CASE STUDY

A 57-YEAR-OLD WOMAN WITH LOSS OF APPETITE, LOW-BACK PAIN, SHOULDER STIFFNESS, MALAISE, AND HEADACHE

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BACKGROUND

A 57-year-old woman presents to her primary care physician (PCP) with loss of appetite, fatigue, vague low-back pain and shoulder stiffness, malaise, increasingly frequent headache (2–3 times per week), and loss of interest in social activities.

PATIENT HISTORY

PSYCHOSOCIAL HISTORY

Mrs. W. was widowed 2.5 years ago and went through a severe depressive episode. Her husband died in a car accident. Her 3 grown children each live at least 1000 miles away. She has a circle of friends but none that she would consider to be very close.

Mrs. W. is a retired nurse (she retired 2 years ago). Before her husband’s death, she enjoyed gardening and bird watching, reading, and going for long walks each day. After 2 to 3 months of mourning following her husband’s death, she was able to resume activities of daily living, but she suffered from a general loss of interest in activities and had low energy.

She began dating her current companion 6 months ago. They enjoy a strong relationship, but have no plans to get married in the near future. There has been no change in their relationship since the start of her presenting symptoms.

PSYCHIATRIC HISTORY

Mrs. W. suffered from postpartum blues after the birth of each child but was not treated for these episodes with any medication. She took anxiolytics for 3 weeks following her husband’s death.

MEDICAL HISTORY

Mrs. W. has no relevant medical history. Her surgical history includes a hysterectomy 5 years ago.

FAMILY HISTORY

Mrs. W. has no family history of depression. Her mother was considered an uptight and anxious woman in general, but never received associated treatment.

TREATMENT

Based on the patient’s presenting symptoms, the PCP established a diagnosis of depression and initially prescribed fluoxetine 20 mg. Mrs. W. did not feel completely comfortable with this diagnosis and did not appreciate the insinuation that the headaches, back pain, and stiffness were “all in her head.” However, she agreed to try the fluoxetine after the PCP ordered a complete blood cell count to rule out an infection. After 3 weeks of treatment, she stopped taking the fluoxetine, stating that she did not feel any better and her already low sex drive was now completely gone. She was frustrated and a little angry, feeling that she had wasted her time with the doctor.

Her PCP then discussed the potential for sexual dysfunction with selective serotonin reuptake inhibitors and offered to switch her to bupropion. She agreed and her dose was increased over 1 week to 300 mg daily.

She returned to her PCP after 2 weeks saying that her energy level had improved, but she was now experiencing constipation, mild jitteriness, and nausea. Her pain and stiffness had not abated. Her sexual
function had improved. Her PCP suggested that she wait at least 2 more weeks for the side effects to subside and the antidepressant to have a greater benefit.

After 3 more weeks, the patient returned to her PCP stating that she had stopped taking the bupropion about 10 days previously because she could no longer tolerate the side effects, and her depression “wasn’t that much better.” The PCP suggested that she see a psychiatrist and offered a referral, but she refused. The PCP did, however, make a referral to a neurologist for her tension headaches.

**DISCUSSION**

The clinician missed the opportunity with this patient to explain the relationship between her physical symptoms and her depression. Although the PCP was diligent in ruling out other possible causes of the fatigue, malaise, and muscle stiffness, the patient was left feeling that the physician attributed her symptoms to a psychosomatic disorder (ie, it was “all in her head”).

The broader range of symptoms in depressed patients needs to be addressed when initiating a treatment plan, as failure to address physical symptoms can hinder treatment adherence and ultimately impair resolution of the emotional symptoms. Medications proven to address both aspects of depression are reasonable choices in this regard with due consideration given to efficacy, tolerability, and safety. The PCP began with fluoxetine, an attractive antidepressant choice given its availability in generic form. However, the clear presence of physical symptoms warranted an antidepressant acting on both the serotonergic and nonadrenergic systems as a first-line therapy.

The true benefits and side effects of any antidepressant should be discussed up front so the patient can know what to honestly expect from treatment. Mrs W. became frustrated with her condition and her physician after experiencing the sexual dysfunction and gastrointestinal disturbances with her antidepressant medications. Had they been discussed with her initially, she would have felt more involved in her treatment plan and perhaps would not have been as put off by the side effects. Certain antidepressants with a dual mode of action on serotonin and norepinephrine might help to better address the associated vague physical symptoms of depression she was clearly experiencing. This could have prevented a visit to the neurologist for a headache syndrome clearly related to her depressive episode, a possible referral to a psychiatrist, and the frustration and anger on the part of the patient and her significant others as the depression continued for months, undertreated.