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Time for Some Drugs or Drugs for Some Time

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Background

Treatment resistant depression is a loosely defined term typically used to describe depressive episodes that have not responded sufficiently to trials of antidepressant monotherapy (1, 3). The term “difficult to treat” has also been used to refer to patients with depression who do not respond satisfactorily to antidepressants (4, 8). In these patients, response to next-step treatments may be reduced (10 – 12), and remission rates may be affected by comorbid anxiety disorders (14 – 16).

A depressive episode is qualified as severe when eight or nine symptoms that define major depression are present (19). It is also generally characterized by suicidal ideation and behavior, obvious impairment of functioning, and psychotic or catatonic features (18).

Major depression was found to be less common in the elderly population (> 65) with prevalence around half that of adults aged 18 – 64 years (37, 38). When present, it is also generally less severe and tends to occur in the elderly with a greater burden of medical illness (37, 39). Rapid onset of depressive symptoms is less likely to occur in patients with new onset depression (43).

Introduction

Here, we present a case of late life, rapid onset, severe, treatment resistant major depression with psychotic features. This case was viewed with for consideration for ultimately led to an unusual choice of pharmacotherapy. We highlight our experience dealing with this uncommon presentation of a common disorder. We discuss limitations to treatment and further recommendations when faced with difficult to treat depression.

History Course

80 year old female with no psychiatric history or significant medical comorbidities was admitted to LGBHU following an aborted suicide attempt. The patient had prepared a bottle of

Patient had poor PO intake and was help-rejecting. Initially declining all psychotropics. She eventually consented to a trial of psychotherapy and was discharged home on Day 12 with a plan for close supervision by her children, and husband remained at rehab.

Discussion

Our elderly patient had a unique presentation to a common disorder: namely, she had a later but rapid initial onset of illness. She was severely depressed, delusional, and anxious with rocking behavior, episodic poor PO intake, hempenic Hyperviscosity, and hemodynamic changes, a history of disabling anxiety, and impaired PO intake.

Electroconvulsive therapy (ECT) was considered after nonresponse to antidepressants and marked deterioration in functioning. ECT may be regarded as superior to pharmacotherapy in patients with severe, treatment resistant major depression; with persistent suicidal ideation or intent; or with severe weight loss secondary to hypothyroidism (21 - 33). In geriatric patients, ECT may have a smaller risk of complications and potentially better treatment response when compared to pharmacotherapy (34, 35).

However, our patient’s indecisiveness and fluctuating decision-making capacity caused a delay in preparations for ECT. In the meantime, she began to exhibit adequate response to paroxetine treatment with risperidone augmentation. After failing a trial of mirtazapine, paroxetine was chosen despite the patient’s age in an effort to better address her anxious distress, obsessive-compulsive tendencies, and sleep disturbance.

According to the Beers Criteria and the Pharmacy Quality Alliance, paroxetine is identified as a high-risk medication to be avoided in those 65 years and older due to its strong anticholinergic properties, high potential for sedation, risk of hypotension, and risk of orthostatic hypotension (41). In contrast, this case demonstrates that some elderly patients may benefit from good side effects from paroxetine. Notably, our patient’s only medical comorbidity was mild hypertension, and she had excellent functionality prior to depression onset.