When Things Don’t Make Sense

You grab the next chart, and notice a chief complaint of abdominal pain. You notice the patient is a 35 year old female. You immediately formulate a differential diagnosis in your head before entering the room. The first thought that pops up is a possible pregnancy, but before you go into the room, your nurse provides you with a negative pregnancy test.

You walk in, introduce yourself, and proceed to ask the patient how you can help. She begins to describe her abdominal pain, which has been present for the past week, not associated with meals. She also denies any alleviating factors. You continue to ask questions, but her answers are just not consistent with a specific diagnosis. She then proceeds to tell you she has been having progressively worsening headaches, back pain, and has been losing weight. Naturally, you think that the weight loss and abdominal pain are related; but again, her story doesn’t make sense.

To recap: we have a 35 year old female presenting with abdominal pain, worsening headache, back pain, and weight loss. Where do we go from here?

When things just do not make sense, the next question I want you to ask is, “Have there been any major changes in your life that might be causing you to feel this way”? You will get one of three answers:
1. What do you mean?
2. No
3. Yes

If the answer is yes, then you inquire about what it is that has changed. If the answer is no, or what do you mean, then you need to inquire about the patients sleeping habits. Do they have a hard time falling asleep, or staying asleep? Have they had a loss of appetite? Do they feel more tired than normal?

From these questions, you can clearly see in what direction I am going. The trick is to not directly ask the patient, “are you depressed”. Being this direct, will more than likely cause a reflex “no”. What you instead want to do is have the patient come to this realization on their own. A lot of patients will not link their somatic symptoms to their depressed mood. Even more commonly, they will be in denial regarding their depression, therefore you must tread lightly.

If there was an inciting event, such as a loss of a loved one then this might be considered bereavement, so long as they are grieving in a way that is expected. If the patient has recently moved, lost a job, etc., then this is consistent with adjustment disorder with or without depressed mood, based on their answers.

The problem arises, when these symptoms start to affect their daily living. This is when we need to intervene. It is much more common than you might think, and the majority will go undiagnosed and untreated.

It is thought that over 50% of patients who visit a primary care office (most visit a primary care office - not a psychiatrist) will go undiagnosed.

Therefore, it's important for you to be on the look out. Depressive symptoms include:

-Depressed mood most the day
-Loss of interest or pleasure in most activities
-Insomnia or hypersomnia
-Significant weight loss or weight gain (eg, 5 percent within a month) or decrease or increase in appetite nearly every day
-Psychomotor retardation (slowed speech or movements, or decreased speech output) or agitation (hand-wringing, pacing, and fidgeting) nearly every day that is observable by others.
-Fatigue or low energy
-Decreased ability to concentrate, think, or make decisions
-Thoughts of worthlessness or excessive or inappropriate guilt
-Recurrent thoughts of death or suicidal ideation, or a suicide attempt

Don't forget, any patient presenting with depressive symptoms should be questioned about suicide risk.

Initial lab tests should include CBC, BMP, TSH, HCG (women), and possible urine toxicology screen.

The management and treatment of those who are depressed will be left for another day. Today, I just wanted to give you a little clinical pearl. When things just don't make sense, don't forget to rule out depression.