

• 世界全科医学工作瞭望 •

【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。今年本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《全科医学之心理健康》已经由中国全科医学杂志社与国内外专家合作进行翻译，并在中国出版发行。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本刊编委、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！

Case Studies of Mental Health in General Practice (29)

—Mental Health Side Effects of Medications

全科医学中的心理健康病案研究 (二十九)

—药物在心理健康上的副作用

Steven Ellen, Sasha Fehily, Hui Yang, Rob Selzer, Grant Blashki

【Key words】 Medication; Side effect; Mental health

【关键词】 用药; 副作用; 心理健康

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目前中国已成为老龄人口大国，60 岁及以上老年人口数已经占国民总数的 15%^[1]。人口老化的结果之一是有越来越多的人生活在慢性病中，因此每天需服用大量和多种药物^[2]。医生们对药物之间相互作用及其给人们躯体健康带来的副作用是非常熟悉的，然而医生们经常忽视的是药物可能产生的精神病学方面的副作用。很多药物能产生精神病学方面的副作用，如果患者表现出精神病学障碍，那么医生应该考虑到药物副作用的可能性。

1 病史

易先生，58 岁，已婚，有 1 个成年的儿子。今天，易先生由他的妻子陪同来全科医学诊所看病，这有些不

同寻常，因为以往他来看病时从不让妻子陪同。易先生的身体一直是比较健康的，只是长期以来患原发性高血压病和高脂血症。大概从 1 年前开始，他开始服用 β -受体阻滞剂。

这次他来看病，你首先注意到的是，他看上去闷闷不乐。他不愿意说话，所以他妻子替他说“这几个月他好像变成了另外一个人”，他睡眠不好，吃得比以前少，体质量也下降了。所以她担心易先生是不是病了。

易先生说自己一直感到很疲劳，不能集中精力工作，工作成绩也变得糟糕。他非常担心丢掉自己这份工作，担心自己今后怎么生活。你问易先生有什么兴趣爱好，他说生活中没有什么让他感到高兴的地方。他很勉强地承认自己甚至想到过自杀，不过他说为了家庭他不能这样做。当易先生讲到这里时，他的妻子哭泣起来。这时易先生看上去也很悲伤，但他说自己哭不出来。你继续鼓励他谈谈自己的心境，易先生说感到忧郁，这种感觉是从 10 个月前开始的，当时并没有什么触发忧郁情绪的事情发生。这几个月来，症状慢慢变得越来越明显。

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注：作者简介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

2 进一步的病史

易先生没有精神病的既往病史。近3年来血压有轻度的升高，最初通过饮食和限钠（限盐）得到控制。大约1年前，他出现过1次胸痛，做了一系列与冠心病有关的检查，结果都正常。不过心脏病学专家让他开始服用β-受体阻滞剂（外周作用的β-肾上腺素阻滞剂）。易先生还开始使用羟甲基戊二酰辅酶A还原酶抑制剂（HMG-CoA还原酶抑制剂），用来降低血胆固醇水平。

3 体检

体检发现易先生轻度超重，没有发现甲状腺功能减退的体征。全身各系统的体检结果都正常，生命体征和血压也正常。在心理健康状态检查中发现，易先生穿着上班时才穿的工作服，看上去不那么整洁。他没有刮胡子，他以前不是这样的。其他方面看起来还正常。他努力地对你表现出恰当的尊重，只是断断续续地跟你保持目光接触。他的心境看上去是抑郁的，而且显得心烦意乱。没有迹象表明他存在思维障碍，也没有任何迹象表明他有认知紊乱。为他进行记忆力和注意力筛查测验，也没有异常发现。

4 提问

- 4.1 有哪些常用药能造成抑郁？
- 4.2 有哪些常用药能诱发躁狂？
- 4.3 有哪些关键特征帮助你做出重性抑郁障碍与药物副作用的鉴别诊断？
- 4.4 你应该怎样管理那些因药物引起抑郁的患者？

5 解答

5.1 能造成抑郁的常用药 有不少研究认为很多药物能造成抑郁，不过这些研究在方法学上还存在很多问题。我们现在还很难从下面列出的情况中，明确地分辨出某药物导致的抑郁：以往就存在的抑郁，被误解为抑郁的药物副作用（如厌食和疲劳），由治疗其他疾病的药物造成的抑郁症状。

β-受体阻滞剂是一个很好的例子。有些研究报告说这类药物有抑郁副作用；但也有其他研究报告说即便β-受体阻滞剂能造成性功能障碍和疲劳，但与抑郁无关^[3]。

尽管如此，已经明确发现与抑郁有关的药物是皮质甾类药物（如泼尼松龙）和干扰素类药物（用于治疗某些病毒、肿瘤和免疫疾病），除此之外的其他药物也有可能和抑郁有关：苯二氮草类药物（常用于治疗焦虑）、甲氰咪胍（常用于治疗消化性溃疡）、左旋多巴（常用于治疗帕金森病）、伪麻黄碱（用于治疗各种感冒和流感）、磺胺类药物（包含在某些抗生素、抗痉挛、治疗糖尿病的药物中）。

5.2 能诱发躁狂的常用药 与抑郁类似，某些躯体疾病或某些药物也能造成躁狂。如果患者是第一次发生躁

狂，或者是老年人发生躁狂，那么你要特别地关注这些患者。某些中枢神经系统感染、卒中、甲状腺功能亢进等，是最常见的引起躁狂的（而非双相障碍的）躯体疾病。同时，能引起躁狂的药物可能包括皮质甾类药物（用药早期可引起躁狂，用药后期趋向于发生抑郁）、多巴胺激动剂、任何兴奋剂（非法毒品或药物，如利他灵）、戒酒硫、巴氯芬。需要注意的是，给双相障碍患者使用抗抑郁药，特别是同时不服用心境稳定剂的情况，可能是躁狂的触发因素。

5.3 重性抑郁障碍与药物副作用的鉴别诊断 从临床上，通常不可能区别原发性抑郁和躯体或药物引起的抑郁。发病时间也许是一个很好的线索——是否在生病或服药之后不久发生了抑郁？是否存在其他触发因素，比如重要的生活应激因素？在没有生病或服药的情况下是否有抑郁的既往史？只有在撤掉被怀疑的药物，并随后抑郁症状消退的情况下，才能建立起药物与生病或服药之间的联系。

5.4 因药物引起抑郁的患者管理 对药物引起的抑郁的治疗方法，与其他形式的抑郁治疗策略是相同的。

首先要完成对患者的评估，其中包括自残和自杀风险的评估。然后根据抑郁的严重程度进行治疗。轻度抑郁的管理方法主要是提供支持，并根据心理健康服务的主要原则，对患者进行跟踪评估和观察（睡眠情况、饮食情况、酒精使用情况、身体锻炼情况、减轻压力措施、对人际关系的关注等）。中度抑郁的管理方法，是在上面措施的基础上，加上心理学服务的支持（通常采用认知行为治疗方法），或者采用药物治疗。重度抑郁的管理方法，是要综合性地使用药物治疗、心理学治疗、特别关注危险因素这些措施，并要求患者入院治疗^[4-5]。

当然，在全面和平衡地考虑危险、收益和其他因素之后，你还可以考虑更换可能造成抑郁的药物。以易先生的例子看，我们可以先考虑继续使用饮食控制和限盐的措施，然后考虑采用另外一种一线药物，比如血管紧张素转换酶抑制剂或噻嗪类利尿剂。

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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 need for the development 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 and psychological problems in general practice. A 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 the new wave of general practice and mental health service 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. Professor Blashki, Professor Judd and Professor Piterman are authors of the text *General Practice Psychiatry*; the Chinese version of the book was published in 2014. 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 (29) ——*Mental Health Side Effects of Medications*

Steven Ellen, Sasha Fehily, Hui Yang, Rob Selzer, Grant Blashki

【Key words】 Medication; Side effect; Mental health

China has an aging population with the average person living well into their 70s and 15% of the population are already aged over 60^[1]. As a consequence more people are living with chronic illnesses requiring multiple medications^[2]. Whilst physicians are well aware of the risk of drug interactions and physical side effects, the possibility of psychiatric side effects is often overlooked. Many medications can cause psychiatric side effects, and when a person presents with a psychiatric disorder, the possibility of medication side effects should be considered.

1 History

Mr. Yi is a fifty-eight years old married man with one adult son. He presents to your practice with his wife, which seems unusual, as he has never brought her in before. His health is usually quite good, apart from long-term essential hypertension and hyperlipidemia. He was commenced on a beta-blocker approximately one year ago.

The first thing you notice is that he appears quite subdued. He also seems reluctant to talk, so his wife takes over. Mrs. Yi reports "he has not been himself for months," and further explains that he is sleeping poorly, eating less and has lost weight. She is concerned

he is sick.

Mr. Yi then reports being constantly tired, he cannot concentrate at work and his work performance has deteriorated. He is very worried that he will lose his job and is concerned about how he will survive in the future. When you ask questions about his interests and hobbies, he reports no longer enjoying any aspects of his life. He reluctantly admits that he has even thought about suicide, but says he could never do such a thing to his family. Mrs. Yi cries when she hears this, and Mr. Yi looks very sad, but he says that he feels unable to cry. When encouraged to talk about his mood, Mr. Yi says he feels depressed and noticed the onset of these symptoms around 10 months ago. There was no trigger at the time. The symptoms slowly got worse over the following months.

2 Further history

Mr. Yi has no past psychiatric history. He has had mildly elevated blood pressure for three years, which was initially controlled with diet and sodium restriction. Approximately one year ago, he had an episode of chest pain and had a series of tests assessing coronary artery disease, which were all normal. Despite this, the cardiologist commenced a beta blocker (peripherally-acting beta-adrenergic blocker). He was also started on a 'statin' medication (HMG-CoA reductase inhibitor) due to his elevated cholesterol levels.

3 Examination

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Physical examination reveals a mildly overweight man. No signs of hypothyroidism are apparent. The rest of his systemic examination was normal, as were his vital signs, including his blood pressure. On mental state examination, Mr. Yi is wearing a work-suit but looks untidy. He has not shaved, which is unusual, but is otherwise well presented. He strains to maintain appropriate rapport with you, with only intermittent eye contact. His affect is depressed with a distracted quality. No formal thought disorder is evident, nor are there any features suggestive of perceptual disturbances. Screening tests for memory and attention were unremarkable.

4 Questions

- 4.1 What commonly used medications can cause depression?
- 4.2 What commonly used medication can precipitate mania?
- 4.3 What key features assist in differentiating between major depressive disorder and medication side effects?
- 4.4 How should you manage a patient with the medication induced depression?

5 Answers

- 5.1 What commonly used medications can cause depression?

Many medications are listed as causing depression; however the studies have significant methodological problems. It is hard to distinguish true medication induced depression from: pre-existing depression, medication side-effects that are misinterpreted as depression (like anorexia and fatigue), depressive symptoms that have resulted from the underlying disease for which the medication was originally prescribed.

Beta-blockers are a good example of this problem – some studies report depressive side effects, whilst others show no correlation other than beta blockers causing sexual dysfunction and fatigue^[3].

Nevertheless, the most well established medications associated with depression are corticosteroids (e.g. prednisolone) and interferons (used to treat some viruses, cancers and immune problems), but there are many other possibilities including: benzodiazepines (often used for anxiety), cimetidine (usually used for peptic ulcers), L-dopa (usually used for Parkinson's disease), pseudoephedrine (in many cold and flu remedies) and sulfonamides (contained in some antibiotics, anticonvulsants and anti diabetes medications).

- 5.2 What commonly used medication can precipitate mania?

Like depression, mania can result from medical conditions or medications. You should be especially concerned if the mania occurs for the first time, or in older patients. Whilst medical illnesses like central nervous system infections, strokes and hyperthyroidism are the commonest causes of mania in the absence of bipolar disorder, medications can also cause mania. Some examples of these medications include corticosteroids (especially early in the course, whereas depression tends to occur later in the course), dopamine

agonists, any stimulants (illicit or medical e.g. methylphenidate), disulfiram and baclofen. Note that anti-depressants when prescribed in bipolar disorder have been reported to trigger mania, especially when prescribed in the absence of mood stabilising medications.

5.3 What key features assist in differentiating between major depressive disorder and medication side effects? Clinically it is often impossible to distinguish new onset primary depression from depression due to medical illnesses or medications. The duration is often the best clue – did the depression occur soon after the illness or medication? Were there any other triggers like major life stressors? Was there a past history of depression in the absence of illness or medications? Often the link cannot be established until the suspected medication is ceased and the depressive symptoms subsequently resolve.

5.4 How should you manage a patient with the medication induced depression? The treatment for medication-induced depression is the same as for all forms of depression.

Complete your assessment including assessing risks such as self-harm and suicide. Then treat according to severity. Mild depression requires support, review and attention to the key principles of mental health (sleep, diet including alcohol, exercise, stress reduction and attention to relationships). For moderate depression ADD psychological support (usually cognitive-behaviour therapy) or medications. Severe depression usually requires all of medications, psychological support and special attention to risk and admission to hospital^[4-5].

Of course you should also consider changing the suspected medication – after balancing the risks, benefits and other options—for example in Mr. Yi's case we would retry diet and sodium restriction, and then perhaps a different first line medication therapy such as an angiotensin-converting enzyme (ACE) inhibitor or a thiazide diuretic.

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