Does this woman need an antidepressant?

COMMENTARY BY BOB RUSSELL MB BS, FRANZCP

We ask an expert how he would manage this case of an elderly woman who had a stroke less than a year ago and is showing features of depression.

Case scenario

A 73-year-old patient of mine experienced a stroke eight months ago. She remains at home living independently but has almost total paralysis of the right arm, which she wears in a sling, and minor dysphasia. At her last visit, she was far less cheerful than usual, had lost 3 kg in weight, and told me she was always tired. Screening blood tests failed to reveal any abnormality. I suspect she is depressed and wonder if the depression is likely to be a direct result of the cerebral damage or a reaction to her disability. Also, should I treat this woman with an antidepressant and is any class of agent preferable over others in this situation? She is taking low dose aspirin and an antihypertensive agent.

Commentary

Stroke is a well recognised precipitant for depression, particularly in the first 12 months after the event. Caution, however, is needed early on (within the first few weeks) in making the diagnosis of a true depressive disorder rather than a normal response to a major adverse life event.

From the clinical point of view, it is not particularly crucial to differentiate between depression resulting from cerebral damage and depression as a reaction to the resulting disabilities. It is the severity of the syndrome that matters most in terms of number and the intensity of symptoms and signs, and the resulting degree of dysfunction. There have been conflicting data concerning the relevance of stroke localisation in post-stroke depression. At this stage, most experts would probably agree that it is not particularly helpful, diagnostically or prognostically, and certainly not in relation to the individual patient.

In the case scenario in question, the depressive features listed are in the mild to moderate range. I would want to explore more the patient's motivation, capacity for enjoyment, thought processes and content (including suicidal ideation), and sleep pattern, to get a better picture of severity and a better evaluation of level of social supports and risk factors (for self-harm or self-neglect).

It is usually preferable, however, to treat (pharmacologically) such patients because some severe treatable depressions can be 'masked', particularly in the presence of dysphasia and severe physical disability. There is also the frequent occurrence of emotional lability after stroke, which often creates an impression of profound distress. This is very troublesome, but the level of emotional lability does not necessarily correlate with the overall severity of the depressive syndrome. Many antidepressants are available today, and most are safe, effective and user friendly. It has also been reasonably well demonstrated that prospective antidepressant medication can have a protective effect in terms of post-stroke depression, but routine prescription of antidepressants for all stroke sufferers has not yet become established practice.

Dr Russell is a Staff Specialist, Psychogeriatric Unit, Department of Aged Care and Rehabilitation Medicine, Royal North Shore Hospital, St Leonards, NSW.

HIGGINS PICTURES DALE , PHOTO LIBRARY

Suggestions for this case

In this case scenario, the SSRI sertraline (Zoloft) would be a reasonable choice (much of the recent research has been done using this particular drug), but other SSRIs could be just as effective. The patient's hypertension (albeit treated) might limit the attractiveness of antidepressants that may cause postural drop in blood pressure (the tricyclics, the old monoamine oxidase inhibitors and the serotonin and noradrenaline reuptake inhibitor venlafaxine, for example). Likewise, her tiredness would probably not be helped by more sedating antidepressant agents, such as mianserin and mirtazepine.

If antidepressant therapy is decided upon, it is important that a drug is given an adequate trial (for at least four weeks at an adequate dose). It is becoming increasingly common to start antidepressants in the elderly at half-dose for five to seven days (and then full dose), to minimise adverse effects. Other aspects of management that may be at least as important as medication (for example, psychological and social supports, domiciliary services) should also be addressed. Once treated, and assuming a good response, my recommendation would be to maintain the antidepressant agent indefinitely because the risk of relapse in these situations is quite substantial. MT

DECLARATION OF INTEREST: None.