·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（二十）——唐氏综合征

Julian Davis，Fiona Judd，Grant Blashki，Leon Piterman，Hui Yang

【关键词】 唐氏综合征；心理健康；全科医学
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Julian Davis，Fiona Judd，Grant Blashki，等．全科医学中的心理健康病案研究（二十）——唐氏综合征［J］．中国全科医学，2013，16（8）：2549-2551．［www.chinagp.net］

1 病史

简是一位38岁的患唐氏综合征的单身女性，和81岁的母亲和84岁的父亲生活在一起。她父亲带她来找你看病，因为她最近8个星期以来个人功能明显下降。她父亲告诉你，简变得坐卧不宁，有挑衅性，而且还把自己的头往墙上撞。她父亲还告诉你说，有些事情以前就注意到了但没有跟你说，就是简的父母18个月以前就发现她的一般情况在恶化，思维混乱，记不住事情。

2 其他病史

简的智商评分为50分，日常生活中的大部分活动都需要别人帮助。她的视觉和听觉功能没有问题，但掌握的词汇量非常少，所以语言表达很困难。她母亲因结肠癌住院，父亲患有多种慢性病，即使有外部帮助，照顾起简来也很困难。

体检发现，与她以往来诊所看病相比，简显得更不愿意说话。她呆坐在椅子上，没有了她以往的友好态度。她经常站起来，慌慌张张地跑到门口。你问她哪里不好，怎么不舒服，遇到了什么麻烦，她对这些简单的提问采取不合作的态度。

简表现出唐氏综合征的各种异形特征。她身高5英尺2英寸（157.1 cm），体质量85 kg，血压160/95 mm Hg（1 mm Hg =0.133 kPa），没有体位性低血压情况，脉搏不稳定，平均80次/min。检查发现可能存在右侧甲状腺瘤。她没有白内障，听觉系统也正常。心血管检查发现左肋间向锁骨中线2 cm处心尖搏动音，呈现泛收缩期轻微杂音。此外没有其他异常发现。

3 提问

3.1 什么诊断可以解释简的临床表现？

3.2 可能的精神病学诊断是什么？

3.3 应该考虑哪些其他的诊断？

3.4 如果要确定诊断，你需要做什么？

3.5 你能提供什么治疗服务？

4 解答

4.1 什么诊断可以解释简的临床表现？ 可以解释简的临床表现的诊断包括：轻中度抑郁；适应障碍伴抑郁和焦虑心境；Alzheimer痴呆症早期发作。此外，必须考虑和排除她临床表现的器质原因。

4.2 可能的精神病学诊断是什么？ 最能解释简最近发生问题的精神病学诊断是抑郁。在智障人士中，抑郁的表现与其他人是不同的，经常表现为对自己和他人的进攻性行为，并表现出不可解释的思维混乱[1-2]。病人经常表现为睡眠和食欲紊乱，并经常不可预料地哭泣。日常生活能力下降主要表现为自我照顾能力差，进食能力缺失，有些情况下功能退化到大小便失禁。可能会发生依赖行为，需要别人不断地安慰，有时言语中有自杀倾向。智商水平稍高（智商60~70）且行动自如的智障患者如果表达自杀倾向，则应引起足够重视。病人可能会说他（她）很悲伤、恐惧，或者害怕别人。对于害怕别人的病人，可能对他（她）害怕的人采取攻击行为。

4.3 应该考虑哪些其他的诊断？ 鉴于简的环境变化——她的母亲住院，她的父亲需要额外帮助才能照顾简，所以可以考虑适应障碍伴焦虑和抑郁心境。

对于简的病例来说，很有可能在38岁的时候出现Alzheimer痴呆症的认知下降问题。唐氏综合征的病人在40岁左右会出现Alzheimer疾病的神经病理学表现，发病高峰期在刚过50岁的时候。对于简来说，要进一步从家人、照顾者和其他支持人员那里采集确凿的关于记忆力问题、日常生活能力下降问题、词汇和表达能力降低问题，以及逐渐出现的行为问题，如进攻、躁动、游走，以及日落后症状加重（指病人从傍晚开始焦躁、思维混淆、记忆减退情况加重的情况）的各种特征的信息。

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注：Grant Blashki、Fiona Judd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

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一旦智障病人出现任何行为或心境紊乱，都要考虑和排除器质性（躯体）疾病的诊断。与易患精神疾病一样，智障病人也容易患躯体疾病，而且躯体症状也不容易被发现。病人经常发生隐秘的感染，特别是尿路感染、口腔和牙龈感染、耳道感染等。无论任何原因造成的痛苦，都会表现为行为紊乱。这类病人更经常患糖尿病，并表现为心境和行为紊乱。甲状腺问题、胃食管反流、便秘、高血压，以及女性病人的痛经等问题，在这类病人中表现的都不是很典型的症状。不过这些躯体疾病都应该排除。简有甲状腺瘤、高血压，并有迹象表明出现左侧心室功能不全和左房室瓣关闭不全。这些躯体情况都需要进一步检查和治疗。

4.4 如果要确定诊断，你需要做什么？ 只有在得到确凿的病史的情况下，才能做出明确的精神病学诊断。你可以通过与家庭成员和其他与病人有长期接触的人的深入讨论，来获得病史信息。对于显著残疾并表达能力差的智障病人来说，精神病学障碍检查的价值是有限的。病人经常有对情感和举止的标示和表达困难，因此容易受到测验者提问方式以及其他在场人的影响。

你需要通过生物－心理－社会的模式和评估方法，去发现可能存在的器质性问题、精神病学障碍，以及社会层面的问题。在简的病例中，虽然器质性疾病不可能单独地造成她目前的症状，但器质性疾病肯定会造成心理紊乱的恶化，在采用精神病性药物治疗她的抑郁的时候，也要考虑到器质性疾病问题。

鉴于简有可能出现 Alzheimer 病的早期发作情况，需要对她进行正式的认知和功能评估，如果可能的话，还应该做颅脑 CT 或者 MRI 检查。她还需要做一些血液检查，如甲状腺功能、维生素 B_{12}、叶酸，以便排除其他造成痴呆症的原因，并需要通过尿液检查来排除感染。

4.5 你能提供什么治疗服务？ 可以采用抗抑郁药来治疗她的抑郁。SSRI 类抗抑郁药是最常见的药物选择。记住，智障病人通常患有躯体共病，而且药物相互作用的风险也比较高。用药剂量应该从低剂量开始，然后逐渐增加药量。智障病人可能不会跟你报告药物不良反应，因此，需要你小心谨慎地对药效进行监测[3]。应该告诉简的父亲有关药物不良反应的信息，请他随时观察这些不良反应的迹象。对简的父亲提供支持，并保证简和她父亲能够得到恰当的支持，这一点很关键。在持续管理方面，要考虑到简今后的照顾和居所安排问题，特别是考虑到她父母去世后的安排。

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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 amongst community health professionals in managing mental illnesses in general practice. Patient－centred 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 research. A number of Australian experts from the disciplines of general practice, mental health and psychiatry will contribute to the Column. 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 reach new heights under this international cooperation.

Case Studies of Mental Health in General Practice (20)
——*Down Syndrome*

Julian Davis, Fiona Judd, Grant Blashki, Leon Piterman, Hui Yang

【Key words】 Down syndrome; Mental health; General practice

1 History

Jane is a 38－year old single woman with Down syndrome who lives at home with her elderly mother and father aged 81 and 84 years old respectively. Her father has brought her to see you because he is concerned that there has been a significant decline in personal functioning over the last 8 weeks. In addition he tells you she has been agitated and aggressive and has commenced banging her head on the wall. Her father tells you that he has actually noticed, but not previously mentioned to you, that he and his wife have been concerned abouta deterioration in general functioning over the past 18 months where at times Jane has appeared confused and forgetful.

2 Other History

Jane has an IQ of 50 and requires assistance with most activities of daily living. She has no sensory impairments (visual or auditory) but has a very limited vocabulary with difficulty in verbal ex-

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【编者按】 我刊推出的"全科医学中的心理健康病案研究"学术专栏已有一年有余，翔实的介绍了国外知名专家在处理社区常见的心理问题时的诊疗经验，对我国社区心理服务的发展起到了极大的促进作用，受到了读者的广泛好评。本刊作为国内外全科医学交流的窗口，为推动社区心理研究的继续深入，也为向世界展示我国社区心理工作的成果，本刊特邀李荐中教授撰写本文，以期通过全面的案例分析向国外的同行们展示我国精神心理领域独有的中国文化思想。如果读者您希望推广自己的案例处理经验，希望得到国内外专家的点评，欢迎您投稿至本栏目，投稿时注明本栏目即可，投稿方式参见本刊2013年1期的《中国全科医学》稿约。

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中国社区中的心理健康案例研究（一）
——心理生理反应（境遇性呕吐）

李荐中，王海娜，李江波

【关键词】 心理生理反应；境遇性呕吐；心理治疗；全科医学；精神卫生服务

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李荐中，王海娜，李江波．中国社区中的心理健康案例研究（一）——心理生理反应（境遇性呕吐）［J］．中国全科医学，2013，16（8）：2552-2553．［www.chinagp.net］

1 病史

惠娟，女，15岁，初中生。平素学习成绩好，很听话。在家庭中一同进餐时（在校就餐无此现象）出现恶心、欲呕吐症状3个月余。父亲为内科主任医师，为其多次体检及医学检查，无阳性所见，并为此查阅大量文献，称用过15种治疗方法，包括各种暗示治疗，均未奏效，故前来求治。

2 背景

惠娟生母半年前因车祸去世，在此3个月之后其父与一女同事再婚。继母原有比惠娟小一岁的女儿，一同来到惠娟家组成新家庭，共同生活。尽管继母对惠娟态度很好，视如己出，"妹妹"也聪明懂事，举止得体，但是惠娟心中对此还是很反感。只是觉得自己大了，应该明事理，因此没有表现出不满的态度。此后出现上述症状。医生问反感的原因，惠娟说："我妈妈去世后，爸爸把所有的爱都给了我，现在我爸爸把爱分成三份。那两个人与我没有任何关系，凭什么分享我的爱？"

3 心理状态检查

意识清晰，衣着得体，举止得当，接触良好，问答自如，自知力完整，知、情、意协调。未见精神病性症状。

4 提问

4.1 如何诊断？

4.2 治疗中应该注意什么？

4.3 治疗思路与治疗经过是怎样的？

4.4 治疗的理论依据是什么？

5 解答

5.1 诊断 惠娟的症状只有在家庭就餐（继母母女二人在场）时出现，在学校就餐时并不出现，因此症状可以认为是"境遇性呕吐"。因为心里没有真正接纳继母，所以引发躯体症状出现，那么"心因性呕吐"的诊断是成立的（此前已排除器质性疾病）。在精神病分类学上，凡是由于心理因素导致的饮食、睡眠和性功能这三个方面出现障碍，统称为"心理生理反应"。

5.2 治疗注意事项 对于心理生理反应的治疗，不能"头痛医头脚痛医脚"，这是舍本求末。只有解决了心理因素，症状才能够缓解。因此，必须以心理治疗为主，以期解决心因；否则盲目进行躯体治疗或者针对躯体症状进行暗示治疗，不仅不能取得较好疗效，而且还可能延误病情，使治疗复杂化。

5.3 治疗思路、经过与结果

5.3.1 建立心理模型 医生为惠娟构建并讲述了一个心理模型：未来某年，有10名像惠娟一样优秀的同学在大学毕业后一同进入某著名外资企业，试用期满后，全部留用。一天，老板召集这10位员工开会，让大家选出其中2位，然后送美国总部培训2年，回来后担任部门经理。大家认为机会难得，每个人在选票上首先写下自己的名字，另外一个选谁呢？大家不约而同地想，这一个人要与我在国外一起生活两年，所以一定要合得来，要有度量，能理解人、关心人、体谅人。这其中恰恰只有小王具备这些优点，结果只有小王得了10票，首先脱颖而出，获得这难得机会。

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pression. Her mother has recently been hospitalised with Carcinoma of the Colon and her father who has several chronic illnesses has had difficulty caring for her even with outside assistance.

On examination, Jane is less talkative when compared with previous visits to your surgery. She sits slumped in the chair and lacks her usual friendly demeanour. At times she gets up and runs to the door in an agitated fashion. She is not co－operative with simple questioning about how she feels and when asked if anything is troubling her.

Jane presents with the dysmorphic features of Down syndrome. Her height is 5 foot 2 inches and she weighs 85 kg. BP lying is 160/95 with no postural drop, her pulse is irregularly irregular at 80 bpm. Examination reveals a possible right thyroid nodule. She has no cataracts and examination of the auditory system is normal. Examination of the cardiovascular system reveals the apex beat in the 6thleft intercostal space 2cm to left of mid clavicular line. There is a soft pan－systolic murmur at the apex. There are no other abnormalities evident.

3 Questions

3.1 What possible diagnoses might explain Jane's presentation?
3.2 What is the probability psychiatric diagnosis?
3.3 What other diagnoses should be considered?
3.4 What will you need to do to confirm your diagnosis?
3.5 What treatment can you offer?

4 Answers

4.1 What possible diagnoses might explain Jane's presentation? The possible psychiatric diagnoses in Jane are: clinical depression of mild－moderate severity; an adjustment disorder with depressed and anxious mood; early onset of Alzheimer type dementia. In addition, an organic cause for her presentation must be considered and excluded.

4.2 What is the probability psychiatric diagnosis? The diagnosis which best describes Jane's more recent problems is that of a clinical depression. Depression presents differently in people with an intellectual disability and frequently manifests as aggressive behaviour towards self or others and unexplained agitation[1-2]. Sleep and appetite disturbance are common and unexplained crying episodes are frequent. Regression of activity of ADL skills is evident with poor self－care, loss of feeding skills and sometimes regression to urinary and faecal incontinence. Clinging behaviours and need for frequent reassurance may occur, and sometimes suicidal ideation is expressed. The expression of suicidal ideation in higher functioning persons with ID (IQ 60－70) who are mobile is a warning sign of great significance. The person may tell you they are sad, afraid or fearful of others. The latter may result in aggressive behaviour towards the person who is feared.

4.3 What other diagnoses should be considered? An adjustment disorder with anxious and depressed mood should be considered given the changes in Jane's environment with her mother's admission to hospital and her father needing to recruit outside assistance to help him care for Jane.

In Jane there is a very real possibility that at 38years old she is starting to show cognitive decline from Alzheimer's style dementia. By the fourth decade, people with Down syndrome will exhibit neuropathological changes of Alzheimer's disease with the peak incidence occurring early in the 5th decade. In Jane, further corroborative history from family, carers and other support persons is required focussing on problems with memory, decline in activities of daily living, reduced vocabulary and expression and gradual emergence of behavioural problems such as aggression, irritability, wandering behaviour, features of sundowning (agitation, confusion and memory problems worse in the late afternoon).

Whenever disturbances in behaviour or mood occur in persons with ID (intellectual disability), an organic diagnosis (physical illness) must be excluded. Physical disorders, like psychiatric disorders, are more prevalent in those with ID and the presentation may be masked. Occult infections, especially of the urinary tract, the mouth and gums, and ear canal are frequent. Pain from whatever cause may manifest only as behavioural disturbances. Diabetes mellitus is more common in this group and often presents with disturbances in mood and behaviour. Thyroid problems, gastro－oesophageal reflux, constipation, hypertension and in women problems with painful menstruation may not present in the typical fashion and all must be excluded. Jane has features of a thyroid nodule with AF, hypertension and evidence of emerging left ventricular failure and mitral incompetence. These conditions will need investigation and management.

4.4 What will you need to do to confirm your diagnosis? The probable psychiatric diagnosis can only be obtained after further corroborative history is obtained such as discussing with family members and others spend time with the patient. Cross－sectional examination for psychiatric disorder in people with intellectual disability who are significantly impaired and have poor expression is of limited value. The patient often has difficulties in labelling or in conveying emotion and the conduct in the examination can be influenced by the examiner, the way of asking questions and the presence of others in the room.

A comprehensive biopsychosocial approach and assessment is required looking at possible organic problems as well as psychiatric disorders and social issues. In Jane's case, whilst the physical disorders are unlikely to be solely responsible for her presentation they will certainly make any psychological disturbance worse and will need to be considered in the management of her depression with psychotropic medication.

Given the possibility of early onset Alzheimer's disease, formal cognitive and functional assessment is required together with a cerebral CT or MRI scan if such investigations are available. She will also require some blood tests to rule out other possible causes of dementia such as thyroid function, vitamin B12 and folate levels, and urine test to rule out infection.

4.5 What treatment can you offer? Depression can be treated with antidepressant medications and SSRI antidepressants are usually the treatment of choice. Remember that people with ID have higher rates of medical co－morbidity and have more risk of medication interactions. The medication should be started at a low dose and the dose increased gradually. People with ID may not be able to advise you of adverse effects, so careful monitoring is required, and Jane's father should be told about potential side－effects and asked to watch carefully for any evidence of these[3]. Supporting Jane's father and ensuring there are adequate supports in place for both him and Jane is essential. In the long run, consideration will be needed regarding Jane's long term accommodation and care when her parents have passed away.

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