Clinical Vignette 1: Mood Disorder

You are asked to see a 52-year-old married woman with a history of non-Hodgkins Lymphoma 7 years ago that was treated with a combination of chemotherapy and radiation therapy. The lymphoma has been in remission since that time and she has returned to work part-time for a large bank. She was admitted to your hospital 10 days ago complaining of chest pain and shortness of breath. Evaluation revealed a right lower lobe pneumonia and she was started on IV antibiotics. At first, the pneumonia seemed to be responding to treatment but then she began spiking fevers. Blood cultures revealed gram-positive cocci and the Infectious Disease consult recommended switching the antibiotic regimen to linezolid (Zyvox) and vancomycin. Labs revealed an elevated WBC and mildly elevated LFTs. The treatment team was also concerned about a recurrence of the lymphoma and ordered several tests to evaluate her including an MRI of her chest and abdomen, a PET scan, and a bone marrow biopsy. So far all the tests have come back negative and a repeat CXR shows improvement of the pneumonia; repeat blood cultures have been negative.

The team requests a psychiatry consult because even though all of the tests indicate that the patient is getting better, she hardly ever gets out of bed. The internal medicine intern reports that even when he gives her good news about her tests she starts crying. The nurses report to you that she is not eating and has lost 5 pounds in a week. She has told one of the nurses that "it would be so much easier to just be dead already." You learn from the patient and her husband that she has been treated twice in the past for depression; once in her 20s while she was still in college, and once at age 30 for a post-partum depression after the birth of her second daughter. The husband also tells you that she "actually wasn't doing so well before she came into the hospital." He reports that for at least one month before she was admitted she wasn't sleeping well and had lost about 10 pounds, she was calling in sick to work and they hadn't socialized with any of their friends for quite awhile. He attributed this to her feeling "run down" from increased stress at work and worries about her mother's deteriorating mental state.

On interview, the patient is frequently tearful. She says she does not think she is getting better and has no hope that she will ever get out of the hospital. She is sure the lymphoma has returned. She feels like she is letting her whole family down. She says she has no desire to eat, and she has no desire to read or watch TV. When asked why she is not getting out of bed, she says "what's the use?" She admits that she has had thoughts of "jumping out the window when no one is looking so I don't have to suffer anymore." She refuses to cooperate with a full cognitive exam but you do determine that she is fully oriented and is able to remember details about her personal history as well as what has occurred during her hospitalization.

QUESTIONS

Competency Areas: Medical Knowledge, Patient Care

1. What is your differential diagnosis based on the clinical data provided in the vignette?

- Major depression, recurrent
- Mood disorder due to general medical condition
- Substance-induced mood disorder
- Adjustment disorder with depressed mood
- Anxiety disorder, e.g., PTSD given past history of non-Hodgkin's Lymphoma
- Demoralization in the context of chronic medical illness

		Score
Unacceptable:	1-3/6	_____
Pass:	4-5/6	_____
Exceptional:	6/6	_____

2. How would you differentiate between major depressive disorder, adjustment disorder, and a mood disorder due to a general medical condition in this patient?

- Length of time patient has been depressed- history indicates that depressive symptoms may have been present prior to hospitalization
- Previous history of major depression
- Melancholic symptoms: hopelessness and anhedonia in particular may be associated with a diagnosis of major depression
- Remains depressed even as physical/medical symptoms improve: if this were and adjustment disorder, may expect some improvement in mood symptoms
- Acute medical illness can lead to neurovegetative symptoms of depression especially decreased energy, impaired appetite and impaired sleep so the presence of these symptoms does not necessarily help clarify the diagnosis

		Score
Unacceptable:	1-2/5	_____
Pass:	3-4/5	_____
Exceptional:	5/5	_____

Competency Areas: Medical Knowledge, Patient Care

3. Is there any additional information that can help you clarify the differential diagnosis?

- Family psychiatric history: the presence of genetic loading may add support to the diagnosis of major depression
- More details about previous presentations of depression as well as past response to treatment. This includes history of hypomania/mania episodes, need for psych hospitalization, medications, ECT, etc.
- More information about how she coped with previous treatment for lymphoma might help get a clearer picture of how patient copes with serious medical illness, hospitalization, and prolonged treatment
- Should also be asking about anxiety symptoms, flashbacks and/or nightmares about previous treatments and consider whether PTSD should be included in the differential diagnosis
- Need to evaluate for possible psychotic symptomatology, e.g., guilt of delusional intensity, somatic delusions, etc.

		Score
Unacceptable:	1-2/5	_____
Pass:	3-4/5	_____
Exceptional:	5/5	_____

Competency Areas: Medical Knowledge, Patient Care, Interpersonal & Communication skills

4. What treatment recommendations would you make for this patient?

- Patient should be placed on 1:1 observation due to suicidality. This needs to be communicated to the treatment team and to the nursing staff caring for the patient.
- Supportive psychotherapy
- Could take a "watch and wait" approach
- However, given the severity of reported depressive symptoms, antidepressant/psychostimulant medication is probably indicated

		Score
Essential:	First item	_____
Unacceptable:	1-2/4	_____
Pass:	3-4/4	_____

Competency Areas: Medical Knowledge, Patient Care, Interpersonal & Communication Skills

5. The treatment team asks you about antidepressant therapy for the patient. How would you approach this request and communicate your ideas to the team?

- Two main considerations: severity of patient's depressive symptoms and medical illness/treatment
- SSRIs/SNRIs/mirtazapine/TCAs are contraindicated with linezolid due to risk of serotonin syndrome.
- However, secondary-amine TCAs (norepinephrine and desipramine) have little to no serotonin enhancing effects and may be safer
- Stimulants/MAOIs are contraindicated with linezolid due to risk of hypertensive crisis
- Bupropion combined with linezolid poses a potential risk of hypertensive crisis
- Educate the team about antidepressant interactions with linezolid and ask about alternate antibiotic regimens – if you feel it is important to begin antidepressants now; then speak with team and infectious disease consultant about some of the morbidity associated with untreated depression and see if antibiotic regimen that does not include linezolid can be used
- If an alternative to linezolid is not possible, risks and benefits of using antidepressants should be weighed and if they are started, then the patient will need close monitoring by you and the medical team
- ECT is an alternative consideration, especially if patient is severely depressed or medically fragile

		Score
Unacceptable:	1-3/7	_____
Pass:	4-5/7	_____
Exceptional:	6-7/7	_____

Competency Areas: Medical Knowledge, Systems-Based Practice

6. How would you determine hospital discharge plans for this patient?

- Determine if patient is still having suicidal thoughts when she is ready for discharge
- Consider transfer to psychiatry unit if she remains severely depressed, develops psychotic depression, or if treatment for the depression had to be delayed due to the medical problems
- Family meeting: this should probably happen during the course of your involvement with the patient to get a sense of their concerns and to keep them involved in her care. It may be particularly important to have an alliance with the family if a transfer to psychiatry is being considered.
- If inpatient psychiatric care is not indicated at the time of discharge, then work with the primary team to arrange for outpatient psych after-care. If you have an outpatient PM clinic, this might be an excellent patient for you to follow up with
- Partial hospital programs are another consideration if she needs more care/monitoring than can be provided in clinic but less than inpatient psychiatric hospitalization

		Score
Unacceptable:	1-3/5	_____
Pass:	4-5/5	_____

Summary of Fellow's Performance:

References:

Ferrando SJ, Levenson JL, Owen JA. Infectious Diseases. In: Ferrando SJ, Levenson JL, Owen JA (eds), Clinical Manual of Psychopharmacology in the Medically Ill, American Psychiatric Publishing, Washington DC 2010: 371-404

Rodin GM, Nolan RP, Katz MR. Depression. In: Levenson JL (ed), American Psychiatric Publishing Textbook of Psychosomatic Medicine, Washington DC, 2005: 193-217