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Clinical Rounds

Common conditions look similar

Dying Patients Need Tailored Mental Health Care

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NEW ORLEANS - Mental disorders can be difficult to diagnose in terminal patients, but not impossible, said Dr. Steve Taylor at the annual meeting of the American Academy of Family Physicians.

Often, the symptoms overlap and the patient gives you little to go on. But the right diagnosis and treatment can make all the difference. "It is possible to tease these things apart and to treat these illnesses and to have people respond," said Dr. Taylor, a Covington, La., psychiatrist specializing in the treatment of terminal patients.

Anxiety and depression share some symptoms and, outwardly, can look the same, he said. "But if a patient says to you 'I'm afraid,' it's anxiety. If he says, 'I'm no good,' it's depression."

Sleep patterns provide another clue. "The number one question for a psychiatrist is 'How did you sleep?' followed by 'How did you wake up?'" Patients with anxiety have trouble falling asleep, while patients with depression often have trouble staying asleep. "If you're depressed, you don't have enough catecholamines to hold you down and get rid of consciousness."

For anxiety, Dr. Taylor recommends using a selective serotonin reuptake inhibitor (SSRI). You may have to use a benzodiazepine initially as well, until the SSRI takes effect. After adding risperidone, haloperidol, or olanzapine to the SSRI, most patients will have a remission of their depression.

Grief and depression also appear very much alike. The key to telling the two apart is whether the patient is functioning. A grieving person can still function-get the kids off to school or go to work. Depressed patients can't or won't function.

"The chief way that I tell grief from depression is whether they have the mirth response," said Dr. Taylor. For example, a woman who is grieving will temporarily lighten up upon seeing her grandchildren. A woman who is depressed will not respond even to her grandchildren.

You can almost differentiate between dementia and depression on appearance alone, he said. A demented patient is polite, tries hard to answer your questions, and tries to hide memory problems. Typically there is a slow onset of cognitive problems. On the other hand, a depressed patient looks shoddy and unkempt. He or she is petulant and won't answer questions. The onset of this behavior is sudden.

The selection of a drug for the treatment of depression in these patients may depend on how long the patient is expected to live.

For patients with only a few weeks to live, Dr. Taylor often uses methylphenidate. The benefits of the stimulant outweigh the potential for addiction in these cases. However, if a patient is expected to live several months, he generally uses SSRIs. If these aren't entirely effective he may add bupropion.

Check with the patient to find out if sexual dysfunction-a typical side effect of SSRIs-is a concern.

Likewise, delirium and dementia appear similar on the surface. Delirium typically has a fluctuating course marked by a clouding of consciousness and major attention deficit. In contrast, a patient's dementia is believed to have no foundation in their consciousness.

Delirium usually responds well to the antipsychotics (haloperidol, risperidone, olanzapine, quetiapine, droperidol, ziprasidone). But don't use benzodiazepines. "All you're doing is making the problem worse," said Dr. Taylor.

If you've eliminated anxiety, grief, depression, and delirium and still aren't sure that a patient has dementia, have him or her draw a box. Most forms of dementia involve the parietal lobe and exhibit spatial disruption. As the severity of dementia increases, so does the distortion of the cube that the patient draws.