ASSESSING DEPRESSION IN MEDICAL PATIENTS

When evaluating a patient with depression, it is essential to assess the patient's potential to commit suicide. Suicidal ideation is an intensely personal matter, and many patients may be alarmed by questions about it. Therefore, it is best to approach the subject obliquely, starting with less threatening questions and progressing to more specific ones.

For example, it may be best to first ask the patient whether he or she has been feeling worse than usual. Then: "Have things been so bad that you've thought you'd be better off dead?" and then: "Has it gotten to the point where you may have had some thoughts about taking your own life?"

The common misconception that asking the question prompts the patient to consider and to act on it may prevent some physicians from broaching the subject, but patients who are distressed by suicidal thoughts may be relieved that someone has asked. If the patient has been hiding these thoughts, it is imperative that the clinician help the patient to disclose them. For example, if the clinician suspects hopelessness or suicidal ideation and the patient denies it, it may be helpful to follow up with the question, "If you did have suicidal thoughts, would you be able to tell me about them?" If the patient admits to suicidal thoughts, it is imperative that the clinician inquire about intent, plan, and the access to means.

It is crucial as well that the clinician determine whether the patient is suffering from psychotic (delusional) thinking, because patients with psychotic depression are at significantly higher risk of suicide. Any psychiatric disorder increases the risk of suicide; however, major depression is responsible for 50% or more of suicides in the United States. In assessing a patient's potential for suicide, one should take into account whether the patient has made suicide attempts in the past, is alcoholic, lives alone, is unemployed, lacks social supports, and has access to firearms. More women attempt suicide than men do, but more men succeed in killing themselves. There is a bimodal distribution in incidence according to age, with peaks in adolescence and in men older than 65.

DIAGNOSING MAJOR DEPRESSION

Major depression is common, occurring in approximately 5% of the general population and in approximately 5% to 10% of general medical outpatients. However, depression is not always easily detected and is easy to confuse with normal despondency, bereavement, adjustment disorder with depressed mood, bipolar disorder, organic affective mood disorder, or organic mental disorder.

Depression has a negative impact on quality of life, function, and perceived level of health. Medical illnesses such as cancer, cerebrovascular disease, coronary artery disease, diabetes mellitus, and fibrositis are commonly associated with depression and depressive symptoms. The available data suggest that morbidity and mortality from these diseases increase in the presence of untreated depression.

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) provides specific criteria for diagnosing major depression. The mnemonic aid is SIG E CAPS: sleep disturbance, interest diminished (anhedonia), guilt excessive and inappropriate, energy diminished, concentration impaired, appetite disturbance, psychomotor disturbance (retardation or agitation), and suicidal ideation. Five of these eight must be present for at least 2 weeks in order to make the diagnosis of major depression.

There are five subtypes of major depression: melancholic, psychotic, postpartum, seasonal, and atypical. Melancholic patients are relatively easy to treat with pharmacotherapy. Psychotic patients, who have hallucinations or delusions, are more difficult to treat and frequently must be hospitalized. It is absolutely necessary to rule out suicidal or homicidal tendencies in these patients. They also frequently need electroconvulsive therapy. Patients with seasonal disorder may respond to phototherapy and pharmacotherapy. Depression is common postpartum. Atypical depression, fairly prevalent in general medical settings, may be difficult to recognize. Instead of being melancholic, the patient may be irritable, angry, apathetic, or extremely fatigued, and may overeat and oversleep. The symptoms may not last for 2 weeks; instead, there may be a precipitous decline for a few days followed by recovery. These patients may be particularly responsive to monoamine oxidase inhibitors or serotonin-specific reuptake inhibitors.

Factors confounding the diagnosis

Patient factors that may make the diagnosis difficult are denial, somatization, psychomotor retardation or impaired concentration, irritability, and obsessiveness. It may be difficult to determine whether

somatic symptoms such as fatigue, anorexia, or insomnia are a consequence of the medical illness or of depression. Affective criteria such as melancholia, tearfulness, and anhedonia have specificity. Concomitant medical and psychiatric disorders may obscure the diagnosis of depression, and, in general, comorbidity reduces the likelihood of successful treatment response. Finally, clinicians may resist making this diagnosis by overvaluing the precipitating factors, failing to employ the criteria of the DSM-III-R, and by being reluctant to open a Pandora's box.

Evaluation

The diagnosis of depression depends exclusively on information obtained from the history and the mental status examination. Laboratory data may help to identify related or incidental medical disorders, but laboratory measures of depression lack sufficient sensitivity and specificity to be useful clinically.

The history is directed at symptoms, focusing on their intensity and the degree to which they represent a significant change from baseline. Is there evidence of current or past hypomania or mania? If there is a history of depressive episodes, how were they treated, and what was the response to treatment? Has another psychiatric disorder been diagnosed? Is there a history of alcohol or substance abuse? Is there a family history of depression? (Approximately one third of first-degree relatives of patients with major depression suffer from either depressive disorders, anxiety disorders, or alcoholism.) Are there concomitant medical disorders?

As part of the mental status examination, one should observe the patient's general appearance and behavior, mood, affect, thinking (does the patient have suicidal ideation?), perceptions (to determine whether the patient is experiencing auditory hallucinations commanding self-destruction or violence toward others), and cognition (the depressed patient may exhibit a disturbance of attention or concentration). The individual with concomitant depression and dementia will likely exhibit more extensive disturbance of cognition and memory.

The differential diagnosis must include other nonmood psychiatric disorders such as alcohol abuse or personality disorder, normal despondency, bereavement (uncomplicated grief), adjustment disorder with depressed mood, bipolar disorder, organic affective mood disorder, and organic mental disorder.

Emphasizing to patients that they may be suffering from a treatable illness rather than a weakness of their moral fiber may help combat stigmatization that often interferes with getting necessary psychiatric care.

GEORGE E. TESAR, MD
Chairman, Department
of Psychiatry and Psychology
The Cleveland Clinic Foundation

SUGGESTED READING

American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 3rd ed. Washington, DC: American Psychiatric Press; 1987.

Kaplen HI, Sadock BJ. Pocket Handbook of Clinical Psychiatry. Baltimore: Williams and Wilkins; 1990.

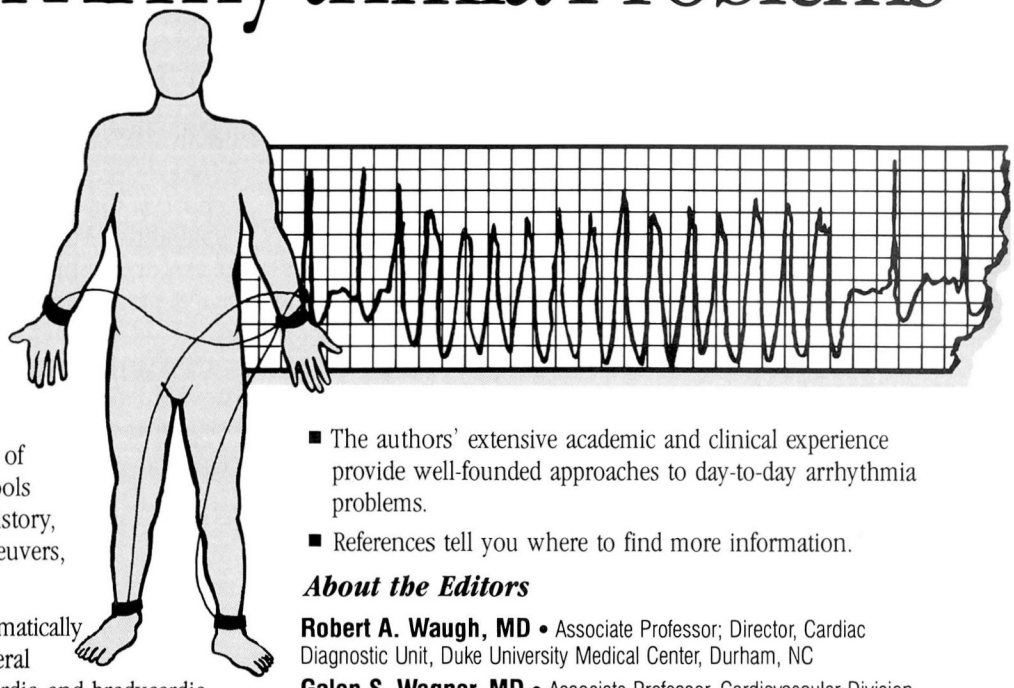
Schulberg HC, Saul MS, McClelland M, et al. Assessing depression in primary medical and psychiatric practices. Arch Gen Psychiatry 1985; **42**:1164-1170.

von Korff M, Shapiro S, Burke JD, et al. Anxiety and depression in a primary care clinic. Arch Gen Psychiatry 1987; **44**:152-156.

CME CREDIT

To earn CME Category I credit, see test on p. 240

The One Book You Need to Diagnose and Manage Most Common Arrhythmia Problems



Diagnosticians of arrhythmias at all levels will be well-served by the highly practical emphasis of

Cardiac Arrhythmias: A Practical Guide for the Clinician, 2nd Edition,

an up-to-date guide for understanding the diagnosis and care of patients with arrhythmias.

After a brief review of the physiology of heart rhythms, Section I covers the tools you need to diagnose arrhythmias: history, physical examination, autonomic maneuvers, and electrocardiographic monitoring.

Sections II and III thoroughly and systematically examine diagnostic methods and general treatment of various forms of tachycardia and bradycardia. The book concludes with a detailed discussion of drug treatment options, pacing for bradycardia, and non-drug treatments for tachycardia, including new modalities such as ablation techniques and implantable cardioverter-defibrillators.

Some Of Its Key Features:

- Extensive illustrations guide you in understanding arrhythmias and principles of their treatment.
- Detailed tables guide you in selecting the best drug regimen for each patient.
- Both traditional and "cutting edge" treatment approaches are included.
- The authors' extensive academic and clinical experience provide well-founded approaches to day-to-day arrhythmia problems.
- References tell you where to find more information.

About the Editors

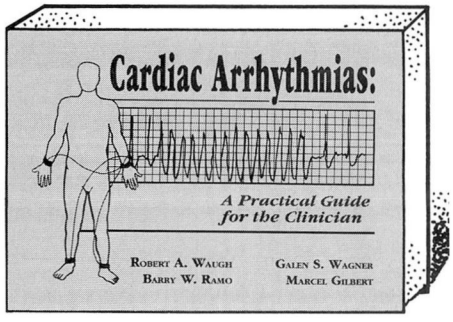
Robert A. Waugh, MD • Associate Professor; Director, Cardiac Diagnostic Unit, Duke University Medical Center, Durham, NC

Galen S. Wagner, MD • Associate Professor, Cardiovascular Division, Department of Medicine, Duke University Medical Center, Durham, NC

Barry W. Ramo, MD • Clinical Professor of Medicine, University of New Mexico School of Medicine; Director, Cardiology Education, Presbyterian Hospital, Albuquerque, NM

Marcel Gilbert, MD • Director, Electrophysiology Laboratory, Institut de Cardiologie de Quebec, Ste. Foy, Quebec, Canada

Ready May 1994.
About 420 pages.
Illustrated.
$75.00.



YES! Send me these practical texts on 30-day approval

- ☐ Please send me my copy of **Cardiac Arrhythmias: A Practical Guide for the Clinician,** 2nd Edition for $75.00 today! ISBN 9114-9.
- ☐ #3792-6 Frankl & Brest: **Valvular Heart Disease: Comprehensive Evaluation and Treatment,** 2nd Ed., 1993. $80.00.
- ☐ #8088-0 Spittell: **Contemporary Issues in Peripheral Vascular Disease.** 1992. $65.00.
- ☐ #5653-X Lowenthal: **Geriatric Cardiology.** 1992. $70.00.
- ☐ #4343-8 Greenspon & Waxman: **Contemporary Management of Ventricular Arrhythmias.** 1992. $75.00.
- ☐ #7726-X Saunders: **Cardiovascular Diseases in Blacks.** 1991. $75.00.
- ☐ #5646-7 Lipman & Cascio: **ECG Assessment and Interpretation.** 1994. $22.95.
- ☐ #9085-1 Waters & Bourassa: **Care of the Patient with Previous Coronary Bypass Surgery.** 1991. $75.00.

PLEASE PRINT

Full Name_____

Address_____

City_____ State_____

Zip_____ Phone_____

- ☐ **Payment enclosed.** We pay postage and handling. Pennsylvania residents please include appropriate state sales tax.
- ☐ **Bill me.** An invoice, including a small charge for postage and handling, will accompany each book you order. State sales tax will be charged where applicable.
- ☐ **I would like to charge my purchase through:** ☐ VISA ☐ MasterCard

Signature_____

Account no._____ **Exp. date**_____

Prices are subject to change without notice. *9114—9A*

F.A. Davis

F.A. Davis Company ▪ Publishers ▪ 1915 Arch Street, Philadelphia, PA 19103 ▪ 215-568-2270 / 800-523-4049 ▪ FAX 215-568-2807