Patient stories: Another professor's illness

Introduction

This brief account may be read in conjunction with the preceding account of 'a professor's illness' in this link:

https://psychotropical.com/patient-stories-a-professors-illness/

Details of this second 'Professor's story' have been altered or ommitted for reasons of confidentiality, but the essential elements are attested to by firsthand accounts given to me by other eminent professors [this is the same case as is referred to by Blackwell in a post on the INHN website here https://inhn.org/index.php?id=4022&utm_source=INHN+Members&utm_campaign=27735745b6-EMAIL_CAMPAIGN_2017_06_12_COPY_01&utm_medium=email&utm_term=0_3788e1c52f-27735745b6-234302617&goal=0_3788e1c52f-27735745b6-234302617

This professor's illness appears as if it may have been misdiagnosed and untreated; he died in a state of apathy which was interpreted as dementia, after a prolonged illness of several years, which caused immense distress to his family, as well as suffering for him.

Why tell the story at all? Well, I suppose it emphasises that no matter how eminent or famous you are, you are still subject to the same kind of problems and vicissitudes in the medical care system as others — hence it is in all our interests to try to make sure that these sorts of things happen less frequently in the future. I remember treating several patients like this in London in the 1970s, one of whom had been in a delusional state (with what seemed to us obviously depressive delusions), consigned to a nursing home for dementia sufferers, for many months before we treated him. The only reason he got treated was because his wife was a nurse and had read something about our research unit in the Sunday Times, which led her to insist on a referral. When he improved dramatically, he described his improvement as 'like being released from the grave'. One of the students who was sitting in on the interview became tearful at that, as anyone else less inured to suffering, and with a capacity for empathy, might also have done.

My confidence in the likely correctness of the supposition that he suffered retarded melancholic depression, not dementia, is based on the account of another very eminent professor of psychiatry who was a decades-old friend of the patient, since their days at a famous teaching hospital. I will not mention on which continent that was. This professor — they were both professors of psychiatry — made a long journey to see his old friend at home in the early stage of the illness. He formed the clear view that he was suffering from a major depressive episode.

It became increasingly severe until he was in a state of inactivity and apathy which was interpreted as dementia. Said professor approached yet another famous professor, who was in much closer geographical proximity to the patient, and who he supposed might be able to influence the thinking behind this treatment. This was unsuccessful. Nothing was done.

He seems never to have had any appropriate antidepressants treatment.

My comment is that whatever the 'correct' diagnosis, it is probable that a drug which improved neurotransmitter levels, especially dopamine, would probably have been of clinical benefit, irrespective of the exact aetiology of

Address for correspondence. Dr Ken Gillman: kg@matilda.net.au

the condition, or whether it was due to a reversible pharmacological disturbance or neuro-degeneration, or a bit of both. After all, we do not fail to treat Parkinson's because it's a degenerative disease. We try to boost dopamine levels, usually with L-dopa, although I suspect that now we have the selective MAO-B inhibitor Rasagiline, that will make people think again about the possible benefits of TCP in such patients — I would certainly have given him a trial of it.