EDITOR'S NOTE

Dr. Wolff is a board-certified family physician in private practice in Cornelius, North Carolina. He finished his family practice residency in 1997. He has graciously consented to share stories from the trenches of primary care. While his practice diary is taken from actual patient encounters, the reader should be aware that some medication references may represent off-label uses.

We at the *Companion* are certain that these vignettes will inform, entertain, challenge, and stimulate our readers in their effort to address behavioral issues in the everyday practice of medicine.

Sexual Dysfunction to the Rescue

Christian G. Wolff, M.D.

Monday
You will recall the difficulties I was having with a gentleman who refused his antidepressant because of concerns regarding his insurance and the subsequent plea by his wife to get him back on his medication? Interestingly, he came to see me a couple of weeks ago complaining of ejaculatory dysfunction. He said that his "lasting power" had significantly diminished over the last month or 2. I seized upon this opening and suggested restarting his medication, an SSRI, which he gladly did. After seeing him in follow-up, I can't help but wonder, sure, his demeanor is markedly improved with the resumption of medication. But how much of the "sexual effect" was the face-saving ruse of a gentleman who realized he needed an antidepressant and how much of that delayed ejaculation was the *primary* reason he and his wife wanted to restart medication? I guess I'll never know.

Tuesday
CP is in for her annual exam today. Last month, her aging mother finally passed away after a massive stroke. She, too, was my patient, and I had been treating her for depression among other medical problems. CP thanked me for that treatment today. I think it's so easy to overlook depression in the chronically ill elderly, but the impact of depression on the quality of life of both the patient and the family is really immeasurable. No one should close out his or her life depressed.

Wednesday
I know I'm not the only one who has done this. Several weeks ago I wanted to start a 40-year-old man on an SSRI, and the only samples I had were for fluoxetine, but labeled under the brand Sarafem. I knew that if he got the printout from the pharmacy there was a strong chance that he wouldn't take any medication, so I bit the proverbial bullet and gave him the samples rather than writing a prescription. Of course, his wife recognized the brand from a print advertisement. He's feeling better, and he understands my strategy, but now he tells me he has to endure PMS jokes from his wife. Fortunately, he's laughing, too.

Thursday
HP is a 23-year-old woman whom I have seen for about 5 years for routine medical care, including the care of her depression and anxiety. She has been taking 1 SSRI or another since she was 16, when an adolescent psychiatrist in Connecticut initially evaluated her. Her mother, also a patient of mine, has a similar affect as hers: very personable and delightful punctuated by periods of anxiety that seem to be managed well with her medication. For the last year or so, HP's office visits for somatic complaints had increased and her usual well-composed nature seemed, well, a little frayed. Finally, last week, she came in complaining that "her medicine just wasn't working" and that she was having trouble sleeping. I began to suspect that she was exhibiting hypomanic symptoms, so we

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tried a small dose of olanzapine—just 2.5 mg at suppertime. Today, 1 week later, she returns as the well-composed woman I had known before. “I wish we had tried that long ago,” she told me. “I can sleep, I can focus, and everyone says I seem so at ease!”

Just when I begin to worry that I am over-diagnosing bipolar disease, cases like hers remind me that it is widely under-diagnosed.

Friday

Some of the times that I revel in my profession are those times that fall out of the practice of “evidence based medicine.” What do I mean? Take the case of TR, a 40-year-old gentleman fixated on heart disease after a coworker had an unexpected heart attack. TR has minimal risk factors: no family history of heart disease, an active lifestyle without significant symptoms, and a very reasonable lipid profile. The problem was that since his friend died, every twinge in his chest made him think he was next in line for a heart attack. So, although he really had little justification for a cardiac stress test, I did one for him last month. I could almost see the anxiety melting away while he was running with a normal ECG at 14 METS of exercise.

Today, his wife was in the office with their daughter for the evaluation of a sore throat. “Thanks for getting Tom straightened out,” she said. When I responded that I hadn’t really done anything, their daughter chimed in, “Since that test you did, Daddy isn’t weird anymore.” But will his managed care provider approve?