Chronic Fatigue Syndrome or Affective Disorder? Implications of the Diagnosis on Management

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This paper reports a case of a 13 1/2 year old boy with a bipolar affective disorder, who was assumed to be suffering from a post-viral fatigue syndrome. The diagnostic problems in differenting the postviral fatigue syndrome from affective disorders in children/adolescents are discussed. The consequences of misdiagnosis in young people, bearing in mind the developmental tasks that they face, are considered.

Introduction

Chronic fatigue syndrome (CFS), known also as myalgic encephalomyelitis or chronic postviral syndrome (PVFS), has aroused considerable interest (White, 1989; Bass, 1989), and although predominantly a disorder of young adults, it has been recognised in children (Lask & Dillon, 1991; Garralda, 1992; Walford et al., 1993). In adults, its overlap in symptomatology with depressive disorders is considerable, and the cardinal feature of fatigue, affecting both physical and mental functioning, is common to both conditions (Hickie et al., 1990). The specificity of the symptoms in CFS is poor, and the importance of psychiatric disorder in fatigue states of longer duration has been stressed (Wessely & Powell, 1989). Recent work has shown significant differences in depressive symptomatology between the two conditions in that CFS subjects were less likely than depressed ones to report feelings of self-blame, guilt and worthlessness, and more likely to attribute their illness to physical cause (Powell et al., 1990). A recent systematic study of 12 children who were diagnosed as suffering from CFS confirms a clinical picture similar to that described in adults: high levels of subjective fatigue affecting both mental and physical functioning, precipitated by mental as well as physical effort, and an association between CFS and depression, with a currently depressed case rate of 42% as assessed by the use of children’s depression inventory (Walford et al., 1993). The study, however, does not clarify the interrelationship between fatigue and depression in CFS, due to the lack of comparison with appropriate control groups. To our knowledge there are no studies to date comparing and discriminating the clinical features between chronic fatigue syndrome and affective disorder in children and adolescents. Nevertheless, an increasing number of children appear to have been given the diagnosis of CFS in recent years which carries considerable implications for treatment (Lask & Dillon, 1990). Harris and Taitz (1989) have pointed out that the diagnosis of CFS may be harmful if it prevents the patient from pursuing further assessments or psychiatric treatments. In the present paper we report a clinical case which provides an opportunity to discuss these issues.

Case

A 12-year-old boy, of good health and intellectual ability, with normal premorbid personality, and with no previous history of emotional/behavioural disturbance experienced marked mood changes following an influenza-like illness. He presented with fatigue, anxiety, insomnia, depressed mood, tearfulness, decreased appetite, lack of concentra-
tion and energy. All symptoms resolved spontaneously after 3 weeks but recurred again a month later. Thereafter he suffered them intermittently for seven to ten days, every 3–4 weeks. Additional complaints included headaches and aching joints. In between these episodes he was irritable, overactive, distractible, aggressive, and complained of a sore throat.

Postviral fatigue syndrome (PVFS) was diagnosed and he was seen by several doctors for an assessment. Physical examination and medical investigations were negative. No screening for infectious diseases was performed. The family was told that the PVFS would eventually resolve spontaneously. A psychiatric opinion was not requested, and “alternative” treatments, such as massage and yoga, were recommended with no beneficial effects. Meanwhile the episodic mood changes had severely incapacitated this boy’s life; his school attendance was seriously disrupted and he became socially isolated. His school work substantially deteriorated mainly due to his poor concentration and school non-attendance.

A psychiatric opinion was requested 15 months into his illness when it was suggested that his symptoms were not typical of persistent PVFS. Meanwhile he was admitted to a paediatric ward. Physical examination and investigations were all normal except for positive Coxsackie B IgM test and insignificant enlargement of the thymus on CAT scan. An admission to an Adolescent Psychiatric Unit was arranged because his behaviour became increasingly disturbed and unmanageable on the paediatric ward. During his psychiatric admission two distinct depressive episodes were observed, each lasting for 7 to 10 days, during which he expressed feelings of guilt, self-blame, worthlessness, and fleeting suicidal ideation. He complained of feelings of physical fatigue (feeling tired all the time, lacking in energy, wanting to spend longer hours in bed resting but not feeling weak or having less strength in the muscles once involved in a physical exercise) as well as of mental fatigue (having problems with memory, concentrating and thinking clearly). During the depression-free periods, each lasting for about 3 to 4 weeks, his mood was observed to be irritable but never elated, and his self-esteem to be inflated. He also presented with overactivity, impulsiveness and inattentiveness. Conduct problems were the most prominent clinical feature during these depression-free periods.

Family assessment identified no gross family pathology but led to a hypothesis that both parents were possibly contributing to the maintenance and severity of their son’s behavioural problems. The family had organised their lives around his mood changes, feeling that they were able to predict when a shift in his mood was going to occur and being convinced that their child’s illness was purely physical in origin. During the “low periods” they were highly responsive to him (spending more time with him, being very affectionate towards him) and over-protective (allowing him to spend more time in bed, not encouraging participation in physical and other activities). In between “low periods” they were unable to exert parental authority, believing that their child’s conduct problems were purely due to his illness.

After six weeks’ observation (drug-free) he was commenced on a double blind trial of carbamazepine (200 mg b.d.) versus placebo, each phase lasting six weeks with the first being the placebo. In addition individual and family therapy were used to help with the management of his conduct problems. Daily ratings of his behaviour and mood (derived from Beck’s Depression Inventory and Conner’s scale) were completed. A gradual improvement of the conduct-type problems was noted from the third week of the trial, but overactivity, inattentiveness, mood irritability and a depressive episode were observed only during the placebo phase of the trial.

By the end of the trial his symptoms had resolved and his parents reported that he was “back to normal”. He was discharged after 5 months on no medication and was followed up in the out-patient clinic. In the third week following discharge he relapsed presenting with moderate depressive symptomatology. He was restarted on carbamazepine and since then has remained well. At a 9 month follow-up his mood was stable, he was attending the school regularly and was doing well academically.

Discussion

This boy’s clinical presentation was suggestive of a rapid cycling bipolar affective disorder. It seems likely that the following points led to the misdiagnosis of PVFS. Firstly, an “influenza-like” illness precipitated the onset of recurrent episodes of fatigue and low mood. Secondly, his initial presentation, in particular anergia, was suggestive of PVFS. Thirdly, there was no familial history of af-