Diagnostic overshadowing in learning disability: think beyond the disability

Amir Javaid MBBS, MSc, MRCPsych, Vera Nakata MBChB, Dasari Michael FRCPsych

Diagnostic overshadowing is increasingly recognised as contributing to health inequalities experienced by the learning disability population. This case is that of a 54-year-old male with mild-to-moderate learning disability who displayed abnormally aggressive behaviours and self-neglect. He had multiple transfers between the psychiatric and medical units during an inpatient episode, partly due to his physical health symptoms being misattributed to learning disability and challenging behaviour.

In 2016–17, 1 in 218 people in England were recorded as having a learning disability. People with learning disabilities suffer from higher rates of respiratory disease, epilepsy and sensory impairments than the general population. However, people with learning disabilities experience barriers to accessing good quality healthcare, which result in compromised patient safety and avoidable, premature death.

Diagnostic overshadowing is increasingly recognised to contribute to health inequalities experienced by the learning disability population. Diagnostic overshadowing refers to when symptoms arising from physical or mental health problems are misattributed to an individual’s learning disability, leading to delayed diagnosis and treatment. The Confidential Inquiry into premature deaths of people with a learning disability also concluded that 38% of people with a learning disability died from an avoidable cause as compared with 9% in a comparable population of people without a learning disability. The Leder report into the deaths of people with learning disabilities was very concerning and according to the report people with learning disabilities die, on average, 15–20 years sooner than people in the general population, with some of those deaths identified as being potentially amenable to good quality health care. Life expectancy for people with learning disabilities has been found to be 13 years lower for men and 20 years lower for women than for the general population.

Presentation

Presentation prior to admission

The patient was a 54-year-old male with background of mild-to-moderate learning disability and schizoaffective disorder. There was no previous family history of psychiatric disorder and no history of alcohol or recreational drug use. He was admitted to the psychiatric unit in March 2017, following deterioration of behaviours of screaming, shouting and being physically aggressive to others, as well as poor appetite and self-neglect.

Four weeks prior to admission to the psychiatric unit, the patient was hospitalised in an acute medical hospital for pneumonia and cholecystitis. While in hospital, he was found to have frequent episodes of hyperglycaemia, and was newly diagnosed with type 2 diabetes mellitus. It was reported that while the patient was in the acute medical hospital, he did not receive his morning dose of psychotropic medication – trifluoperazine 7mg. On discharge, his carer noted that the patient appeared to be struggling with the need to have finger-prick tests three times a day to check his blood sugar levels, and was also observed to be increasingly anxious and had reduced appetite.

A Mental Health Act assessment then took place, following concerns raised by the carer due to further deterioration in the patient’s behaviours, and episodes of the patient being physically aggressive towards his carer and the staff at the day centre he attended. The patient was thus admitted to a learning disability unit under Section 2 of the Mental Health Act.

Mental state on admission

During the assessment, the patient did not engage, and was avoiding eye contact. However, when there was eye contact, it was intense or staring in a hostile manner. He did not reply to any questions, only howling or shouting ‘no’. His mood was objectively angry, distressed and tense. Risks to self and others were assessed to be high due to self-neglect and aggressive behaviours towards others. He was not observed to be responding to unseen stimuli. The patient lacked insight into his mental health, and was assessed to lack capacity to consent to an informal admission or consent to treatment.

Progress on the unit

While on the unit, his trifluoperazine dose was increased from
pre-admission dose of 7mg in the morning and 5mg at night to 7mg twice daily. However, the patient remained uncommunicative and did not engage. He refused physical examinations, blood tests and several doses of his medications. He also had poor oral intake, and needed staff prompting for food and fluids. Due to concerns about deterioration in his physical health he was transferred to the acute medical hospital for one week where he was treated for pneumonia. Shortly after discharge back to the learning disability unit, the patient became physically unwell again, and had to be readmitted to the acute medical hospital. On readmission, he was discharged back to the learning disability unit with oral antibiotics for pneumonia and potassium supplements for hypokalaemia.

On the unit, as there was no significant improvement in his mental and physical health since admission, and continued risks to self and his own health, he was regraded to Section 3 of the Mental Health Act for further treatment.

While on the unit, his trifluoperazine dose was further increased to 10mg in the morning and 7mg at night, but the patient continued to become increasingly aggressive, and assaulted staff members. He also developed bizarre behaviours including stripping and faecal smearing. He then developed vomiting with streaks of blood, and a medical transfer was arranged. However, he was discharged on the same day with no interventions from medical unit. While on the unit, the patient continued to have poor engagement, reduced oral intake and assaults on staff members. His trifluoperazine dose was further increased to 10mg twice daily, and he was started on haloperidol 2.5mg im as required. When no improvement in engagement was noted, his trifluoperazine was increased to 10mg three times daily.

However, on one occasion, the patient was noted to develop slurred speech and confusion, and was transferred to the acute medical hospital. The patient then had a CT head scan, which showed established lacunes in both genu of the internal capsules bilaterally and left subganglionic regions. This was reviewed by the neurology and stroke team, and no acute management was required. He was subsequently commenced on medications for secondary stroke prevention. On admission, the patient’s blood results also showed raised inflammatory markers.

When the patient was reviewed on the medical ward by the psychiatric team, concerns were raised regarding his health and CT head scan findings. The psychiatry team discussed with the medical team regarding diagnostic overshadowing and reiterated the need to rule out physical health problems given the investigation results, and how the patient’s current presentation was different to his previous presentations of mental health deterioration. The patient then went on to have an abdominal ultrasound, which showed multiple gallstones. This was discussed with the surgical and gastroenterology teams who stated that no intervention was required as his liver function tests were within normal limits. The patient was also treated with a course of antibiotics for a possible lower respiratory tract infection and phosphate enema for faecal impaction. During his inpatient stay, which lasted for 17 days, the psychiatric team continued to review him in the acute medical hospital and commenced him on haloperidol im and lorazepam as required, while the complex care team and liaison nurse provided ongoing support.

Outcome
When the patient was deemed medically fit, he was discharged back to the learning disability unit. However, his trifluoperazine had been stopped by the medical team in the acute medical hospital. Thus, when he was back on the unit, his haloperidol was increased to 3mg im twice daily and he was commenced on risperidone. As the patient’s oral intake and behaviours improved, and he was more adherent of medications, his haloperidol im medication was titrated down and discontinued, diazepam was stopped, while his risperidone dose was increased. His psychotropic medications were titrated, and he was stabilised on risperidone 4mg once daily, Risperdal Consta im 25mg fortnightly, mirtazapine 30mg once daily and lorazepam as required. The patient was then discharged with an upper gastrointestinal endoscopy appointment, a GP review to consider outpatient surgical referral for gallstones and psychiatric outpatient clinic follow-up.

In October 2018, the patient was readmitted to the acute medical hospital due to pneumonia and escalation of behaviour, and a transfer to the learning disability unit was requested due to his escalation in behaviour. However, the psychiatry team was mindful of diagnostic overshadowing and requested the medical team to further investigate the cause of patient’s recurrent pneumonia. A video fluoroscopy was subsequently conducted, which showed aspiration pneumonia secondary to muscular dystrophy (idiopathic), and a PEG feed was planned for the patient.

Discussion
An element of diagnostic overshadowing contributed to the patient’s repeated acute medical hospital admissions as the medical team was
attributing his presentation to learning disability and challenging behaviour. This could have been detrimental for the patient if the psychiatric team did not reiterate the importance of ruling out physical health conditions. The learning point from this case would be that both psychiatry and medical teams need to be mindful of diagnostic overshadowing, and that physical, psychiatric and social causes need to be considered when a learning disability patient presents with new or escalating behaviours. Psychiatry and medical teams will also need to work together to deliver safe and effective care for patients with both mental and physical health problems, particularly in the learning disability population. Disabilities need to be placed at the heart of policy on health inequalities.

The follow-up to this report would be to conduct a case series, and observe the occurrence of diagnostic overshadowing in the learning disability population.

Dr Javaid is a Consultant Psychiatrist and Honorary Senior Lecturer, Dr Nakata is a FY2, and Dr Michael is a Consultant Psychiatrist, all at Townend Court, Hull, East Yorkshire

Declaration of Interests
No conflict of interests were declared

References