A Brief Note on Medical Mimics of Psychiatric Disorders in the Geriatric Population

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Abstract

The act of diagnosing medical conditions is complex and can become difficult as patients present with behavioral health symptoms such as mania and psychosis. This process becomes more complicated as patients age because of physical fragility and patients often present with polypharmacy. Medical providers need to develop a comprehensive differential diagnosis for patients presenting with behavioral health concerns including medical mimics of these conditions. The term medical mimic has been used to describe the clinical condition of an underlying medical condition masquerading as another disorder.

Keywords: Diagnosis • Psychosis • Poly pharmacy

Description

It looks like a duck, quacks like a duck, but it is really a goose. Patients presenting in the primary care setting often present with a variety of symptoms and the picture becomes more muddled when psychiatric symptoms are involved [1]. This is further complicated by the distress and noise of the psychiatric symptoms, especially when mania or psychosis are included in the presentation. Providers need to create a comprehensive differential diagnosis for psychiatric symptoms that considers medical mimics [2]. Medical mimics should be higher priority on the differential list when the patient had normal functioning prior to symptom onset, are presenting with symptoms at an unusual age of onset, or there is sudden onset of symptoms. The following symptoms should raise a red flag for medical mimics when encountering a patient presenting with psychiatric concerns: greater than 40 years of age with no previous mental health history, no history of these symptoms in the past, no history of these symptoms worsening in the past, the existence of a comorbid chronic disease, history of traumatic brain injury, a change in typical headache, a decline in functioning after being prescribed an antipsychotic of anxiolytic medication, a history of multiple psychiatric diagnoses and changing diagnoses, changes in vision, new onset hallucinations, dysarthria or aphasia, unusual body movement and a difficult patient [3]. Furthermore, medical mimics should be of particular concern when psychiatric problems arise in a geriatric patient as they are at an elevated risk for encephalopathy and polypharmacy [4,5]. Mania symptoms are found in 5% to 19% of geriatric patients who receive mental health care; however, it is rare for a late life first presentation of bipolar disorder. Differentials to consider for late onset mania include infectious diseases, vitamin deficiency, polypharmacy, substance abuse, uremia, neurological diseases, carcinoid syndrome, and endocrine diseases. Mania can also present in the elderly following a vascular event. Imaging has shown a high incidence of vascular and white matter changes with new onset mania in geriatric patients [6]. Psychosis in the elderly is often attributed to encephalopathy or delirium. About 40% of patients with Alzheimer's disease have psychosis. Other conditions that can produce psychotic symptoms in the elderly include endocrine diseases, metabolic causes, autoimmune disruptions, infections, narcolepsy, seizures, space-occupying, lesions, vascular events, head injuries, demyelinating diseases, basal ganglia disorders, and nutritional deficiencies. Polypharmacy and adverse drug interactions can also produce psychotic symptoms [1]. In order to tease out potential causes of late onset psychiatric symptoms in the geriatric population, clinicians should perform a comprehensive assessment including physical examination, laboratory screening, and history before attributing the symptoms to a mental health diagnosis [7]. In addition, patients with chronic mental health problems are more likely to have co-occurring medical problems. Medical professionals should be cautious to avoid participating in diagnostic overshadowing, where medical providers misattribute a person's physical symptoms to their mental illness [8].

References