Case 1. (slide 27)
Always ask about suicide risk as well as substance use. Prior to assuming this is a garden-variety case of depression, also inquire about manic symptoms and psychotic symptoms. The pt's weight gain raises Q's about whether the pt may have hypothyroidism, and so other physical sx's of hypothyroidism should be explored, too.

The standard lab work-up outlined in this talk should be used. Especially important given that this is a woman of child-bearing age is a urine pregnancy test.

Assuming there were no red flags on Mania and Psychosis ROS, and the history, exam, and lab w/u did not suggest a GMC or substance phenocopy, this would appear to be a case of MDD. An SSRI would be a reasonable first choice for tx.

Suicide risk should be reassessed, and, if the patient is not safe to return home, inpatient hospitalization should be considered.

Whether her management is continued on an outpatient basis or she goes inpatient, a decision should be made about whether to switch or augment her existing Rx. Partial response usually suggests an augmentation route while non-response (or intolerable side effects) a Rx switch.

The pt should be educated about the statistics of MDD relapse. It would be a reasonable option to consider weaning the pt from her antidepressant after 1y of tx, but less so w/ successive MDE's.

(slide 36)
There are at least a couple of possibilities here. One is that the patient is actually bipolar. A more subtle consideration, however, might be that this is still MDD but now with a superimposed Substance/Medication-induced Bipolar & Related D/O, where the offending agent is the SSRI. Manic switch is a controversial phenomenon, as we discussed in today's lecture. Strengthening the SMI possibility would be a closer correlation in time between SSRI initiation and manic sx onset, relatively short duration of psychiatric sequelae (following DC of the SSRI), as well as no subsequent manic episodes w/o an offending agent (e.g., SSRIs). Strengthening the BD possibility would be subsequent manic episodes unprovoked by drugs (Rx'd or illicit).

Regardless of which of the two dx's is correct, it would make sense to remove the SSRI for now and consider introducing a mood stabilizer such as Li+. Again, if there is an acute safety issue, inpatient hospitalization should be considered.

Case 2.
Good histories, timelines are frequently difficult to reconstruct, but to hone this pt's dx it would help to better understand what range of mood sx's/presentations the pt has had. It would also be important to establish whether psychotic sx's have only tracked w/ acute mood episodes or if they have ever been present independent of severe mood sx's. Family psychiatric history might also help swing the provider's diagnostic thinking toward a mood disorder with psychotic features or to a primary psychotic disorder. Even if the pt has not had manic symptoms, a first depressive episode accompanied by psychotic features may indicate a higher probability of bipolar disorder.

A full lab work-up (as outlined earlier in this lecture) is important. In particular, a toxicology screen could be particularly illuminating. Also, since this is a young patient presumably with his first psychiatric episode, it would be reasonable to obtain brain imaging.
There is **not enough** information here to make a clean diagnosis. Possibilities could include: MDD with mood-congruent psychotic features (note that the pt *does not seem to have had a prodrome with social withdrawal/isolation*) & though there is no history of a manic or hypomanic episode (and, thus, this dx cannot yet be formally made), a healthy suspicion for bipolar D/O should be maintained: adolescent/young adult onset, psychotic features. A primary psychotic d/o (e.g., schizophrenia) is a reasonable consideration, too. **For now, Other Specified Depressive D/O, Unspecified Depressive D/O, Other Specified Psychotic D/O, Unspecified Psychotic D/O** are all preliminary dxs, *though a single unifying dx would be more likely than two separate psychiatric illnesses*. One might also potentially consider Schizoaffective D/O.

**Case 3.**

Duration is key. Are the mood swings over a matter of **hours or days**? (Might lean more towards personality D/O issues if this is the case.) Also, if the mood changes do meet DSM duration criteria, what **amplitude** of changes are we talking about? Smaller changes (i.e., c/w Cyclothymic D/O)? Larger changes (i.e., c/w BD?) The pt’s irritability could substitute for euphoria en route to a dx of BD. Duration is also key as far as venlafaxine response/non-response. Did she give this Rx a full trial? Only a week? Naturally, SUI risk should be explored and one should also ask about substance use.

As it turns out, this pt did not report ‘upslings’ in mood that sounded particularly impressive or of sufficient duration, and so I dx’d her with MDD. W/o extra data, however, any range of mood dxs is possible, including [Other Specified v. Unspecified] [Depressive v. Bipolar & related] D/Os. B/c the pt’s venlafaxine was suboptimally dosed, I increased her dose at the end of her first appointment.

Tell the sister nothing, except that you would need signed consent to release information.

The new data does make one lean more towards a diagnosis of Bipolar D/O, *at least Other Specified v. Unspecified Bipolar & Related D/O*. Careful consideration has to be given to the possibility of **methamphetamine** as etiologic, given the potential for acute intoxication to mania and acute withdrawal to mimic depression. From this perspective, one might also speculate that this is Substance/Medication-induced Bipolar and Related D/O. Bipolar patients **often have comorbid** substance issues, though, and so teasing apart these two possibilities would require very good history of what mood sx have been present during extended periods of sobriety (if there ever have been any). A **chemical dependency referral** should be recommended and it would also be reasonable to swap-out the pt’s venlafaxine for a mood stabilizer.