

mindovermatter

by Professor Gordon Parker

Bypassing the rule of parsimony

The clinical world does not always reflect the theory.

AS medical students and clinicians we are encouraged to operate to the rule of diagnostic parsimony – that it is important to nail ‘the’ diagnosis.

In real (clinical) life, the exceptions often appear the rule, and any diagnostic imperative to reduce the differential diagnosis down to a single condition can be challenging.

HISTORY

Toni, a 28-year-old woman, was referred with a four-page referral letter and 60 photocopied pages of notes written by GPs, psychiatrists, social workers, community nurses and case workers, detailing management nuances over the preceding 10 years.

She also provided a wealth of written personal data, with a 30-page summary of a turbulent life and many diary extracts: a brutal father who physically abused her; a cold and indifferent mother; two brothers who sexually abused her from the age of six; a number of neighbours and relatives who continued the physical and sexual abuse; and extensive bullying at school.

Over a 10-year period she had married three times, with each husband being violent, and with marital rapes producing two of her four children – one developmentally disabled, one with serious medical problems, and two teens with major conduct disorders.

Her dramatic diary notes portrayed life as constantly turbulent, without any quiet moments or periods of relative satisfaction.

Toni was referred for assessment and management

recommendations for a ‘treatment-resistant depression’. Over the previous 10 years she had tried most antidepressants and mood stabilisers without any clear benefit. Most antidepressants had been prescribed at very high doses.

She was currently receiving four psychotropic drugs (including 400 mg of a tricyclic) and denied any noticeable side-effects.

MANAGEMENT QUESTIONS

The signals flagged a distinct level of social dysfunction, suggestive of somebody with a profound personality disorder – whether caused by her traumatic childhood and/or contributing to it.

A SECOND FRONT

At presentation, she had features indicative of a melancholic depression – in particular, a non-reactive mood, significant impairment of concentration, and psychomotor slowing. She described many melancholic symptoms, including appetite and weight loss in recent months, diurnal variation with mood and energy being worse in the morning, early morning waking and pathological guilt.

Historical review identified clear episodes of mania from her early twenties. At such times she would develop grandiose ideas, need little sleep,

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spend large amounts of money and become quite sexually disinhibited.

A review of her family history identified a number of relatives with mood disorders, and several who had killed themselves.

THE RULE OF PARSIMONY

At the Black Dog Institute, we argue for the importance of mood disorder sub-typing. In essence, is it a unipolar or bipolar disorder? If unipolar, is the condition likely to be melancholic or non-melancholic? If bipolar, Bipolar I or Bipolar II, or medication-induced Bipolar III?

When patients such as Toni present to a tertiary referral service, the unstated imperative is to make ‘the’ definitive diagnosis – with the view that

if that diagnosis is valid, then a rational treatment plan can be applied.

There were two choices in Toni’s case. Firstly, did she have a primary biological mood disorder (bipolar disorder in this instance), or a primary person-

ality disorder? The decision is of some moment to the referring agents and often dictating a therapeutic trajectory that can be followed for years.

A single clinical assessment is generally inconclusive at such times in allowing the clinician to confidently establish a diagnosis. Intermittent review of Toni (and her mixed response to therapeutic approaches) over the next year suggested that she had both longstanding personality dysfunction and bipolar disorder.

In addition, the nature of her ‘treatment resistance’ was clarified. Essentially, she was a ‘drug excretor’ or ‘rapid metaboliser’. In such instances the individual’s metabolic system effectively disallows many drugs obtaining therapeutic ‘traction’, negating any therapeutic benefit, and commonly associated with the absence of any side-effects.

Regrettably, our capacity to

establish who might be a true ‘rapid metaboliser’ is somewhat limited in relation to psychotropic drugs. In Toni’s case, we were able to measure her serum tricyclic levels (while on high dose) as virtually non-existent on two occasions (including one test when hospitalised).

When multiple diagnoses coexist, they may be independent or interdependent. Clinicians may need to proceed across all fronts, and address the higher-order determining condition (if any) or the most serious condition.

In this instance, Toni benefited from the first approach. Her depressive episode responded well to ECT, and her turbulent social world was eased by working with an empathic social worker. ☺

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