Depression and anxiety are among the most frequently occurring emotional symptoms experienced by patients with multiple sclerosis. It is reported that more than 50 percent of patients with MS experience depression. This is about three times higher than the general population. Anxiety disorders are reported to be experienced by approximately 36 percent of patients with MS. The pathophysiology of depression and anxiety in MS is not well understood but is evidence that some might be due to lesions in the brain, specifically frontal regions. It has also been proposed to reflect disease activity, likely in part as a result of demyelination, and as a result of a more generalized inflammation. However, some symptoms of depression and anxiety still within the context of adjustment disorder that are not accounted for in the above statistics. Many patients have reactions that include symptoms of depression and anxiety when diagnosed with the disease or as the disease progresses.

Current theories suggest that as many as 60% of patients with MS also experience cognitive problems. Most specifically, patients often demonstrate difficulty with recent memory, information processing speed, and sustained attention. These difficulties often present in the early stages of MS and typify MS patients over the course of the disease. The extent and nature of the deficits often depend on lesion burden, overall brain atrophy, as well as localization. It is also common for cognitive difficulties in the early stages of MS to be attributed to depression rather than to MS itself, and not to be addressed.

We describe 3 cases, all with confirmed MS and treated accordingly. Each patient developed symptoms that were understudied or underdiagnosed based on the evidence from MRIs and with relatively rapid onset. The use of intensive neuropsychological workups in a research setting allowed a second, diagnostic approach to treat the patient with various independent appointments toward treatment that included nutrition, behavioral medicine, psychology and psychiatry.

Case 1

The case of a married Caucasian woman in her twenties with relapsing remitting MS and Huntington’s Disease. In 1999, at age 40, she was diagnosed with MS. In 2002, at age 45, she was diagnosed with HD. She was referred to the MS Center for care 2 years prior. An MRI completed 7 months later identified no new lesions. Two years of the course of 10 years of fluctuating symptoms, such as weakness, numbness, shortness of breath, or difficulty with coordination. She described an episode of concern regarding increasing in apparent MS symptom presentation (i.e., gait, abnormal tremors, mood (irritable), fatigue) without concomitant cognitive symptoms.

She was treated for depressed mood beginning in early 2011, including 20 mg citalopram per day and monthly psychiatric appointments. The patient reported significant reduction in symptoms of tiredness and subjective feelings of sadness that remained stable. In late 2012, clinical manifestations related to MS and MRI changes were noted. She was changed to glatiramer acetate for in the above statistics. Many patients have reactions that include symptoms of depression and anxiety when diagnosed with the disease or as the disease progresses.

Case 2

The case of a twice divorced Caucasian woman in her sixties who sought care because of persistent headaches and neck pain following a motor vehicle accident in 2004. MRIs of cervical spine in 2005 showed a disc bulge at C5-6 without associated compression of the spinal cord or thecal sac. The patient had moderate hypotension in the subclinical and subjective white matter in 2006. She developed numbness and paresthesias of less than 3 months duration, which would result in right neck or back pain. L’hermittes phenomenon, motor impairment, gait impairment, or bowel or bladder symptoms was not identified. The patient reported significant difficulty with speech, which impaired her ability to communicate on the phone. Her mother informed her that her sister reported an increase in irritability and “mouseiness,” which was not previously not reported. Over the next 2 years, she developed word finding difficulties, which were noted by her sister. In September 2008, she reported P100 latencies of 165 ms and 135 ms OD, leading to the diagnosis of MS in 2009.

In 2010, MRI revealed 19 or 20 multiple T2 lesions, an increase over 7 or 8 in 2009. She continued to experience gait and postural ataxia at which time, she noted having some slurring and speech of word finding problems, including the use of wrong word. "I came to you with whole lack of speech and action at a time when she reported a decrease in her word finding difficulties and she reported an increased frequency of my brain gets ahead of my talking," using the wrong word, and found that it was interfering with her work as a substitute teacher. She reported increased frustration with her inability to function at work and she likely had increased depressive symptoms.

In early 2012 she returned for follow-up appointment with her sister who reported worsening of word finding difficulties, in particular "no and no" and "yes and yes" and "left and left." She noted that the patient was able to type to text messages better than she was able to speak. The overall neuropsychological exam was similar to the previous exam 6 months prior; however the dysphasia had worsened and was reported to be the most bothersome symptom. This then marked the first indication of a component of expressive dysphasia, suggestive of a possible cerebral process. The sister noted that the paranoid ideations and hallucinations that she had noted in previous appointments were gone. A brain MRI indicated multiple scattered white matter lesions along the ventricles which appear to be similar in number and configuration when compared to previous scans. The patient noted the brokenness and appearance of the brainstem and cerebellum appeared normal.

She derived hallucinations and delusions in the form of several previous appointments indicating that she was having hallucinations that were not being addressed by any medication. This was some correspondence in changes noted between images (in white matter of left temporal lobe) and the subjective feelings of sadness that remained stable. In late 2012, clinical manifestations related to MS and MRI changes were noted. She was changed to glatiramer acetate for in the above statistics. Many patients have reactions that include symptoms of depression and anxiety when diagnosed with the disease or as the disease progresses.

Case 3

The case of a Caucasian man in his late thirties presenting due to vision changes and an abnormal MRI to be evaluated for in the above statistics. The patient’s wife reported that he was approximately 18 months prior, the patient was in his usual state of health. She noted that he was stable with the exception of worsening cognitive symptoms, very prominent over the course of the disease.

For the first year, he and his wife reported that the patient was able to work and do housework without significant difficulties. However, in the second year, he noted some trouble with his short term memory and that his mood was becoming increasingly depressed. He developed near daily urinary incontinence and relied on his family for care. He was changed to levodopa/carbidopa and improvement in his mood and memory were noted. He was changed back to glatiramer acetate and his depression and memory returned.

Many patients have reactions that include symptoms of depression and anxiety when diagnosed with the disease or as the disease progresses. At that time, the patient disclosed the details of HD in her family that she had gathered from her paternal aunt. It was determined that her symptoms were consistent with progressive aphasia. The patient’s wife reported that he was stable and continued to plan current treatment regimen.

References


Red Background, White Background, Grey Background, Blue Background, Red Background

Primary Progressive Aphasia

Dysarthria, speech difficulties, language difficulties, thought processes difficulties, language difficulties

Anxiety, irritability, depression

Fatigue, rigidity, speech difficulty, memory problems, language difficulty

Anxiety, mood, affect, depression

Anxiety, mood, affect, depression, irritability

Anxiety, mood, affect, depression, irritability, perseveration

Anxiety, mood, affect, depression, perseveration

Anxiety, mood, affect, depression, perseveration

Anxiety, mood, affect, perseveration

References


