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Chronic Fatigue Syndrome: Diagnostic Enigma

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Author's contribution

This whole work was carried out by author PN.

Case Study

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ABSTRACT

Patients with unexplained fatigue often have secondary anxiety and depressive symptoms. The symptoms are unlikely to resolve unless their primary illness is diagnosed and treated. Many patients labeled with treatment-resistant depressionare misdiagnosed. Chronic fatigue syndrome may simulate depression and hence is under recognised and under treated. It presents with a cluster of neurological and gastrointestinal symptoms that evade routine diagnoses. Multiple referrals to several specialists are aimed at uncovering the diagnosis. The following case report demonstrates how consultation liaison psychiatry may play a role in conceptualising patient's illness and legitimising the symptoms; thereby alleviating anxiety and restricting use of anti depressants.

Keywords: Chronic fatigue syndrome; treatment-resistant depression; fatigue.

1. INTRODUCTION

30-40% of patients with major depressive disorder are found to be unresponsive to a trial of antidepressant medication. Many patients labeled with treatment-resistant depression actually have pseudo resistance, in that they have been inadequately treated or are misdiagnosed. We often fail to recognise medical conditions that may simulate resistant depression. Chronic fatigue syndrome (CFS) is one of them. It is likely to be under recognised and undertreated [1]. Prevalence rates of CFS vary from 2 to 4/1000 [2]. Severe unexplained fatigue of new onset that does not respond to rest and that is functionally impairing is the hallmark of the syndrome.

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2. CASE REPORT

Ms A was a 47 year old divorced lady who was referred to psychiatry in 2014 as a possible case of depression. She had seen multiple doctors in neurology, endocrinology and memory clinics for symptoms such as gait disturbances, hair loss, cold intolerance and word finding difficulties. She was also reviewed for depression and had tried three antidepressants over the past three years to no avail. She was off work on medical grounds since 2010.

Ms A was asymptomatic until 2009 before her trip to a tropical destination. On her return, she noticed that she would be exhausted at her desk job as a receptionist by lunch time. She would lose her focus and would experience a fogginess descending on her brain. She would forget important appointments and phone calls. She soon developed excruciating headaches never experienced before. She noticed she could no longer tolerate the radio in the background while she worked in her kitchen. She was no longer able to tolerate her favourite air freshener and developed an aversion to her usual dish washing fluid. She complained of blurred vision and was no longer able to play the guitar as she gradually lost coordination of fine movements. She would lose her balance while walking. She would hear buzzing noises in her ears and experienced syncopal attacks. She complained of muscle aches and joint pains. These symptoms caused functional impairment and prompted referrals to different specialists.

In due course she was diagnosed with anemia. Underlying fibroids and endometriosis were treated. This addressed her anemia but not her fatigue. No abnormalities were detected in vitamin D levels and thyroid hormones. However she gained significant weight despite no dietary changes. Her BMI (21) was however was within the normal range. She underwent a surgical correction for an incidental Arnold Chiari malformation that corrected her gait disturbances and headaches for up to three months.

Ms A was seeing a gastroenterologist for alternating diarrhea and constipation when first seen in my consultation liaison clinic. She was awaiting appointments with a respirologist for recurrent sore throat and swollen occipital lymph nodesthat had set in after 2009. She was frustrated as in her own words; she was a “diagnostic enigma”. She thought that doctors believed she was making up her symptoms. She had earlier been labelled with laziness and even malingering. She was unhappy with this referral to mental health clinic. Psychiatric referral only added to her fear of being called crazy and not being taken seriously enough. She was apprehensive of her symptoms being dismissed as imaginary because a diagnosis was not forth coming.

Daily routine: On a typical day Ms A would wake up at 5.30hrs from an unrefreshing sleep. She would take an hour to get out of her bed. She would then sip her coffee while checking her emails. The most productive hours for her would be between 8.00 to 11.00hrs when she would attend to most of her household chores such as laundry, dishes and vacuuming. She would need frequent periods of rest in between these tasks. By 12.00noon she would find herself drained and would take to bed and would remain there until late evening. After her dinner she would retire to bed. She described initial insomnia.

On one occasion that she shared her room with a friend, her friend had commented on Ms A’s snoring and frequent awakenings with gasping for breath. On one week end she described feeling so energetic that she crammed multiple physical activities in one day. She experienced pay-back fatigue a day alter and spent the next four days in bed recouping from her fatigue.

Psychiatric comorbidity: Ms A endorsed experiencing panic symptoms in the form of palpitations, sweats and tremors especially after feeling light headed. She complained of fatigue and being emotional. However she did not describe any pervasive low mood or disinterest in previously pleasurable activities. She denied any habitual substance use. She commented on her new aversion towards red wine which had taken away her occasional drink too.

3. DISCUSSION

Ms A's previous history of anti-depressant use and failure to diagnose her cluster of symptoms prompted a referral to psychiatry. However a clear absence of a mood component and anhedonia rules out a major depressive disorder. Ms A's symptoms are of a sudden onset and unresolving fatigue seems to be predominant. It is masked by neurological and gastrointestinal symptoms. Foggy memory, muscle pain, arthralgias, sore throat with occipital lymph nodal swelling and unrefreshing sleep of more than six months durationsatisfy the CDC criteria for chronic fatigue syndrome. Circumstantial evidence of preceding tropical travel further corroborates the diagnosis. Cytomegalovirus and Epstein-Barr virus as a cause for chronic fatigue syndrome in tropical travelers has been well documented [3]. In addition she also exhibits word finding difficulties, blurred vision, hair loss, new sensitivity to noise, smell and alcohol and poor fine motor coordination which are associated with chronic fatigue syndrome. Essentially Ms A suffers from chronic fatigue syndrome and has fibromyalgia, irritable bowel syndrome and panic disorder as the commonly described comorbidities. She does have symptoms suggestive of obstructive sleep apnoea that can contribute to unrefreshing sleep and fatigue thereby clouding the picture and mimicking depression. The findings of endometriosis and Arnold Chiari malformation are coincidental. Fatigue and neurological symptomsoverlap with chronic fatigue syndrome. The endometriosis led to anemia which could have contributed to fatigue. Arnold Chiari malformation presented with headache and gait disturbances. It is pertinent to note that these symptoms failed to resolve completely even after the basic primary diagnoses were addressed. The other common causes of fatigue such as vitamin D deficiency and underactive thyroid were ruled out based on normal laboratory values.

Often patients with chronic fatigue syndrome are suspected to be malingering or exhibiting culturally sanctioned illness-behaviours [4]. Hence despite experiencing genuine impairment these patients are at a risk of stigmatisation [5]. Consultation liaison psychiatry was involved in collating the history for diagnostic clarification and exploring comorbid psychiatric symptoms. Validation of reality of symptoms has been found utmost essential to address overwork or self-negating tendencies that can perpetuate the condition [6]. Ms A was provided psychoeducation on the aetiology and course of chronic fatigue syndrome to conceptualise the illness model. The mind-body unity was discussed to explain relationship with anxiety.Role of certain tropical viruses [3] and oxidative physical stress [7] as contributory factors for fatigue was explained in order to assuage self-blame and guilt. Over production of pro-inflammatory cytokines coupled with dysregulation of anti-inflammatory cytokines is yet another postulate that may clinically correlate with her fatigue and dysphoria [8].

A cognitive-behavioural approach [2] was implemented to manage Ms A. She was asked to maintain an activity diary for a week which was reviewed in subsequent follow ups. Her complaints of fatigue were addressed through pacing, grading and cognitive behavioral therapy aimed at lowering her unrealistic expectations and challenging faulty cognitions. She benefited from practical tips around household chores to minimise her time at work. A

referral to a pain clinic for comorbid fibromyalgia and to the sleep clinic for obstructive sleep apnoea was initiated. Legitimising the diagnosis in the absence of specific objective biological markerspartly alleviated her anxietyand no pharmacotherapy was warranted.

Researchers from Maes' Clinics in Antwerp [9] have reported common findings of lower plasma CoQ10 in treatment resistant depression patients and in chronic fatigue syndrome patients compared to the other depressed patients. Though the two conditions may co-exist it is important to remember that CFS may simulate depression. It is imperative to diagnose it to avoid unnecessary prescription of anti-depressants.

Controversies exist regarding benefits versus harm of primary diagnosis of CFS [10]. Sharpe [11] argues that it conceptualises patients' illness and allows them to talk about it. Getting a diagnosis may put a closure to patient's uncertainty and may minimise irrelevant referrals. Hadler [12] on the other hand argues the potentially harmful effect of diagnosis intensifying socio-occupational morbidity. Nonetheless, clear diagnosis is an essential starting point for effective management and potential reversibility of symptoms as demonstrated by the above case.

4. CONCLUSION

It is recommended that the diagnosis of depression be questioned if fatigue is the presenting symptom as opposed to the affective component. Validating symptoms in chronic fatigue symptoms is an important aspect of diagnosis and management. It also prevents unwarranted polypharmacy.

CONSENT

Author has declared that 'written informed consent was obtained from the patient for publication of this case report.

ETHICAL APPROVAL

Necessary ethical approval from suitable Institutional Committee is in progress.

COMPETING INTERESTS

Author has declared that no competing interests exist.

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