CASE REPORT

Cerebral Metastasis Masquerading as Late onset Depression- A Case Report

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ABSTRACT

A case of a 63 year-old woman with no past psychiatric illness presented with 5 months history of depressive symptoms but minimal neurological signs and symptoms is discussed. She met the ICD-10 diagnostic criteria of depressive disorder. Chest radiograph revealed a radio-opaque lesion and CT scan brain showed a large frontal lobe mass that was neurologically silent. This case demonstrates that intracranial metastasis can manifest as late onset depression without significant accompanying neurological deficits.

INTRODUCTION

Metastasis to the brain is the most feared complication of systemic cancer and the most common intracranial tumor in adults. The incidence of brain metastasis is rising with the increase in survival of cancer patients. Approximately 40% of intracranial neoplasms are metastatic. Multiple, large autopsy series suggest in order of decreasing frequency that lung, breast, melanoma, renal, and colon cancers are the most common primary tumors to metastasized to the brain.1 Metastatic spread to the brain occurs through blood circulation occurs mostly via arterial circulation; less often, it occurs via the Batson venous plexus (pelvic and GI tumors). Most metastases are round, well-demarcated lesions located at the junction of gray and white matter.2 Cerebral tumors presenting with symptoms of raised intracranial pressure, focal neurological signs, or epileptic seizures are usually first seen by neurologist or neurosurgeons. Rarely, psychiatric symptoms may be the initial presenting features in patients with brain metastasis.

The case was brought by relatives to see the psychiatrists because of the patient's psychiatric symptoms.

CASE REPORT

A 63 years old illiterate female from rural background presented to psychiatric OPD with features of lack of sleep, sad feelings, decreased social interaction, feelings of hopelessness and suicidal thoughts for past 5 months. She also reported of gradual onset of forgetfulness for the same period. Patients relative also reported that she talks irrelevantly sometimes for past few days. Past history of the patient did not reveal any significant psychiatric problems or any mental illness in her family. There was no history suggestive of DM/HT/TB/Cardiac problems/ thyroid disorder. Her illness was followed after she lost money in business and had constant family problems in the past 2 yrs. She was a chronic smoker for many years but discontinued for many months.

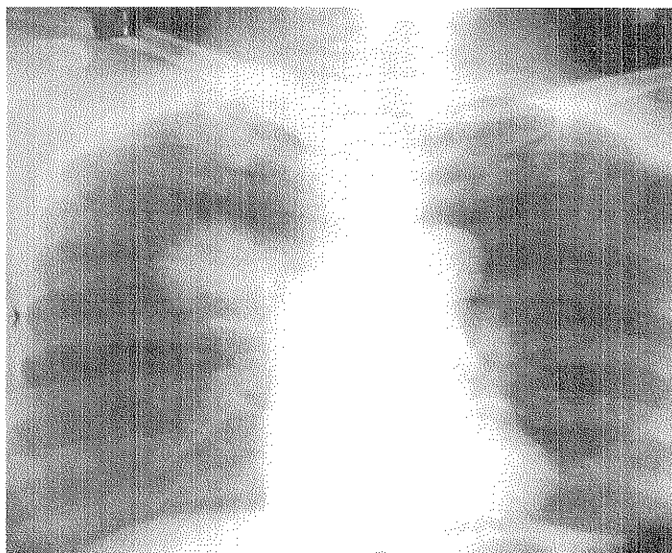

Figure 1. PA View Chest X-Ray showing a radio-opaque lesion on right upper lobe of lung.

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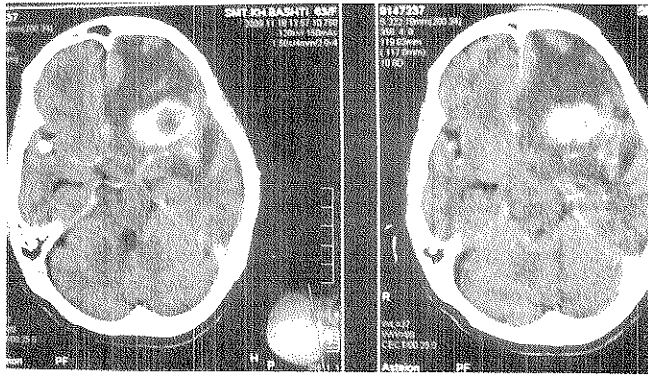

Figure2: A round, cystic space occupying lesions with central hypodensity, perifocal edema, mass effect in frontal region.

Details physical and neurological examination did not reveal any significant findings. On MSE, she was found to be conscious, oriented, depressed mood and speech occasionally irrelevant but coherent. On the basis of positive clinical history, depressed mood and intact cognitive function in MSE which was precipitated by stressors before illness, we initially diagnosed the case as "Severe depression with psychotic features"

After she was diagnosed as depression, we initiated Escitalopam 5mg, antipsychotic Olanzepine 5 mg. Her condition was deteriorated further within next 2 weeks and she did not show any signs of improvement with the above treatment rather she complained of sudden onset of weakness on right side of body with difficulty in walking. She was readmitted again for proper evaluation and management.

All the routine investigations like Blood R/E, LFT, KFT, and RBS were within normal limits. Chest X-Ray revealed a mass occupying lesion on the right side of Chest. The patient was referred to Radiotherapy Dept for opinion. The USG whole abdomen and USG of B/L Breast advised and reports were found to be normal except Rt. Renal cortical cyst. CT scan brain showed solitary metastatic lesion in left frontal lobe. The final diagnosis was made as lung carcinoma with intracranial metastasis. The patient was finally shifted to Dept. of Radiotherapy for further management.

Discussion

Lung cancer has the greatest predisposition for brain metastasis, the predominant type of intracranial neoplasm found in adults. Approximately two thirds of brain metastases are symptomatic at some point. Symptoms primarily are caused by 1increased intracranial pressure resulting in headache, nausea, vomiting, confusion, and lethargy and 3focal irritation or destruction of neurons resulting in hemiparesis, visual field defects, aphasia, focal seizures, ataxia, and other focal neurologic signs or deficits.

Suriya A & Anand (2008)4reported that Lung cancer frequently causes neurological complications from direct and indirect effects and brain metastatic tumours may be associated with a greater incidence of mental problems than primary tumours and may be probably due to tumours being scattered throughout brain substance. Similar findings is also been reported by Michael L. Pearl et al5 (1998) who demonstrated that majority of the patients with brain metastases may present with neurological symptoms but a minority may develop psychiatric symptoms.

The clinical manifestations of intracranial lesions are generally dictated by the location of the metastases. Increased intracranial pressure and mental changes are symptomatic of a frontal metastatic lesion, visual field defects and cortical blindness are indicative of an occipital metastasis, motor weakness suggests a front parietal lesion, and a cerebellar metastasis may manifest itself as ataxia or symptoms related to hydrocephalus.

Madhosoodanan et al. (2006)6 also reported psychiatric symptoms as a initial presentation in case of brain tumour and similar findings are also reported by other authors. In our case, the patient initially presented with depressive symptoms like sad feeling, sleep disturbances, hopelessness, suicidal ideation precipitated by a stressor and since patient did not have any abnormality in either positive and deficits in neurological examination, we thought this a case of clear cut depression without any organic origin.

Manic symptoms in a case of small cell carcinoma of the lung with ectopic adrenocorticotropic hormone (ACTH) production have been reported 8 but few others are found only neurological symptoms in a case of brain metastasis in case of lung carcinoma.9

Neuropsychiatric symptoms like cognitive impairment, impaired memory for recent events, nominal aphasia may be present in case of cerebral tumours and clinical neurological examinations sometimes generally unremarkable with no evidence of focal signs or features of raised intracranial pressure. The factors contributing to the psychiatric symptomatology of cerebral tumours are raised intracranial pressure, location of the tumour, nature of the tumour and the individual constitution and response of the patient.10

This case demonstrates that intracranial metastasis can manifest as late onset depression without significant

accompanying neurologic deficits. Therefore, clinician should conduct extensive investigations for each and every patient who presents with such symptoms especially in old age. It is also suggested that thorough and systematic physical, mental status examination is necessary in every patient with late onset of mental problems to prevent lapse in diagnosis and delayed treatment which has potentially serious consequences. Appropriate intervention may improve the patient's prognosis and quality of life, hence early and accurate diagnosis is crucial.

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BOOK REVIEW

Transformative Tales: How Stories Can Change People

Parkinson, R. *London:* Jessica Kingsley, 2009, 327 pp. Pb £17.99

'There is one story, and one story only / That will prove worth your telling,' wrote the poet Robert Graves. He was referring to the idiosyncratic mythology of *The White Goddess*. In this story, crystallised from his fabulous 'grammar of poetic myth', Graves avows the eternal feud between the God of the Waxing moon and the God of the Waning mood who compete yearly for the favour of the Goddess. Each successively wins the Goddess only to be eventually betrayed by her and supplanted by the other. Rob Parkinson would not agree with this reductionist notion, nor Jungian archetypes, nor the work of Northrop Fry (1957), nor the current manifestation of this general point of view, popularised by Christopher Bookers (2004). *Seven Basic Plots*, that all the multitudinous stories available world-wide are reducible to a single pattern, or numerous archetypes, or in Brooker's case, just seven basic plots. He appears to despair of any such Procrustean chopping up of stories to fit with systems or formula.

Transformative Tales, as the subtitle suggests however, does not see stories as mere forms of entertainment that must never be formulised or theorised. The author views stories as invested with therapeutic potential: 'story metaphors can be used as powerful instruments for inspiring change' (18), and 'present an important means of overcoming limitations and developing personal autonomy' (31). Underlying this view there seems to be a desire to display the author's rich explorations into the traditions of storytelling. Though he claims to be merely presenting 'a primer in the language of story' and not, as it were, the storytellers worldview, 'the philosophical and mystical traditions that have used stories for centuries' (20), Parkinson cannot resist dangling these traditions before our jaded Western eyes.

Despite the confusions of intentionality, the author manages to squeeze in an incredible amount of interesting material into the book's 336 pages. After chapter one's discussion of the inherent story making tendencies in human nature, the author moves on to a chapter long-handbook on guided imagery and visualisation and describes its positive effect upon sufferers of post-traumatic stress disorder. Next Parkinson sets out the business of telling stories, defining their distinct, if dubious categories, how they are constructed, and how to harness the psychological dynamics between teller and audience. Chapter four describes the main traditions of storytelling and a little about traditional storytellers, for example, the Irish *seanachie*, the Celtic *filidh*, French minstrels (the *jongleur*, literally juggler), the Moroccan *rawi qissas* and the tribal shaman. The next chapter, 'Marvellous Miniatures' explores brief story types and includes maxims, aphorisms, analogies, parables and vignettes. Here Parkinson also includes allegories and satires, a curious choice given the length of the better known such as *Gulliver's Travels* and *Pilgrim's Progress*. For the remaining twenty pages of this chapter Parkinson turns rather abruptly to 'reframing' stories, stories which can shift the often static frame through which we view our experience, a technique he had first mentioned on page 28! Chapter six returns to theoretical issues as the author illustrates how stories interact, change and develop. But first Parkinson attempts to disentangle stories from Jungian archetypes and Richard Dawkins tedious evolutionary 'memes'. This section marks a happy moment of acceleration in which the author gives way to the brief 'flow' of impassioned thought and feeling about his subject. This leads more logically to a technical section about transposing stories from one situation or culture to another.

The final chapter is symptomatic of the text as a whole. Rather worryingly in a last chapter of a book about stories, it begins with an exploration of symbols and metaphors including a breakdown of five traditional symbols. The material here is fine, but seems redundant by this stage. There is no marked out conclusion to *Transforming Tales* as such, and this chapter ends in a coda using three interwoven stories. But there are what I took to be concluding remarks made on pages 301-2 for the interested reader.

To compare *Transformative Tales* with other work about therapeutic stories, for example the work of Alida Gersie, seems unfair. What Parkinson lacks in formal structure and theoretical strength – qualities clearly found in Gersie's work – he makes up for through his lively and engaging style. The book does contain moments of depth and brilliance, and the author is incredibly generous with his

knowledge of stories and how they work. The reflective reader will learn a good deal about themselves as well as the subject. On the other hand Parkinson's book is hopelessly muddled. He presents a theoretical case for the potential of stories to effect change in the listener, and he illustrates his points using a dazzling variety of stories from around the world. The argument is dressed in modern clothing, especially utilising the *Human Givens* approach, as well as research on dreaming, trauma and neurology. In regard to the function of dreaming for example, though the author differentiates his approach to that of Freud, it does not seem substantially different to the old notion of wish fulfillment:

...strange stories in dreams can be traced to emotionally arousing introspections occurring specially during the previous day's experience – arousals that remained essentially unresolved since they didn't lead to actions. In other words, dreams reflect unfulfilled expectations. (47)

Since he wishes to inhabit the similar ground as psychotherapists, but, of course to inhabit it in a very different way, Parkinson occasionally adopts a critical stance towards the profession. On page 78, he gives an extreme example of psychoanalytic interpretation, where the therapist is quizzing the patient about why she chose a particular seat in the waiting room. Parkinson asserts: 'This kind of spurious "psychologising" and covert domination is what many people mistrust in the therapy/ counselling industry'. He would not then agree with Camille Paglia (1992) who suggested that every thought bears some emotional burden: 'Had we time or energy to pursue it, each random choice, from the color of a toothbrush to a decision over a menu, could be made to yield its secret meaning in the inner drama of our lives' (26). There are more unresolved interactions with psychodynamic approaches. Pakinson hi-lights the link between hypnosis and the trance-state which he believes can be induced by listening to stories. He is not the first writer or storyteller to suggest this, but it is interesting to view his argument in relations to Freud, who is regularly accused of going too far in the art of persuasion. The point is that Freud himself abandoned hypnosis in favour of free association because, while the patient was susceptible to suggestion and open to change in a trance-state, they were not enough in control, the executive self, the ego, was in abeyance and consequently change could not be consciously owned.

However, the main difficulty with *Transformative Tales* is that the author has not sufficiently worked out what the book is intending to do. Is it making a case for the centrality and necessity of stories in human life, is it a theoretical argument about how stories work therapeutically upon the individual, is it a manual for would-be story tellers or, finally, is it a collection of tales? As the author puts all of these chicks into the same nest it becomes difficult to deduce the species of the mother. The situation could have been rescued with a little re-structuring. The history and nature of storytelling and the case for its therapeutic potential needed to be drawn properly and cohesively together into sustained argument which might then be lightly peppered with relevant story examples. Unfortunately the author's overuse of this pepper means we don't properly taste the food he offers us however good it may be. After a clear section on technique (with relevant examples) if a final section collected the majority of the stories the author introduces then we would have a vastly more memorable account which the student or professional storyteller could easily use.

Having said this, I imagine that many professionals will enjoy this book, and if you are happy to just go along with the author, to follow his wayward tale, then his not inconsiderable knowledge of both tales and telling will repay you generously for the ride.

Chris Nicholson

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BOOK REVIEW

Children and Adolescent in Trauma: Creative Therapeutic Approaches

Edited by Chris Nicholson, Michael Irwin and Kedar Nath Dwivedi; ISBN: 978-1-84310-437-7, Jesica Kingsley Publishers, UK, 2010, Pages: 251

Trauma in the formative years of life often leads to deleterious consequences. Effective treatment of traumatized children and adolescent is of paramount importance. A mental health professional must be equipped with special expertise to deal with this problem. To work with traumatized children and adolescent is difficult. It is often a team work incorporating different approaches. A professional in isolation will not be able to offer effective services to these group of people. When a traumatized child, feels that he has no control of a situation, he will predictably get more symptomatic. If a child is given some choice or some element of control in an activity or in an interaction, he will feel safer, comfortable and will be able to feel, think and act in a positive way. The book "Children and Adolescent in Trauma: Creative Therapeutic approaches" offers insight into this baffling subject.

The editor of this book, Chris Nicholson, is a lecturer in the Centre for psychoanalytic studies at the University of Essex. Nicholson has vast experience of working in a range of Children's service. Michael Erwin is Emeritus Professor of English at the University of Kent. Kedar Nath Dwivedi is a visiting professor at the London Metropolitan University and Director of the International Institute of Child and Adolescent Mental Health. Formerly he served as a consultant child psychiatrist at Northampton General Hospital. The contributors of this book also include psychotherapist, psychiatric nurse and manager of in-patient adolescent unit and art therapist. So, the vast experiences of these professionals working with traumatized children are put together in this comprehensive book.

The book consists of thirteen chapters written by eight different authors. For the benefit of the reader there is an introduction followed by five main parts- Trauma, Story, Self-harm, Art Therapy and Violence. Each topic is discussed in different chapters so that the reader can smoothly understand the subject. The authors described the concepts that relate to psychodynamic and therapeutic community principles through story, art, film and biography and case studies

This book provides a new approach to understanding traumatized children and adolescent and highlights a variety of creative therapeutic approaches for this group in different residential settings – children's home, secure or psychiatric units and special schools. The approaches include art therapy, literature and story telling. The authors explored how creative methods are applied in cases of abuse, trauma, violence self-harm and identity development. The authors discussed the impact of abuse and maltreatment on mental health drawing links between psychoanalytic theory and practice and study of literature and the arts. The potential of using the creative arts such as film, biography, sculpture, painting, poetry and stories in training to convey psychoanalytic concepts to those working with traumatized children is stressed. The book may be used as a training material as most of the standard textbook on child and adolescent psychiatry cannot afford to discuss this topic in such a detail and pragmatic way. We would like to recommend this book to all busy practitioners who are dealing with problems of children and adolescents.

The contents of the book are clearly written. Chapter one describes the problematic nature of traumatic experiences, their effects and management. The second chapter stressed upon predictability of an ordered daily routine for traumatized young people. Using corollary from the biography and poetry the author described the early life traumatic war experience and subsequent post-traumatic stress disorder of the poet Robert Graves. Chapter three and four narrates neurobiology of trauma and the impact of trauma on brain development taking example from Hitchcock's film *Marine*. A range of treatment options like eye movement desensitization and reprocessing (EMDR) and their appropriateness is discussed. In chapter five Christine Bradley discussed early trauma from psychotherapist's perspective using analogy from children's story, *The Velveteen Rabbit*. In chapter six, Prof. K. N. Dwivedi from his vast experience of using stories within a group setting based on long tradition of story telling in

India explores how story telling can enable therapeutic change. Therapeutic benefit of story telling is supported by a number of fascinating stories. Chapter seven and eight deals with self-harm In these chapters Chris Nicholson shows how self-harm can also be seen as an attempt at recreating the self rather than self-destruction using case examples. Episodes of self-harm may be symbolic representations of early abusive acts. Chapter nine and ten provides an introduction to art therapy and its role in enabling traumatized young people to work through severely damaging life events such as neglect, violence and sexual abuse with striking case examples. In chapter eleven the factors implicated in childhood violence and how these children can be helped within a therapeutic community setting are discussed. In chapter twelve Chris Nicholson explores adolescent violence and its relationship with poor early attachment and parenting. The attachment theory is re-examined in this chapter using the children's poetry of A.A. Milne.

The intention of the editor to promote innovative and creative practice in working with traumatized young people is mostly successful. This book can also serve the purpose of training manual for the staff engaged in this work. This book will be of immense help for practitioners of various mental health traditions- social workers, psychotherapists, art therapists, psychiatrists, residential child care workers, teachers, counsellors, psychologists and students in these fields as well as parents, teachers and interested lay people. As the Editor hoped in the preface, we also expect that definitely the book will provide nourishment for all those who are working often without thanks and in very challenging circumstances, to provide therapeutic care and education for the troubled young people.

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BOOK REVIEW

Managing Anger

Edited by: B. Sujatha, G. Sushuma; ISBN: 978-81-314-1891-8, The Icfai University Press, Hyderabad, India, 2008, Pages: 223

"Holding on to anger is like grasping a hot coal with the intent of throwing it at someone else; you are the one who gets burned". Buddha

The natural emotion of anger if uncontrolled often becomes disastrous. At the same time this powerful emotion could be helpful and it can motivate people to succeed. In this competitive modern world everybody is under some kind of stress which often reduces their tolerance level. Anger irrespective of whether expressed outwardly or inwardly often lead to negative impact on the physical and psychological well being of the individual and it also affect the environment. So, anger management has become crucial. Anger management commonly refers to techniques and exercises by which someone with excessive or uncontrollable anger can control or reduce the triggers, degrees, and effects of an angered emotional state. Not to speak of the lay people even mental health professionals sometimes do not feel comfortable while dealing with cases of problems related to anger. This is because topic like anger management is not given adequate importance in the course curriculum of mental health.

In this compilation, the editor from management and commerce background embodied articles from various authors from diverse fields to cover mechanism of anger, its expression in various contexts, understanding anger and its causes, physical symptoms, strategies to overcome anger and anger management for different group of people.

This well-organized book is divided into three sections- "Understanding anger", "Managing Anger- Strategies and Techniques", and "Managing Anger: Specific Insights". The first section deals with what is anger, anger styles, causes and its effects with illustrative examples. There is an article on Shakespearean perspective on anger taking examples from the four great tragedies. The second section contains articles on managing anger using various tips and techniques- cognitive behavioral,rational-emotive behavioral therapy, meditative approach and multidimensional approach. This section also has an article on spiritual aspect drawing essence from Bhagavad Gita and other scriptures. The value addition from different sources of website containing signs of anger, cause for angry feeling, how to react to those feeling and suggestions of anger management activities has given the book a different format from the conventional book on similar subject. Definitely it will help the reader to have a better grasp on the subject and they can practice some of it in their life. The third section details anger management in marital and other relationships, children and at workplace.

The articles are already published in electronic and print media and the editor reprinted it with permission. The book is handy and useful not only for the general public but also for the mental health professionals. But the annexure on anger statistics is an overdose of information.

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BOOK REVIEW

Psychiatry: An evidence-based text

Edited by Basant Puri and Ian Treasaden; ISBN: 9780340950050, Hodder Arnold, London, UK, 2010, Pages: 1323

Rapid progress in the basic and clinical neuroscience in the recent years has led to information explosion. To keep oneself abreast of the recent developments in the related fields is a challenging task. The development in basic sciences has helped in better understanding of many clinical conditions. As a result of which clinicians are expected to deliver 'high quality cost-effective patient-focused care based upon best evidence available.' The book "Psychiatry: An evidence-based text" is likely to help the reader to achieve this goal.

This book attempts to provide an integrated overview of current knowledge of Psychiatry. The contributions from 84 authors, some of whom are acknowledged international leaders in their respective fields and pioneer in shaping psychiatric research and practice, are complied in this evidence based text book.

Evidence-based medicine (EBM) is defined as the process of systematically finding; appraising and using contemporaneous research data as the basis for clinical decisions1. The debate for and against evidence based practice is still going on. There has long been a tension between research and clinical practice, which are viewed respectively as inhabiting 'an ivory tower' and 'the real world'. EBM seeks to remedy this by joining research to best clinical practice2. It emphasizes the importance of sound scientific methods and the use of the best available information, generally that derived from well-designed and carefully interpreted research studies. The evidence-based approach de-emphasizes intuition and unsystematic clinical experience applied without integrating empirical evidence. Treatments should not be whimsical, neither should they be driven by fashion, tradition or advertising. Perhaps the most compelling reason to adopt an evidence-based approach is an ethical obligation to support patients and families in making informed choices about medical decisions3. Rapid advancements in information technology have facilitated the development of evidence-based medicine. A clinician can now swiftly extract information relevant to a clinical question. At the same time to get rid of unwanted information is becoming a major concern in this era of information explosion. This text book has made the task much easier. Though the text book is based on the syllabus of MRCPsych in UK and Ireland , this book will be useful for trainees of psychiatry elsewhere. Basic sciences related to psychiatry e.g. Research methodology, epidemiology, psychology, neuroanatomy, neurophysiology, neuroendicrinolgy, neurochemistry, neuropathology, neuroradiology and genetics are presented in a succinct manner in the initial chapters. Clinical disorders and their various modalities of treatment are described comprehensively emphasizing the evidence underlying theory and practice. Though the book is written for the trainees of MRCPsych, but it will be useful for all students of psychiatry and allied disciplines around the globe as well as for consultant psychiatrist for ready reference.

The book is thoughtfully divided into 79 chapters under 8 parts for better organization. Chapters are standardized and cross referenced and it includes important and up to date references. The generous use of tables, figures, boxes and pictures has made the book reader-friendly. The major learning points at the end of the chapter will help the students for recapitulation. Though the chapters are written by a galaxy of authors, the overlapping in content is negligible. But contents of few chapters suffered for preference of brevity for which it may not fulfill the expectation of some readers and they have to consult some other source for detail. The chapter on Risk assessment is helpful for all clinician. Topics like assessment of disability and rights of mentally ill are totally ignored. In a nutshell it is true that the editor succeeded in the attempt to provide the sound foundation of

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evidence- based theoretical knowledge required for psychiatric practice.

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Types of manuscripts and word limits

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Text of the Article

In **Introduction**, the purpose of the article and rationale for the study or observation should be summarized. For case reports incidence of similar case in the past should be given. Describe the selection of the observational or experimental subjects clearly in **Patients and Methods** section. Identify the age, sex and other important characteristics of the subjects. Identify the methods, apparatus (give the manufacturer's name and address in parentheses) and procedures in sufficient detail. Give references to established methods, describe new or substantially modified methods, give reasons for using them, and evaluate their limitations. Identify precisely all drugs and chemicals used, including generic name(s), dose(s) and route(s) of administration.

When reporting experiments on human subjects, procedures followed should be in accordance with the standards ethical committee on human experimentation. Do not use patient's name, initials or hospital numbers especially in illustrative material. Present the results in logical sequence in the text, tables and illustrations. Do not repeat in the text all the data in the tables or illustrations; emphasise or summarise only important observations. Emphasise the new and important aspects of the study and the conclusions that follow from them along with implications of the findings and their limitations in the **Discussion** section.

References

For Reference, Vancouver pattern should be followed. The titles of journals should be abbreviated according to the style used in *Index Medicus*. Avoid using abstracts, unpublished observations and personal communication as references.

Tables and figures

This should be self-explanatory with no duplication of textual material. Tables with more than 10 columns and 25 rows are not acceptable. Limit the number to minimum required. The table/figure should be numbered in Arabic numerals (not in Roman), consecutively in the order of their first citation in the text and supply a brief title for each.

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