess and to manage. If these diseases associate mental problems, well beyond our clinical training, it is easy to explain the difficulty in correctly treating these conditions.

The growing evidence that many psychiatric disorders could have a physiopathological relationship with COD requires ophthalmologists to change our approaches. By way of example, a few years ago we described alterations in corneal sensitivity of fibromyalgia patients. 9 It must be accepted that the discomfort referred by a patient is genuine and could even be within the framework of the psychiatric disorder. The perception of symptoms and its influence on quality of life are more acute in these cases. We must also understand that unsuccessful treatments which fail to control COD could

☆ Please cite this article as: Durán de la Colina JA. Ojo seco y salud mental. Arch Soc Esp Oftalmol. 2014;89:345–346.
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worsen the psychiatric condition of these patients and more importantly, simple artificial tears will not achieve a balance in the entire process.

However, there is a twofold positive side in this story. On the one hand, it opens up a research path which could explain what is happening on the ocular surface of patients who complain “without reason” (we must admit that we do not carry out a full examination in all patients). On the other hand, it is possible that the more severe and persistent cases could benefit from psychiatric treatment or psychotherapy. Basically, for minor disorders such as anxiety and stress, an explanation by the ophthalmologist will surely be appreciated by patients and will prove very positive for managing their blepharitis.

In summary and by way of practical conclusion, evidence justifies cooperation of the ophthalmologist with a psychiatrist or psychologist for adequate management of a specific group of patients with COD. It is probable that said professionals will not be aware of the impact of this discomfort in the course of the disease of their patients and for this reason an in-depth understanding of the issue would benefit both their ocular and psychological conditions.

REFERENCES