Letters

DEMENTIA OR DEPRESSION?

"From Active to Apathetic" (CURRENT PSYCHIATRY, February 2005, p. 78-85) reports the decline of a 66-year-old man's cognitive function as "sudden."

If the decline was truly sudden, Drs. Rehan Aziz and Rajesh Tampi should have listed many more differential diagnoses than they did. At least major depression or so-called pseudodementia should have been included.

Except for apparent dementia related to some gross organic cerebral lesions, most of the dementias listed in the article would not suggest a pathological process deemed as sudden.

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Dr. Tampi responds

Dr. Liu makes a very good observation that depression should be among the differential diagnoses for early dementia. We did not consider depression in our patient because:

- **Decline was not 'sudden,'** although the headline used that word. The changes in cognitive functioning, behaviors, and activities of daily living were unfolding for more than a year before the family brought him to our clinic for evaluation. His cognitive deficits were also severe enough to be in the moderate range for a dementia.
- **The patient's flat affect and lack of initiative** were consistent with a frontal executive dysfunction as there was no subjective report of depressive symptoms. Also, family members noticed no neurovegetative depressive symptoms.
- **The patient was started on bupropion** and then was switched to citalopram. Neither medication resolved his apathy.

Depression-associated dementia is a neuropsychiatric manifestation of a depressive disorder. In this condition, treating the depression resolves the cognitive deficits. By contrast, primary dementias are progressive.

We included only the most common differential diagnoses for frontotemporal dementia. Including other neurodegenerative conditions would have made our case review very long and confusing.

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PSYCHIATRY'S 'TEAMMATES'

Many thanks for your warm welcome to advanced practice psychiatric nurses (APNs) and for recognizing our need for clinical information (CURRENT PSYCHIATRY, January 2005, p. 3).

As Dr. Hillard noted, many psychiatrists refuse to accept APNs even though we offer crucial support to psychiatrists, especially to those practicing in rural, underserved areas.

APNs are teammates to—not replacements for—psychiatrists.

For the record, my supervisor—who is also my consulting psychiatrist—is very supportive of my career. I hope that someday many other APNs will be as fortunate as nursing's relationship with psychiatry evolves.

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