·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（二十二）
——帕金森病和抑郁

Sasha Fehily，Grant Blashki，Fiona Judd，Malcolm Horne，Leon Piterman，Hui Yang

【关键词】 帕金森病；抑郁；心理健康；全科医学
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随着中国快速的人口老龄化，人群中的帕金森病流行率也呈明显的上升趋势。上世纪末中国调查的 65 岁及以上人口患病率为 1.7%[1]。大多数全科医生在看病过程中，都会遇到患帕金森病的患者。在这类患者中，抑郁的患病率是比较高的。据研究报告，40%～50%的帕金森病患者患抑郁[2]。与其他导致失能的疾病相比，帕金森病患者的严重抑郁患病率是其他失能疾病的两倍[3]。由于帕金森病与抑郁的症状有很多相似的地方，因此区分两者是比较困难的。我们建议对帕金森病患者每年至少做一次抑郁筛查，这样做的理由是很多帕金森病患者的抑郁问题没有得到诊断和治疗。如果患者的抑郁得不到治疗，那么会导致患者运动功能和认知功能减退，迫使患者更早地服用抗帕金森病的药物，并降低患者的生活质量[4]。

1 病史

李太太带着她的丈夫来你的全科医学诊所看病。李先生和李太太已经共同生活 40 年了。李太太给你诉说她对丈夫的担心。她说李先生变得越来越退缩，脾气越来越大。他不想去孩子家，也不愿去见孙子，这可完全不像他原来的样子。他现在几乎足不出户。李先生年轻的时候是学校校长，曾经是一个非常活跃的人。10 年前当他 57 岁的时候，出现了一些帕金森病的症状。最开始的时候，他发现左手颤抖，而且有些僵硬，那时候他曾经找你来看过病。这几年来，你一直给他看病，并同时配合神经科专家的治疗。他已经开始服用各种抗帕金森病的药物，最近服用的药物是美多巴（Madopar），同时服用左旋多巴（Levadopa）和卡比多巴（Carbidopa），此外还服用克金平（Selegiline，一种多巴胺激动剂）。

近两年内，他的病情不断发展，他运动方面的症状时好时坏，以前调整左旋多巴的剂量还能控制症状，但后来效果变得不明显了。他特别是在行走方面出现困难，经常不能起步行走。他还很难离开椅子站起来。在过去的 1 年中，他需要别人帮助才能穿上衣服。这些困难给他造成很大压力，也给他的家人带来不少负担。特别是李太太，因为她要照顾李先生。每个星期会有一位护工到家里来两次，帮助李太太照顾患者。但是李太太还是感到身心疲惫，因为她要一天 24 h 守在李先生的身边。

2 进一步的病史

你进一步采集李先生的病史。他说自己睡眠不好，经常感到活着没有什么意义。他说自己到目前为止还没有自杀计划，不过感到自己已经成为妻子和家庭的巨大负担，而且自己再也不能做以前喜欢做的事情了。由于当过学校校长，所以他以前很喜欢读书和写作，可是现在他感觉集中力很差，一本书只看

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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

几页就感到很疲劳，再也看不下去了。他说现在很难写作。他还说让妻子帮助自己做很多生活上非常琐碎的事情，这让他心里非常不安。

3 体检

体检发现，李先生有很多典型的帕金森病的症状。他的面部表现为典型的“面具脸”（面部表情少），说话声轻、单调、平淡。从椅子里站起来有困难，走向检查床的过程中呈现曳性步态。他左手明显震颤，神经学检查证明他有典型的帕金森“齿轮状肌强直”。腹部检查有便秘迹象，其他体检方面均无异常。

精神状态检查发现，李先生表现为平静和拘谨。他呆坐在椅子里，目光下垂，几乎不与别人有目光接触。他的心境表现为悲伤；情绪平淡，没有反应性。他说自己活着很没有意思，不过他否认目前有任何自残或自杀想法。没有观察到他有妄想或幻觉的证据。他对事件、地点和人物有定向力。

4 提问

4.1 随着病情进展，帕金森病患者可能出现哪些日常生活的困难？

4.2 当帕金森病患者出现什么主要症状的时候，提示他/她有抑郁问题？

4.3 抑郁与帕金森病之间的关系是什么？

4.4 针对帕金森病的抑郁问题，有哪些治疗措施？在开始使用抗抑郁药时，应该主要考虑哪些问题？

4.5 在家庭和照顾者照顾帕金森病患者的过程中，会存在哪些主要的问题？

5 解答

5.1 帕金森病患者可能出现的日常生活困难 帕金森病患者的症状和病情严重程度是因人而异的。最常见的可观察到的初期症状是静止状态下的单侧震颤，不过这个症状在做出帕金森病诊断的时候是不一定出现的。单侧震颤不会造成患者特定的失能问题，因为震颤本身不会让患者的用手功能损伤。随着病情的发展，会出现运动徐缓、肌肉强直、步态紊乱等情况。躯干运动徐缓会造成患者行走缓慢、起身动作困难（比如从坐姿站立起来）、上床困难、转身困难等。患者在运动功能上的问题，往往让帕金森病患者体验到很大的挫败感。

左旋多巴可以提高患者脑部多巴胺的水平，因此可能明显地改善患者运动方面的症状。此外，也可以采用某些非药物性的措施，比如使用较高的并且带扶手的椅子。不过左旋多巴存在“逐渐削弱”的药效作用，即随着病情发展，患者脑部多巴胺减少，左旋多巴的有效时间越来越短。因此患者的症状会呈现波动，往往在下次服药前出现症状恶化的情况。运动症状恶化主要表现为突然不能活动、暂时性地不能行走、不能控制身体平衡，从而给患者带来很大的跌倒危险。

除了大多数老年患者存在的明显运动症状之外，非运动性症状的出现频率是非常高的，这些非运动性症状同样给新确诊的帕金森病患者带来困难[5-6]。由于自主神经系统的改变，减缓了肠道运动，延缓了胃排空的速度，造成便秘、恶心、腹部胀气等症状。此外，常见的早期非运动性症状还包括疲劳、睡眠紊乱、唾液分泌过多、嗅觉减退、尿急尿频等。早期帕金森病会出现轻度认知损伤，不过某些微小的变化（如健忘）经常会被忽视掉。帕金森病晚期的非运动性症状包括情绪木讷、老年痴呆症，或严重的认知紊乱，使患者丧失自我照顾的能力。

5.2 提示帕金森病患者有抑郁问题的症状 帕金森病患者经常存在的抑郁症状包括心境低落、缺乏动机、失眠、集中力差、思维缓慢等，如果出现这些症状，则需要引起医生的注意。不过，大多数帕金森病的症状也是抑郁的症状。抑郁的其他症状也常常出现在帕金森病患者身上，比如疲劳、体质量降低、快感缺乏、集中力问题。需要特别引起注意的是情绪木讷（即面具脸）。左旋多巴对帕金森病晚期的患者失去疗效，这时患者多表现为木讷，会经常误以为是抑郁。

不过抑郁与帕金森病之间还是有一些可以鉴别的特征。要区别广泛性抑郁心境与运动功能波动有关的波动心境。抑郁患者会更多地存在负罪感、自我谴责、自杀想法等。另外，要注意观察其他的“抑郁认知”，比如感觉自己没有价值、无助感、对未来的消极看法等，这将有助于鉴别出抑郁性障碍。

5.3 抑郁与帕金森病的关系 抑郁在帕金森病中是非常常见的，50%以上的帕金森病患者有轻度或中度的抑郁症状。在帕金森病初期（最初5年），抑郁更可能是一种可以做出单独诊断的心理健康问题。早期帕金森病的患者面临着与躯体疾病有关的心理－社会应激原，以及与被诊断为慢性退行性疾病有关的心理上的悲伤。对应激源和悲伤的反应，很有可能是造成抑郁的原因。帕金森病的抑郁还可能与神经递质缺乏（比如5－羟色胺）的生物学机制有关。另外一个可能的因素是大脑额叶的心境调节功能，帕金森病患者的额叶功能活性不足。随着病情的进展，并由于长期使用左旋多巴，患者会出现波动的运动性症状和运动障碍。患者会出现焦虑，并继而引起快感缺乏，通常表现出继发性抑郁。

5.4 针对帕金森病患者抑郁的治疗措施以及使用抗抑郁药时的考虑 针对帕金森病早期患者出现的悲伤，可以采用心理学治疗。心理学治疗方法与药物治疗方法通常是两种相互排斥的方法，即如果某问题适合用心理学治疗，则意味着不需要使用药物治疗。认知行为疗法（cognitive behaviour therapy）对改变患者的消极思维模式是非常有效的。人际关系治疗（interpersonal therapy）和心理咨询方法也非常有效。然而到了帕金森病晚期，生物学因素造成抑郁的可能性更大，这时则需要使用抗抑郁药。鉴于患者经常会存在焦虑共病，因此用药应该有抗焦虑的成分，或者同时使用心境稳定剂。

抗抑郁药对情绪木讷患者的效果不好。对这类患者的药物治疗要特别注意避免潜在的药物副作用和配伍禁忌。

5－羟色胺再摄取抑制剂（SSRIs）是抗抑郁的一线药物。在临床服务中，SSRIs是最常采用的处方药，用来治疗帕金森

病患者的抑郁。全科医生在管理有抑郁的帕金森病患者时，应该更经常地考虑把患者转诊给心理学专家，让患者得到专家的评估和管理。这样做的特殊意义在于：有些抗帕金森病的药物可能有利于、也可能不利于患者的精神状态。

5.5 家庭和照顾者的主要问题 全科医生既要照顾帕金森病患者，也要关注患者的照顾者。帕金森病患者的照顾者经常处理不好与朋友和家人的关系。照顾者往往越来越感到身心疲惫，而且社会上经常认为患帕金森病是一种污名。因此，照顾者本身需要大量的支持，才能维持自己的心理和躯体健康。如果他们得不到足够的支持，就会面临失去正常工作和与社会隔离的危险。另外，照顾者要能够得到准确和全面的关于帕金森病的信息，这些信息对照顾者来说非常有帮助。下面的这些网站可以给照顾者提供高质量的有关帕金森病的信息：

http://www.pdf.org;

http://www.parkinsons.org.au;

http://www.parkinson.org;

http://www.mayoclinic.com/health/parkinsons-disease/DS00295;

http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Parkinson's_disease_explained。

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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 (22)

——*Parkinson's Disease and Depression*

Sasha Fehily, Grant Blashki, Fiona Judd, Malcolm Horne, Leon Piterman, Hui Yang

[Key words] Parkinson's disease; Depression; Mental health; General practice

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With China's aging population, it was found high prevalence of Parkinson's disease in the community. According to Zhang and his colleagues, prevalence for Chinese people aged 65 or above was 1.7%[1]. Parkinson's disease is a problem that that most GPs come across in their clinical practice and depression is highly prevalent affecting approximately 40% -50% of these patients[2]. When com-

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pared to equivalently disabled patients, the rate of severe depression is doubled[3]. There is significant overlap between the symptoms of Parkinson's disease and depression and therefore distinguishing between the two can be difficult. We recommend screening patients at least once a year for depression as it is commonly under diagnosed and under treated. Without treatment, depression can exacerbate the decline in motor and cognitive function requiring earlier commencement of anti – parkinsonian medications and reduce the patient's quality of life[4].

1 History

Mrs. Lee comes into your practice concerned that her husband of 40 years has become increasingly withdrawn and irritable. He doesn't want to go to visit the children or grandchildren, which is very uncharacteristic for him, and hardly leaves the house. In his younger years, Mr. Lee was a school principal and lived a very active life. Ten years ago when he was aged 57 he developed some Parkinsonian symptoms. Initially he noticed a tremor and some stiffness in his left hand and came to see you. In conjunction with the care of a neurologist over the years he was commenced on a range of anti – parkinsonian medications and is currently taking Madopar, which is a combination of Levadopa and Carbidopa, in addition to Selegiline, a dopamine agonist.

Over the last two years his condition has progressed and as a result his motor symptoms fluctuate and the Levadopa does not last as long between doses as it use to. He has particular difficulty with walking and often has trouble getting going. He also has difficulty getting out of the chair and overthe last 12 months he has needed help when getting dressed. This has caused a lot of stress for him and for the family and in particular Mrs. Lee who has been looking after him. A carer comes to help twice a week but Mrs. Lee is feeling the strain of looking after him 24 hours a day.

2 Further history

On further history, Mr. Lee, he tells you that he has trouble sleeping and that he often feels that life is no longer worth living. He denies any suicidal plan per se but says that he feels like he is a big burden on his wife and his family and that he cannot do any of the things that he used to enjoy. As a former school principal he has always loved reading and writing and now he finds that his concentration is so poor he can only get through a few pages of a book and he gets tired and puts it down. He says that he has trouble writing. He also tells you that he finds it very embarrassing that he needs so much help from his wife with the most basic tasks.

3 Examination

On examination Mr. Lee has many of the typical symptoms of Parkinson's disease. He has the classic mask like face, and his speech is quiet and monotonous and flat. He has difficulty getting out of the chair and walks over to the examination couch with a shuffling gait. He has an obvious tremor in the left – hand and on neurological examination he has the typical cogwheel rigidity associated with Parkinson's disease. The rest of his physical examination is unremarkable apart from evidence of constipation on abdominal examination.

On mental status examination he is quiet and reserved, sitting in the chair looking down and rarely engages in eye contact. His mood is described as sad, his affect is flat and not reactive. He acknowledges that he has felt life is not worth living but denies any current thoughts about self – harm or suicide. There is no evidence of delusional thinking or hallucinations. He is orientated in time, place and person.

4 Questions

4.1 Question 1: What are the common day to day difficulties that someone with Parkinson's disease may experience as the disease progresses?

4.2 Question 2: What are key symptoms to look for that may suggest depression in a patient with Parkinson's Disease?

4.3 Question 3: How are depression and Parkinson's disease linked?

4.4 Question 4: What treatments are available for depression in Parkinson's Diseaseand what are key considerations in starting an antidepressant.

4.5 Question 5: What are some important issues surrounding the family and carers in looking after a person with Parkinson's disease?

5 Answers

5.1 Answer 1: The common day to day difficulties that someone with Parkinson's disease may experience as the disease progresses

The progression of symptoms and disease severity varies from person to person. A unilateral resting tremor is the most common initial symptom noticed, however it does not have to be present for the diagnosis of Parkinson's disease to be made. This symptom is not particularly disabling, as it does not impair functional use of the hand. As the disease progresses, bradykinesia (slowness of movement), rigidity (stiffness) and gait disturbance occur. Truncal bradykinesia causes walking to be slow and difficulty initiating movements such as rising from a chair, turning in bed and turning around. The impact on mobility is often one of the key frustrations for people experiencing Parkinson's disease.

Levadopa may result in noticeable improvements in motor symptoms due to increased dopamine levels in the brain. Additionally non – pharmacological measures can be instigated such as using a high chair with armrests. An unfortunate outcome of Levadopa use is the 'wearing off' effect, as the disease progresses and the availability of dopamine in the brain reduces the doses of levadopa are effective for a shorter period of time. Symptoms therefore fluctuate and are often worsen before next dose. The worsening of motor symptoms includes freezing, which is the transient inability to walk, and unsteadiness, both of which increases the patient's falls risk.

Despite the archetypal patient being an elderly person with obvious motor symptoms, the frequency of non – motor symptoms is extremely high and can be equally debilitating in patients with newly diagnosed Parkinson's disease[5-6]. Constipation, nausea and abdominal bloating occur due to the altered autonomic nervous system

slowing down the intestinal tract and delaying stomach emptying. Fatigue, sleep disturbance, excessive salivation, hyposmia, urinary urgency and frequency are also early common non – motor symptoms. Mild cognitive impairment can occur as early as the time of diagnosis however, being such subtle changes, such as forgetfulness, it frequently goes unnoticed. The non – motor symptoms demonstrated in later disease include apathy, dementia or serious cognitive disturbance impairing the patients' capacity to care for themselves.

5.2 Answer 2: Key symptoms to look for that may suggest depression in a patient with Parkinson's disease The common symptoms of depression such as lowered mood, poor motivation, insomnia, poor concentration and slowing are often present, and should be looked for, however most are also symptoms of Parkinson's disease. Other symptoms which are usually seen in persons with depression such as fatigue, weight loss, anhedonia and difficulty concentrating may also be seen as part of Parkinson's disease. An important area requiring special consideration is the symptom of apathy. At the final stages of the disease, in the bradykinetic patients who are unresponsive to Levadopa, apathy is common and often mistaken as depression.

There are, however, some differentiating features. It can be helpful to distinguish between a pervasive depressed mood and fluctuating mood associate with motor fluctuations. Guilt, self blame and suicidal ideations are more frequently associated with depression. Further, looking for other 'depressive cognitions'; such as feelings of worthlessness, hopelessness, and negative view of the future can also help differentiate a depressive disorder.

5.3 Answer 3: How are depression and Parkinson's disease linked? Depression is quite common in Parkinson's disease with up to 50% of people experiencing mild to moderate depressive symptoms. Depression as a separate entity is more common in the in the early stages of Parkinson's disease (first 5 years). The cause of depression early in PD is likely to be a reaction to the psychosocial stressors associated with the physical illness and grief associated with being diagnosed with a chronic progressive disease. Depression may also be linked to Parkinson's disease through biological mechanisms, particularly deficiency of neurotransmitters, such as serotonin, which is one postulated cause of depression. Another likely contributing factor is the frontal lobe's role in mood regulation, an area of the brain that is underactive in Parkinson's disease. Prolonged used of levadopa and disease progression sees the onset off luctuating motor symptoms and dyskinesias. The associated anxiety becomes a driver for anhedonia and consequential depression frequently becomes apparent.

5.4 Answer 4: Treatments available for depression in Parkinson's diseaseand key considerations in starting an antidepressant The typical grief related depression in early disease can be treated with psychotherapy, which will often negate the need for medications. Cognitive Behaviour Therapy is tremendously effective in changing negative thinking patterns. Interpersonal Therapy and counselling are also useful. The more biological depression affecting the patient's later on in the disease may require treatment with an antidepressant. Given the frequent co – morbid anxiety, medications with an anxiolytic component or the addition of a mood stabilizer can be useful.

Apathetic patient's do not respond to antidepressant agents and are better off without the potential risk for adverse effects and drug interactions.

Selective Serotonin Reuptake Inhibitors (SSRIs) are first line antidepressant medications and in clinical practice are the most commonly prescribed antidepressants used to treat depressed patients with Parkinson's disease. GPs managing depression in patients with Parkinson's Disease should have a low threshold for referring the patient for specialist assessment and management, especially as some of the anti – parkinsonian medications can have beneficial or detrimental effects on the patient's mental state.

5.5 Answer 5: Important issues surrounding the family and carers in looking after a person with Parkinson's disease The GP often is looking after the carer as well as the patient affected by Parkinson's disease. Being a carer can often disrupt relationships with friends and family due to increased fatigue, psychosocial stressors and often the stigma associated with patient's suffering from a chronic illness. The carer needs a lot of support to help maintain their own mental and physical health, and there is a risk that they can become isolated form their usual work and social activities without sufficient support. Having access to accurate and comprehensible information about Parkinson's Disease can be very helpful for carers too. A number of websites provide good quality information about Parkinson's disease:

http: //www. pdf. org;

http: //www. parkinsons. org. au;

http: //www. parkinson. org;

http: //www. mayoclinic. com/health/parkinsons – disease/DS00295;

http: //www. betterhealth. vic. gov. au/bhcv2/bhcarticles. nsf/pages/Parkinson's_ disease_ explained.

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