

A case of endometrial carcinoma with depression – diagnostic dilemma

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Depressive symptoms such as loss of appetite, weight loss, tiredness and lack of energy may be due to a psychiatric disorder or equally be due to physical illness, including carcinoma. Here, Drs Guruvaiah and Kranidiotis describe the diagnostic challenge faced when a patient presents with the above symptoms without any obvious signs or symptoms of physical illness.



Psychiatric disorder is present in as many as one in three patients with serious acute, recurrent or progressive medical conditions.¹ It is difficult to ascertain the exact proportion because the standard criteria for the diagnosis of psychiatric disorder include some symptoms that can also be caused by physical illness.¹

Late-life depressive disorder, occurring in those over the age of 60 years, is common, affecting over 9% of people living in the community and 25% of those living in institutions.² It is associated with reduced quality of life and high morbidity.³

The aetiology of late-life depression is multifactorial⁴ and includes the following:

- Biological: physical illness
- Psychological: death of spouse, loss of role, personality traits, and
- Social factors: reduced independence, retirement and loneliness.

Weight loss in depressive disorders often seems greater than can be accounted for merely by patients' reported lack of appetite.⁵ Complaints about physical symptoms are common and take many forms but complaints of constipation, fatigue and aching

discomfort anywhere in the body are particularly common in depressive disorders.⁵

Some depressive symptoms such as loss of appetite, weight loss, tiredness and lack of energy may equally be due to physical illness,⁶ including carcinoma.

When a patient, who has had an episode of depression in the past presents with the above symptoms, without any obvious signs or symptoms of physical illness, it can pose a diagnostic challenge: we faced this with one of our patients.

Case report

Our patient was a 66-year-old retired teacher, married for 43 years. Her husband passed away in August 2013 as a result of terminal stomach cancer. She has lived alone since then. She has been known to psychiatric services on and off since 1995. She has no children and has a sister living in the east of England who is very supportive. There is no family history of mental illness. The patient does not smoke or misuse alcohol. She has never used any illicit drugs.

Medical history

She suffered from iron deficiency anaemia and was treated with ferrous sulphate in 1995. She had hormone replacement therapy in the same year for menopausal symptoms.

Psychiatric history

Our patient came into contact with the mental health services in October 1995 following an overdose of fluoxetine. She presented with symptoms such as low mood, loss of appetite, weight loss (almost 13kg in four months), poor sleep, lack of confidence and poor concentration. She weighed 70kg and her BMI was 26.7. This episode was precipitated by her mother's death and work-related stress. She was admitted to the psychiatric ward and treated with antidepressants.

She remained reasonably stable under the care of her GP from 1996 to February 2013.

She was referred back to the mental health services in February 2013 following her husband's diagnosis of stomach cancer. She took an overdose of Oramorph and was subsequently admitted to an inpatient unit. Her symptoms at that time were low mood, feelings of guilt and anxiety. She improved with the antidepressant treatment and was eventually discharged from the ward in May 2013.

She remained under the care of the home treatment team on and off due to the concerns regarding her mental health until her husband passed away in August 2013. She later moved to stay with her sister until March 2014.

Current episode

Community psychiatric nurse support was resumed in March 2014 when she presented with low mood, significant weight loss, loss of appetite and lack of confidence. Her weight was 48kg in March 2014 and her BMI was 18.3. It was reported that she had lost around 32kg between August 2013 and March 2014.

She presented emaciated in appearance. She was reported to be non-concordant with her medications. She was assessed and taken on by the home treatment team. There was a very gradual improvement in her mood and dietary intake following commencement of antidepressants but no improvement was noted in terms of her weight.

She continued to suffer from low mood and weight loss in spite of receiving intensive input from the home treatment team and the community team. Her weight was 45kg in October 2014 and her BMI was 17.1.

Current admission

In November 2014, she was admitted to the inpatient unit following significant concerns regarding her mental state. She presented with low mood, loss of appetite, tiredness and lack of energy. She was initially treated with venlafaxine and mirtazapine. Then quetiapine was added to her treatment regimen. She reported feeling bloated and constipated, which were attributed to side-effects of quetiapine. Physical examination and routine bloods at that time were uneventful. As she was not responding to the above combination of medications lithium was added as an augmentation. Along with the medication, she was maintained on input and output charts to monitor her fluid and food intake. She was given food supplements to

improve her weight and general physical well-being. Despite all these interventions, she continued to lose weight (she weighed 42kg in January 2015 and her BMI was 16.0) and felt tired. However, she reported slight improvement in her mood, though objectively she appeared flat in her affect. The team felt that she had become treatment resistant to conventional medications and hence considered a course of ECT.

At the beginning of January 2015, the patient presented with urinary incontinence and within a few days she complained of back and pelvic pain for which she underwent investigations. Her X-ray pelvis showed a suprapubic rami fracture as a result of suspected secondary metastasis. An urgent CT scan was arranged which revealed advanced cervical cancer with hydronephrosis, metastatic lesions to lungs, bones, pleura, adrenal glands and abnormal lymph nodes. She was immediately transferred to a gynaecology ward and the biopsy confirmed the primary as endometrial adenocarcinoma extending to the cervix.

Discussion

Our patient had a history of depression that was precipitated by stressful life events. She had responded well to treatment and remained stable for 17 years. The symptoms at that time were self-neglect, weight loss, low mood, anxiety, lack of confidence and low self-esteem.

During the most recent admission, she presented with similar symptoms, precipitated by her husband's death, and hence she was diagnosed with depression complicated by prolonged bereavement. Her routine physical examination and bloods were normal. She was treated with antidepressants and psychological therapy. However,

she was not responding to the treatment as she did in the past.

Reflecting on the history after she was diagnosed with carcinoma, we could see a difference in her recent presentation as she not only presented with the significant weight loss, but also had tiredness and lack of energy. She also complained of bloated feelings in her lower abdomen, constipation and urinary incontinence, possibly as a result of the mass pressing on her rectum and bladder. These unusual concerns were assumed to be medication side-effects (quetiapine). One of the early and common symptoms of endometrial carcinoma found in 90% of cases is vaginal bleeding or discharge,⁷ which was absent in our patient. Her cachexic symptoms were interpreted as symptoms of depression due to her past history and recent bereavement.

The similarity between the symptoms of depression and common carcinoma symptoms was a challenge for us in this case, especially when the patient had the past history of depression. The absence of typical symptoms of endometrial carcinoma such as vaginal bleeding and discharge further complicated the clinical picture.

Conclusion

Our patient's predominant symptom in the last few months was significant weight loss, which was attributed to depression. It should have been given more significance considering her age, and the duration and extent of weight loss.

Her physical complaints, such as bloated feeling, constipation and urinary incontinence during the inpatient stay, should have alerted a thorough physical examination (including *per vaginal* and *per rectal* examination) and other relevant investigations.

However, internal examination is not a part of usual care in psychiatric patients unless patient symptoms indicate further assessment. She also had risk factors for endometrial carcinoma, which included nulliparity, hormone replacement therapy and postmenopausal age.⁸

When our patient was not responding to the strategies for treatment-resistant depression we should have reviewed the diagnosis and explored the other possible aetiological explanations.

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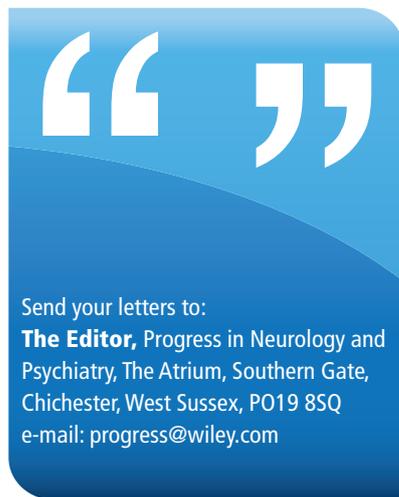
Declaration of interests

No conflicts of interest were declared.

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Agomelatine and adolescent depression

We have recently seen an increased trend to prescribe agomelatine in adolescents with major depressive disorder (MDD) more in Western Australia than the UK by general practitioners (GP's). Use of Valdoxan (agomelatine) in children and adolescents (under 18 years of age) is not recommended as safety and efficacy have not been established in this age group¹⁻². We wanted to know that if there is any evidence to use Agomelatine in adolescent population for depression or resistant depression. The literature search involving EBSCO,

PsycINFO, Medline and Embase, only revealed 4 studies and on further exploration only two studies were relevant but in adults with no reference to adolescent population.

Chronos³ was a large naturalistic study designed to evaluate the effectiveness and safety of agomelatine in the management of patients with major depression in routine clinical practice in 54 regions of the Russian Federation, involving over 6000 patients with moderate or severe major depressive episode. Authors of the study's view was that Agomelatine was effective and well tolerated in a large sample of depressed patients in an observational treatment setting, and showed a rapid onset of benefit across all HAMD-17 items.

A pooled-analysis of four head-to-head studies, comparing agomelatine with fluoxetine, sertraline and escitalopram shows that, clinically (in terms of remission rates) at 24 weeks, agomelatine is 'at least as efficacious as the three SSRIs with a trend to fewer discontinuations due to adverse events'⁴.

There is still a limited evidence for use of agomelatine in depression even for adults and is 'off-label' in paediatric population.

Base line liver function tests should be performed in all patients and before starting treatment and then around 3 weeks, 6 weeks (end of acute phase), 12, 24 weeks (end of maintenance phase) thereafter when clinically indicated¹⁻².

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