INTRODUCTION

Generalized and persistent fatigue or tiredness is a common problem that is seen across multiple diagnostic entities, e.g., depression, somatoform disorders, and sleep disorders. Patients having depression with somatic symptoms rarely report classical symptoms of depression. In addition, sleep disorders are frequently missed because of limited awareness. We are presenting a case that presented with a 30-year long history of tiredness and fatigue and was given multiple antidepressants. However, he did not improve till the time sleep disorders were diagnosed and treated.

CASE REPORT

A 58-year-old male shopkeeper, on antihypertensive for the last 2 years, without any contributory family or past history, presented with complaints of persistent and slowly but progressively worsening fatigue for the last 35 years. He recollects being quite energetic up to his 20s, when he noticed the insidious onset of fatigue leading to limitation of functional capacity. It did not show diurnal variation; it was generalized and did not have a history of weakness or exertional dyspnea. Consultation to faith healers did not bring relief.

Over the years, he started feeling tired even after trivial activities. He complained of generalized aches in the body, mostly after mild exertion, which would not be persistent. He was distressed about his ever-tired body. There have been times when he felt hopeless because of nonremitting situation and hoped that death would end his agony. He has complained of frequent episodes of flu-like symptoms, for most of the time in a year, for the last 4–5 years. In the last month, he reported a delay in sleep initiation by 2–3 h and persistent nonrefreshing sleep. Sleep schedule and sleep hygiene were normal with a total sleep time of 8–9 h/day and subjective sleep efficiency of 89%. However, bed partner reported occasional snoring. Substance use disorder, neurological disorders, and chronic inflammatory disorders were ruled out. Treatment history showed escitalopram up

Key words: Depression, fatigue, limb movements, sleep

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to 20 mg/day, venlafaxine up to 300 mg/day, clonazepam up to 0.5 mg/day for the optimal duration at different time periods without any improvement and amlodipine 5 mg/day for hypertension.

General physical examination and neurological examination did not reveal any abnormality. Craniofacial examination depicted slender jaw, high-arched palate, crowding of teeth, and mild retrognathia. Body mass index was 25.3 kg/m$^2$ and neck circumference was 14” Based on the history and clinical examination, the diagnosis of chronic fatigue syndrome with obstructive sleep apnea (OSA) was made. The score on the fatigue severity scale was 60 and on the insomnia severity index was 13. Routine laboratory examination, serum thyroid-stimulating hormone, glycosylated hemoglobin, and serum ferritin were within normal limits.

Overnight video synchronized polysomnography was planned to assess the reasons for chronically nonrefreshing sleep [Table 1].

Based on polysomnography findings, the diagnosis was revised to periodic limb movement disorder (PLMD) with supine position-dependent OSA with systemic hypertension. Antidepressants were discontinued, tablet ropinirole 0.25 mg at night was started, and weight reduction was advised. Amlodipine 5 mg was continued. He was followed up at interval of 4 weeks up to 36 months that showed progressive and clinically significant improvement in fatigue, mood, sleep quality, and working capacity.

**DISCUSSION**

This case depicted that PLMD and OSA can present with fatigue and somatic symptoms that may be mistaken for major depressive disorder,$^{[3]}$ PLMD is characterized by the recurrent limb movements during sleep that are seen during overnight polysomnography and are often associated with microarousals. Similarly, sleep apnea events are also often associated with recurrent microarousals[Figure 1].

These microarousals worsened the quality of sleep and lead to fatigue during the day.$^{[3]}$ The severity of fatigue and daytime sleepiness usually correlates with the periodic limb movement index, i.e., higher the index, higher the disability. Although at present no treatment is recommended for PLMD, considering its pathophysiological overlap with restless legs syndrome, dopamine agonists may be effective.$^{[4]}$ Ropinirole has been found to improve depressive symptoms in patients with restless legs syndrome.$^{[3]}$ In the present case, ropinirole 0.25 mg at bedtime reduced the daytime fatigue and tiredness and improved sleep quality as well as mood.

OSA can also add to daytime fatigue, but in this case, it was limited to rapid eye movement sleep and supine position only. Hence, weight management was initiated and the patient was kept in follow-up.

In summary, in patients presenting with symptoms of depression and somatoform disorders, sleep should be carefully assessed.

**Declaration of patient consent**

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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**Conflicts of interest**

There are no conflicts of interest.

**REFERENCES**

1. Stadje R, Dornieden K, Baum E, Becker A, Biroga T, Bösner S, et al. The differential diagnosis of tiredness: A systematic review. BMC Fam Pract 2016;17:147.

2. Tylee A, Gandhi P. The importance of somatic symptoms in depression in primary care. Prim Care Companion J Clin Psychiatry 2005;7:167–76.
3. American Academy of Sleep Medicine. International Classification of Sleep Disorders. 3rd ed. Darien, IL: American Academy of Sleep Medicine; 2014.

4. Aurora RN, Kristo DA, Bista SR, Rowley JA, Zak RS, Casey KR, et al. The treatment of restless legs syndrome and periodic limb movement disorder in adults—An update for 2012: Practice parameters with an evidence-based systematic review and meta-analyses: An American Academy of Sleep Medicine Clinical Practice Guideline. Sleep 2012;35:1039-62.

5. Benes H, Mattem W, Peglau I, Dreykluft T, Bergmann L, Hansen C, et al. Ropinirole improves depressive symptoms and restless legs syndrome severity in RLS patients: A multicentre, randomized, placebo-controlled study. J Neurol 2011;258:1046-54.