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Diagnostic Problem

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Abstract
Subject: A.F., widowed, female, aged 67.
Complaint: Blackouts, dizziness, anorexia.

History: This patient had a four year history of extensive investigation and treatment for essential hypertension. She was noted on both in and out-patient interviews to be a very nervous and anxious woman, and her blood-pressure was extremely labile. There was no doubt that the diagnosis of idiopathic hypertension was established, but treatment was unrewarding as the patient lived alone and was never able to fully understand her quite complicated drug regimes. She had been a widow for 30 years and had only one child — a married daughter, with whom she came to live because of her increasing lack of confidence on her own and the failure of therapy to control her symptoms. The “blackouts” were infrequent, but frightening, in that they involved transient partial loss of consciousness, often in crowded places. The dizziness consisted of an unspecific feeling of faintness (not vertigo). The persistent anorexia was the symptom which most troubled the patient and her relatives.

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DIAGNOSTIC PROBLEM

Set by J. J. C. Cormack, M.B., Ch.B., D. Obst., R.C.O.G.

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Examination :

A thin, anxious-looking woman. There was no detectable abnormality in the respiratory, central nervous, alimentary or genito-urinary systems. In her cardiovascular system her pulse was regular, 90/min., good peripheral pulses, no cardiomegaly, no murmurs, no evidence of failure. BP fluctuated between 210/150 and 150/100. She had grade I retinopathy.

Therapy :

Her current therapy was Bethanidine 35mg/day and Diazepoxide 15mg/day.

Apart from her hypertension, what diagnosis would account for her symptoms, what pointer might there be to this diagnosis from the history and what therapeutic trial might help in elucidating the clinical picture?

(answer on page 45)

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DIAGNOSTIC PROBLEM

(from page 39)

DIAGNOSIS

This woman was suffering from a depressive illness of long standing. It took some time to establish any rapport with this patient, and she was reluctant to talk about her past history, but when pressed on the subject of her widowhood of 30 years duration, it transpired that her husband was an alcoholic who committed suicide. She had feelings of guilt about this and was a lonely soul who admitted to feeling low in spirits with some diurnal variation of mood and sleep disturbance. Her presenting symptoms fitted the diagnostic complex and a therapeutic trial of imipramine produced a dramatic improvement. Depression is an illness which presents in many guises and its recognition is not infrequently masked by the finding (as in this case) of some coincident organic disease. If a careful history elicits clear pointers to this condition, a therapeutic trial of tricyclic antidepressants is often of value, particularly in elderly patients.

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