Case Report

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AN ELECTRO-CONVULSIVE REFRACTORY, DIFFICULT TO TREAT CASE OF RECURRENT SEVERE DEPRESSION WITH CATATONIA

Arish Khan, Kushagra Varma, Jai Singh, Hina Bano, Saloni

Department of Psychiatry

Era's Lucknow Medical College & Hospital, Era University, Sarfarazganj Lucknow, U.P., India-226003

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Address for correspondence
Dr. Kushagra Varma
Department of Pathology
Era's Lucknow Medical College & Hospital, Era University, Lucknow-226003
Email: Kushagravarma1@gmail.com
Contact no: +91-8408082333

ABSTRACT

We report on a 24 year old woman presented with low mood, reduced appetite, disturbed sleep and anxiety for which she was prescribed oral medication from a local practitioner in form of antidepressant(SSRI), anxiolytic(BZD) and upon no improvement, she underwent 8 rounds of successful electroconvulsive therapy (ECT) on which she responded partially and was discharged on SSRI. A few days after visited the same doctor and reported of having low mood, crying spells, referential and paranoid ideas and an attempt of suicide for which 10 more sessions of ECT were given. She presented in psychiatry OPD with catatonia where she was advised admission and diagnosed as a case of recurrent depressive disorder with catatonia and was managed with suprathreshold doses of SSRI and responded well.

KEYWORDS: Pyloric Gland Adenoma, Endoscopy, Stomach.

INTRODUCTION

Major depression can be due to multiple factors including predisposing temperament , personality traits, exposure to traumatic and stressful life events and genetic susceptibility. Depression can be unipolar or bipolar type. Typically the course of the disease is recurrent - 75% of patients experience more than one episode of major depression within 10 years(1).Although most patients recover from major depressive episode, about 50% have an inadequate response to an individual antidepressant trial (2). It is crucial to adequately treat depression in the early stages of the illness, in order to prevent morphological and functional abnormalities. The presence of residual symptoms should be carefully considered leading to the prescription of treatment in order to prevent recurrences from the first depressive episode. According to IPS guidelines adequate treatment for at least 4-6 weeks is necessary before concluding that a patient is not responsive to a particular medication.(3) It can take two successive trials of medications of different categories for adequate duration before considering treatment resistant depression.(3) ECT is generally not used as a first line treatment in major depressive disorder unless there are specific indications for it. Brain stimulation techniques should be reserved for situations of treatment resistance and recommended only from the fourth line of treatment i.e after the failure of three adequately conducted trials on first line antidepressant(4)

CASE REPORT

A 24-year- old female from lower middle socio-economic rural family with a well adjusted pre morbid personality came to psychiatry OPD with the complaints of low mood which was persistent and pervasive, reduced appetite, disturbed sleep and anxiety in form of dry mouth, palpitation and abnormal tingling sensation which would occur for whole day from last 8 months. Patient's family members noticed she was interacting less with them. She use to stay in bed all day and also had frequent crying spells. They consulted a private psychiatry hospital where the patient was prescribed oral medication in form of antidepressant(SSRI), anxiolytic(BZD) and multivitamins in optimum doses, on which in next 20 days she reported partial improvement in her symptoms of anxiety but no significant reduction in her low mood symptoms. In repeated follow-ups she received 8 sessions of Electroconvulsive therapy over a period of 20 days on which she responded partially as she reported 30 percent reduction in her low mood symptoms. She was discharged on SSRI and was compliant on medication but after two months her condition again worsened as she started having low mood , reduced energy, crying spells, referential and

paranoid ideas and there was also an attempt of suicide in the form of jumping from roof after which she was again taken to the psychiatrist. There she was admitted and 10 more sessions of ECT were given over a period of 25 days after which patient reported 50 per cent improvement in her depressive symptoms. Patient was discharged on oral medication i.e. tab fluoxetine 20 mg in a day. One month after the ECT, patient again developed depressive symptoms with similar severity. In addition to her depressive symptoms patient used to keep standing on the door and listen to the conversations of the family members. Since the last seven days patient was staying quiet and kept holding food in her mouth. She kept staring for long durations, maintaining same posture for hours and would not respond to anyone. She was not accepting food from two days so thefamily members brought the patient to ELMC&H Psychiatry OPD where she was advised admission. Here she was diagnosed as a case of recurrent depressive disorder current episode severe with psychotic symptoms with catatonia (ICD 10) and was started on tab olanzapine 10 mg at night, tab escitalopram 10mg at night, tab lorazepam 2mg three times a day.

On admission HAMD and BFCRS were applied on which her scores were 25 and 18 respectively. The dose of escitalopram was uptitrated up to 30 mg/day in 2 weeks' time frame. Patient was also given Tab Lithium 450mg/day to prevent recurrence and suicidal tendency, Tab. Olanzapine 10mg/day for paranoid symptoms and Tab. Lorazepam 2mg thrice a day for catatonic symptoms. Gradually Lorazepam was withdrawn seeing the improvement in her catatonic symptoms. Over a period of 1 month significant reduction in depressive symptoms was seen on HAM-D scale(reduced to 13) and BFCRS from 18 to zero. Patient is currently maintaining well in follow-up with regular compliance.

DISCUSSION

A general principle with antidepressant therapy is that treatment for the acute phase is also used in the continuation treatment. According to the British Association for Psychopharmacology and the CANMAT, the decision between switching and adjunctive strategies should be individualised based on clinical factors including the tolerance of the current first line antidepressant, the number of previously failed treatment, the severity of the illness, patient preferences and partial/insufficient response on the current first line antidepressant.(5)

A recent meta-analysis has shown that there is substantial evidence for increase in efficacy with higher doses of SSRIs starting from the point of initial titration.(6)There is evidence for raising the SSRI dose to higher levels when there is an inadequate response if patient can tolerate the higher doses as in our case. Higher doses tends to give a 5% greater 5-HTT occupancy, which raise extracellular serotonin and thus increases efficacy of the antidepressant.(7).There is evidence that when ECT is used in the acute phase of depression patients tend to have higher relapse rates. High relapse rates are not surprising given that most patients are medication-resistant, and ECT is usually withdrawn at the moment it becomes effective. Although continuation/maintenance ECT is a successful option in preventing relapse, it is not a practical solution for persons still in their productive years, and is resource intensive.(8) The relapse rates have been reported to be as high as 84% within the first 6 months after ECT(9) Seeing the recent evidence we have used suprathreshold doses of SSRI in our patient.

CONCLUSION

It is important to follow standardized treatment guidelines while treating a patient. Proper trial of a drug should be done and slowly increasing the dose of medication and waiting for optimum duration to see the desired effect instead of changing the drug frequently or choosing any other treatment modality like ECT.

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Orcid ID:

Arish Khan - https://orcid.org/0000-0002-2052-7999

Kushagra Varma - https://orcid.org/0000-0001-7839-1644

Jai Singh - https://orcid.org/0000-0002-0045-2977

Hina Bano - https://orcid.org/0000-0002-5905-8544

Saloni - https://orcid.org/0000-0001-5134-942X

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