

• 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 (28)

——HIV and Mood Disturbance

全科医学中的心理健康病案研究 (二十八)

——HIV 与心境紊乱

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【Key words】 HIV; HIV associated neurocognitive disorder; Hypomanic episode; Mental health; General practice

【关键词】 HIV; 艾滋病病毒感染相关神经认知障碍; 轻躁狂发作; 心理健康; 全科医学

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本案例研究向大家展示的是一个比较复杂的情况,即针对一个已知躯体健康问题,同时又表现出精神紊乱的病人,在进行诊断性评估的时候应该考虑哪些方面。本案例还展示了一个全科医学服务的重要特点,即在面对复杂病例的时候,既要充分地采纳专家的建议,又要理解全科医学本身也有诊断和治疗上的局限性。

1 背景

吉姆,男,现年 22 岁。很多年来,他和他的家人在你的诊所看病。不过近 4 年来你一直没有见到他,这段时间他到中国某城市上大学。这 4 年来你很少听到吉姆的消息,他也很少和父母联系。他父母只知道他跟一个男生好上了。不过你注意到吉姆有一些躯体健康问题,而且在 12 个月前曾因治疗抑郁住过院。

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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

吉姆的父亲找到你,问你是否可以给吉姆看看病。他父亲说吉姆最近突然回家来,好像“变成另外一个人”。吉姆告诉父母说他发现了一种根治肿瘤的方法。他父亲担心吉姆是否患上了吉姆妈妈 20 多年前的心理疾病。

2 进一步病史

吉姆很不情愿地来到你的诊所,他坚称自己根本不需要来看病。你把他请进诊室,把他安顿下来,并给他一些鼓励。然后他告诉你,他最近在大学一直非常忙,白天黑夜一直忙着做实验,而且已经发现了根治癌症的办法。你提示他讲得更详细一些。他说自己的男伴 14 个月前去世了。从那时起,他就努力地让自己关注学习和研究。他承认自己那段时间很难把思想集中在工作上,他自己认为的原因是过于疲劳和药物的不良反应。他说因为出现这些问题,所以在 9 个月前停止服用药物。

吉姆跟你说,在他与男伴开始同性恋关系之前,一起去做过 HIV 检查,结果他们两个都是阳性。吉姆说自己的躯体健康状况“非常好”,最近的病毒载量检查是在 12 个月前,结果是病毒载量低到“不可检测”的水

平。他说并没有按照要求复诊，因为他已经不吃药了，认为没有复诊的必要。

3 体检

吉姆的穿着很随意，不过显得有些蓬头垢面。很显然，他已经有好几天没有刮胡子了。你注意到，吉姆穿的是浅橘黄色的袜子，红色的瘦腿紧身裤。他显得非常躁动不安，不停地坐下去又站起来。他的语言有轻微的压迫感，不过还是能够理解他说话的意思。在回答你提问的时候，他显得有些烦躁。

他的血压是 120/75 mm Hg (1 mm Hg = 0.133 kPa)，脉搏 76 次/min，规律。体温正常。胸部和腹部检查没有异常发现。没有发现淋巴结肿大，没有发现皮肤损伤，口腔和牙齿检查结果没有异常发现。眼睛检查结果也没有异常发现。

除了上述的检查结果外，你对吉姆的精神状态检查的主要发现包括：感到“很伟大”的自我感觉以及过多的滑稽的想法，在你和他交谈过程中所表现出来的躁动不安。除了他说已经发现根治肿瘤的办法外，他还有各种浮夸的想法，比如他预言自己今年将获得大学最高的科学奖。他没有思维形式的障碍，也没有感知的紊乱。

4 检查

鉴于他跟你讲 HIV 病毒阳性的诊断结果，你告诉吉姆说需要从给他施治的医生那里获得进一步的信息。吉姆不认为你应该这样做，说他自己知道的比医生知道的更详细。不过他还是同意你与施治医生联系。你给他安排了一系列检查，包括全血检查，尿和电解质检查，肝功能检查，CD4 检查（淋巴细胞表面标志，用于评估免疫系统状态），病毒载量检查（评估 HIV 感染状况）以及脑部 CT 检查（评估是否存在 HIV 感染相关的脑部疾病）。

你联系了吉姆的精神病学医生。12 个月前吉姆因抑郁住院治疗的时候，这位医生给吉姆提供过服务。精神病学医生告诉你，当吉姆的男伴去世时，吉姆在情感上被击垮，不能应对。这位医生认为这种发作属于强烈的悲伤，而不是抑郁发作。

中国某城市的医生也证实吉姆接受了针对 HIV 感染的治疗，医生最近一次给吉姆看病时，他正在服用抗艾滋病病毒的药物，包括齐多夫定、拉米夫定和依非韦伦。他找你看病之前最近的一次 CD4 检测结果是 250。你给他安排的 CD4 检查结果是 30（表明他有明显的免疫抑制反应），病毒载量检查结果是 430（非常高）。脑部 CT 的检查结果没有异常发现。

5 提问

5.1 可能的诊断是什么？

5.2 需要考虑哪些鉴别诊断？

5.3 需要哪些进一步的信息？

5.4 你给吉姆安排什么治疗？

5.5 吉姆的预后怎样？

6 解答

6.1 可能的诊断 可能的诊断是轻躁狂发作。吉姆有很多特点符合这个诊断，比如心境高涨、焦躁和亢奋的情绪、躁动、言语迫切、睡眠需要降低、浮夸思维等。

6.2 鉴别诊断 主要有两个方面的鉴别诊断。

6.2.1 双相障碍过程中的轻躁狂发作 这种情况下，轻躁狂发作是双相障碍的一部分，即诊断应该是双相情感 II 型障碍。正如轻躁狂这个病名所表达的那样，它是“比躁狂弱的”障碍。轻躁狂的病人通常表现为过度自信、过分地滔滔不绝地讲话、不正常地冒险。病人往往缺乏睡眠需要，而且性行为高涨。轻躁狂可以发展成为完整的躁狂。

6.2.2 继发性轻躁狂 即具有明确器质性原因的轻躁狂发作^[1]。这些原因包括：（1）物质滥用障碍，比如安非他明类药物或者其他兴奋剂。所以要跟病人核实是否服用过这些药物，这一点很重要。（2）能导致心境紊乱的处方药物，如皮质类固醇激素。（3）脑损伤，包括肿瘤或感染。如果涉及额叶，则导致病人的行为改变、去抑制行为，或者不正常的行为，而且突出表现为浮夸思想。在艾滋病病毒感染者中会出现机会性感染，比如脑弓形虫病，也会让病人表现出轻躁狂。（4）吉姆的病例表现为明显的免疫功能抑制和活动性疾病（病毒载量非常高），你要进一步考虑与艾滋病病毒感染相关的脑部疾病，即病毒广泛地侵袭脑部，而不仅仅是额叶肿瘤或局灶性感染^[2]。

6.3 进一步信息 首先，吉姆的父亲询问过吉姆的问题是否与他妈妈以前的病有关系。你开始注意到吉姆的妈妈曾经患双相障碍，而且吉姆妈妈的姨妈也有同样的问题。那么你要探索的一个问题是：吉姆这次的病情是否是家族性心理障碍的表现。

很显然，吉姆的问题有很强的家族病史；然而，他的问题并不能简单地归因为家族性问题。他 12 个月前曾接受过抑郁治疗（虽然精神病学专家认为他当时是悲伤反应）。鉴于吉姆的艾滋病病毒感染的诊断结果以及潜在器质性原因的高风险，家族史并不能很好地解释他的问题。

你进一步与中国某城市的医生联系，希望掌握更进一步的信息。你从中国医生那里得知，当吉姆第一次做病毒载量检查的时候，结果已经是低 CD4（免疫抑制）和高病毒载量。这个信息提示，在吉姆第一次检测之前，他已经感染相当长的一段时间了。你还了解到，吉

姆曾经静脉注射毒品，而且患丙型肝炎。随着他的病程进展，他会面临艾滋病病毒相关的脑部疾病的高风险。

你给吉姆安排了磁共振成像（MRI）检查，因为MRI比CT能更敏感地发现艾滋病病毒感染相关的脑部改变。MRI的结果显示，吉姆呈现轻度脑萎缩和双侧脑室高强度T2信号，提示脑部存在活跃的艾滋病病毒感染。

你还给吉姆安排了神经精神测试（该测试是由接受过专门培训的心理专家操作的一组特定的心理和认知测验），以确定吉姆是否有艾滋病病毒感染相关的神经认知障碍（HIV associated neurocognitive disorder, HAND）。HAND涵盖了各种与艾滋病病毒感染有关的神经学问题。患HAND的病人通常有心理过程减缓、记忆力缺失、集中力差等问题。鉴于吉姆目前的精神状态，你建议不马上做这个测试，等到他的心境稳定下来后再做。

最后，你找到中国某城市给吉姆提供治疗的精神病学专家以及一直参与治疗他艾滋病病毒感染的医疗团队。中国的精神病学专家建议说，虽然吉姆有双相障碍的家族史，但病人的精神病问题的表现以及他艾滋病病毒感染的病程，都一致性地说明他存在继发性躁狂。换句话说，吉姆的轻躁狂发作很可能是艾滋病导致的。精神病学专家建议应该根据这个假设进行治疗。

6.4 安排治疗 你认识到，最基本的是要治疗吉姆的心境障碍的症状，这个治疗策略有助于预防心境高涨的恶化，并阻止发展到躁狂的病程。你还认识到，心境高涨病人的行为通常表现为去抑制化，或采取危险的行为方式，包括无保护性行为、通过静脉使用毒品，或者对他人造成危险的行为。因此，要针对吉姆的情况采取措施。

你询问吉姆，问他的父母是否知道他艾滋病病毒阳性的情况。吉姆说父母不知道，不过父母知道他男伴因艾滋病去世的情况。不过吉姆说有必要让父母知道这件

事，而且让你跟他父母讨论这件事。于是你与他的父母取得联系，把吉姆的诊断情况向他父母做了解释。你还向他父母表示了你的担心，认为吉姆的情况可能变得更糟糕，所以他既需要接受艾滋病学专家的服务，也同时需要尽快得到精神病学专家的服务，以便应对他心境紊乱的问题。

虽然吉姆并不情愿接受你的建议，去做必要的评估和治疗，不过他最终还是同意开始服药，因为他自己也注意到自己的生活失去控制。精神病学专家建议你给吉姆开药，首先使用非典型抗精神病药奥氮平（olanzapine），初始剂量5 mg/d。精神病学专家告诉你，吉姆以往不愿意使用心境稳定剂，因为有躯体健康问题的病人服用心境稳定剂（如锂剂或丙戊酸钠）的时候，更倾向于产生药物毒性反应以及药物相互作用。

中国某城市的精神病学专家还认为，重要的是要让吉姆尽早重新开始服用抗艾滋病病毒的药物，因为控制病毒载量可以减少病毒在脑部的繁殖。不过因为你对抗艾滋病病毒药物不熟悉，所以你等吉姆在中国某城市专科诊所就诊后再给他开药。

6.5 预后 病人的预后取决于多种因素。这些因素包括：吉姆对抗病毒药物治疗的依从性和用药效果；和吉姆是否患有HAND。有证据表明，患HAND的病人预后较差，包括病毒控制差、同时有药物滥用，以及同时感染丙肝等。重要的是要理解，虽然有些病人有艾滋病病毒感染相关的躁狂，并导致认知衰退，但不是所有的艾滋病病人都出现这种情况。

最后，鉴于吉姆有双相障碍的家族史，他的精神疾病问题也有可能在艾滋病病毒感染的某个阶段表现出来，虽然他的家族性精神病与艾滋病没有直接的关系。

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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 to be 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 (28)

—HIV and Mood Disturbance

Fiona Judd , Leon Piterman , Grant Blashki , Hui Yang

【Key words】 HIV; HIV associated neurocognitive disorder; Hypomanic episode; Mental health; General practice

This case demonstrates the complex issues which need to be considered in the diagnostic assessment of an individual with a known medical illness presenting with psychiatric disturbance. It also demonstrates the importance of the general practitioner using specialist consultation and advice to work through this complexity , and the importance of understanding one's own diagnostic and therapeutic limitations in such situations.

1 Background

Jim C and his family have been patients of your clinic for many years , but you have not seen Jim , now aged 22 years , for 4 years as he has been away in X city of China at University studying. You have heard little about Jim over this time , in part as he has had little contact with his parents after telling them he was in a same - sex relationship. However , you are aware he has had some health problems , and was hospitalised for a period for the treatment of depression 12 months ago.

Jim's father has asked if you will see him as he is concerned that Jim is 'not himself' after coming home to visit unexpectedly to tell his parents he thinks he has found the cure for cancer. His father wonders whether Jim is developing the same kind of mental health problem he has seen his wife deal with over the past 20 years.

2 Further history

Jim reluctantly comes to your clinic , protesting that there is no reason for him to see a doctor. However , once settled in your office , with little encouragement he tells you he has been very busy at university , has been 'experimenting day and night' and has found the cure for cancer. As you probe for more detail he tells you his partner of 2 years died 14 months ago , and since that time he's been trying to focus on his studies and research. He acknowledges that at times he's had troubles concentrating on his work , and attributes this to fatigue and the side effects of his medications. He states he stopped his medications because of these problems around 9 months ago.

Jim reports to you that he , and his partner were both found to be HIV positive when they went to be tested before starting their relationship. Jim has been 'pretty good' physically and when he last had his viral load tested 12 months ago it was undetectable. He states he has not been attending regularly for review as he did not see the point if he was off his medications.

3 Examination

Jim is casually dressed , but a little dishevelled , he has obviously not shaved for a couple of days and you notice he is wearing bright orange socks and red jeans. He is quite agitated , getting up and down in his chair. He has mild pressure of speech , but can be interrupted , but does become a bit irritable in response to your questions.

His BP is 120/75 mm Hg (1 mm Hg = 0.133 kPa) , pulse 76 and regular , he is afebrile. Examination of the chest and abdomen reveals no abnormality. He has no enlarged lymph nodes , skin lesions , mouth or dental abnormalities. His eye examination is also unremarkable.

In addition to the features described above , key findings on mental state examination include his self - report of feeling 'great' , quite a lot of jocularity as well as his irritability as you talk with him and a range of grandiose ideas in addition to his claim he has found the cure for cancer. These include his prediction he will win the top science prize at University this year. There is no disorder of form of thought and no perceptual disturbance.

4 Investigations

In view of Jim's disclosure of his HIV diagnosis , you tell him you need to seek details from his usual treating doctor. He is dismissive of this , saying he knows more than those doctors do , but he does consent to you contacting them. You order a series of tests including FBE , U&E , LFT , thyroid function , CD4 count , viral load (to assess the status of his HIV) , and CT scan brain (to see if he has any HIV related brain disease) .

You contact the psychiatrist who looked after Jim when he was hospitalised for depression for 12 months ago. He tells you that Jim was devastated when his partner died and just could not cope. He defined the episode as one of intense grief rather than a depressive episode.

The doctors in X city confirm they have been treating Jim for HIV infection , and when they last saw him he was taking three HIV medications; AZT , 3TC and Efavirenz. His most recent CD4 count was 250. Results of the blood tests you have ordered show his CD4 count is 30 (which is indicative of significant immunosuppression) and his viral load is 430 (which is very high) . The CT scan is unremarkable.

5 Questions

- 5.1 What is the likely diagnosis?
- 5.2 What are the differential diagnoses?
- 5.3 What further information do you require?
- 5.4 What treatment will you offer Jim?
- 5.5 What is Jim's prognosis?

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6 Answers

6.1 What is the likely diagnosis? The likely diagnosis is a hypomanic episode. Jim has a number of the features of this including elevated mood, irritable and elevated affect, agitation, pressure of speech, decreased need for sleep, grandiose thinking.

6.2 What are the differential diagnoses? The differential diagnoses fall to 2 groups.

6.2.1 Hypomanic episode occurring as part of bipolar disorder – and in this case the diagnosis would be bipolar type II disorder. Hypomania, as the word sounds, is literally "less than mania". People experiencing this are often overconfident, over talkative and take uncharacteristic risks. Lack of need for sleep and heightened sexual behaviour are common features. It can go on to become full blown mania.

6.2.2 Secondary hypomania i. e. a hypomanic episode with an identified organic cause^[1], this includes: (1) Substance use disorders such as amphetamines and other stimulants, so its important to check with the patient if they are taking these. (2) Prescribed drug induced mood disturbance e. g. corticosteroids. (3) Cerebral lesions such as tumour or infection. When frontal lobes are involved, behavioural change and disinhibited or uncharacteristic behaviours and grandiose ideas may be prominent. Opportunistic infections that occur in HIV such as cerebral toxoplasmosis, may present in this way. (4) In a patient such as Jim, who has marked immunosuppression and active disease (as indicated by his high viral load) a further consideration is HIV – related brain disease i. e. widespread cerebral involvement by the virus rather than a focal lesion such as a tumour or localised infection^[2].

6.3 Further information First, Jim's father has raised the question of a relationship to the illness Jim's mother has. You are aware she has suffered from bipolar disorder and that her aunt also has this problem, which certainly raises the question as to whether Jim's presentation reflects his first presentation of this familial disorder.

Whilst Jim obviously has a strong genetic loading, and he has had depression previously (although importantly his treating psychiatrist regarded this as a grief reaction). Given Jim's HIV diagnosis, and his high risk of an underlying organic cause for this presentation, this cannot be assumed to be the case.

You seek further information from the doctors in X city and find that when Jim first presented for HIV testing he had a low CD4 count and high viral load, suggesting he had already been positive for some time when first tested. You also discover that he has used IV drugs in the past and that he is also Hepatitis C positive. His advanced disease certainly increases his risk of HIV – related brain disease.

You order an MRI as this will be more sensitive in detecting any HIV related brain changes than a CT scan. The MRI shows mild atrophy and bilateral periventricular high T2 signal intensities, which suggests the HIV is active in the brain.

You also arrange for neuropsychiatric testing (a detailed set of specific psychological and cognitive tests usually performed by a specially trained psychologist) to determine whether Jim has any evidence of HIV associated neurocognitive disorder (HAND). This is an umbrella term which refers to a range of HIV related neurological problems – patients with HAND usually experience problems of mental slowing, loss of memory and poor concentration. Given Jim's current mental state you will delay the timing of this testing until his

mood is settled.

Finally, you seek a secondary consultation from the psychiatrist involved in the HIV treatment team in X city who have been managing Jim's illness until recently. He suggests that although Jim does have a family history of bipolar disorder the presentation of psychiatric problems accompanying the course of Jim's HIV are consistent with a secondary mania (in other words, the hypomanic episode is likely to be due to the HIV), and he recommends management should be based on this assumption.

6.4 What treatment will you offer Jim? You are aware that it is essential to treat Jim's mood disorder symptomatically, and in doing so hopefully prevent any worsening of the elevated mood and progression to mania. You are also aware, that people with elevated mood often behave in a disinhibited and/or risky manner, including unprotected sex and IV drug use and either could present a great risk to others, so needs to be addressed with Jim.

You talk with Jim and ask if his parents are aware he is HIV positive. He indicates they are not, although they were aware his partner died from AIDS, but agrees they will need to know and agrees for you to discuss this with them. You speak to Jim's parents and explain your diagnosis, and your concerns about possible worsening, and about the need for Jim to receive specialist care for both his HIV and his mood disturbance as soon as possible.

Although Jim is reluctant to accept your assessment and treatment recommendations, he does eventually agree to start a medication as he can see that his life is spinning out of control. The psychiatrist recommends that you start an atypical antipsychotic, olanzapine, initially 5 mg/day. The psychiatrist explains that he was reluctant to use a mood stabiliser because patients with physical illness are more prone to medication toxicity and problematic drug interactions when taking mood stabilisers such as lithium or sodium valproate.

The psychiatrist in X city also explains that it is important Jim restart his antiretroviral (HIV) medications as soon as possible as suppression of systemic viral load may result in reduction of viral replication in the brain. However, since you have no experience in the use of these medications you defer any prescribing of these agents until Jim can be seen by the clinic in X city.

6.5 Prognosis Prognosis is dependant on a number of factors. These include Jim's compliance with and response to antiretroviral therapies, and whether Jim does in fact have any evidence of HIV neurocognitive associated disorder (HAND) – it is known that the poor prognostic features for HAND include poor viral control, comorbid drug abuse and co – infection with hepatitis C. Importantly, whilst cognitive deterioration accompanies HIV related mania in some cases it does not occur in all.

Finally, as Jim has a familial risk for bipolar disorder this may still become manifest at some stage irrespective of his HIV infection.

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