# Patient Cases



Polling Question

## Which Patient Case Would You Like to Discuss?

### A. Sam

27 year old referred for psychiatric evaluation after threatening to "knock the lights out" of a colleague

### B. Anna

20 year old referred by parents for "failure to thrive" behavior

### C. David

50 year old urged by wife to seek help because of mood swings

Hypothetical patient cases.

Note: The 2 patient cases not discussed can be found as an additional resource for this activity.

# Patient Case 1: **DIAGNOSING AND TREATING SAM**

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## Meet Sam

- 27-year-old single aspiring actor, raised with his fraternal twin by their divorced mom
- Low-grade persistent depression since childhood plus social phobia
- Binge drinks before auditions, acting jobs, or first dates; becomes “sloppy drunk” with bad results
- Treated off and on with supportive psychotherapy, adequate trials of SSRIs or SNRIs, and benzodiazepines without benefit
- Instances of dramatic, bossy, loud irritable outbursts attributed by his therapist to “diva” personality traits and/or alcohol after-effects
- Referred by union manager for psychiatric evaluation after threatening to “knock the lights out” of a lighting technician for making too much noise

SNRIs=serotonin and norepinephrine reuptake inhibitors. SSRIs=selective serotonin reuptake inhibitors.

# All of the following would help to corroborate a possible diagnosis of bipolar disorder EXCEPT:

A. A history of either bipolar disorder or panic disorder in his fraternal twin

B. The presence of alcohol use disorder as a freestanding condition

C. A personal history of a suicide attempt

D. A personal history of psychotic depression

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The correct answer is B.

References: 1. MacKinnon DF, et al. *Am J Psychiatry*. 2002;159(1):30-35. 2. Dome P, et al. *Medicina (Kaunas)*. 2019;55(8). 3. Goldberg JF, et al. *Am J Psychiatry*. 2001;158(8):1265-1270.

## Gathering More Information About Sam

The consulting psychiatrist contacted Sam's current psychiatrist to gather more background information.

When the consultant asked about past symptoms of either psychosis or mania/hypomania, Sam's current psychiatrist interjected that Sam did not have bipolar disorder because when he administered a Mood Disorder Questionnaire (MDQ), the score was only 5.

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# Which of the following statements is TRUE about making a diagnosis of bipolar disorder?

A. Sam's Mood Disorder Questionnaire (MDQ) score below 7 means he does not have bipolar disorder

B. Epidemiological studies report prevalence rates for comorbid alcohol use disorder of up to 90% of individuals with bipolar disorder

C. The MDQ may be a less reliable screening instrument in patients with mood disorders with active alcohol or substance use disorders

D. It is not necessary to have a history of mania or hypomania to make a diagnosis of bipolar I or II depression



The correct answer is C.

References: 1. Regier DA, et al. *JAMA*. 1990;264(19):2511-2518. 2. Goldberg JF, et al. *J Clin Psychiatry*. 2012;73(12):1525-1530. 3. Zimmerman M, Galione JN. *Harv Rev Psychiatry*. 2011;19(5):219-228.

## DISCUSSION

How can screening tools (eg, the Mood Disorder Questionnaire [MDQ], Rapid Mood Screener, Bipolar Spectrum Diagnostic Scale [BSDS], and Bipolar Disorder Screening Scale) be used in the context of a patient's lived experience?

What are their limitations?

**The consultant psychiatrist raised a differential diagnosis of (1) bipolar I disorder, depressed phase with mixed features (based on the presence of irritable mood, diminished need for sleep, grandiose thinking, and psychomotor agitation) vs (2) major depressive disorder with mixed features (MDD-MF).**

**The key point of differentiation between these 2 DSM-5 diagnoses is which of the following?**

A. Agitation and sleep disruption occur in bipolar depression but not MDD-MF

B. Patients with MDD-MF have never met the DSM-5 criteria for a hypomanic episode

C. Irritability is unique to the mood disturbance in bipolar but not MDD-MF

D. In a patient with mixed features, irritability, distractibility, and agitation are symptoms that can "double count" toward simultaneously defining both manic/hypomanic and depressive episodes.

DSM-5=Diagnostic and Statistical Manual of Mental Disorders, 5th Edition.

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The correct answer is B.

References: 1. Fiedorowicz JG, et al. *Am J Psychiatry*. 2011;168(1):40-48. 2. Judd LL, et al. *J Affect Disord*. 2012;138(3):440-448. 3. Judd LL, et al. *JAMA Psychiatry*. 2013;70(11):1171-1180.

## Diagnostic Disagreement

**Consulting psychiatrist**

- Diagnoses Sam with bipolar I depression

**Sam's current psychiatrist**

- Disagreed with the consultant's opinion
- Felt that Sam has treatment-resistant major depression plus "anger management issues" rather than bipolar depression

**DISCUSSION**

How would you resolve this diagnostic disagreement?

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## Deciding on Treatment for Sam

### Sam's current psychiatrist

- Disagreed with the consultant's opinion and felt that Sam has treatment-resistant major depression plus "anger management issues" rather than bipolar depression
- Proposed a trial of olanzapine/fluoxetine combination (OFC) saying that it "would cover both diagnoses"

### Consulting psychiatrist

- Agreed that OFC would be a reasonable option for treatment-resistant depression
  - However, felt that its metabolic liability outweighed its possible benefit
- Suggested first considering a treatment for bipolar depression with lower risk for metabolic disturbances

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## All of the following evidence-based treatments for bipolar depression are associated with relatively little weight gain during long-term clinical trials EXCEPT:

A. Quetiapine (QTP)
B. Lamotrigine*
C. Lurasidone
D. Cariprazine

*Not FDA-approved.

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The correct answer is A.

References: 1. Meyer JM, et al. *Int Clin Psychopharmacol*. 2015;30(6):342-350. 2. Nasrallah HA, et al. *BMC Psychiatry*. 2017;17(1):305. 3. Sachs G, et al. *Bipolar Disord*. 2006;8(2):175-181. 4. Brecher M, et al. *J Clin Psychiatry*. 2007;68(4):597-603.

## Sam: Response to Lurasidone

- Sam began treatment with lurasidone 40 mg/day
  - Initially showed improvement in mood
  - Within a few months, began binge drinking again, citing work stresses, and became increasingly depressed
- He reports that he cannot concentrate and thinks that he really has ADD and would like to try taking a stimulant
  - You are skeptical about Sam's self-diagnosed ADD and do not think he needs to take a stimulant
- In reviewing his treatment, he indicates that he has been adherent with the medication, has begun a regular psychotherapy, and has begun attending AA meetings
- You are concerned about both his increased alcohol use as well as the risk for worsening depression
- Previously, Sam's dose of lurasidone was increased to 60 mg/day, but he encountered sedation and akathisia without greater mood benefit

AA=alcoholics anonymous. ADD=attention deficit disorder.

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## Which of the following would be an evidence-based next step in his treatment?

A. Discontinue the lurasidone and try an SSRI that he has not taken previously
B. Switch Sam's lurasidone to topiramate
C. Insist that he retry a higher dose of lurasidone
D. Augment his lurasidone with divalproex

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The correct answer is D.

References: 1. Loebel A, et al. *Am J Psychiatry*. 2014;171(2):169-177. 2. Salloum IM, et al. *Arch Gen Psychiatry*. 2005;62(1):37-45. 3. Ghaemi SN, et al. *J Clin Psychiatry*. 2007;68(12):1840-1844. 4. Davis LL, et al. *J Affect Disord*. 2005;85(3):259-266. 5. Swann AC. *J Clin Psychiatry*. 1999;60 Suppl 15:25-28. 6. Johnson BA, et al. *JAMA*. 2007;298(14):1641-1651.7. Loebel A, et al. *Am J Psychiatry*. 2014;171(2):160-168.

# Patient Case 2: **DIAGNOSING AND TREATING ANNA**

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## Meet Anna

- 20-year-old female adopted from infancy
- Performed well academically until senior year of high school
- Uneventful developmental history; no significant medical history
- History of tumultuous relationships
  - Hypersexual and promiscuous
  - Argumentative
  - Self-described “moody”
  - Friends call her a drama queen; demands attention; loud and boisterous at times, though at other times becomes quiet and withdrawn
- Dropped out of design school

## Meet Anna (cont.)

- Previously diagnosed with **borderline personality**
  - Never suicidal
  - No nonsuicidal self-injury
  - Denies alcohol or substance use
- Spends much of the day in her room watching TV and sleeping
- **No motivation**
- Thinks she has **OCD** because she ruminates about failure and "never having a life"
- Exam notable for
  - **Flamboyant "goth" appearance**
  - Thin
  - Subdued affect; psychomotor slowing; impoverished thinking
  - Denies current suicidal thoughts but "thinks a lot about what it would be like to be dead"
  - No psychosis

OCD=obsessive-compulsive disorder.

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## Which of the following best describes the pros and cons of giving Anna an SSRI* as an initial treatment for her apparent depression?

A. If Anna has undiagnosed bipolar depression, the greatest risk of giving her an antidepressant is a high likelihood of conversion to mania

B. There is a high probability that because of her age, conventional antidepressants are more likely than not to induce or aggravate suicidal thoughts

C. If Anna has undiagnosed bipolar depression, the greatest risk of giving her an antidepressant is that it will not be effective

D. Anna should be given an antidepressant only if pharmacogenetic testing results say that she will respond to a particular antidepressant

***SSRI monotherapy is not approved for the treatment of bipolar I depression.**

SSRI=serotonin reuptake inhibitor.

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The correct answer is C.

References: 1. Sidor MM, Macqueen GM. *J Clin Psychiatry*. 2011;72(2):156-167. 2. Sachs GS, et al. *N Engl J Med*. 2007;356(17):1711-1722. 3. Fornaro M, et al. *Bipolar Disord*. 2018;20(3):195-227. 4. Hamad T. Relationship between psychotropic drugs and pediatric suicidality: review and evaluation of clinical data. Silver Spring, MD: Food and Drug Administration. Available at: http://www.fda.gov/ohrms/dockets/ac/04/briefing/2004-4065b1-10-TAB08-Hammads-Review.pdf. Accessed March 8, 2021. 5. Bauer MS, et al. *J Clin Psychiatry*. 2006;67(1):48-55. 6. Leon AC, et al. *J Clin Psychiatry*. 2011;72(5):580-586.

# Anna's Comprehensive Psychiatric Assessment

- Meets DSM-5 criteria for a major depressive episode
- Family history unknown
- First aware of depression during middle school
  - Felt lonely
  - Crying spells for no reason
  - Thought about death
  - Fitful sleep
- Placed in gifted and talented classes
  - Precociously articulate
  - Found it very easy to excel academically **until late in high school** when she started to lose motivation

DSM-5=Diagnostic and Statistical Manual of Mental Disorders, 5th Edition.



# Anna's Comprehensive Psychiatric Assessment (cont.)

- After a summer trip to Italy
  - Periods of intense interest in sex
  - Staying up "for most of the night" watching pornography but denying exhaustion the next day
- Has had many brief sexual encounters with both men and women and does not use birth control
  - Denies periods of euphoria but acknowledges she can be "the centerpiece of attention"
  - Periods can last "maybe a couple of days"

## Which of the following statements would best describe the clinical impression of Anna thus far?

A. Anna cannot have bipolar disorder
B. Anna seems to have a behavioral (sexual) addiction
C. Anna could have bipolar disorder
D. Anna's symptom presentation is too ambiguous to draw clinical inferences about

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The correct answer is C.

References: 1. Scott J, et al. *JAMA Psychiatry*. 2017;74(2):189-196. 2. Geller B, et al. *Am J Psychiatry*. 2001;158(1):125-127.

## Which of the following would help corroborate a provisional diagnosis of bipolar disorder for Anna?

A. Learning that she may be particularly sensitive to psychomotor activation and decreased need for sleep after a transcontinental flight or other circadian dysregulating events, such as sleep deprivation
B. The discovery from a geneology website that Anna's great-great-great grandfather spent years in a psychiatric hospital
C. Obtaining neuropsychological testing now
D. Neuroimaging

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The correct answer is A.

References: 1. Grandin LD, et al. *Clin Psychol Rev*. 2006;26(6):679-694. 2. Goldberg JF, Chengappa KN. *Bipolar Disord*. 2009;11 Suppl 2:123-137.

# Gathering More Information About Anna

- Anna completes a Patient Health Questionnaire 9 (PHQ9), scoring 17

**DISCUSSION**

What is the usefulness of the PHQ9 when diagnosing a patient? What are its limitations?

What other screening tools might also be useful when diagnosing a patient like Anna? How would you recommend using them in practice?



# Gathering More Information About Anna (cont.)

- She is passively but not actively suicidal, not psychotic, and demonstrates no mixed features
- Her drug screen is negative, as is an STD screening panel

**DISCUSSION**

What do you think Anna's diagnosis should be?

STD=sexually transmitted disease.

## Treating Anna

- As mentioned earlier, Anna's presentation was not straightforward
- Her father, a psychologist, asks if she should be given **lithium** because she is near the onset of her first episode and says that lithium tends to work better early rather than late in the course of bipolar disorder
- Her mother, a pharmaceutical representative, asks if she should take **lamotrigine** because she has heard from colleagues that it works well for "moody young people" and is a "lite" mood stabilizer that does not require blood work and "almost" got FDA-approved for bipolar depression
- Her aunt, a social worker, thinks she is severely ill, maybe should be in the hospital, and probably should get "**electrocution plus IV ketamine**"

Anna asks: What do you think I should do?

IV=intravenous

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## Which of the following would you do next?

A. Start fluoxetine
B. Start lithium
C. Start lamotrigine
D. Consider either lurasidone or cariprazine as Anna's best first-line treatment

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The best answer is D.

References: 1. Amsterdam JD, Shults J. *Am J Psychiatry*. 2010;167(7):792-800. 2. Gelenberg AJ, et al. *N Engl J Med*. 1989;321(22):1489-1493. 3. Geddes JR, et al. *Am J Psychiatry*. 2004;161(2):217-222. 4. Yatham LN, et al. *Bipolar Disord*. 2018;20(2):97-170.

## Anna is begun on lurasidone 40 mg/day, and after one week, her dose is brought up to 60 mg/day. Still unimproved a week later, the dose is raised to 80 mg/day, and she reports worsening anxiety and agitation.

## What would be the best next step in her care?

A. Change nothing, tell Anna that it takes time to recover from depression, and reassure her that she is on an appropriate medication
B. Switch to cariprazine due to lack of efficacy of lurasidone
C. Begin either clonazepam or propranolol to manage Anna's apparent akathisia from lurasidone
D. Lower the lurasidone dose because it is likely higher than necessary to treat bipolar depression and is causing akathisia

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The correct answer is D.

Reference: Loebel A, et al. *Am J Psychiatry*. 2014;171(2):160-168.

## Despite a lurasidone dosage reduction, Anna continues to report ongoing symptoms of depression, although agitation and restlessness have subsided.

## All of the following would be evidence-based next step pharmacotherapy interventions for her <u>EXCEPT</u>:

A. Add divalproex or lithium to the lurasidone
B. Switch the lurasidone to venlafaxine
C. Switch the lurasidone to olanzapine/fluoxetine combination (OFC)
D. Switch the lurasidone to quetiapine (QTP) plus lamotrigine

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The correct answer is B.

Note: the combination of lamotrigine plus quetiapine for acute bipolar depression is off-label use of lamotrigine.

References: 1. Leverich GS, et al. *Am J Psychiatry*. 2006;163(2):232-239. 2. Loebel A, et al. *Am J Psychiatry*. 2014;171(2):169-177. 3. Geddes JR, et al. *Lancet Psychiatry*. 2016;3(1):31-39.

# Patient Case 3: **DIAGNOSING AND TREATING DAVID**

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## Meet David

- 50-year-old male, married, violinist who teaches at a classic music conservatory presents with a lifelong history of depression and irritability
- Multiple traumas in childhood, including loss of mother at an early age and intermittent bouts of irritability and depression
- Performance anxiety interfered with a potential career as a concert violinist
- Treated with beta-blockers and cognitive behavioral therapy for performance anxiety with moderate success
- In late 20s, started to have several days of high energy with a decreased need for sleep, increase in productivity with composing music, and feeling that he had high energy only to crash with feelings of fatigue and lack of motivation
- Wife urged him to seek help because of mood swings

# How could you distinguish between a history of hypomania and mania?

A. Persistent insomnia
B. Decreased need for sleep
C. Increased energy
D. Psychosis

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The correct answer is D.

Reference: Vieta E, Phillips ML. *Schizophr Bull*. 2007;33(4):886-892.

## David: Comprehensive History

- The psychiatrist met with David alone first and obtained a comprehensive history
- David told him that he had been severely depressed while at the music conservatory and stayed in bed for 2 weeks until he started to feel better without treatment
- He attributed this to his realization that while talented, he would never be able to earn a living by playing his violin
- He also denied ever having a manic episode but instead would have periods of increased creativity

**DISCUSSION**

What could you do next to help you distinguish unipolar depression from bipolar depression?

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## Gathering More Information About David

- When the psychiatrist met with David and his wife, she described 3-4-week periods per year over the last 10 years in which David would exhibit the following behaviors:
  - Sleeping only 2 hours at night
  - Increased talking
  - More gregarious
  - Increased sex drive
  - Spending more money than usual
  - Becoming more argumentative
  - Talking more about the connection between his music and God in ways she could not understand
- Screening for bipolar disorder with the Rapid Mood Screener showed that 4 items were positive

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## What could be the reasons for the differences in descriptions from David and his wife?

A. Mood dependent memory
B. Cognitive disruption
C. Wish to minimize symptoms
D. All of the above

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The correct answer is D.

References: 1. Nutt RM, Lam D. *Clin Psychol Psychother*. 2011;18(5):379-386. 2. Van Rheenen TE, et al. *Bipolar Disord*. 2020;22(1):13-27.

## DISCUSSION

What do 4 positive items on the Rapid Mood Screener tell you?

How can screening tools (eg, the Mood Disorder Questionnaire [MDQ], Rapid Mood Screener, Bipolar Spectrum Diagnostic Scale [BSDS], and Bipolar Disorder Screening Scale) be used to detect bipolar I depression earlier?

What are their limitations?



## David's Diagnosis

- After listening to David and his wife and reviewing his history and current symptoms, the psychiatrist diagnosed **bipolar disorder I with a current major depressive episode**
- Looking at his history, David had been experiencing symptoms of bipolar I disorder for some time

# David was diagnosed with bipolar disorder I with a current major depressive episode.

## Which of the following treatment options is <u>NOT</u> FDA-approved for bipolar I depression?

A. Quetiapine (QTP)
B. Cariprazine
C. Lurasidone
D. SSRI plus aripiprazole

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The correct answer is D.

References: 1. Goldberg JF, et al. *J Clin Psychiatry*. 2021;82(1). 2. Citrome L. *J Clin Psychopharmacol*. 2020;40(4):334-338.

## Initiating Treatment for David

- Another component of David's history was the traumatic loss of his mother when he was young
  - He has had long-standing anxiety as a result
  - He would frequently feel as if he was about to lose everything he had worked hard for, as if a disaster could happen at any minute
- Based on his current state of having a bipolar I major depressive episode plus a trauma-related generalized anxiety disorder and a long-term risk of mania, the psychiatrist decided to prescribe **quetiapine (QTP) plus lamotrigine***

***Not an FDA-approved indication for acute bipolar I depression, but lamotrigine is approved for the long-term prevention of mood episodes and can be added at any time if one wants to be consistent with FDA approval.**

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# Why did the psychiatrist decide to combine quetiapine (QTP) plus lamotrigine?

A. The combination is FDA-approved
B. The combination works better than QTP monotherapy
C. Lamotrigine should target the insomnia
D. QTP will not work without lamotrigine

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The correct answer is B.

Reference: Geddes JR, et al. *Lancet Psychiatry*. 2016;3(1):31-39.

## David's Response to Quetiapine (QTP) Plus Lamotrigine

He was started on

- QTP 50 mg at night with an increase of 50 mg every 3 days to maximize tolerability
- Lamotrigine 25 mg with the plan to increase by 25 mg per week (target dose of 200 mg to minimize the risk of Stevens-Johnson syndrome)

After his first 3 days

- He slept better and felt slightly sedated but was able to tolerate it
- He also felt that his anxiety was somewhat better

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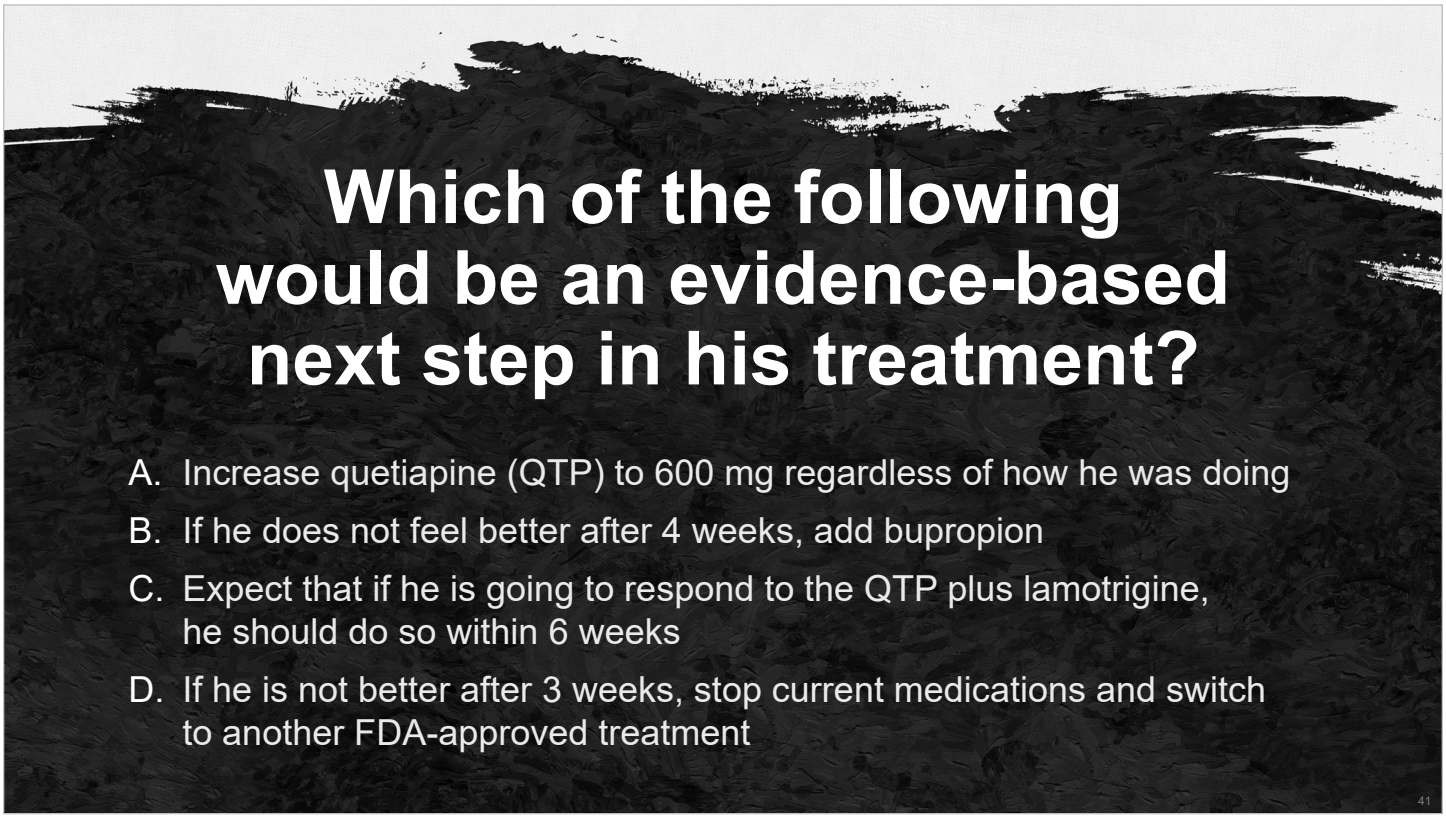


The correct answer is C.

Reference: Geddes JR, et al. *Lancet Psychiatry*. 2016;3(1):31-39.