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DEPRESSION VERSUS EARLY DEMENTIA: A BRIEF CLINICAL CHECKLIST

ABSTRACT

The clinical differentiation between depression and early dementia (non-specific type) is developed for the clinician. Twelve items relating to the differential diagnosis between these two disorders are offered to assist the clinician in making a more accurate and reliable diagnosis based on findings from the literature.

INTRODUCTION

Approximately 40% of chronically hospitalized psychiatric patients are afflicted by an undiagnosed organic brain disease (Geschwind, 1976), and 20% of the population over age 65 have dementia (Gruenberg, 1978). In contrast, approximately 50% of psychiatric patients over 65 are admitted for depression (Myers et al., 1963), and 19% of the population over 65 suffers from either minor or major depressive disorders (Blazer and Williams, 1980). The difficulty in differentiating between these two disorders occurs in the symptomological overlap of memory disturbances, psychomotor retardation, cognitive impairment, and personality change.

Early stages of dementia (non-specific) frequently mimic depression, and vice-versa. The term "pseudo-dementia" refers to this characteristic (Kiloh, 1961). Alternate viewpoints consider the two disorders as interacting variables (Heidell and Kidd, 1975). The studies listed in Table I show the percent of patients found with depression co-existing with dementia when either disorder was the initial diagnosis. Table II refers to studies where the diagnosis was initially erroneous, based on presenting symptoms, and later changed.

DIFFERENTIAL DIAGNOSIS

Despite the fact that endogenous depression is probably the most common disorder present when the erroneous diagnosis of early dementia is given (Kiloh, 1961), no study has comprehensively outlined the clinical differentiation between these two syndromes. The literature does, however, yield some clinical signs and symptoms to aid in the formulation of a more valid and reliable diagnosis.

Memory and Recall. Nott and Fleminger (1975) found that severe memory disturbances were consistent with a diagnosis of dementia, and Liston (1979a & b) found that memory impairment was the most frequent symptom in dementia. Depressed patients also perform poorly on measures of memory (Miller, 1975) though there was improvement after treatment with anti-depressant medication (Sternberg and Jarvick, 1976). Early dementia patients frequently do not complain of memory impairment, while depressed patients frequently complain of memory loss. In addition, patients with dementia display intact remote memory, but poor recent memory (Post, 1975).

Onset of Illness. Depression usually appears quickly and progresses rapidly, while the degenerative process of dementia tends to be insidious in oneset and slow in course (McHugh and Folstein, 1979). In depression, the history is more precise and the date of onset more certain (Wells, 1977), while in dementia, an onset with a short history is rare (Kiloh, 1961).

Emotional Lability. Nott and Fleminger (1975) found that emotional lability discriminated demented from non-demented patients. In depression, a distinguishing feature is the pervasive and stable feeling of dysphoria, whereas in demen-

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tia, lability of affect is dominant.

Physical Symptoms. Shraberg (1978) views the clinical presentation of depression similar to the anaclitic depression of the infant, wherein the individual manifests physical symptomatology such as appetite and sleep disturbance, weakness, dry mouth, constipation, and psychomotor retardation. These vegetative symptoms are less frequent in early dementia. In addition, according to Sim et al. (1966), symptoms such as headaches, focal neurological signs, muscular atrophy, and convulsions are rare in early dementia (sometimes more apparent in the final phases) although they may be more common with other specific organic illnesses.

Diurnal Variation. Endogenously depressed patients are usually worse symptomalogically while demented patients are worse late in the day due to fatigue (Parr, 1955). In addition, diurnal variation of mood and appetite, along with early morning waking, are more characteristic of depression than dementia (Post, 1975).

Coping Mechanisms. Demented patients often conceal symptoms and impairment by such tactics as changing the subject, avoiding questions, or keeping written reminders (Bower, 1971; Wells, 1979). Thus, while "near miss" responses to questions and denial of errors are more consistent with dementia (Weinstein and Kahn, 1955), the depressed patient may respond with "don't know" answers and complaints related to changes in mental functioning.

Medical Tests. Computerized tomography (CT) and the electroencephalogram (EEG) cannot definitively rule out or confirm the presence of dementia (Wells, 1979). The only reliable diagnosis of dementia occurs with histological examination (Tomlinson et al., 1970; Katzman, 1979; Liston, 1979a & b). However, lateralized neurological signs are consistent with organic conditions so that such procedures as the Face-Hand Test (Fink et al., 1952) may provide significant data to aid in the differential diagnosis.

Mental Status Examination (MSE). Depressed patients are usually oriented on the MSE, while demented patients, especially in later stages, typically perform poorly. (Cohen, 1967; McHugh and Falstein, 1979). Several studies have reported on the high validity of the MSE in diagnosing dementia (Kahn et al., 1960; Irving et al., 1970; Liston, 1979a & b; Gurland, 1980).

Psychological Tests. Orne (1955) and Kendrick (1972) used a series of tests to differentiate dementia from non-dementia, however, the results were only moderately successful. They found that the Mill Hill Vocabulary Score, the Wechsler Adult Intelligence Scale (WAIS), and the Progressive Matrices used in the test-retest sequence seem to be effective in differentiating between depression and dementia in the age group above 60, with demented patients performing poorer in terms of intellectual productivity. Neverless, according to Post (1975), when clinical methods cannot firmly support a diagnosis, psychological testing usually produces equally questionable results.

RECOMMENDATIONS

The concept of dementia is neither a well defined entity, nor clinically unique in its presentation. Yet, the literature does yield some clinical signs and symptoms that may aid in making a differential diagnosis, though none of these may be considered pathognomic of either illness. Table III may serve as a brief check list to assist in more accurately differentiating the two disorders.

These signs and symptoms can serve as a clinical guide to more accurately evaluate patients and increase diagnostic reliability. Further research is needed to isolate clinical states in dementia in order to clear up some of the ambiguity of previous studies. This brief check list can function as an additional aid for the clinician

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TABLE I

PERCENT OF PATIENTS WITH OVERLAP OF DEPRESSION AND DEMENTIA

AUTHOR	% of Patients with Mixed State
1. Ziegler (1954)	15
2. Sim and Sussman (1962)	50
3. Lipowski and Kiriakes (1972)	30
4. Reifler et al., (1981)	25

TABLE II

PERCENT OF PATIENTS WITH ERRONEOUS MENTAL DIAGNOSIS

AUTHOR	% of Patients
1. Gustafson (1975)	30 (originally depression changed to dementia)
2. Haward (1977)	35 (originally dementia changed to depression)
3. Liston (1977)	25 (originally depression changed to dementia)

until further research is available on these items (research in progress).

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TABLE III

BRIEF CLINICAL CHECKLIST

A. DEPRESSION	B. DEMENTIA
1. Complaints of early memory impairment.	1. Denial of early memory deficits.
2. Memory impairment usually diffused and circumscribed.	2. Intact remote memory; poor recent memory.
3. Symptoms appear quickly and progress rapidly with a more certain date of onset and probable precipitating event.	3. Insidious onset and slow course with a non-certain date of onset and no apparent precipitating event.
4. A personal or family history of affective disorders.	4. A family history of dementia.
5. Mood consistent with depression: e.g., dysphoria, failure, guilt, and beliefs of loss.	5. Lability of mood and affect.
6. Vegetative physical symptoms: e.g., dry mouth, constipation, appetite and sleep disturbance.	6. No obvious vegetative symptoms during the early stages.
7. Symptoms worse in the morning.	7. Symptoms worse later in the day due to fatigue.
8. Complaints about loss of functioning with a tendency to give "don't know" responses.	8. Denial about loss of functioning with a tendency to give "near miss" responses in early stages.
9. Negative CT and EEG findings are consistent with depression, but since they are not pathognomic, caution should be exercised related to false negatives.	9. Positive CT and EEG findings are consistent with dementia, but they are not pathognomic, so caution relating to false findings should be exercised.
10. Generally not disoriented on MSE.	10. Errors on the MSE.
11. No evidence of lateralization of aphasic symptomatology.	11. Evidence of lateralization on such instruments as the Face-Hand test; aphasic symptoms may be seen as illness progresses.
12. Intellectual productivity less impaired on cognitive tests.	12. Impairment or loss of functioning on intellectual measures, especially less stable measures during early course of illness.

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