Is it Medical, Psychiatric, or Both?

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Disclosures

- Dr. Susan Padrino and Dr. Michelle Romero have no conflicts of interest to disclose.
- There is no discussion of off-label treatment recommendations in this presentation.

Learning Objectives

- Participants will be able to:
  - List clues to distinguish between medical and psychiatric diagnoses.
  - Identify common illnesses that have overlapping medical and psychiatric symptoms.
  - Access resources to perform a suicide risk assessment.

Why is this important?

- Primary care physicians write most prescriptions for anti-depressants and anxiolytics.
- Those with chronic illness are at an increased risk for the development of mood disorders, anxiety disorders, and substance-related disorders.
- Most patients with psychiatric disorders are seen in primary care settings.

Wise, M. G., & Rundell, J. R. (2005). Effective psychiatric consultation in a changing health care environment. In *Clinical manual of psychosomatic medicine: A guide to consultation-liaison psychiatry* (pp. 1-10). Arlington, VA: American Psychiatric Pub.

Clues

Information	Medical	Psychiatric
Age	>55 & no past psych hx >65yo	Late teens/Early 20's
Medication	Many medications, "suspect" medications	
Physical Symptoms	Multiple specific physical complaints	Fewer physical signs/symptoms, or vague complaints
Onset of Symptoms	Acute Onset	Weeks to Months
Patient Report	Lack of subjective report of mood/anxiety	

Clues

Specific symptom	Medical	Psychiatric
Sleep	Overweight, obese, shortened chin; Falling asleep quickly; Always tired	Initial Insomnia End Insomnia
Appetite/Weight	Rapid fluctuation or weight change w/o change in appetite	Change of appetite consistent with change in weight
Change in Cognition	Rapid (watch out for Delirium!)	Slower decline/difficulty concentrating
Hallucinations	Visual	Auditory

Sadock, B. J., Sadock, V. A., Ruiz, P., & Kaplan, H. I. (2009). Medical assessment and laboratory testing in psychiatry. In *Kaplan & Sadock's comprehensive textbook of psychiatry* (pp. 995-1013). Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins.

Conditions with Overlapping Symptoms

- Anemia
- Thyroid Disease
- Hormonal Changes
- Neurological Illness
- Cardiac Illness
- Infectious Disease

Case #1: Mr. Summers

- **CC**: "I can't sleep!"

- **HPI**: Mr. Summers is a **64yo** divorced male with a medical history significant for **COPD** and **Bipolar I Disorder** who was recently hospitalized with a **COPD Exacerbation**. On follow-up in your office today, he reports that he has not been able to sleep since he got out of the hospital. He feels "great" and his breathing is "the best it's ever been!" Mr. Summers has been taking his medications as directed on hospital discharge. He has tried alcohol to help fall asleep, but this has been ineffective. Rather than sleep, he has been going to the local casino at nighttime. He went to work on Monday, but his boss told him to stay home for the remainder of the week. Mr. Summers is not sure why, but he has been trying to work from home, having a lot of ideas for new projects.

History

- **ALL**: NKDA
- **Meds**: Tiotropium Inhaled, Prednisone Taper, & Quetiapine XR
- **PMHx**: COPD, HTN, Hyperlipidemia, & Bipolar I d/o
- **PSHx**: None
- **Social Hx**: Mr. Summers is a 64yo who is living in his own apartment after 2 past divorces. He has had several past jobs, most recently working for a local advertising agency for the past 6 months. He has 2 grown children with whom he has a limited relationship. Mr. Summers has a 60 year pack history, quitting at 60yo. He reports drinking alcohol on a nightly basis, anywhere from 1-6 beers. He drinks 1 pot of coffee daily, but has not been drinking any since hospital discharge. Mr. Summers has a remote history of cocaine use, but none in the past 10 years.

Review of Systems

- **General**: no acute distress, has trouble sitting on exam table, pacing about the exam room; no fevers/chills
- **HEENT**: no headaches, runny nose, congestion, cough
- **Neuro**: unable to remain focused on interview, talking in tangents
- **Psychiatric**: mood euphoric, racing thoughts, no SI/intent/plan
- **Resp**: no shortness of breath, wheezes or cough
- **Cardio**: no heart racing/palpitations or chest pain
- **GI**: no nausea/vomiting, no constipation/diarrhea
- **Endocrine**: recent increase in appetite with a 5-lb weight gain in past week

Physical Exam

- **Vitals:**
  - BP: 142/86 P: 90 Temp: 98.0 Ht: 5'11" Wt: 225lbs
- **General Appearance:** NAD, trouble sitting on exam table, pacing about room
- **HEENT:** normocephalic, PERRL/EOMI, no lymphadenopathy or thyromegaly
- **Chest:** heart with RRR, no murmurs/gallops/rubs; lungs CTAB
- **Abd:** soft & non-tender, normal bowel sounds in all 4 quadrants
- **Neuro:** grossly intact

Differential Diagnosis: Mr. Summers

- Hyperthyroidism
- Cocaine Use
- Bipolar Mania
- Steroid Induced Manic Episode

Hyperthyroidism & Anxiety

Symptom	Hyperthyroidism	Anxiety
Nervousness	x	x
Sweating	x	x
Heat Intolerance	x	
Weight Loss	x	x
Muscle Weakness	x	
Psychomotor Agitation	x	x
Persistent Tachycardia	x	
Irritability	x	x
Cognitive Difficulties	x	x

Levenson, J. L. (2011). Endocrine and metabolic disorders. In *Textbook of psychosomatic medicine* (pp. 503-524). Washington, DC: APPI.

Medications & Psychiatric Symptoms

- Steroids
  - May cause symptoms of depression, mania, anxiety, or psychosis
- Leuprolide
  - May contribute to anxiety, depression, and suicidality
- Beta-blockers
  - Generally DO NOT contribute to depressive symptoms
- Interferon-alpha
  - Historically used for the treatment of Hep C
  - Known to increase levels of depression

Psychiatric Medications & Medical Conditions

- Anti-psychotics: second generation/atypicals
  - Metabolic Syndrome
- Anti-depressants
  - Sexual Dysfunction
- Lithium
  - Renal Insufficiency & Hypothyroidism
- Valproic Acid
  - Liver Failure
- Lamotrigine
  - Stevens-Johnson Syndrome

Differential Diagnosis: Mr. Summers

- Hyperthyroidism: (+) nervousness, psychomotor agitation, irritability, and cognitive difficulties
- Cocaine Use: remote history (reported abstinence)
- Bipolar Mania: (+) h/o Bipolar I disorder, lack of sleep, increased energy/psychomotor agitation, euphoric mood, racing thoughts, increased goal-directed behavior, and risky behavior
- Steroid Induced Manic Episode: (+) Prednisone taper related to recent COPD exacerbation, continued treatment of his Bipolar disorder with Quetiapine XR (reported adherence)

Diagnostic Criteria for a Manic Episode

- A: A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).
- B: During the period of mood disturbance and increased energy or activity three (or more) of the following symptoms (four or more if mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:
  - Inflated self-esteem or grandiosity; Decreased need for sleep; More talkative than usual or pressure to keep talking; Flight of ideas or subjective experience that thoughts are racing; Distractibility as reported or observed; Increase in goal-directed activity or psychomotor agitation; Excessive involvement in activities that have a high potential for painful consequences.

Diagnostic Criteria for a Manic Episode

- C: The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

- D: The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or to another medical condition.

American Psychiatric Association. (2013). Bipolar and related disorders. In *Desk reference to the diagnostic criteria from DSM-5* (pp. 65-69). Washington, DC: American Psychiatric Publishing.

Most Likely Diagnoses for Mr. Summer

- **Bipolar Mania:** (+) h/o Bipolar I disorder, lack of sleep, increased energy/psychomotor agitation, euphoric mood, racing thoughts, increased goal-directed behavior, and risky behavior

- **Steroid Induced Manic Episode:** (+) Prednisone taper related to recent COPD exacerbation, continued treatment of his Bipolar disorder with Quetiapine XR (reported adherence)

Next Steps

- Thyroid Studies
- Urine Drug Screen
- Medication Adjustments
  - Possibility of tapering steroids at a faster pace
  - Increasing his mood stabilizer
- Consider Psychiatric Hospitalization
  - Is he at risk of harm to self or others?
  - Is he unable to care for himself?
  - Are there others we can involve in his care (family, friends, outpatient psychiatrist, case manager, therapist, etc.)?

Clues

Information	Medical	Psychiatric
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Hallucinations	Visual	Auditory

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The Rest of the Story

- Mr. Summers did not require hospitalization
- His psychiatrist was able to see him the following day and recommended an increased dose of his Quetiapine XR while he completed his course of Prednisone.
- At psychiatric follow-up 2 weeks after completing his Prednisone taper, Mr. Summers was feeling increasingly sedated and his mood was stable.
- Quetiapine XR was decreased back to normal dosing and Mr. Summers continued doing well.
- **This was a Steroid-Induced Manic Episode.**

Case #2: Mr. Fall

- **CC**: From wife: "He doesn't seem to want to do anything anymore. He says he is too tired all the time."

- **HPI**: Mr. Fall is a **75yo** married man with a medical history significant for **CAD** and **Type 2 Diabetes** who is brought to your office by his wife with the concern that he has become apathetic and doesn't seem to have much energy. The patient does not seem bothered by this although he admits he is more tired that he used to be. He attributes this to getting older and wanting to slow down. His wife feels that he is slowing down more than he needs to. She states that he used to be very active, playing tennis and golf several times a week, and now he barely leaves the house other than to run basic errands. He states he's just not interested in playing any more, he had some trouble playing and feels like he's just too old and tired. His wife has noticed a mild tremor, but says she thought nothing of it because essential tremor runs in his family.

History

- **ALL**: NKDA
- **Meds**: Metformin, Metoprolol, Aspirin, Atorvastatin, Lisinopril
- **PMHx**: DM (A1c 6.3), HTN, NSTEMI 5 years ago (medical management), Shingles 8 years ago, no history of depression
- **PSHx**: None
- **Social Hx**: Mr. Fall is a retired chemist, married with 3 adult children and 6 grandchildren. He was born and raised in the Akron area, never smoked, used to drink 1-2 glasses of wine per night but mostly stopped alcohol for the past 5 years, except for special occasions. No illicit drugs.
- **Family Hx**: 2 siblings with essential tremor, father also had it. Denies family Psychiatric history.

Review of Systems

- **General**: no weight loss or gain
- **HEENT**: mild headaches, less than monthly, no change from usual
- **Neuro**: mild tremor of R hand (see HPI)
- **Psychiatric**: denies feeling depressed, reports satisfaction with his life and feeling grateful for all he's been able to do in his life, sleep is good, no SI
- **Resp/Cardiac**: no chest pain, palpitations, SOB
- **GI**: mild constipation, possibly worse lately
- **Endocrine**: no change in appetite

Physical Exam

- **Vitals:**
  - BMI: 28 BP: 133/82 P: 65
- **General Appearance:** Well nourished, ambulates independently
- **HEENT:** no LAD, no scleral icterus or conjunctival pallor
- **Chest:** nl S1S2, regular rhythm, no M/R/G, lungs clear
- **Abd:** soft, NTND, NABS
- **Extremities:** no edema
- **Neuro:** resting tremor of R hand
- **Psych:** affect flattened/serious, limited spontaneous speech, fully oriented and alert

Differential Diagnosis: Mr. Fall

- Depression
- Deconditioning, aging
- Parkinson's or other neurologic disorder
- Early dementia, Alzheimer's type or vascular
- Heart failure

Chronic fatigue

- 452 consecutive FM patients
  - 9.9% (42) complained of chronic fatigue

Final Diagnosis	Percent
Depression	40.4%
Non-specific fatigue	37.5%
General medical condition	16.6%
Chronic fatigue syndrome	2.4%
Fibromyalgia	2.4%
Sleep apnea	2.4%

Ward, et al. The Journal of the American Osteopathic Association, January 1996, Vol. 96, 34

Fatigue

- 259 visits, 167 patients, between March 2006 and June 2010
- 10 FP practices in Ontario

Outcome	
Psychosocial diagnosis	23.9%
No specific diagnosis	29.7%
Hypertension	20.1%
Diabetes	12.7%
Afib	5.8%
Hypothyroidism	2.4%

MacKean, et al. Canadian Family Physician • Le MŽdecin de famille canadien | Vol 62: august • aožt 2016

Neurological Illnesses

- Parkinson's Disease
  - Affective Flattening & Psychomotor Slowing may look like Depression
  - Treatment may lead to Psychosis with increased levels of Dopamine
- Myasthenia Gravis
  - Affective Flattening may look like Depression
- Stroke
  - High Risk of Post-Stroke Depression
- Dementia
  - May present with apathy or personality changes

Levenson, J. L. (2011). Neurology and neurosurgery. In *Textbook of psychosomatic medicine* (pp. 759-796). Washington, DC: APPI.

Parkinson's disease and fatigue

- 55% of newly diagnosed patients with Parkinson's reported clinically significant fatigue (compared with 20% of matched controls)
- Fatigue was significantly associated with
  - Depression
  - Impairments in Activities of Daily Living
- No correlation with cognitive impairment or hypersomnia

Herlofson, et al, European Journal of Neurology, Vol 19(7) July 2012.

Cardiac Illness

- High Risk of Post-MI Depression
- Supraventricular Tachycardia/Paroxysmal Arrhythmias may increase Anxiety
- Heart failure
  - Diagnosis or worsening may be associated with fatigue

Levenson, J. L. (2011). Heart disease. In *Textbook of psychosomatic medicine* (pp. 407-440). Washington, DC: APPI.

Differential Diagnosis: Mr. Fall

- Depression: denies depressed mood, (+) expresses anhedonia
- Deconditioning, aging: previously active, decline for no apparent reason
- Parkinson's or other neurologic disorder: (+) tremor, apathy, fatigue
- Early dementia, Alzheimer's type or vascular: risk factors are well-controlled
- Heart failure: no evidence of LV dysfunction by exam

Most Likely Diagnoses for Mr. Fall

- **Depression:** denies depressed mood, (+) expresses anhedonia
- **Parkinson's or other neurologic disorder:** (+) tremor, apathy, fatigue
- **Early dementia, Alzheimer's type or vascular:** risk factors are well-controlled

Next Steps

- Mini-Mental State Exam; Neurologic or neurocognitive evaluation
- Full screening for depression
- Consider treating depression
  - May be co-morbid with either Parkinson's or dementia and both may improve with treatment

Clues

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The Rest of the Story

- Further neurological exam demonstrated a typical resting tremor of the right hand, rigidity, bradykinesia, but no memory impairment
- Patient was referred to a neurologist and started on pramipexole and an exercise plan
- He was not started on an antidepressant, but a significant improvement in his engagement with family and interest in other activities was noted following initiation of treatment for PD

Case #3: Ms. Winters

- **CC**: "I'm tired all of the time."

- **HPI**: Ms. Winters is a **52yo** married female with a past medical history significant for migraines who presents with **fatigue**. She first began to notice her fatigue about 5 months ago and it has not improved. Over the past 2 months, she has been having difficulty with sleep, noticing end insomnia and not feeling rested in the mornings. Her daytime energy has been poor and she feels badly for not keeping up with her usual household/family management. Ms. Winters is not interested in an upcoming family vacation, feeling too worn out to prepare for the trip.

History

- **ALL**: NKDA
- **Meds**: Sumatriptan PRN migraines
- **PMHx**: Migraines (3-4/year)
- **PSHx**: 2 C-sections
- **Social Hx**: Ms. Winters has been married for 28 years and is a stay-at-home mother of 2 teenage boys; having previously worked as a bookkeeper. Her mother died when she was a young child of ovarian cancer and she was raised, as an only child, by her father. Her father is still living and she is his primary caretaker as well since his diagnosis of prostate cancer 1 year ago. Ms. Winters has an occasional glass of wine with dinner, has never smoked tobacco, has 2 cups of coffee daily, and has never used any illicit substances.

Review of Systems

- **General**: no acute distress; appears fatigued; no fevers/chills
- **HEENT/Neuro**: reports difficulty concentrating on the multiple schedules in the house, occasionally forgetting about one of her sons' activities
- **Endocrine**: some weight gain reported/clothes fitting a bit more tightly; no heat/cold intolerance
- **Gastrointestinal**: no nausea/vomiting, no diarrhea/constipation
- **GYN**: inconsistent menstrual cycles; LMP 2 months ago; sexually active with husband of 28 years
- **Skin**: some drying
- **Resp**: no shortness of breath, cough, wheezing
- **Cardio**: no heart racing/palpitations or chest pain
- **Psychiatric**: low mood, no SI/intent/plan

Physical Exam

- **Vitals:**
  - BP: 128/72 P: 84 Temp: 97.9 Ht: 5'6" Wt: 175lbs
- **General Appearance:** NAD, appears fatigued with black circles under her eyes
- **HEENT:** normocephalic, PERRL/EOMI, no lymphadenopathy or thyromegaly
- **Chest:** heart with RRR, no murmurs/gallops/rubs; lungs CTAB
- **Abd:** soft & non-tender, normal bowel sounds in all 4 quadrants
- **Neuro:** grossly intact

Differential Diagnosis: Ms. Winters

- Anemia
- Cancer
- Hypothyroidism
- Pregnancy
- Perimenopause
- Major Depressive Disorder

Anemia & Depression

Symptom	Anemia	Depression
Increased Sleep	x	x
Lack of Interest	?	x
Feelings of Guilt		x
Lack of Energy	x	x
Poor Concentration	x	x
Change of Appetite	?	x
Psychomotor Slowing	x	x
Thoughts of Suicide		x
Physical Signs	x	

Levenson, J. L. (2011). Hematology. In *Textbook of psychosomatic medicine* (pp. 551-570). Washington, DC: APPI.

Hypothyroidism & Depression

Symptom	Hypothyroidism	Depression
Weakness	x	
Fatigue	x	x
Somnolence	x	x
Cold Intolerance	x	
Weight Gain	x	x
Constipation	x	
Hair Loss	x	
Low Mood	x	x
Poor Concentration	x	x
Thoughts of Suicide		x

Levenson, J. L. (2011). Endocrine and metabolic disorders. In *Textbook of psychosomatic medicine* (pp. 503-524). Washington, DC: APPI.

Perimenopause & Depression

Symptom	Perimenopause	Depression
Hot Flashes/Night Sweats	x	
Palpitations	x	
Dizziness	x	
Fatigue	x	x
Headaches	x	?
Insomnia	x	x
Lack of Concentration	x	x
Decreased Libido	x	x
Joint Pains	x	x
Irregular Menses	x	

Levenson, J. L. (2011). Obstetrics and gynecology. In *Textbook of psychosomatic medicine* (pp. 797-826). Washington, DC: APPI.

Hormonal Fluctuations

- Pregnancy: sleep, appetite, and energy changes
- Perimenopause
- Post-Partum
- Premenstrual
- Polycystic Ovarian Syndrome Treatments
- Endometriosis Treatments

Levenson, J. L. (2011). Obstetrics and gynecology. In *Textbook of psychosomatic medicine* (pp. 797-826). Washington, DC: APPI.

Differential Diagnosis: Ms. Winters

- Anemia: fatigue, low mood
- Cancer: fatigue, family history
- Hypothyroidism: fatigue, weight gain, dry skin, low mood
- Pregnancy: fatigue, weight gain, LMP 2 months ago, sexually active
- Perimenopause: fatigue, weight gain, inconsistent periods, low mood
- Major Depression: low mood, decreased sleep, lack of interest, (+) guilt, low energy, poor concentration, weight gain/increased appetite, no SI/intent/plan

Diagnostic Criteria for Major Depressive Episode

- A: Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
  - Depressed mood most of the day, nearly every day (feels sad, empty, or hopeless; appears tearful)
  - Markedly diminished interest or pleasure in all
  - Significant weight loss or weight gain, or decrease or increase in appetite
  - Insomnia or Hypersomnia
  - Fatigue or loss of energy
  - Feelings of worthlessness or excessive or inappropriate guilt
  - Diminished ability to think or concentrate, or indecisiveness
  - Recurrent thoughts of death

Diagnostic Criteria for Major Depressive Episode

- B: The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- C: The episode is not attributable to the physiological effects of a substance or another medical condition.

American Psychiatric Association. (2013). Bipolar and related disorders. In *Desk reference to the diagnostic criteria from DSM-5* (pp. 65-69). Washington, DC: American Psychiatric Publishing.

Most Likely Diagnosis for Ms. Winters

- **Major Depression**
  - low mood
  - decreased sleep
  - lack of interest
  - (+) guilt
  - low energy
  - poor concentration
  - weight gain/increased appetite
  - no SI/intent/plan

Next Steps

- Screening Labs
  - CBC, Thyroid Studies, Urine Pregnancy, Hormone Levels
- Initiation of Treatment for Depression
  - Referral for counseling
  - Consideration of medications
- Suicide Risk Assessment

Suicide risk assessment

SUICIDE ASSESSMENT CHECK LIST

1. Quantify Severity of Depression
2. Assess and document Impairment of Function
3. Evaluate Pertinent History/Comorbid Conditions
   - Past history of depression
   - Past history of other mental health problems
   - Past history of mental health treatment
   - History of suicide attempt*
   - Family history of depression and other mental health problems (especially bipolar)
   - Stressful life events*
   - Social isolation*
   - Substance abuse*
   - Bipolar illness
   - Current medications
4. Evaluate Suicide Risk
   - High Risk/Suicide Risk Assessment Guidelines

**Indicates risk factor for suicide*

Suicide risk assessment

- Have these symptoms/feelings we've been talking about led you to think you might be better off dead?
- This past week, have you had any thoughts that life is not worth living or that you'd be better off dead?
- What about thoughts about hurting or even killing yourself? IF YES, what have you thought about? Have you actually done anything to hurt yourself?

Suicide risk assessment

ASSESSMENT OF SUICIDE RISK

Risk	Description	Action
☐ Low Risk	No current thoughts, no major risk factors * See risk factors above and helplessness.	Continue follow-up visits and monitoring
☐ Intermediate Risk	Current thoughts, but no plans, with or without risk factors	Assess suicide risk carefully at each visit and contract with patient to call you if suicide thoughts become more prominent; consult with an expert as needed.
☐ High Risk	Current thoughts with plans	Emergency management by qualified expert.

What do you do if risk is elevated?

Clues

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The Rest of the Story

- Her suicide risk assessment revealed low risk of harm to self.
- Referral for therapy was made during her appointment.
- She was started on a course of an SSRI.
- Ms. Winters improved and was able to enjoy her family vacation on the beach!

Summary

- Remember to include psychiatric diagnoses in your differential of many common complaints.
- Consider clues that may help distinguish.
- Have a low threshold for suicide risk assessment.
- Never worry alone – seek consultation with others in your office or consult with a mental health colleague.

Questions

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- http://www.integration.samhsa.gov/clinical-practice/macarthur_depression_toolkit.pdf