SECTION 2: DIFFERENTIAL DIAGNOSIS

SYMPTOMS

Emotions: tension, irritability.
Cognitions: exaggerated fears, worries.
Behaviour: avoidance of feared situation, checking, seeking reassurance.
Somatic: tight chest, hyperventilation, palpitations, decreased appetite, nausea, tremor, aches and pains, insomnia, frequent desire to pass urine and stools.

DIFFERENTIAL DIAGNOSIS

Psychiatric

GAD
Panic disorder (see below)
Phobias
OCD
PTSD
Acute stress disorder
Depression
Substance misuse – especially withdrawal symptoms
PD
Dementia

Medical

Hypoglycaemia
Hyperthyroidism
Phaeochromocytoma
Delirium

MANAGEMENT

Full history and MSE.
Exclude medical disorders – glucose, TFT, etc.
Acute anxiety may be relieved by anxiolytics, e.g. benzodiazepines, but for short courses only. Patients may become dependent on them if used long term.
Antidepressants may help anxiety, even when the patient is not depressed.
Try to find out the cause/precipitants of anxiety – treat with psychological therapy, e.g. CBT.

SYMPTOMS

Main features: persistent low mood, anhedonia, lack of energy, decreased concentration and attention, bleak and pessimistic views of future, feelings of guilt or worthlessness, ideas of self-harm or suicide.

Somatic features: sleep disturbance, decreased appetite, weight loss, constipation, amenorrhoea, decreased libido, diurnal variation of mood.

DIFFERENTIAL DIAGNOSIS

Psychiatric

Depression
BAD
Anxiety
PTSD
Schizophrenia
Schizoaffective disorder
Dementia
Substance misuse (chronic alcohol)
Borderline personality disorder

Medical

Hypothyroidism
Cushing's syndrome
Hypercalcaemia (malignancy)
Infections (HIV, syphilis)
Multiple sclerosis
Parkinson's disease
Medication (sedatives, anticonvulsants, steroids)

Others

Life events involving loss (e.g. death of partner)

MANAGEMENT

Full psychiatric evaluation and assess for suicidal ideation and psychotic features.

Exclude medical cause for depression.

Antidepressants.

Psychological therapies.

SYMPTOMS

Main features: elevation of mood, overactivity, overcheerfulness, overtalkativeness.

Other features: irritability, flight of ideas, distractibility, grandiose ideas, decreased sleep, delusions (mood-congruent), hallucinations, impaired judgement, irresponsibility, loss of normal social inhibitions, promiscuity, decreased appetite.

DIFFERENTIAL DIAGNOSIS

Psychiatric

Hypomania
Mania
Mania with psychosis
Schizoaffective disorder
Schizophrenia
Substance misuse (cocaine, amphetamines), acute intoxication, drug-induced psychosis
Brief reactive psychosis (to stressful situation)

Medical

Brain disorders affecting the frontal lobes (e.g. space-occupying lesion, HIV infection, syphilis, Alzheimer's disease)
Alcohol withdrawal
Corticosteroids
Anabolic androgenic steroids
Hyperthyroidism

MANAGEMENT

During the interview maintain a calm, non-confrontational manner. Manic patients may become aggressive or violent in response to even minor irritations. Antipsychotics may be used in the acute phase (see Bipolar Disorder for more information).
Admit if overt mania.
Exclude other/medical causes.
Antipsychotics in acute episode (e.g haloperidol).
Lithium is used as prophylaxis for recurrent mania (BAD).
ECT in severe cases resistant to other treatment.

The hallucinating patient

SYMPTOMS

Features: auditory, visual, somatic, olfactory or gustatory hallucinations.
Auditory and somatic are more likely in psychiatric disorders, while visual and olfactory suggest an organic disorder.

DIFFERENTIAL DIAGNOSIS

Psychiatric

Schizophrenia
Schizoaffective disorder
Mania with psychosis
Severe depression with psychosis
Alcohol and drug misuse, e.g. hallucinogenic drugs – LSD, 'magic mushrooms'
Delirium tremens (medical emergency)/acute alcohol intoxication

Medical

Epilepsy, e.g. temporal lobe
Space-occupying lesion
Delirium
Metabolic disturbances, e.g. liver failure
Infection – encephalitis
Head injury

MANAGEMENT

Full psychiatric assessment.
Exclude organic disorders.
Antipsychotic drugs for psychosis.
Antipsychotic drugs may take 10–14 days to have effect, but cause sedation in the meantime. The patient will require admission and monitoring.

A discrete episode of extremely severe anxiety, which may occur in many of the anxiety disorders. If the panic attacks are recurrent and cannot be explained by other psychological or physical illness, panic disorder is diagnosed. The circumstances of the attack need to be clarified to exclude other disorders.

In a panic attack, the anxiety starts abruptly in the absence of any objective danger and reaches a peak within a few minutes. The anxiety is very intense, but has a limited duration (usually 10–40 minutes).

SYMPTOMS

Autonomic

Palpitations/chest pain
Sweating
Trembling/numbness/tingling
Dry mouth/nausea
Muscle tension
Chills/hot flushes
Dizziness

Behavioural

Urge to get away from the current situation (flight)
Restlessness

Cognitive

Perception of difficulty in breathing/choking sensation
Unpleasant feeling of anticipation/threat
Fear of losing control, dying
Derealisation/depersonalisation

DISORDERS THAT FEATURE PANIC ATTACKS

Specific phobia
Agoraphobia
Social phobia
GAD
Panic disorder
OCD

The patient with obsessions/compulsions

SYMPTOMS

Unwanted distressing thoughts/images entering the patients' mind even though they try to resist them (obsessions). Thoughts are recognised as the patients' own.

The patients may feel they must perform stereotyped acts to ease their anxiety (compulsion). May be repetitive and recognised as senseless.

DIFFERENTIAL DIAGNOSIS

OCD
Anankastic personality disorder
Depression
Psychosis, e.g. schizophrenia
AN
Phobic disorders
Gilles de la Tourette's syndrome/tic disorders

MANAGEMENT

Full history and MSE.

In particular find out about any features of depression (it accounts for up to 30% of obsessional symptoms). Have they always been perfectionist-type of persons?

Are they having any other symptoms that might suggest psychosis: thought insertion, withdrawal, broadcast, hallucinations?

Treat OCD with CBT, although SRIs may reduce symptoms.

Treat depression – SRIs.

SYMPTOMS

Underweight patient: BMI $<$ 19. The patient may complain of amenorrhoea, constipation, cold intolerance, fatigue, irritability.

DIFFERENTIAL DIAGNOSIS

Psychiatric

AN
BN – these patients are more likely to have normal BMI
Depression/hypomania/mania
Psychosis/schizophrenia
OCD

Medical

Any disorder causing weight loss, especially:
malignancy
thyrotoxicosis
inflammatory bowel disease

MANAGEMENT

Full history and MSE. Diet history. Has there been any deliberate weight loss, excessive exercise, restriction dieting, vomiting or laxative abuse? (Suggests AN or BN.)
Are there any features of depression or psychosis?
Are there any other symptoms?
Exclude medical cause for weight loss – TFT, investigate any other symptoms. Malignancy must be excluded.
Aim to increase BMI to normal range (20–25). Inpatient treatment may be needed if weight $<$ 65% of normal or if suicide risk.

The patient who overeats

SYMPTOMS

Bingeing food, then vomiting/purging with laxatives. Preoccupation with body weight and shape.

DIFFERENTIAL DIAGNOSIS

Psychiatric

BN
Atypical depression/SAD
PD

Medical

Kleine–Levin syndrome
Klüver–Bucy syndrome

MANAGEMENT

Full history and MSE. Features of depression? In SAD, patients may have increased appetite. Antidepressants may have an antibulimic effect. Medical stabilisation. Establish normal eating pattern.

SYMPTOMS

Alert with eye movements only/absent body movements.
Mutism (absent speech).
Absent movements.
Decreased attention span for environmental stimuli.
Speech may be present but there may be amnesia for personal identity and history.

DIFFERENTIAL DIAGNOSIS

Psychiatric

Schizophrenia (catatonic state)
Affective psychosis (depressive stupor)
Neuroleptic malignant syndrome
Psychogenic amnesia
Conversion disorder

Medical

Hypoglycaemia
Delirium
Encephalitis
Parkinson's disease
CVA
Acute intoxication, e.g. alcohol, solvents, phencyclidine

MANAGEMENT

ABC.
Exclude life-threatening brain pathology.
Check vital observations – BP, pulse, GCS.
Initially obtain brief history from an informant (? known psychiatric illness, medication, illicit substances; is the patient deaf and/or blind? what language does the patient speak?).
Perform complete physical examination.
Perform investigations guided by the history and examination.
Ensure that the patient is adequately hydrated – IV fluids.
Once life-threatening brain injury has been excluded, obtain a full history from an informant, obtain old notes and attempt MSE on the patient.
Admit the patient; further management will depend on the underlying aetiology.