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Hidden in Plain Sight: Overlapping Symptoms That Challenge a Diagnosis of MDD

Announcer:
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Dr. Goldberg:
This is CME on ReachMD. Hello, everybody, I'm Dr. Joe Goldberg. With me today is my colleague, Dr. Manpreet Kaur Singh.

Welcome, Manpreet.

Dr. Singh:
Thank you, Joe. Great to be here.

Dr. Goldberg:
Ditto. We're going to tackle, in a very succinct way, the all-important question of how do you make sense of overlapping symptoms or disease characteristics that can make the diagnosis of major depressive disorder so challenging? Imitators, mimics, comorbidities, what's your soundbite on that, Manpreet?

Dr. Singh:
Well, Joe, the problem is, is that we don't have a diagnostic test. A gold standard clinical interview helps us get to the bottom of a diagnosis, but we can't, oftentimes, delineate a depressant diagnosis from other things that might look exactly like it. Bipolar disorder – two-thirds of patients with bipolar disorder present with a unipolar depressive episode at its first blush. If you don't screen out or rule for mania, you'd never know that that's part of your differential diagnosis.

Patients also experience other mimickers, like hypothyroidism, autoimmune conditions, nutritional deficiencies like anemia, iron, or vitamin D deficiencies, medication exposures. Certain medications that patients take for other health conditions can often look like depression as an adverse event. And of course, you can't ignore alcohol and substance use disorders. So there are a number, and I'm sure there are many more that are great mimickers of depression, and it's worthy

of our patients' time and energy to be able to delineate and have a broad differential diagnosis.

Don't necessarily feel committed to one particular diagnosis. And you know, horses are horses, zebras are zebras. Common things, common. You should definitely be thinking more common things are going to be rising to the top. But the rare conditions require a little bit more due diligence and thoughtful recognition and elimination of other more common things first.

So that's the way that I approach great mimickers. How about you?

Dr. Goldberg:
Yeah, you know, you're making me think, in some ways, it's not that hard to go through your SIGECAPS [Sleep disturbance, Interest (diminished), Guilt or feeling worthless, Energy (loss), Concentration difficulties or indecisiveness, Appetite abnormality or weight

change, Psychomotor retardation or agitation, and Suicide or death (acts or thoughts of)] checklist with anybody anywhere, and say, yes, you have a depression. But then the issue is, is that your diagnosis? Or do you have a syndrome of major depression superimposed on somebody with the illness of major depressive disorder or bipolar disorder or schizophrenia? And is that different from negative symptoms? We think. Or how about somebody with active substance use disorder who has a major depression? They're allowed to have a major depression, but you're not really technically that able to say, “I know your symptoms are not caused by your substance use,” so we have to kind of sort that through. And on and on the list goes. We can have post-traumatic stress disorder, anxiety disorder, major cognitive disorders. I mean, when you go through all 265 diagnoses in the DSM-5, it's probably not that hard to accommodate a major depression.

So I think some of the takeaways on this, in my mind, are have a comprehensive approach. If you've diagnosed major depression, is that it, or is there any broader context? Epidemiology – is this your first rodeo, or this is your 14th major depression? What was your age at onset? As a child psychiatrist you may not know this, Manpreet, but depression that occurs in youth may even have a higher risk for polarity conversion to bipolar disorder. And someone has late-life-onset depression, you worry more about secondary depressions and underlying medical conditions. So we can almost sort of play detective in this sense, in thinking, not just is a major depression present or absent, but rather, in what context does it arise? What else might be going on? Is the treatment that's currently in place or has previously been undertaken appropriate, accurate, adequate, so that I can benefit as much as possible from my predecessors in deciding is this someone who's likely going to have a robust response to treatment? Is this someone who's had chronic depression that may have residual symptoms? Or maybe this isn't even depression at all; maybe this is somebody who's got Addison's disease and a TSH [thyroid stimulating hormone] up to here, and then up till now, people have construed it as clinical depression when it's something else. So therein lie the challenges.

Dr. Singh:
And you know, Joe, I have to say that depression doesn't happen in a box. It's clearly environmentally influenced. And just to give you an example of the social media hype that everybody's been talking about and its influence on depression evolution, in adolescent girls especially, really, there have been very, very few causally inferring studies that have been designed to look at this question that have found any significant association between screen exposure and depression in kids.

Dr. Goldberg:
Play detective. That's my parting advice for you today.

Well, this has been a great micro discussion. Our time's unfortunately up. So thanks for joining.

Announcer:
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