

Augmentation Strategy with Low Dose Aripiprazole in Long Standing Persistent Depressive Disorder: A Case Report from India

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Abstract

Depression is the leading cause of disability among women in the world, frequently under recognized and inadequately treated. In spite of the different antidepressants available at the present time, they are far from ideal and show a similar slow & frequently incomplete response. This case report describes a 75 yr. old woman with persistent depressive disorder with intermittent major depressive episodes lasting for almost 40 years who was inadequately treated. It highlights the effectiveness of augmentation of low dose Aripiprazole in long standing persistent depressive disorder with intermittent major depressive episodes. After optimization of treatment with a known anti-depressant the augmentation strategy can produce a therapeutic response as early as 2 weeks with more than 50% reduction in symptoms on PHQ-9 scores.

Key words: Augmentation strategy, Aripiprazole, Persistent depressive disorder, Recurrence.

Introduction

Depression is the leading cause of disability among women in the world with a female to male risk ratio of approximately 2:1 [1, 2]. But although depression affects a significant proportion of the population [1], it is under recognized and if diagnosed, frequently inadequately treated.

In spite of the different antidepressants available at the present time, they are far from ideal and show a similar slow & frequently incomplete response [3, 4]. Thus the need for new compounds & augmentation strategies is as urgent and compelling as ever [1].

Case Presentation

This is a case of a 75-year old lady who was diagnosed with persistent depressive disorder with intermittent depressive episode for nearly 40 years. She was widowed, living by herself and having 4 children who were in close contact with her daughter, living close by visited on a regular basis taking care of her medical and at times, domestic needs as well. The case report is based on the verbal communication or clinical interview of the patient as well as corroborative clinical evidence from available medical records. The patient had her first major depressive episode in 1974 after the birth of her first baby. She had been somewhat opposed to the arranged marriage and developed some depressive symptoms even before her marriage.

She described very vividly what happened during the course of her pregnancy and thereafter when she gave birth to her baby. She reported domestic abuse after marriage, continuing through her pregnancy and thereafter. At first she developed low backache and excessive fatigue with sadness of mood present on most days. Slowly the depression worsened to the point where she started to neglect caring for the baby after childbirth and also started having poor sleep and appetite. She felt she was not being a good mother to her baby and eventually began having suicidal ideations. This was when she was taken to a doctor for the first time and was prescribed a tricyclic antidepressant and she continued to be on the same for about a year. She reported around 20% improvement with the medication but discontinued the medications as she planned to conceive again. Within a month she began to have severe symptoms of depression again. She also described continued stressors and domestic abuse on the part of her husband and his family all through this time lasting for nearly twenty years till the death of her husband. During this second episode of depression, which continued during her second pregnancy, she started to have bouts of suicidal ideations and even had a deliberate self-harm attempt by overdosing on her medications. This resulted in a spontaneous abortion. She reportedly was started on the same treatment again, however, this time around she was given Electro Convulsive Therapy (ECT) treatment as it was; at the time; one of the best treatments

available according to her doctor. Although she reported around 40% improvement in symptoms with the new treatment modality, she continued to have intermittent episodes with severe depressive symptoms. Among these she described depressive episodes during postpartum periods for her next 3 pregnancies as well. She subsequently had more episodes, relapsing every two to four years with a new episode of depression never returning to 100% baseline functioning in between the episodes. However she never reported suicidal ideations during any of these recurrent episodes except during her second pregnancy. She was given a trial of many antidepressants individually, including monoamine inhibitors, tetracyclic antidepressants, selective serotonin reuptake inhibitors, serotonin nor-epinephrine reuptake inhibitors, nor-epinephrine dopamine reuptake inhibitors, serotonin antagonist and reuptake inhibitors but never up to the maximum therapeutic dose. However, she was never initiated on any kind of medication that was used as an augmentative therapeutic modality. She did report consulting a local Ayurveda doctor who had given her medications in their armory but did not see any consistent effect in terms of complete recovery. The patient was also given a trial of two more courses of ECT during 2 of these episodes.

Diagnosis and Treatment

When she presented to us finally she was in her fifteenth episode as she recalled it. She met the DSM V diagnostic criteria for Persistent Depressive disorder with intermittent major depressive episodes, with current episode. She had a PHQ 9 (Patient Health Questionnaire 9) [5] of 12 despite being on antidepressants at the time she consulted us. She was on Sertraline 150 mg at night along with a multivitamin supplement on presentation to us. She was also recently diagnosed with hypertension and was started on Atenolol 20 mg daily. We increased her Sertraline to 200 mg and since she was tolerating the medication well we started her on Aripiprazole 2.5 mg daily at night as an augmentative strategy.

Outcome and Follow Up

The response to treatment, with a higher dose of antidepressant along with a small dose of antipsychotic as an augmentative strategy, was dramatic and her PHQ-9 score at the next visit, two weeks later was 2.

Discussion

Thus it can be argued that augmentative strategies in persistent depressive disorder even in geriatric age groups are worth a trial after optimization of treatment with a known antidepressant. This is especially important knowing the fact that for each depressive symptom the annual decline on global cognitive measures decreases by an average of 24% in the elderly [6]. The patient in this case report presented with similar symptoms as during her previous visits with a psychiatrist and this was not unusual for her. Not being suicidal was also a good reason for using an augmentative strategy to be on the safer side. A review of literature shows that augmentation with a small dose of an antipsychotic for treatment resistant Major Depressive Disorder works and works well enough to the point where the patient has complete remission from symptoms [1]. Furthermore, when considering antipsychotics, the question of the least harm is answered in the usage of Aripiprazole for the treatment and augmentation strategy, as it has been proven to have minimal side effects at low dosages [7].

In conclusion, this case illustrates using an augmentative strategy like low dose aripiprazole. While at the same time optimizing the dose of the antidepressant is one of the augmentation strategies possible for treatment of persistent depressive disorder. In the present case, a fast and safe response in the acute phase of illness is significant [8]. What remains to be seen is whether this treatment strategy is effective in relapse prevention and more so with treatment adherence in larger population studies.

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