The Importance of Accurate Diagnosis

Henry Olders, MD, FRCPC

CLSC René-Cassin

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I would like to say a few words about the importance of obtaining an accurate diagnosis, when it comes to mental illness. I will begin by telling you a little story.

Bipolar Affective Disorder vs Schizophrenia

I was covering the emergency room at the Douglas Hospital one Sunday evening, several years ago, when I was paged to come and see a patient who had returned to the hospital after running away several days earlier. He was a patient on the Research Unit, part of a study on a new antipsychotic medication for the treatment of schizophrenia.

On the unit, I met the patient, a man in his middle thirties, tall, slim, goodlooking, and nattily dressed in a three-piece business suit. Mr. X. was in excellent humour, jovial, cracking jokes, talking a mile a minute. His cheerfulness was infectious. He informed me that he was married, with two young children, that he owned his own successful business, and that he had left the unit several days earlier to look after the business. He felt he had no choice but to run away, as he had been refused permission to go out on pass. He admitted to receiving treatment for depression several years previously, and that his mother had also suffered from depression after the birth of Mr. X.'s brother.

Does anyone have any ideas about the illness that this man was suffering from?

If you guessed bipolar affective disorder, hypomanic state, you are almost certainly correct. Another name for bipolar disorder is manic depressive illness.

However, this man was enrolled in a drug study for an antischizophrenia drug, which meant that his official diagnosis was schizophrenia.

You might well ask, what difference does it make, schizophrenia, bipolar affective disorder, they're both mental illnesses, right?

Yes, you'd be right, or at least you'd have been partially right up until 1972. That was the year that lithium was first used to treat manic depressive illness. For the 20 years before that, the usual treatment for both conditions was medication with antipsychotic drugs such as largactil, mellaril, or modecate.

prognosis is good in bipolar disorder, if properly treated

But with the advent of what are called mood stabilizers, which could prevent both depressions and manic episodes, people with manic-depressive illness could lead normal lives.

Do you remember the wife of Pierre Elliott Trudeau? Margaret made headlines when she took off to New York City and had a fling with Mick Jagger and the Rolling Stones. It turns out that she was manic at the time. Now she's on lithium, happily remarried to a real estate developer and living a quiet life in British Columbia.

antipsychotic medications produce schizophrenia-like symptoms; this obscures correct diagnosis

In contrast, the mainstay of treatment for schizophrenia remains antipsychotic medication. And although a small number of new antipsychotics are just coming on the market which may have fewer troublesome side effects, the overwhelming majority of individuals labeled as being schizophrenic receive medications whose side effects resemble symptoms of schizophrenia.

parkinson syndrome

The most problematic of these side effects are Parkinsonian syndrome, a condition which resembles Parkinson's disease. In the elderly, tremor is frequent, but even young people develop rigidity. Let me show you.

The facial rigidity is called mask-like facies. We can no longer tell how the person is feeling, because their facial expression and body language no longer work. Similarly, their speech becomes aprosodic, a word meaning that it lacks inflection, the usual rise and fall which again communicates emotion.

impairment of affective communication

Much more subtle is the side effect of antipsychotic medication which impairs the patient's ability to read the emotions of others. This makes it extremely difficult to enter into rewarding long-term relationships such as marriage.

amotivational syndrome

Finally, antipsychotic drugs cause an amotivational syndrome as a side effect. People taking these medications lack the drive or the energy to undertake projects. I don't recall a single patient taking the usual doses of these drugs who was able to hold down an ordinary job.

Typical scenario

So here's what typically happens. Let's say a young man has a nervous breakdown, and experiences auditory hallucinations, for example he hears God talking to him, and he begins to have a delusional belief that the Hell's Angels want to kill him. He's brought to a psychiatrist, who gives him a label of schizophrenia, and starts him on antipsychotic medication.

Chances are that the initial diagnosis is wrong: in the United States, the historical tendency is for schizophrenia to be diagnosed three times more often than in the rest of the world. Two out of three diagnoses are most likely incorrect. The tragedy is that this means that much of the research on schizophrenia is invalid because many of the subjects in a study may not have schizophrenia.

So, we now have this young man on medication which makes him look and behave like a chronic schizophrenic. For the psychiatrist, this is wonderful: it just confirms what a wonderful diagnostician he thinks he is.

Thirty or forty years later, someone like myself may see this man and suggest, maybe he doesn't have schizophrenia after all. Let's take him off the antipsychotic medication and see what the actual diagnosis should be.

What are the chances that the treating psychiatrist would happily follow such a suggestion? Pretty small; if you were in his shoes, would you want to have to admit that you'd made a mistake, and had been prescribing a wrong treatment for forty years? Not likely!

To return to my story of the young man that I saw in the Research Unit at Douglas Hospital: afterwards, I spoke to the psychiatrist who was doing the research study and asked what this man, who clearly was manic, was doing in a study of schizophrenia patients. The psychiatrist said, lamely, "Well, he fits the diagnostic criteria we use for schizophrenia."

dementia vs pseudodementia of depression

There are several other psychiatric disorders in which incorrect diagnosis can have serious effects. When elderly patients experience memory problems, Alzheimer's disease may be diagnosed. However, depression can also cause cognitive impairment which resembles Alzheimer's. Depression can be successfully treated, but there is no cure for Alzheimer's disease. The tragedy

that can occur is that if the diagnosis of depression is missed, or if depression is suspected but inadequately treated, the pseudodementia caused by the depression turns into a permanent dementia after a period of time. As the saying goes, if you don't use it, you lose it: if you don't keep your brain active, it will degenerate.

depression vs hypothyroidism

In elderly women, hypothyroidism is very common, occurring in up to 10% according to some estimates. Hypothyroidism can present as depression, even when there are no physical symptoms of hypothyroidism. Unfortunately, family physicians and even endocrinologists are usually reluctant to prescribe synthroid for these people when there are no physical symptoms.

delirium vs dementia

Finally, when an elderly person demonstrates memory problems of recent onset, chances are that they are caused by a delirium, not a dementia. A delirium itself can be due to just about any medical condition you can think of, but one of the most frequent is urinary tract infection, again, even when there are no physical symptoms of the infection. And again, the tragedy is that an untreated delirium can turn into a permanent dementia.

What can you do?

What can you do to prevent these tragedies from happening?

Become knowledgeable about the illness and about other conditions which may have similar presentations

First, find out as much as you can about the illness that you or your loved one have been diagnosed with, and about conditions which may resemble it. Besides the library and the bookstore, and community resources such as AMI-Quebec, the internet can be a helpful source of information. Unfortunately, the internet is also a source of a lot of misinformation.

Ask the psychiatrist about the differential diagnosis

Second, ask the treating psychiatrist about the differential diagnosis for the condition, that is, what are the other illnesses which should be considered in coming up with a diagnosis. For each of these conditions, what are the features of your case which support or which go against that diagnosis?

Are there psychiatric disorders in other family members?

Because a number of psychiatric disorders have a genetic component, and tend to run in families, find out what mental illnesses, including depression, alcoholism, or drug abuse, have been identified in the patient's blood relatives.

This includes the patient's children or grandchildren, brothers and sisters, parents, grandparents, and also uncles, aunts, cousins, nephews, and nieces. Make sure that the psychiatrist is aware of these conditions in family members.

What were the symptoms at the very beginning of the illness?

Frequently, in the case of longstanding illness, a careful and complete description of the way the illness first manifested itself, without any masking of symptoms by medication, can be helpful. For example, I would look for evidence of depression, such as suicidal behaviour.

If necessary, ask for a second opinion

Finally, if you think the diagnosis in your situation needs to be re-evaluated, don't be shy about getting a second opinion. An ethical physician would not obstruct your getting another opinion. And you wouldn't want anyone other than an ethical doctor looking after you or your loved one, would you?

Thank you for coming, and being such a great audience.