Case Report

Depression in Acromegaly Treated with Escitalopram and Cognitive Therapy

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ABSTRACT

Depression is one of the commonest disorders encountered in general hospital psychiatry. Acromegaly is a condition with excessive growth hormone secretion that may at times present with oversychopathology. We present the case of a 33-year-old lady with depression and acromegaly that successfully resolved after treatment with escitalopram and cognitive therapy.

Key words: Acromegaly, depression, escitalopram

INTRODUCTION

Acromegaly is a syndrome seen in adults due to excessive production of pituitary growth hormone as a result of an adenoma or hyperplasia of the eosinophilic cells of the anterior pituitary gland. The main clinical features of acromegaly are skeletal overgrowth affecting the hands, feet, and skull along with spinal deformities like kyphosis. Hypertension, hypogonadism, and diabetes mellitus are also commonly seen. The interface between psychiatry and endocrinology is well documented and psychiatric problems in various endocrine disorders are well known. Psychiatric issues in acromegaly have been addressed sparsely and no systematic studies exist for the same, though anecdotal case reports are present in literature.

Case reports have documented depressive symptoms with acromegaly. One case depicts pure depression with acromegaly, while another reports the presence of depression with pathological gambling. Other psychiatric symptoms like Schneiderian first-rank psychotic symptoms, persecutory delusions, visual and auditory hallucinations, apathy with lack of motivation and mood swings have all been documented in acromegaly. Depression with psychotic symptoms have been shown to be present in an isolated case. In all the cases, response to various medications used has been excellent bringing about a reduction of symptoms.

One study on 12 patients with acromegaly failed to prove a relationship between psychopathology and growth hormone levels, while it did mention a sexual dichotomy with 11 patients being female.

CASE REPORT

A 33-year-old lady from middle socioeconomic class presented with depressed mood, loss of appetite, lack of sleep at night, inability to concentrate on her day-to-day activities, and occasional passive suicidal themes in her thoughts. The onset of symptoms was since three months without any precipitating factors. The patient had good insight and was well oriented with intact memory. Social withdrawal and preference of solitude was also reported. There was no history of any substance abuse or suicidal attempt. No history of any prior medical disturbance or menstrual problems was reported. The patient had a similar episode three years ago and had responded well to Sertraline. The symptoms had remitted within six weeks of starting the medication.
The patient’s father had a history of depression with psychotic features and during his hallucinatory episodes had committed suicide by jumping into a well. The father was untreated for many years. The patient on examination had all vital parameters as normal. Facial features suggesting acromegaly prompted us to get an endocrine opinion. The facial features noted by us were prognathia of the mandible, enlargement of the supra-orbital ridges, enlarged facies, and macroglossia. She also had large hands and feet.

On testing after endocrine consultation, the patient had a high fasting blood sugar of 185 mg% while post lunch blood sugar was 210 mg%. Serum prolactin was within normal limits. No visual field defects were noted on ophthalmic examination and perimetry. The level of growth hormone was 7.2 ng/ml (normal 0.04–4.5 ng/ml). Radiological examination revealed hand and feet characteristic of acromegaly. No kyphosis was present. An MRI revealed enlarged pituitary gland and a large frontal sinus. The optic chiasma was normal. A CT scan revealed an enlarged sella turcica and a thickened skull with pituitary enlargement.

The patient was started on escitalopram 10 mg/day with Zolpidem 10 mg at night for depressive symptoms. The patient was also called weekly for cognitive therapy sessions where suicidal and negative thoughts would be addressed. The patient started responding showing a 20% improvement in the first week itself with 80% symptom reduction at the end of four weeks. The patient was to undergo treatment with the endocrinologist for acromegaly but was noncompliant and did not follow-up after the fifth week. During the five weeks of clinical observation, improvement was 80% with no worsening of acromegaly symptoms. The patient was started on human insulin and her diabetes was brought under control.

**DISCUSSION**

This case adds to anecdotal case reports of acromegaly of depressive symptoms. Response was very good to escitalopram and cognitive therapy. Her insomnia was relieved by Zolpidem at night. It was difficult to label the depression secondary to her acromegaly as the endocrine features did not bother the patient and were detected by us. A strong family history of depression with psychotic features and suicide of her father may have contributed to her depression. Our limited knowledge and lack of data on the relationship between depression and acromegaly makes it very difficult to comment on any associations.

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Source of Support: Nil, Conflict of Interest: None.