Depression is a leading cause of disability worldwide and is commonly encountered in the primary care setting. It is important that primary care physicians detect depression in their patients. Once identified, appropriate management is needed. This includes pharmacological treatment, sufficient rest, and social support. When prescribing an antidepressant, selective serotonin reuptake inhibitors (SSRIs) or serotonin and noradrenaline reuptake inhibitors (SNRIs) are suggested as the first-line treatment for depression, because they are as effective as tricyclic antidepressants but less likely to produce side effects, as compared to tricyclic antidepressants. Exceptions are patients who have had previous adverse reactions to SSRIs, who are on medication that might interact with an SSRI, and who evidently benefited from a non-SSRI previously. It has been 10 years since SSRIs were approved for use in Japan. As of June 2009, three SSRIs (fluvoxamine, paroxetine, and sertraline) and one SNRI (milnacipran) can be prescribed in Japanese clinics and hospitals. It is also a good strategy to work with psychology professionals, like registered psychologists, to provide cooperative psychological support for depressed patients. For example, in one study, supportive psychotherapy was reported to be useful to manage American women with depression in an administrative conference room of a local supermarket (1). Although it is often difficult to arrange for such a conference room in a supermarket or public place in Japan, the circumstances may change when people have sufficient knowledge of depression and when patients can feel less of a psychological hesitation toward the diagnosis of depression. Commonly used guidelines and educational programs are effective, but their simple use may be insufficient to improve the management of depression in primary care. Active participation at study conferences on depression and consultations with psychiatrists should encourage primary care physicians in the management of depressed patients.

Recently, Tanno et al (2) reported that 2.5% of 4,680 outpatients visiting a general medicine clinic at a university hospital between 2004 and 2008 were prescribed SSRIs for depression. The percentage is comparable with the results of a previous study of outpatients visiting a university hospital in 2002-2003 (3), which found that 1.6% of 644,444 prescriptions were for SSRIs and SNRIs. Tanno et al (2) also reported that 24% of depressed outpatients newly prescribed an SSRI discontinued the SSRI within 4 weeks. This is similar to the 28% of primary care patients prescribed tricyclic antidepressants who discontinued medication within 1 month of starting in Western countries (4, 5). Although it has long been suggested that SSRI use is less likely to be discontinued because of side effects, clinicians need to monitor compliance with the SSRI regimen carefully, to minimize the number of dropout cases with depression.

Patients should be discouraged from discontinuing SSRIs on their own volition because discontinuation symptoms occur in approximately one-third of the patients who stop SSRI therapy. In some patients, the discontinuation symptoms can cause considerable morbidity; they can also be misdiagnosed leading to inappropriate treatment, and can adversely affect future antidepressant compliance (6). Although the exact mechanism of the SSRI discontinuation symptoms is still unclear, the symptoms are probably due to an abrupt decrease in available synaptic serotonin in the face of down-regulated serotonin receptors. Once discontinuation symptoms occur, there are two main treatment approaches (7). One approach is to restart the drug, since the symptoms resolve rapidly following the reinstitution of the SSRI. However, there may be clinical indications for discontinuing the SSRI and the symptoms tend to recur when the same SSRI is later discontinued. The alternative approach is to allow the symptoms to run their natural course.

While half of patients experience symptom resolution within 1 week, a significant number may experience symp-
toms for several weeks. Such patients should be educated on the nature of the symptoms and be reassured that they will be resolved. For example, we encountered a case who suffered from SSRI discontinuation syndrome after taking an SSRI for 4 months (8). A 26-year-old Japanese man diagnosed with depression suffered from agitation and irritability, especially in response to noise, 3 to 4 days after his medication was changed from paroxetine 10 mg (4-month duration) to amitriptyline 50 mg, for financial reasons. Initially, SSRI discontinuation syndrome was not diagnosed because the clinical symptoms were masked by the symptoms associated with depression (e.g., irritability, nausea, and headache). Although the impulsiveness and agitation soon disappeared, this patient remained very confused and irritated by the sudden onset of the syndrome and came to distrust the physician responsible for this treatment. He canceled his appointments with this physician, and the physician-patient relationship deteriorated. The symptoms of SSRI discontinuation syndrome were thought to have exacerbated the patient’s anxiety and depression, generating distrust of the physician. The latter attempted to maintain a supportive attitude and explain the nature of SSRI discontinuation syndrome. At the same time, the underlying depressive state was ameliorated and the patient started keeping medical appointments.

Critical appraisals of epidemiological studies of SSRI discontinuation syndrome have shown that the syndrome is self-limiting and abates after a relatively short duration. Furthermore, there is no evidence of a statistically significant relationship between SSRI discontinuation syndrome and suicidal ideation or dose at the time of discontinuation. Nevertheless, a physician planning to terminate or reduce SSRI use should provide adequate information about any possible adverse effects before implementing any changes. By so doing, the physician-patient relationship might be maintained or reinforced, contributing to continued treatment.

References


© 2009 The Japanese Society of Internal Medicine
http://www.naika.or.jp/imindex.html