Depressions you can treat

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Michael is a second year student in history

He had a period of depression when in the sixth form, but did not seek treatment though had to retake the year.

In first year diagnosed as depressed by GP and given fluoxetine, took for about three months and recovered.

Michael

His mother suffered from post natal depression after both childbirths. She was admitted after his sister’s birth, but well since. Maternal aunt ‘hospitalised with a breakdown’.

Through the early summer he had been feeling low, lacking confidence, sleeping a lot and becoming introverted. He finds new social situations difficult as he feels panicky. He is fed up with his course and has quit but aims to return next year. Has been going to university counsellors.

He drinks alcohol to excess at weekends but has only experimented with drugs, and not in the last year.

Referred from the Police surgeon as an emergency in September. He has been arrested after getting into a fight. Not intoxicated.

He is talking non stop, won't let others get a word in. Excitable, irritable & overcheerful. Has needed little sleep in the past week, been up singing and making 'amazing recordings'. Arrested after trying to get on the stage at a music pub. Says everyone wanted to hear him sing. Does also think that people have been breaking into his house to record him as he heard his song on the radio.

What distinguishes bipolar depression?

More family history (& more bipolar)

Gender

Course: **Early onset**

Acute onset and abatement

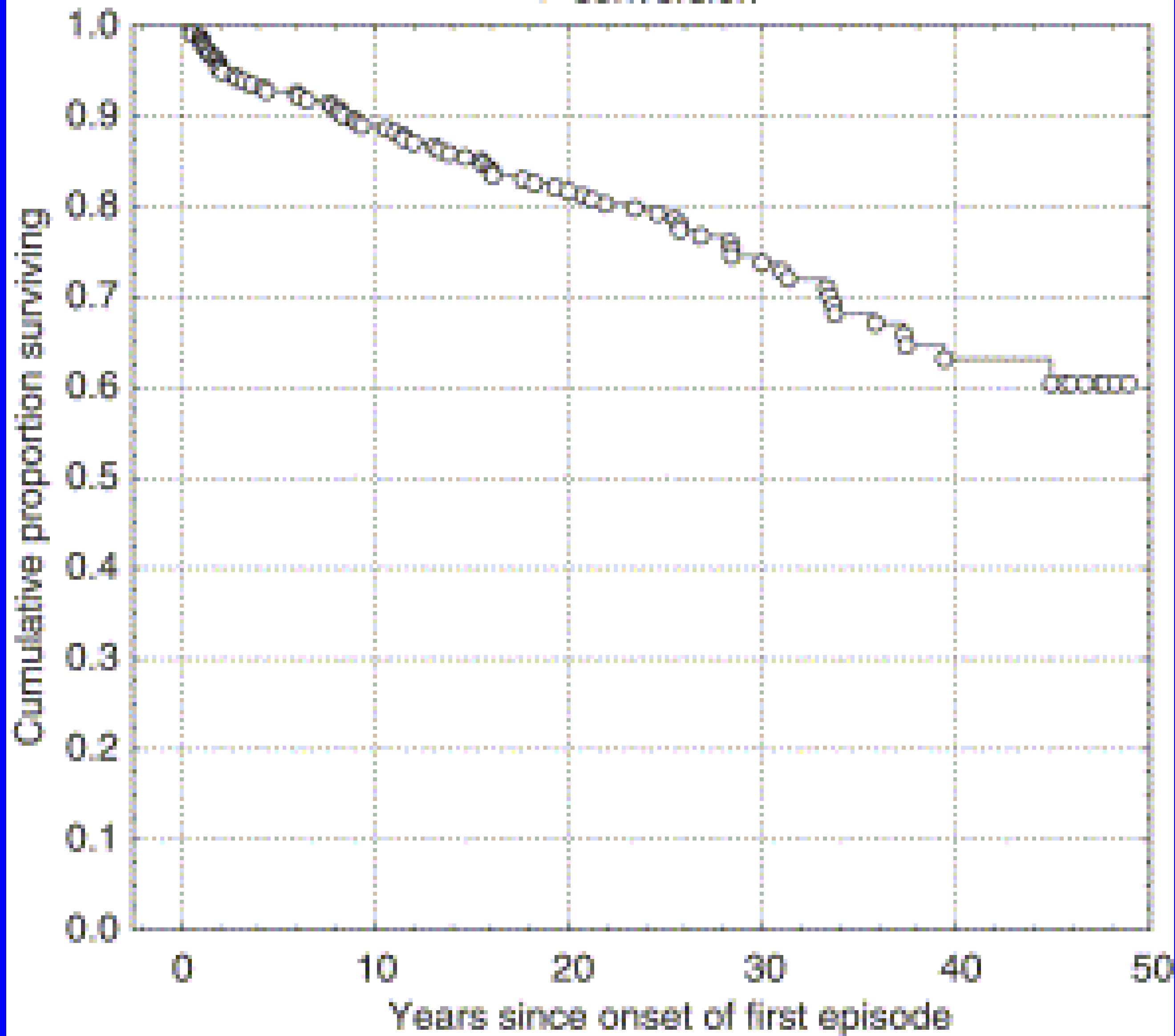
Frequent recurrence

Symptoms: **More sleep increase**

Comorbid anxiety

More psychosis

More mood lability



Angst 2005

NICE: Treatment of bipolar depression

Consider:

Quetiapine

Fluoxetine and olanzapine

lamotrigine

Recurrence of Bipolar Disorder

More common than in depressive disorder

– single episodes occurred in 2 out of 393 patients in *Angst et al 1973*

Suicide in bipolar disorder

- Lifetime risk of 15-20%
- Most have been recently (or are) depressed with a severe illness course
- Often late in the course of illness (15 years) particularly females
- High rates of alcoholism and divorce
- Inadequate (or non compliant) treatment
- Only 30% on lithium

Isometsa 1994

Lithium and suicide

Mortality by suicide for bipolars is 10-20 times higher than the general population

The rates of suicide on lithium are consistently lower than when off lithium

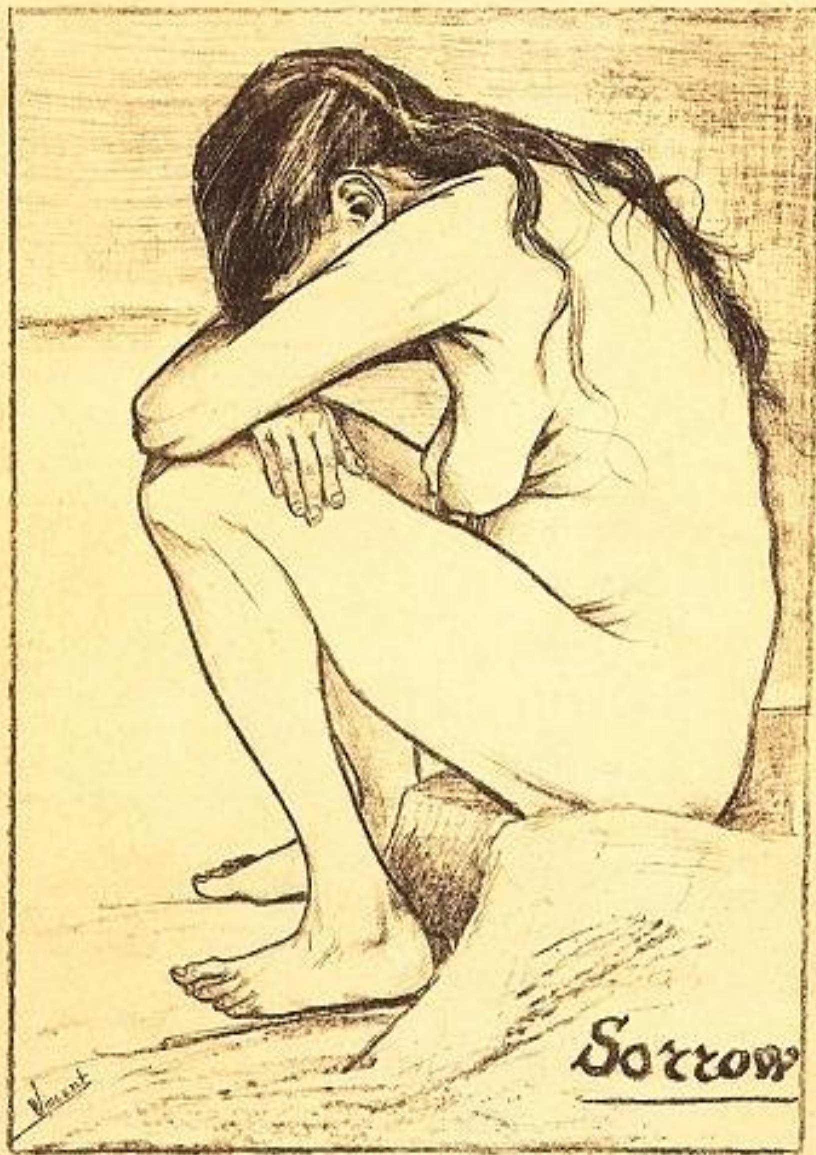
Combined reports: 67 suicides / 5120 versus 74/ 1439 patient years

0.2 versus 1.0 per 100 patient years

(General population: 0.016)

Also Suicide attempts x10 lower in bipolars when on lithium compared to when not on lithium

Tondo et al 2001


Sorrow

Sorrow

NICE: 2014

Offer lithium as a first-line, long-term pharmacological treatment for bipolar disorder

Ask about bipolarity

Have you ever felt too cheerful or overconfident?

Were you overactive and unable to sleep?

Did you do anything to embarrass yourself?

Has this been to a level where others would notice?

For how long?

YOUR QUESTIONS ANSWERED

YQA

YOUR QUESTIONS ANSWERED

BIPOLAR DISORDER

NEIL HUNT

ELSEVIER
CHURCHILL LIVINGSTONE

Are some antidepressants more effective than others?

Amitriptyline and clomipramine are more effective than SSRIs

For inpatients, severe depression and melancholics

Melancholia

NICE

Melancholia

Lack of reactivity of mood (but diurnal variation)

Loss of pleasure - Anhedonia

Retardation / Agitation

Early morning waking

Weight loss

Concentration and memory defects

Family history

Episodic

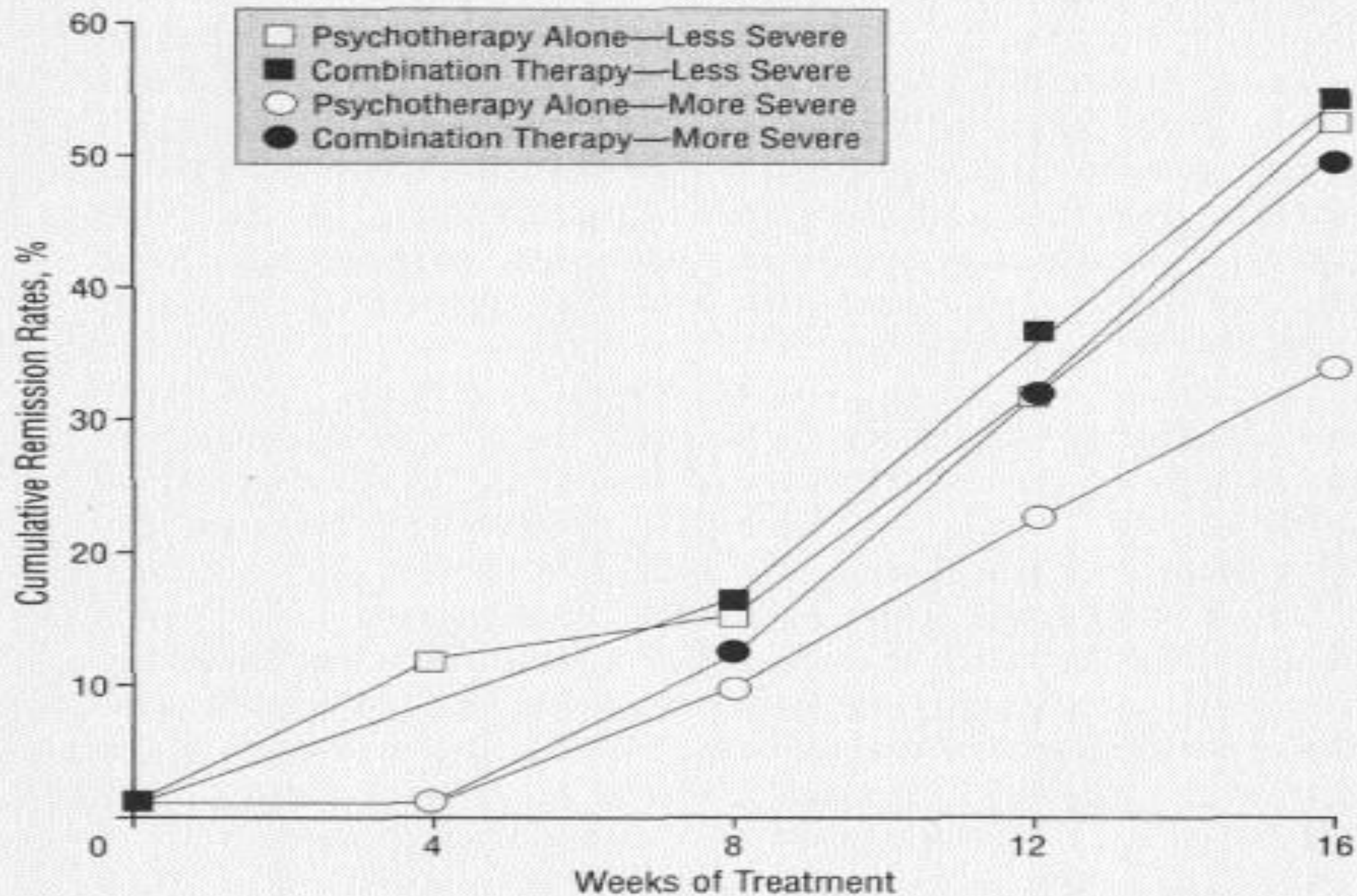


Figure 1. *Cumulative time to recovery curves as a function of pretreatment severity and treatment type. Outcome in the psychotherapy alone—more severe condition was significantly worse than those in the other 3 groups.*

Dysthymia

Long term (at least two years)

low level depression

But not for ever!

Not markedly disabling (except social withdrawal and motivation)

But dysphoric and anhedonic

Hopeless

Antidepressant response

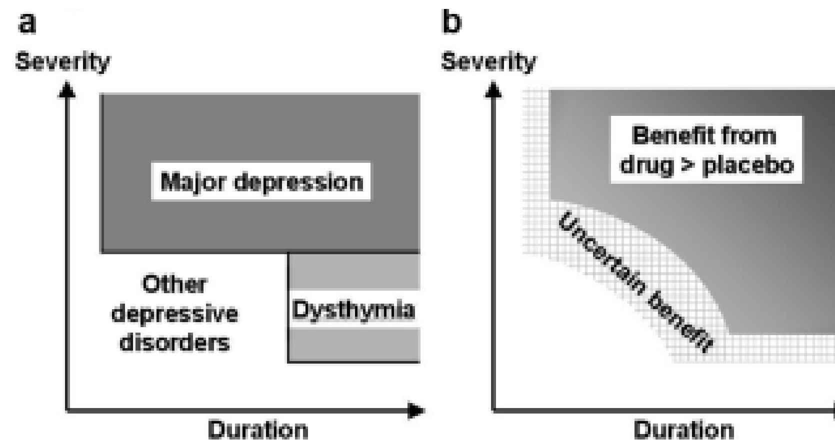


Figure 1 A dimensional approach to depressive disorders and response to treatment. a) Relationship between dimensions and categories of depressive disorder (see Table 2 for criteria for a major depressive episode). b) Benefit from antidepressant drug treatment over placebo increases with severity and duration. There are 'threshold zones' where benefit is uncertain.

MELENCOLIA I
16 3 2 13
5 10 11 8
9 6 7 12
4 15 14 1

How do you make placebos work better ?

Good rapport
Positive view of potential
Setting goals
Discussion of change and planning for it
Prescription rather than proscription
Building on strengths and changes
Maintenance of new behaviours

How long should patients who recover from depression with antidepressant treatment take it for?

Stopping treatment as soon as recovery has occurred

gives a relapse rate of about 50%

Stop at 4 months after recovery about 25% relapse

Those with continuing mild symptoms and/or more previous episodes have a higher relapse rate

Are some antidepressants more effective than others?

Amitriptyline and clomipramine are more effective than SSRIs (but more side effects and more toxic in overdose)

The difference is that these drugs affect both serotonin (5HT) and noradrenaline

Other drugs that have a similar effect are:
Venlafaxine
Mirtazepine
Duloxetine

Are these also more effective?

gives a relapse rate of about 50%

Stop at 4 months after recovery about 25% relapse

Those with continuing mild symptoms and/or more previous episodes have a higher relapse rate