

VENLAFAXINE – QUETIAPINE COMBINATION IN THE TREATMENT OF COMPLICATED CLINICAL PICTURE OF ENDURING PERSONALITY CHANGES FOLLOWING PTSD IN COMORBIDITY WITH PSYCHOTIC DEPRESSION

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SUMMARY

PTSD is a complex disorder, which frequently occurs in comorbidity with anxious disorder, personality disorder, addiction or substance abuse disorder, depressive disorder with or without psychotic symptoms and psychotic disorder. PTSD symptoms may result from deregulation of several different neurotransmitter systems. Pharmacotherapy of PTSD depends on clinical features and the presence of comorbid disorders. Pharmacotherapy of PTSD involves use of anxiolytics, adrenergic receptor antagonists, antidepressants, anticonvulsants and novel antipsychotics. Serotonergic effect of antidepressants is not only effective in treating depression, but also appears to be helpful in PTSD treatment, particularly in reduction of intrusive symptoms, emotional reactivity, impulsiveness, aggression and suicidal ideation. Antipsychotics with serotonergic-dopaminergic antagonism are being prescribed often in treatment of psychotic depression, while in PTSD treatment they are proved to be efficient in relieving intrusive symptoms and nightmares. Quetiapine as serotonergic-dopaminergic antagonist is efficient in treatment of chronic insomnia as well as in reduction of aggressiveness. Considering PTSD refractoriness to therapy, high incidence of comorbidity and significant functional impairment, it is important to search for new psychopharmacological combinations in order to improve mental status of the patient. The paper presents 46 years old male patient with the diagnosis of Enduring personality changes following war PTSD (F62.0) in comorbidity with Recurrent depressive disorder with psychotic symptoms (F33.3), who was treated with combination of venlafaxine and quetiapine.

Key words: enduring personality changes – PTSD – pharmacotherapy – venlafaxine - quetiapine

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INTRODUCTION

Posttraumatic stress disorder (PTSD) is a complex disorder, which frequently occurs in comorbidity with anxious disorder, personality disorder, addiction or substance abuse disorder, depressive disorder with or without psychotic symptoms and psychotic disorder (Kozarić-Kovačić 2008). PTSD symptoms may result from deregulation of several different neurotransmitter systems (Berger et al. 2009). Pharmacotherapy of PTSD depends on clinical features and the presence of comorbid disorders. Pharmacotherapy of PTSD involves use of anxiolytics, adrenergic receptor antagonists, antidepressants, anticonvulsants and novel antipsychotics (Stein et al. 2009). The paper presents case of male patient with the diagnosis of Enduring personality changes following war PTSD in comorbidity with Recurrent depressive disorder with psychotic symptoms who was treated with combination of venlafaxine and quetiapine.

CASE REPORT

A 46 years old war veteran, retired, divorced with three children, was admitted for the third time to ‘Sveti Ivan’ Psychiatric Hospital in 2010. He was previously hospitalized in 2007 due to enduring personality

changes following war PTSD in comorbidity with psychotic depression. After discharge from the hospital patient attended psychiatric check-ups irregularly, but was compliant with prescribed medication. During the period of three years, he was taking olanzapine and fluvoxamine in addition to high doses of diazepam. He was overweight, had high blood pressure and elevated plasma triglyceride levels, which are three risk factors sufficient to diagnose metabolic syndrome.

Patient had feelings of being rejected, guilty and worthless; he had lack of motivation and interest for everyday activities. He permanently felt endangered, was convinced of being followed all the time, he was aimlessly wandering around, wishing for euthanasia, suffering from insomnia and nightmares. These disturbances gradually led to his complete social withdrawal.

At admission he was tense, depressed, anxious, without spontaneity, affect was blunted, had low self-confidence, felt useful and desperate, had lack of interest and pleasure. He had delusions of guilt and of self-accusations and suicidal thoughts. He was irritable, had a sense of pending breakdown, was exaggerating the potential external threats, he had difficulties falling asleep and difficulties remaining asleep, due to hectic nightmares.

After thorough medical workup and supportive psychotherapy, corrections of pharmacotherapy were

made considering his mental status and metabolic syndrome. Even though patient had high blood pressure, he was given venlafaxine, a dual serotonin and norepinephrine reuptake inhibitor, in daily dose of 75 mg, as in low doses its fast onset of action, high efficacy and good tolerance, similar to serotonin reuptake inhibitors, were expected. It was expected that venlafaxine would have positive effects on depressive symptomatology and lack of spontaneity. In addition, patient was given quetiapine in daily dose of 300 mg, divided in morning and evening dose, in order to treat delusions of guilt, intrusive memories, agitation, avoidance of reminders on trauma, chronic insomnia and nightmares, as well as aggression, which was suppressed and presented as depression. High doses of diazepam were substituted by clonazepam, and flurazepam was administered in case of insomnia.

After ten days, his mental status gradually improved. He seemed to be content and motivated for everyday activities, more relaxed, enjoying other patients' company, with more adequate affect and in more stable mood. Delusions disappeared, he was clearly distant from suicidal thoughts and symptomatology of enduring personality changes following PTSD was reduced, enabling patient sufficient social functioning. Gradually, his appetite decreased, his weight reduced which helped in regulation of high blood pressure and plasma lipid levels.

DISCUSSION

PTSD develops after a psychological trauma, which triggers complex neurobiological processes in brain that might include several different neurotransmitter systems (Kozarić - Kovačić 2008). PTSD often occurs in comorbidity with other mental disorders, which makes the treatment even more complicated (Begić & Jokić - Begić 2007). Psychopharmacological monotherapy is rarely effective in reducing all the existing symptoms of PTSD (Berger et al. 2009). Presented patient suffered from enduring personality changes following war PTSD in comorbidity with recurrent depressive disorder with psychotic symptoms and metabolic syndrome, so we needed do adjust our psychopharmacological interventions to his specific needs. He was given venlafaxine, a dual serotonin and norepinephrine reuptake inhibitor, which is next to the selective serotonin reuptake inhibitors (SSRI), considered first-line pharmacological treatment for PTSD (Stein et al. 2009). Trough its serotonergic effect venlafaxine is effective in treating depression, but is also helpful in reduction of intrusive symptoms, emotional reactivity, impulsiveness, aggression and suicidal ideations. In order to treat delusions of guilt and self-accusations, resistant intrusive symptoms and chronic insomnia with nightmares, patient was given novel antipsychotic quetiapine, effective serotonergic-dopaminergic antagonist (Schoenfeld et al.

2004). High doses of diazepam were substituted by clonazepam, which ensured sufficient anxiety reduction. Described psychopharmacological combination contributed to the improvement in clinical picture, with the reduction of symptoms of both PTSD and recurrent depressive disorder, and subsequent positive effect on comorbid metabolic syndrome. Diverse psychopharmacological agents with different mechanisms of action have same goal- to reduce symptoms of PTSD and comorbid disorders, improve patient's functional level and increase his quality of life (Berger et al. 2009). Considering complexity of clinical picture in PTSD, it's refractoriness to therapy and high incidence of comorbidity; psychopharmacological monotherapy is rarely effective enough to achieve remission. It is important to search for new psychopharmacological combinations that would take in account individual characteristics of each patient and aim his specific needs.

CONCLUSION

Enduring personality changes following war PTSD frequently appears in comorbidity with depressive disorder with or without psychotic symptoms. Serotonergic effect of antidepressants is not effective only in treating depression, but also appears to be helpful in PTSD treatment, particularly in reduction of intrusive symptoms, emotional reactivity, impulsiveness, aggression and suicidal ideation. Treatment of psychotic depression involves use of antipsychotics with serotonin-dopamine antagonism, while in PTSD treatment their effectiveness applies to intrusive symptoms and nightmares. Apart from efficient treating chronic insomnia, quetiapine as a serotonin-dopamine antagonist is proved to have antiaggressive effect as well. A combination of venlafaxine and quetiapine proved to be good choice of treatment for our patient. Considering PTSD refractoriness to therapy, high incidence of comorbidity and significant functional impairment, it is important to search for new psychopharmacological combinations in order to improve mental status of the patient.

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