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Case report

Less is More – Possible Option in the Treatment of Depression

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A B S T R A C T

Depression is an illness of modern society, which affects population of different age. Etiological factors differ, and frustration factors as a cause of depression are multiplying. Each new episode presents difficulties, both for patients and psychiatrists. Despite the increasing number of antidepressants we use in treatment, it is sometimes hard to notice an efficient antidepressant in an optimal-efficient dose. In resistant cases we apply combinations of psychopharmacs, and the choice of the same depends on the leading symptoms. We will present the case of a 67-year old patient where a depressive episode (in the terms of a reccurent major depressive disorder) lasts for one year. During this period she was treated as outpatient and inpatient with several antidepresants in combinations with other psychopharmacotherapeutical drugs. Despite regular treatment, mental state was worsening. Clinical presentation was indicating developing of dementia (behavior, cognition outges), which we excluded through diagnostic process. Psychopharmacological combinations (antidepresants, mood stabilizators, antypschotics, anxsiolotix) were not efficant. Progression of simptoms leads to rehospitalisation. In further treatmen, we followed the principle «Less is more» which resulted with an expected and satisfactory outcome.

Key words: *antidepressants, dementia, depression, pharmacotherapy, treatment*

Introduction

Depression is a common, often long-lasting and recurrent mental disorder that significantly impairs a person's functioning, leads to a serious sufferring and diminished quality of life of the person affected with depression. The incidence of depression increases in the last decades so depression is becoming a major public health issue, and World Health Organization states that depression is the leading cause of disability as measured by Years Lived with Disability[1].

Besides depressed mood, depression includes other emotional, motivational, behavioral, somatic and cognitive symptoms, and clinical presentation of depression varies among patients. Many physical illnesses can mimic depression, and many medications have unwanted pro-depressive effects, that is often overlooked.

It has been repeatedly proven that best results in treatment of depression can be achieved by combined therapy, combination of antidepressant medications and various modalities of psychotherapy[2], as compared to medication therapy alone[3]. Despite numerous available antidepressants with different action mechanisms, it is sometimes very demanding to find a medication that will be effective enough in an individual patient, and in cases where monotherapy does not lead to satisfactory symptom remission or in treatment resistant cases, combinations of psychotropic medications can be applied. Polypharmacy (lat. polypragmasia) in psychiatry refers to the concurrent use of two or more psychotropic medications in a patient[4], and is a common practice in the treatment of psychiatric patients[5–8]. Although in many cases necessary, polypharmacy in psychiatry is accompanied by a much greater risk for drug interactions and adverse effects, sometimes even life-threatening[9].

Case Report

A 67-year-old patient had a depressive episode ten years ago, for which she was in psychiatric treatment. Medication was taken regularly the whole time. In the meanwhile she was diagnosed with hypertension, glau-

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coma and osteoporosis, for which she took medications. A second depressive episode appeared gradually about one year ago, and was partially caused by family problems. The documentation shows that she was anxious, tense and irritable, with sleep disturbance, loss of appetite and a drop in body weight. She was diagnosed with recurrent major depressive disorder (current episode severe, without psychotic symptoms F 33.2.). For several months was conducted a titration psychopharmacological drugs (carbamazepine 200 mg/day, fluvoxamine 100 mg/day, oxazepam 60 mg/day flurazepam 15 mg), and given the lack of effect of this treatment, maprotilin 75 mg/day and olanzapine 5 mg/day (then 10 mg/day), and later duloxetin (doses up to 120 mg/day), were introduced.

Despite regular treatment there is no improvement in mental condition, there is a progression of depressive symptoms in terms of increased restlessness, forgetfulness, and suicidality, which led to hospitalization, during which she underwent diagnostic procedures (laboratory located in benchmarking, ophthalmologist-glaucoma, brain CT – normal morphological findings). Correction in therapy was carried out: duloxetin 90 mg/day, olanzapine 5 mg/day, carbamazepine CR 400 mg/day, oxazepam 45 mg/day. After 14 days, she was discharged from hospital treatment, with a partly improved mental condition.

Over the next month, the situation was getting worse again, despite the regular use of drugs. The patient complains of sedation, states somatisations (bad sight despite the glasses, a long-term constipation), and according to her family, delusions occur with depressive ideas from the health sphere. She was re-hospitalized.

Clinical observation was performed in a hospital setting, and reveals a progressive psychopathology pronounced in afternoon and evening hours, when she shows health sphere delusions with severe psychomotor agitation and stubborn insomnia, and cognitive deficits similar to dementia (which was excluded during the previous hospitalization). Therapy was discontinued, and the minimum dose of clozapine (25 mg in the evening), along with mirtazapin 30 mg and 400 mg carbamazepine CR, shows improvement. In ambulatory conditions leads to improvement of the situation, the leading symptomatology is docked, according to information by the family she is functional in everyday life situations.

Discussion

Depression is the most common mental disorder and a common cause of disability in the elderly[10]. Depression in older people has specific features, such as psychomotor symptoms, somatizations, metabolic and electrolyte imbalance due to reduced food and liquid intake, and rather often a domination of cognitive symptoms that resemble dementia, a symptom known as pseudodementia, depressive pseudodementia. Depressive pseudodementia is distinguished from primary dementia by its acute onset without prior cognitive disturbance, history of past mood disorder episodes, psychomotor retardation, diurnal cognitive dysfunction and subjective memory dysfunction in excess of objective findings[11].

There are therapeutic guidelines (algorithms) for treatment of different psychiatric illnesses as well as depression. Antidepressants are used in the treatment of depression, however, at times, a depressive disorder can assimilate a psychotic feature with pronounced delusions, it is indicated that the addition of lower to medium doses of antipsychotics can be effective. The selection of antidepressanst and antipsychotics in the treatment of psychotic depression is completely up to the psychiatrists' choice.

Depending on the clinical picture of a disease, we tend to use combinations of medications that vary in pharmacological profile and effect in order to alter the symptoms of depression. However, psycho pharmacotherapy is not always adequate for healing[12].

When treating depressed elderly patients it is inevitable to consider all the characteristics of their age and the fact that depression in most patients occurs in comorbidity with physical illnesses that are usually under therapy of more medications, and consequently polypharmacy is often a rule in patients of older age. In older age, due to physiological changes and physical co morbidities, medications have altered pharmacokinetic and pharmacodynamic properties, medication metabolism, absorption, distribution and elimination is changed[13]. Since older patients are more sensitive to medications, more prone to adverse effects and medication interactions, and medications are metabolized slower, lower doses of (psychotropic) medications, with a more gradual titration, are needed.

Many medications, for physical illnesses or psychotropic ones, alone and more when combined in elderly patients, can lead to changes in mental status, cause confusion, decline in cognitive abilities[14], and depressive symptoms, that can mislead to diagnose dementia process or depression. The negative impact of depression on patient life quality is well known since it causes various psychosocial problems[15]. We also need to have in mind, serous cognitive deficits cause impairment in occupational and social functioning[16].

Conslussion

In treatment of depression an individual approach must prevail, with consideration of all patient's characteristics. Psychotropic medications can cause adverse effects of all organ systems, especially in psychotropic polypharmacy and in older patients, so monotherapy in a sufficient medication dose and appropriate duration should, when possible, be preferred in treatment of depression. Given that the elderly are more sensitive to the use of psychopharmacological drugs, even lower dose of psychopharmacological drugs can have a therapeutic effect. Since each patient is specific, therapeutic doses of psychopharmacological must be individually tailored to each patient.

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MANJE JE VIŠE – MOGUĆA OPCIJA U LIJEČENJU DEPRESIJE

SAŽETAK

Depresija je bolest suvremenog društva, koja zahvaća populaciju različite životne dobi. Etiološki čimbenici su različiti, a frustracijskih čimbenika kao uzroka nastanka depresije sve je više. Svaka nova epizoda predstavlja poteškoću kako za bolesnika tako i za psihijatra. Unatoč sve većem broju antidepresiva koje koristimo u liječenju ponekada je teško primijeniti djelotvoran antidepresiv u optimalnoj-djelotvornoj dozi. U rezistentnim slučajevima primjenjujemo kombinacije psihofarmaka, a izbor istih ovisi o vodećim simptomima. Prikazati ćemo slučaj 67-godišnje bolesnice u koje depresivna epizoda (u okvirima povratnog depresivnog poremećaja) traje zadnjih godinu dana. Tijekom navedenog perioda liječena je ambulantno i hospitalno sa nekoliko antidepresiva u kombinaciji sa drugim psihofarmacima. Unatoč redovitom liječenju psihičko stanje se pogoršavalo tijekom ambulantnog i hospitalnog liječenja Klinička slika nalikovala je dementnom razvoju (ponašanje, kognitivni ispadi), što smo dijagnostički isključili. Kombinacije više psihofarmaka (antidepresiva, stabilizatora raspoloženja, antipsihotika, anksiolitika) nisu dale nikakve rezultate. Progresija simptoma rezultirala je ponovnom hospitalizacijom. U liječenju smo se vodili principom „manje je više“ što je konačno dalo očekivane rezultate.