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DEPRESSION AND HYSTERIA AS SYMPTOMS OF BRAIN TUMOR

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CASE REPORT

This report involves a 38 year old female patient who was initially diagnosed as having a depressive and hysteric reaction and subsequently was found to have a brain tumor.

The patient was first seen here in January 1962, at which time her major complaint was one of nervousness. She had been feeling nervous for about a year and unable to sleep at night. She also had dysmenorrhea. She denied any other symptoms. After being given a tranquilizer she was sent home. She was not seen again at this hospital until May, 1965, at which time she came to the Emergency Room complaining of nervousness and weakness which had been present for three months. Mild light headiness had developed as her condition worsened.

The examination, including the fundi, was normal. She was discharged with the diagnosis of anxiety reaction and an appointment was made for a complete physical examination.

On June 17, 1965 she had her physical examination, at which time she had complaints of weakness, fatigue, headaches, dizzy spells and cold distal extremities. She complained of her “nerves” being worse for the past two weeks. She felt somewhat depressed and was doing less of her housework than she had done five to seven weeks previously. She seemed disinterested, somewhat lethargic and forgetful. The physical examination was within normal limits except for a mild suggestion of right nasolabial fold flattening. The fundi were normal. The reflexes were normal. She was considered to have a neurotic depressive reaction and was placed on Elavil, 25 mgs. t.i.d. and asked to return in ten days.

She returned complaining of fatigue and said that the Elavil made her dizzy. A psychiatric consultation was suggested. The Elavil was discontinued and Ritalin was initiated. On July 2, 1965 a neighbor called saying that soon after a dose of Ritalin the patient felt numb and weak and had a “loss of memory for a while.” The following day the patient returned to the hospital saying that she had been unable to run the house for several days or make any decisions. She was somewhat anorexic, had difficulty sleeping and was crying. She had trouble deciding whether to stay or to leave but admission to the Psychiatric Service was considered urgent.
She remained on the Psychiatric Ward eight days and was discharged on July 11, 1965. She told the examining doctor on the Psychiatric Ward that she had headaches “in front and on top,” precordial pressure sensations, faintness, blurring and unsteadiness. She said these had started about two months previously with exacerbation during the last few days. There was no appetite disturbance but about a four pound weight loss. Her premorbid personality appeared to be that of a compulsive, somewhat dependent woman.

Past history indicated that she had been born in Poland and lived there through the Second World War and came to the United States in 1947 with her father and two sisters. She was the middle one of the three sisters. She spoke of the father who drank on occasion and who often argued loudly with his wife. She characterized the mother as a good housekeeper and quite nervous. The patient felt very close to her mother.

At the age of 21 the patient married a man ten years her senior after knowing him for about a year. He moved into the same home with the patient’s mother, father, divorced sister, and sister’s son. The husband indicated that he adjusted to the ménage and the situation did not bother him. He further indicated that his wife was a very fussy cleaner and she had to keep busy, constantly sewing in the evening when often he wanted her to take it easy. She had suffered from “being nervous” for many years. The patient’s attitude towards sexual relations was neutral and she took part in it out of duty.

The husband seemed to feel that things changed slowly since the trip they had taken about a year previously to Poland. The husband mentioned that his wife often kept a lot of things to herself. “She just keeps quiet like her mother.” She criticized him and became very upset if he took a drink. She admitted that his family in Poland upset her, especially one of the sisters who complained that not enough money was being sent back there. The living conditions here were such that the patient and her husband were alone only when they went away on weekends. The patient herself did not talk to neighbors and they rarely had company. She “liked to stay home.”

Mental status examination revealed an obese, slightly seductive, shy woman lying cuddled in bed, smiling occasionally, and speaking with a Polish accent. She complained that she couldn’t express herself clearly so she wouldn’t say anything. She understood what was told her although often she asked for repetition of the statement.

Her mood was slightly depressed. Her affect was appropriate. There was no psychotic content. She was placed on Librium, 5 mgs. q.i.d. and Pertofrane, 25 mgs. t.i.d. and was seen daily for psychotherapy.

She discussed some of her feelings about her family living with them and her behavior strongly suggested a hysteric reaction. It was noted by the personnel on the floor that her symptomatology at times included staggering to the right. This got much worse when her husband arrived or when other members of the family were
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present. She seemed to hang onto someone much more heavily when family members were present. She continued to operate like an "overgrown baby," with exaggerated responses of lethargy, slowness and with inappropriate smiles of a seductive nature. She offered the examiner a piece of candy every day with a sad smile, taught him some Polish words and jokingly attempted to spray him with perfume on one or two occasions. She stated that she was ready to go home after the hospital week and that she would be better. Her mood had become reasonably satisfactory. She still had intermittent staggering when she walked.

She was seen one week later. At that time her husband appeared more worried and said that she had been falling while walking. The gross examination after she staggered into the office revealed a negative Romberg sign. She said that on occasions she saw double and complained about being very sleepy. She was referred to Neurology for further evaluation. On July 26, 1965 she was seen in Neurology and the striking finding was papilledema. An intracranial-space occupying lesion was suspected. The skull films revealed an intact calvarian. The dorsum and posterior clinoids showed an abrupt flattening in the most superior aspect. There were also some erosive changes in the remaining portion of the posterior clinoids. The pineal gland showed no shift in midline structure. The impression was posterior clinoid erosion, probably due to a dilated ventricular system and indicating increased intracranial pressure.

A twist drill ventriculogram was performed. It showed evidence of a third ventricle tumor with extension to and obstruction of the aqueduct. The impression was that the tumor was a cranial pharyngioma. On July 28, 1965, a right frontal craniotomy with biopsy from the anterior portion of the third ventricle was performed and the pathological report was astrocytoma. On August 3, 1965, radiation of the central cranial zone was started. Twenty-three treatments in all were contemplated.

On 9/1/65, her Cobalt irradiation treatments were completed. On 10/5/65, she was able to walk without difficulty. The papilledema was not evident. Reflexes were equal and symmetric bilaterally. She had very few headaches and her vision was good. She was performing well at home taking on more chores and was having only occasional problems with her memory.

A case has been reported which showed symptoms appearing initially to need psychiatric intervention, but which subsequently turned out, at least in part, to be the results of an intracranial lesion. This lesion influenced behavior which mimicked very closely idiopathic psychiatric disorders as has been reported elsewhere. This case has been summarized in order to alert physicians and raise their level of suspicion.

REFERENCES