Self-Assessment in Family Practice

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This section of The Journal is designed to present clinical problems which focus on patient management, problem-solving, and other elements integral to family medicine. The intent of this section is aimed more at teaching and learning than self-assessment as an evaluation or scoring device. Reinforcement of major teaching points is therefore included through the further discussion and supplemental references which appear on the following pages. Critical comments relating to these self-assessment materials are invited and should be submitted as Letters to the Editor.

Directions: Each of the following questions contains five possible answers. Select the one best answer (A, B, C, D, or E).

Mrs. L. F., aged 51 years, has visited your family practice office four times during the past three months with complaints of headache, low back pain, and indigestion. Today she reports early morning awakening and frequent crying spells. She bursts into tears while describing her symptoms. She recognizes the presence of depression, which she attributes to her "change of life." The patient has normal menses and no hot flashes, and there have been no recent stressful life events.

1. Which of the following statements is true?
   A. Research studies have shown an increased prevalence of depression around the menopausal years.
   B. Persons, as they age, come for psychiatric treatment with increasing frequency.
   C. Depression at the time of the menopause is distinguished by an absence of previous episodes.
   D. Epidemiologic and clinical studies have failed to support the validity of involutional melancholia as a distinct diagnostic entity.
   E. The prevalence of depression in men and women is approximately equal.
2. Which of the following statements regarding depression is untrue?
   A. Somatic pain, functional, and anxiety complaints have been found to increase in number just prior to the diagnosis of depression.
   B. The somatic symptoms tend to decrease to normal frequency after one year's treatment of depression.
   C. Persistence of somatic symptoms after one year's treatment of depression may indicate that the depression will be chronic in nature.
   D. Both spouses and children of depressed patients have increased numbers of office visits and complaints.
   E. There is no qualitative relationship between the complaints of depressed patients and those of their spouses and children.
3. All but which one of the following are common symptoms of depression?
   A. Impaired recent memory
   B. Sleep disturbance
   C. Appetite disturbance
   D. Anxiety
   E. Hopelessness
4. Drug therapy of Mrs. L. F. might be initiated with which of the following?
   A. Chlordiazepoxide
   B. Phenelzine
   C. Amitriptyline
   D. Tranylcypromine
   E. Methylphenidate

Mrs. L. F. returns one week later, prior to her scheduled appointment. She describes how "everything is going wrong and nobody cares." To her, there seems no way out of the problems. You as the physician are concerned about suicide.

5. You might logically do which of the following?
   A. Discuss with the patient your concern regarding suicide.
   B. Increase the patient's dose of tricyclic antidepressant to 300 mg daily, with sufficient medication for one month.
   C. Switch the patient's medication to lithium carbonate.
   D. Advise the patient that she should contact the hospital emergency room if problems arise.
   E. Arrange a repeat appointment for one month.
6. Which of the following groups are at the least risk of suicide?
   A. Caucasians and Protestants
   B. Blacks and Catholics
   C. City dwellers
   D. Unemployed persons
   E. Physicians and nurses

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Answers and Discussion

1.D. A review of epidemiologic and clinical studies has not supported the validity of involutional melancholia as a diagnostic entity, thus justifying the decision to exclude involutional melancholia from the third edition of the *Diagnostic and Statistical Manual of Mental Disorders*.[1,2] Women predominate in studies of depression prevalence.[3] Epidemiologic studies show no increase in the prevalence of depression during the menopausal years and, in fact, there is a decreasing utilization of outpatient psychiatric services as patients age. Depression occurring at the time of the menopause does not present a distinct symptom picture nor is it characteristically associated with an absence of previous episodes.[1]

2.E. A longitudinal study of 154 persons treated for depression over 24 years of a private family practice revealed the following: somatic pain, functional, and anxiety complaints increased in frequency just prior to the diagnosis of depression and decreased to normal after one year of therapy. Patients with persistent somatic symptoms had an increased risk of developing chronic depression.[4]

Both spouses and children of depressed persons had more physician visits than did a control group of individuals who denied the presence of depression in spouse or parent. The spouses and children of depressed individuals reported pain, functional, and anxiety complaints that were very similar qualitatively to those of the depressed patients.[5]

3.A. Sleep and appetite disturbances are common manifestations of depression. Anxiety is often described by depressed persons.[6] Hopelessness and despondency reported by depressed patients may indicate suicidal thoughts. Impaired recent memory is more characteristic of organic brain disorders such as Alzheimer's disease. At times failing memory may present as depression, perhaps as an exaggerated response to the memory loss of old age.[7]

4.C. Anxiolytic agents may make depression worse. The monoamine oxidase (MAO) inhibitors, generally inferior to other forms of therapy in severe depression, are sometimes used when tricyclic antidepressant therapy is unsuccessful. MAO inhibitors have complex interactions with other drugs and a high risk of toxicity; they are not indicated for initial therapy. Stimulants such as methylphenidate may aggravate agitation and dysphoria, and are outmoded as therapy for depression.[8]

5.A. The family physician should confront Mrs. L. F. with his concern regarding suicide. He needs to assess the intentionality and lethality of any self-destruction plans as well as minimize the accessibility to suicide means. A change in medication to lithium carbonate would be inappropriate, and providing a 30-day supply of high dosage antidepressants would be equivalent to giving the patient a loaded gun. If not admitted to the hospital, the patient would need close follow-up, with ready access to her personal physician if threatened with suicidal impulses. Other treatment principles include decreasing social isolation, providing crisis intervention, and arranging appropriate consultation or referral.[9]

6.B. Blacks and Catholics commit suicide less often than Caucasians and Protestants. City dwellers and the unemployed are at greater risk than rural inhabitants and employed persons. Physicians and nurses, as well as lawyers, policemen, and artists, are at greater suicide risk than persons with other occupations.[10]

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all family practice and other residents at this hospital.

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A System of Newborn Physical Examination. *John W. Scanlon, Thomas Nelson, Lawrence J. Grylack, Yolande F. Smith. University Park Press, Baltimore, 1979, 96 pp., $8.95 (paper).*

This small book aims to help beginners learn the authors' particular approach to physical examination of the newborn. It meets that modest goal but offers little to help the reader reach further.

Using a systems oriented approach, the book outlines the organization and technique of the authors' method of examination. In passing, they comment upon common or interesting diagnostic implications of physical findings but generally do not provide guidance on differential diagnosis. Additional sections cover the assessment of gestational age and the examination of the newborn in the delivery room. A chapter devoted to behavioral evaluation details the senior author's own abbreviated assessment scheme, but does not define normal scores. A final brief review of case histories and diagnostic considerations fails to fill the gap between technique of examination and process of diagnosis. The book's single illustration leaves the reader needing thousands of additional words to make clear the techniques and manipulations described by the authors. There are several helpful tables summarizing normal findings, including quantitative data that would be difficult to locate elsewhere. References are well selected but few.

Physical examination, like most skills, is usually not best learned from a book. Nothing about this book overcomes that problem. It could be a helpful part of a medical student's initial orientation to newborn examination. Most family physicians in training and practice will, however, probably find little in it that is new, useful, or better presented than may be found elsewhere.

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