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· 世界全科医学工作研究 ·

【编者按】中国全科医学杂志与澳大利亚 Monash 大学和 Melbourne 大学的全科医学专家和心理学专家在 2012 年伊始共同推出“全科医学中的心理健康病案研究”学术专栏，该专栏由澳大利亚的几位专家轮流撰写，以介绍社区常见的心理问题及其解决方法为主要内容，获得了读者的广泛好评。今年我刊将继续该学术专栏的登载，以推动我国社区心理学服务的能力建设，并带动社区心理学研究的深入。与此同时，由几位澳大利亚教授合作撰写的著作《全科医学中的精神病学》正在由中国全科医学杂志社与国内外专家合作进行翻译，期望不久在中国出版。希望通过本学术专栏和翻译名著等工作，让中国的全科医学在心理健康服务方面迈上新的台阶。在此衷心感谢担任本栏目翻译点评工作的我刊编委、澳大利亚 Monash 大学杨辉教授对中国全科医学发展给予的帮助和支持！

全科医学中的心理健康病案研究（十四）
——一位老人的抑郁（第一部分）

Fiona Judd，Grant Blashki，Leon Piterman（著），杨 辉（译）

【关键词】 抑郁；老年；注意力；集中力；记忆；全科医学；精神卫生服务
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1 病史

琼是一位 69 岁的老年男性。最近 6 个月左右，他来诊所就诊好多次了，每次来看病都是各种不同的原因。最开始他说睡眠有问题，请医生帮助；几个星期后他再来看病的原因是胸部隐隐的疼痛；再后来的看病原因是让医生帮助解决他的胃肠问题。这次来看病，他的主诉又变成了记忆（memory）减退。

2 进一步的病史

琼没有明显的既往病史。他以前吸烟，曾经每天吸 30 支。他 6 个月前退休，退休前职业是会计师。他曾经想 70 岁以后退休，不过当他的妻子被诊断为乳腺癌后，他就决定退休了。幸运的是，他妻子的治疗效果不错，现在已经痊愈。这对老夫妻有两个孩子，都已经成年，一个住在伦敦，另一个在澳大利亚。在琼的妻子治疗取得很好的效果后，他们计划去伦敦旅行。不过琼比较担心自己的身体状况是否适合这样的长途旅行。他还很担心自己的记忆，担心自己是否会发展成老年痴呆症。他的家族史提示家里有人患老年痴呆症，他亲身经历过他父亲的老年痴呆症，一种进行性的记忆衰退，直到最后连琼也不认识。琼还有抑郁的家族史，他还认为 15 年前父亲去世以后，自己就一直很抑郁。

3 体检

琼的衣着整洁，梳洗干净。他走进诊室的时候，步履缓慢，神情显得很紧张。他看上去似乎有些沮丧，双手轻微颤抖。躯体检查结果表明，生命体征都很正常，根本没有帕金森病的证据，心血管、呼吸和腹部检查均正常。他还是挺乐意回答你的问题，不过他的答案很简单，不涉及具体的内容。他再次提到老年痴呆症的话题，说他担心自己的记忆问题已经有好长时间了。他承认自己想到如果得了帕金森病，生活也就没有什么意义了，他也就不想活了。他否认自己有知觉紊乱（perceptual disturbance），如幻觉（hallucinations）。你对琼进行集中力（concentration）和注意力（attention）检查（见注 1），发现有些缺损。虽然只通过这一次看病不能详细地评价他的记忆能力，但简单记忆测验（见注 2）表明，主要问题是瞬时记忆和短期记忆问题。

4 提问

4.1 可能的诊断是什么？

4.2 应该考虑哪些其他诊断？

4.3 需要进一步收集哪些病史，做哪些检查和化验？

4.4 怎样治疗这个患者？

5 解答

5.1 可能的诊断 最可能的诊断是抑郁[1]。琼几次看病都说感到忧虑，并描述了一些比较模糊的症状，包括睡眠不好、胸疼、消化问题以及最近出现的记忆问题，这些症状都可能是抑郁造成的。琼有抑郁的既往史和家族史，他最近有两个紧张性刺激，一个是妻子诊断为癌症，另一个是自己退休。心理状态检查表明，他表现为悲伤和焦虑，并存在集中力、注意力和记忆问题。他还说有不想继续活下去的想法。

5.2 考虑其他的诊断 必须要考虑的其他诊断包括：（1）症状的躯体原因，比如甲状腺疾病、肿瘤、肝功能受损。（2）老年痴呆症，这是鉴于他有家族史，而且他对记忆的主观担心。之前的检查结果（功能缺损）可能是由抑郁导致，但是你应该记住，这些检查结果也可以提示早期老年痴呆症。

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注：Fiona Judd、Grant Blashki 的作者简介见 2012 年第 1A 期，Leon Piterman 的作者简介见 2012 年第 2A 期，见中国全科医学杂志社官方网站（http：//www.chinagp.net）；文后附英文来稿原文

5.3 进一步的病史、检查和化验 为了排除症状的躯体原因，需要对他进行全面的躯体检查以及各种实验室检查，包括全血检查、血尿素氮和电解质检查、肝功能检查、甲状腺功能检查、维生素 B_{12} 和叶酸检查、红细胞沉降率检查、尿微生物和尿培养检查。鉴于他以前吸烟，需要做胸部X线检查。需要进一步采集病史，以便支持或排除抑郁的诊断，因此要检查患者是否有如下症状：情绪低落或不稳定；食欲和体质量变化；在各种活动中缺乏快乐；缺乏兴趣、精力和动机；焦虑的症状；缺乏性兴趣；社交退缩；以及负罪、自责、无助、自残或自杀等想法。最好让琼自己填写一份问卷，如贝克抑郁量表（Beck depression inventory，BDI），对你要探讨的症状的严重程度进行定量测量[2]。

如果琼表现为抑郁，特别是如果他的症状表现为中等或较高的严重程度，那么在目前这个时候排除老年痴呆可能是困难的，因为抑郁的人的注意力和集中力通常较差，在记忆测验时得分也比较低。对老年患者来说，区别抑郁和老年痴呆症更困难。老年痴呆症具有明确的临床诊断标准。不过在这个阶段给患者做脑部CT可能帮助并不大。

5.4 怎样治疗 在排除躯体疾病的原因后，如果确认诊断是抑郁，则需要进行心理学和药物学的综合治疗。心理学治疗（psychological therapy）应该着眼于让琼能够适应妻子诊断为癌症，并能够适应自己的退休生活。人际关系治疗（interpersonal therapy，IPC）及其在全科医学服务中的应用，可以有针对性地针对失落（loss）和角色转变的问题，是一个很适宜的治疗策略[3]。鉴于琼的症状属于中等严重程度，提示应该让他服用抗抑郁药。最常用的是选择性5-羟色胺再摄取抑制剂（SSRI）。琼的躯体健康状况还是不错的，而且也没有用其他药物，所以抗抑郁药可以使用常规药量，如氟西汀（百忧解）20 mg/d。

应该让琼经常复诊。抗抑郁药要在服药2～4周后才能发挥药效；如果需要增加药量，则至少要推迟到6个星期之后，如果那时他的抑郁症还没有缓解，再增加药量。如果琼的记忆问题是抑郁引起的，那么随着其他抑郁症状的缓解，记忆问题也应该得到相应改善。不过，如果在情绪、睡眠、食欲、兴趣、动机、精力等症状得到缓解的同时，他的记忆症状还没有得到缓解，则需要仔细地对琼进行再评估，并需要进行正式的记忆测验，从而确认或排除客观上的记忆紊乱问题。

译者注：

1 注意力和集中力

注意力（attention）：是注和直接认知过程的能力。采用数字广度测验的方法，让被测验者正向背诵和逆向背诵数字。正常注意力是正向背诵5～7个数字，逆向背诵4～6个数字。

集中力（concentration）：是注并在一定时间内保持注意力的能力，测验方法包括“连减7序列法”，测验者说“现在请您从100减去7，然后从所得的数目再减去7，如此一直的计算下去，请把每减一个7后的答案都告诉我，直到我说‘停’为止”。或者采用“倒拼字母法”，测验者说“请倒着拼写WORLD这个词”。集中力测验结果可能受到被测验者焦虑、情绪紊乱、意识改变或受教育程度较低的影响。

2 简单记忆测验

瞬时记忆：对闪现一次的新知识的立刻记忆能力，通常只持续几秒钟。测验方法：测试者说“请重复我说的四样东西：狗、鞋、蓝色、苹果”。

短期记忆：是一种临时的记忆能力，通常持续几秒钟至几分钟。测验方法：测试者让被测者在5 min后再重复说出先前提到的四样东西。如果被测者说不出来，测试者给出语义上的提示，如“一种动物、一种穿戴、一种颜色、一种水果”。

长期记忆：也称为叙述记忆，包括对数据或事实的记忆。测试方法：（1）场景记忆测试，是对有时间标记的、个体化的、经验性知识的记忆，比如患者对结婚日期的记忆。（2）语义记忆测试，是被测试者已经学习到的普通知识，比如第二次世界大战开始于哪一年。

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· World General Practice/Family Medicine ·

【Introduction of the Column】 The Journal presents the Column of Case Studies of Mental Health in General Practice; with academic support from Australian experts in general practice, psychology and psychiatry from Monash University and the University of Melbourne. The Column's purpose is to respond to the increasing needs of mental health services in China. Through study and analysis of mental health cases, we hope to improve understanding of mental illnesses in Chinese primary health settings, and to build capacity of community health professional in managing of mental illnesses in general practice. Patient-centred and whole-person approach in general practice is the best way to maintain and improve the physical and mental health of residents. Our hope is that these case studies will lead new wave of general practice and mental health development both in practice and academic research. A number of Australian experts from the disciplines of general practice, mental health and psychiatry will contribute to the Column. You will find A/Professor Blashki, Professor Judd and Professor Piterman are authors of General Practice Psychiatry. The Journal cases are helping to prepare for the translation and publication of a Chinese version of the book in China. We believe Chinese mental health in primary health care will step up to a new level under this international cooperation.

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Case Studies of Mental Health in General Practice (14)
——*Depression in An Old Person (Part One)*

Fiona Judd, Grant Blashki, Leon Piterman

【Key words】 Depression; Aged; Attention; Concentration; Memory; General practice; Mental health service

1 History

Jon is a 69 – year – old man, who has been to your practice several times over the past six months or so with various concerns. Initially he presented seeking assistance for his sleep problems, a few weeks later attended because he was experiencing vague pains in the chest and subsequently he came seeking something to 'help my digestion'. On this occasion, he presents complaining that his memory is poor.

2 Further history

Jon has no significant past medical history. He is an ex – smoker, previously 30/day. He retired from his job as an accountant 6 months ago. He had intended to work till 70 years old but decided to retire after his wife was diagnosed with breast cancer. Fortunately she responded well to treatment and is currently clear of disease. The couple have two adult children, one living in London and the other in Australia. Following his wife's good response to treatment the couple had planned a trip to London, but Jon is concerned that his physical health is not good enough to go that far from home. He's also quite concerned about his memory, and is worried he might be developing dementia. He has a family history of Alzheimer's disease, and he watched his father progressively deteriorate until he no longer recognised who Jon was. He also has a family history of depression, and he thinks he might have been depressed himself after his father's death 15 years ago.

3 Examination

Jon is well dressed and groomed, walks slowly into the consulting room and appears quite tense. He seems somewhat dejected, and his hands are shaking slightly. Physical examination shows normal vital signs, no evidence of Parkinson's disease per se, and normal cardiovascular, respiratory and abdominal examinations. He is willing to answer questions, but his responses are brief and without much detail. He returns to the topic of dementia and mentions his concerns about his memory several times. He admits he's thought that if he has got dementia then life would not be worth it, and he'd not want to go on. He denies any perceptual disturbance such as hallucinations. Testing of his concentration and attention (note 1) reveal some impairment. Unfortunately there is no time at this appointment to undertake a detailed memory evaluation but simple memory testing shows (note 2) shows problems in immediate and short – term memory.

4 Questions

4.1 What is the probability diagnosis?

4.2 What other diagnoses should be considered?

4.3 What further history, examination and investigations are required?

4.4 How should he be treated?

5 Answers

5.1 The most likely diagnosis is depression[1]. Jon has presented several times describing vague symptoms, all of which could be due to depression – sleep problems, chest pains, digestive problems and most recently memory problems. Jon has a past history and a family history of depression. He has recently experienced two significant stressors – his wife's diagnosis of cancer and his own retirement from work. On mental state examination he appears sad and anxious, and has problems with concentration and attention and memory. He has voiced thoughts of not wanting to go on.

5.2 Other diagnoses which must be considered include: (1) physical cause for his symptoms such as thyroid disease, malignancy, liver impairment. (2) dementia given his family history and his subjective concerns about his memory. The testing you have undertaken has shown deficits which could be due to his depression, but you note similar results could also indicate an early dementia.

5.3 In order to exclude physical causes for his symptoms a thorough physical examination is required as well as a number of laboratory tests including FBE, U&E, LFT, thyroid function tests, vitamin B12 and folate, ESR, a Urine Micro and Culture, and in view of his smoking history a chest X – ray. Further history is required to support/exclude the diagnosis of depression – so check for symptoms including low or irritable mood, appetite and weight change, loss of enjoyment in activities, loss of interest, energy and motivation, symptoms of anxiety, loss of sexual interest, social withdrawal, and thoughts of guilt, self – reproach, hopelessness, self – harm or suicide. It may be useful to have Jon complete a self – report questionnaire to quantify the severity of symptoms you elicit e. g. the Beck Depression Inventory (BDI) [2].

If Jon is depressed, and particularly if the symptoms are of moderate or greater severity, excluding dementia (at this time) may be difficult, as individuals who are depressed usually have poor attention and concentration and so often perform poorly on tests for memory. This is particularly the case with older depressed persons. As dementia is a clinical diagnosis, tests such as a CT brain scan are not likely to be of assistance at this stage.

5.4 After excluding a physical cause for his symptoms, if the diagnosis of depression is confirmed treatment should include a combination of psychological and pharmacological treatment. Psychological therapy should focus on how Jon has dealt with his wife's diagnosis of cancer and how he is coping with his retirement. Interpersonal Therapy (IPT), or the adaptation of this for use in for general practice Interpersonal Counselling (IPC) is an approach which specifically addresses issues of loss and role transitions and may be particularly suitable[3]. Given that his symptoms are of moderate severity an antidepressant medication is indicated. The most often used

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medications are the SSRI antidepressants. As Jon is physically well and not taking any other medications, the antidepressant can be started at the usual dose e. g. Fluoxetine 20 mg/day.

Jon should be reviewed regularly. The antidepressants will take 2 – 4 weeks to have an effect, and any dosage increase which may be needed should be deferred until at least 6 weeks following which the dose can be increased if his depressive symptoms have not resolved. If Jon's memory problems are due to his depression they should improve along with his other depressive symptoms. If this is not the case, and he continues to have memory difficulties but his mood, sleep, appetite, interest, motivation and energy have improved he will need to be carefully reassessed and formal testing of his memory will be required. This will then confirm or exclude objective memory disturbance.

Notes:

1 Attention and Concentration

Attention: the ability to focus and direct cognitive processes – test using digit span forwards and backwards – expect 5 – 7 numbers forwards and 4 – 6 numbers backwards

Concentration: the ability to focus and sustain attention for a period of time – test using: Subtract serial 7's from 100; spell WORLD backwards. Can be disrupted by performance anxiety, mood disturbance, alteration of consciousness or poor educational level.

2 Simple memory testing

Immediate: registration or capacity for immediate recall of new learning – lasts a few seconds. Repeat 4 items – e. g. dog, shoe, blue, apple.

Short – term: temporary memory, lasts few seconds – few minutes. Repeat the 4 items after 5 minutes. If cannot, prompt with a semantic cue e. g. animal, piece of clothing, colour, fruit.

Long – term declarative memory: data or facts; test both episodic and semantic memory. Episodic memory – time – tagged, personalised, and experiential knowledge e. g. Date of patient's wedding. Semantic memory – general information a person could reasonably be expected to have learnt e. g. year WWII started.

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· 世界全科医学工作研究 ·

WONCA 研究论文摘要汇编 (九十五)

——血管紧张素受体阻滞剂与癌症风险: 英国全科医学研究数据库中接受抗高血压药物人群队列研究

【摘要】 **目的** 对血管紧张素受体阻滞剂是否与癌症风险相关进行调查。**设计** 对用血管紧张素受体阻滞剂与用血管紧张素转换酶抑制剂治疗患癌风险进行对照定群研究。用 Cox 模型校正年龄、性别、体质指数、糖尿病及使用二甲双胍/胰岛素、高血压、心衰、他汀类使用、社会经济状况、饮酒、吸烟等, 用时间协变量做影响探究。**设施** 英国初级保健全科医学数据库。**参试者** 377 649 例患者新用血管紧张素受体阻滞剂或血管紧张素转化酶抑制剂, 且启动治疗至少 1 年。**主要结果测量** 因用血管紧张素受体阻滞剂及使用累积的持续时间, 所有癌症或主要部位某些癌症 (乳腺、肺、结肠、前列腺) 校正危害比。**结果** 跟踪中位数为开始治疗后 4.6 年; 观察癌症患者 20 203 例。尚无证据表明那些曾暴露于血管紧张素受体阻滞剂者总患癌风险增加 [校正危害比为 1.03, 95% *CI* (0.99, 1.06), $P = 0.10$]。某些癌症, 有乳腺 [校正危害比为 1.11, 95% *CI* (1.01, 1.21), $P = 0.02$] 及前列腺癌 [校正危害比为 1.10, 95% *CI* (1.00, 1.20), $P = 0.04$] 风险增加的证据, 其与那些最高基线风险者跟踪评估增添病例分别为 0.5 和 1.1/1 000人年常数项相符。较长治疗持续时间似乎与较高风险不相关 (每例 $P > 0.15$)。而患肺癌风险减少 [校正危害比为 0.84, 95% *CI* (0.75, 0.94)], 但对结肠癌无影响 [校正危害比为 1.02, 95% *CI* (0.91, 1.16)]。**结论** 用血管紧张素受体阻滞剂与总癌症风险增加不相关。所观察到的乳腺及前列腺癌增加的风险在常数项中要小, 与治疗持续时间关联不足, 意味着无关联的解释不能排除。

原文见: Krishnan Bhaskaran, Ian Douglas, Stephen Evans, et al. Angiotensin receptor blockers and risk of cancer: Cohort study among people receiving antihypertensive drugs in UK General Practice Research Database [J]. BMJ, 2012, 344: e2697. published at http: //www. bmj. com/content/344/bmj. e2697.

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