Higher vigilance needed to diagnose and treat MDD

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Selective serotonin reuptake inhibitors (SSRIs) became the first line of treatment of depressive disorders (MDD) during the eighties and has kept its place in the arsenal of options to treat this common disease. MDD accounts for 4,4% of the total overall global disease burden.

Since its introduction, more molecules have become available with similar actions. In spite of different drugs with different mechanisms of actions being available, SSRIs have kept its place as first step in the uphill climb to try and conquer the darkness of depression. Yet SSRIs are not all the same, does have side effects and need to be prescribed with skill and knowledge.

DIFFERENT CHARACTERISTICS OF THE DIFFERENT MOLECULES

Antidepressant are said to be all the same as clinical trials have shown little difference in efficacy or tolerability among the different SSRIs, and even between SSRIs and other classes. However, some differences should be noted.

Rarely has a class of drug changed prescribing habits so drastically in psychiatry, than the introduction of SSRIs, because of its side effect profile. Side effects are usually mild and transient, yet the biggest advantage, is the relative safety in overdose in a population at risk.

SIDE EFFECTS

SSRIs can cause nausea and gastrointestinal upset, especially at the onset of treatment, due to the high concentration of 5-hydroxytryptophane (5-HT) receptors in the gut. This with headache, insomnia and initial agitation is usually transient. Other possible problems include hiponatraemia, bleeding, sweating and a tremor.

Paroxetine has been associated with more anticholinergic side-effects and weight gain than other SSRIs, and sertraline with more diarrhoea. The most troublesome side effect for patients, usually when they have recovered from symptoms and have to stay on the medication for the full treatment period after remission (six to nine months for a first episode, 18 to 24 months for a second episode, or lifelong if more severe recurrent episodes with a positive family history) is sexual dysfunction that can be experienced as a decreased libido or a delayed orgasm.

The management can be to wait for receptor adaptation, and keeping in mind the changes in libido maybe associated with the depression itself. Dose reduction, 'drug holidays' or switching to a different drug in the same class may work, but care should be taken to monitor a relapse of the depression. A Cochrane review found that addition of sildenafil, tadalafil or bupropion may improve sexual function.

SEROTONIN SYNDROME

A serious side effect is serotonin syndrome and is often missed, but may need emergency treatment even in an intensive care unit in severe cases. Symptoms include restlessness, diaphoresis, tremor, shivering, myoclonus, confusion, convulsions, and may ultimately result in death. It is a higher risk when more than one serotonergic drug are combined, or with drug interactions at cytochrome level.

FACTORS INFLUENCING CHOICE OF SPECIFIC SSRI

Even though SSRIs are recommended as first-line agents in the treatment of depressive of disorders, the choice of specific medication should preferably be made in conjunction with the patient, taking into account the presence of co-morbid medical conditions and concomitant medication, age, gender, pregnancy and breastfeeding, a history of a previous good response to a specific molecule, patient preference, specific symptoms experienced, cost and medication side-effect profile. Fluoxetine is the only SSRI with consistent evidence in the treatment of children and adolescence.

As SSRIs are not only registered for the use in depressive disorders, the presence of comorbid conditions can guide one in the choice of the appropriate drug registered to treat both conditions.

DISCONTINUATION SYMPTOMS

Discontinuation symptoms are experienced due to receptor adaptation or receptor rebound after stopping of antidepressants. It can be avoided or reduced by slowly tapering the drug over at least four weeks. The symptoms can be experienced also after missed doses of SSRI's with a short half-life.

Discontinuation symptoms are experienced by at least a third of patients, within five days of stopping treatment. Symptoms include flu-like symptoms, 'shock-like' sensations, dizziness exacerbated by movement, insomnia, vivid dreaming and irritability, even problems with concentration and memory or movement disorders. It is managed by the reintroduction of the SSRI and slower tapering of the molecule.

CONCLUSION

MDD has a lifetime prevalence of 25% and yet it is still vastly underdiagnosed and undertreated in SA. It is a potentially fatal disorder with a suicide rate of 15%.

SSRIs have established themselves as a safe and effective treatment option that is affordable and easily available in the private and public sector. A higher vigilance is needed from all doctors to diagnose and treat MDD disorder timeously. SF