

Clinical-Medical Image

## Symptoms in Patients with Cerebral Endometriosis: A Case Report

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### Clinical-Medical Image

Mrs. L.B. is a 50-year-old woman with bipolar disorder, panic disorder, and a history of endometriosis who was first admitted to our hospital at the age of 46 as an inpatient due to a suicide attempt during a hypomanic episode with mixed features. Her first-degree family history was positive for depressive disorders on the maternal side. Cyclothymic temperamental traits and increased emotional reactivity were reported since adolescence.

The patient's gynecologic history was characterized by the onset at the age of 23 of dysmenorrhea and abdominal–pelvic pain that worsened during menses. The laparoscopy performed a year later showed an endometrioma in the right ovarian and four intestinal endometrial nodules. The ectopic endometrial lesions were surgically removed, and the diagnosis of endometriosis was confirmed via histologic examination. In the following years, the patient had multiple relapses of dyspareunia, pelvic pain, and intestinal diseases, and these symptoms lost their temporal relationship with her menstrual cycle. Different treatment regimens with estrogen-progestin or progestin pills were prescribed without significant beneficial effects on pain and gynecological symptoms. At the age of 28, the patient started GnRH analogues, but after some months the therapy was interrupted due to the onset of psychiatric symptoms. Overall, the patient had seven interventions for removing endometrial ovarian and intestinal cysts before then undergoing a total hysterectomy with a bilateral oophorectomy at the age of 45.

While the patient's subclinical mood fluctuations dated back to early adulthood, her syndromal psychiatric symptoms first occurred at 28 years. At that time, in fact, during the treatment with GnRH analogues, she developed depression, panic attacks, avoidant behaviours, anticipatory and separation anxiety that required temporary psychopharmacological treatment with antidepressants and benzodiazepines. In subsequent years, the patient reported slight fluctuations in mood and energy levels not requiring psychopharmacological treatment and not associated with relevant changes in global functioning. At the age of 32, the patient developed her first hypomanic episode, which was characterized by irritability, hyper arousal, insomnia, agitation, disinhibition, and excessive spending, then followed by a relapse of anxious and depressive symptoms. In order to improve her mood symptoms, psychiatric treatment with gabapentin and sertraline was introduced. Despite an initial improvement, the patient's affective instability then increased. In the following years, frequent mood swings were described with rapid transitions from hypomanic episodes characterized by mixed features, generalized anxiety, panic attacks, emotional lability, and increased interpersonal sensitivity, to atypical depressions characterized by volitional inhibition, asthenia, emotional incontinence, and disrupted circadian rhythms. Despite multiple treatments with mood stabilizers (e.g., lithium carbonate, valproic acid, lamotrigine, and oxcarbazepine) and antidepressants (e.g., paroxetine, escitalopram, venlafaxine, duloxetine, trazodone, and mianserin), mood episodes recurred often and sub syndromal symptoms of mood lability, cognitive and emotional impulsivity, distractibility, and planning and organizational difficulties persisted between major episodes, causing moderate impairments in working and social functioning for the patient [1,2].

### Conclusion

Endometriosis has been linked to a high rate of mood disorders, especially bipolar disorder. Women with endometriosis have a higher risk of developing psychiatric disorders due to problems secondary to endometriosis such as chronic pain, side effects of treatments, altered susceptibility to hormonal fluctuations, altered gene expression, or gray-matter lesions in key regions for mood regulation. In addition to the causes mentioned above, we suggest that cerebral endometriosis may contribute to the onset and course of psychiatric disorders in patients with endometriosis. While some cases of neurological disturbances that emerged due to cerebral endometriosis were previously reported, we described the case of a patient with two brain lesions that presumably were due to endometriosis and whose bipolar disorder was characterized by a pattern of frequent mood swings with mixed features and excitatory/dysexecutive interepisodic symptoms.

**Keywords:** Cerebral endometriosis; Neuropsychiatry; Bipolar disorder

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