

mindovermatter

by Professor Gordon Parker

Late-onset melancholia

Melancholic depression with a vascular cause creates management difficulties.

PRESENTATION

SAM, a retired 76-year-old schoolteacher, described a three-year history of depression that had not responded to several seemingly appropriate antidepressant drugs.

HISTORY

Sam had developed his first episode of depression in his 70s, six months after his wife had died. Features suggested a fairly classical melancholic depressive sub-type.

He described a significantly depressed mood, lacked the energy to get out of bed most mornings, reported impaired concentration and psychomotor changes ("walking slowly and thinking slowly").

His family observed that he had "lost the light in his eyes" and could not be cheered up.

Sam had initially seen a counsellor who had judged that he had a severe and abnormal grief reaction, but after six sessions and no improvement, Sam had sought assistance from his GP.

The GP had trialled him on two selective serotonin reuptake inhibitors (SSRIs)

and, subsequently, on the dual-action antidepressant venlafaxine, without any success. He was referred to a psychiatrist, with the GP noting that Sam had been physically well apart from intermittent hypertensive episodes in the last two years.

By the time Sam got to see a psychiatrist, his clinical state had deteriorated. His family said he lay in bed all day, offered monosyllabic answers to any questions and ate minimally.

On examination, he was clinically dehydrated.

MANAGEMENT QUESTIONS

Why had Sam developed melancholia so late in life, having never seemingly experienced any significant depressive episode previously?

Secondly, at his age, what might be the appropriate management strategies?

PROGRESS

Hospitalisation was arranged. At admission, Sam's blood pressure was 190/120 mmHg, but over the next 2–3 days it normalised fairly rapidly with a low-dose antihypertensive drug, which was then able to be ceased.

Investigations included an MRI scan of the brain. The report stated that there were "scattered foci of abnormal

signal intensity in the cerebral hemispheric white matter consistent with a microvascular ischaemic aetiology".

He was trialled on a broad-spectrum tricyclic antidepressant drug alone (albeit starting at low dose and gradually increasing it) before augmentation with an atypical antipsychotic, but without improvement.

ECT was then initiated, and Sam had a good response, with his family judging him as 90% better.

He was discharged on the medium-dose tricyclic antidepressant, and stayed reasonably well for 12 months before his depression returned – as severe as previously.

On this occasion, ECT was associated with an improvement of only some 70 per cent. Following discharge on maintenance medication, he remained in partial remission for only about three months – and on his next admission, responded only some 50% to ECT.

In the following year, despite quite intensive treatment regimes of ECT and medication, he showed ongoing general impairment and distinct cognitive limitations. Thus, inter-episode intervals and therapeutic response decreased, before becoming non-existent.

At this stage, he was not looking particularly depressed and there was more of a poverty to his mood state.

DIAGNOSIS

Sam had essentially experienced an 'organic' melancholia initially, where the melancholia heralded a vascular dementia.

Melancholia is a state involving a triad of key symptoms (depression, psychomotor disturbance and cognitive impairment) that occur following functional and/or structural interruption of the neurocircuits linking the basal ganglia and the prefrontal cortex.

In functional melancholia, we presume that there is a primary disturbance in neurotransmitter function in those who have a genetic predisposition and where episodes (especially initial ones) are precipitated by stress.

In structural melancholia, the circuits are disrupted structurally, frequently reflecting the individual carrying cardiovascular or cerebrovascular risk factors and having experienced microvascular damage from small infarcts (commonly associated with a hypertensive episode).


The MRI report confirmed the organic nature of such a contribution to Sam's mel-

ancholia. Early in the course of such structural melancholic episodes, there is a functional perturbation that allows some therapeutic optimism.

Untreated, many of these individuals are assumed to have a dementia (in fact, they are experiencing a pseudo-dementia reflecting the severity of their melancholia) and often end up in nursing homes rather than having any depression-based component initially treated.

Rather than viewing them as beyond assistance, most – especially in the early stages – will benefit from assertive treatment (i.e. broad-spectrum antidepressants, augmenting antipsychotic drugs and ECT), but with lower drug doses and decreased ECT frequency to reduce the chance of inducing a delirium.

However, as the vascular dementia becomes more distinctive, the capacity to assist individuals out of their depression becomes more difficult.

Most will experience two to five years where their melancholic episodes can be assisted with assertive interventions. 

Gordon Parker is scientia professor, University of NSW, and executive director, Black Dog Institute.

clinicaltrials

Type I diabetes

MORE than 7000 children and adolescents in Australia have type I diabetes, and by the time they have matured into adulthood, more than 50% will have developed at least one complication of diabetes, such as vision impairment or kidney failure.

A collaborative study being conducted over the next three years will help young

people with type I diabetes effectively self-manage their diabetes and prevent the complications that can occur.

Researchers from the University of Sydney, University of Western Sydney, the Diabetes Clinic at Royal Prince Alfred Hospital and Novo Nordisk Pharmaceuticals are looking for young people with type I diabetes, aged 8–18 years, and their parents to participate in a study being conducted into this condition.

"By identifying the factors which impair or facilitate self-management, more effective healthcare provision can be given and tailored to the individual's personal and family needs," said project investigator Dr Lorraine Smith for the University of Sydney Faculty of Pharmacy.

"This will not only give children with diabetes a healthy start to life but promote their health and wellbeing as adults," she said.

Children participating in the study will be followed for three years to monitor changes as they move from childhood to adolescence to early adulthood. Researchers will visit each family once a year and contact the family by telephone every three months to collect data.

To find out more about this study, please contact Dr Jane Overland on 02 9515 5930 or overlandjane@email.cs.nsw.gov.au.