دکتر سید سادات سپهرتاج- روانپزشک، شیراز

Mood disorder

اگرجوان باپپولاری ازدواج کند بهتر میشود؟

اگر زوجهای باپپولار بچه دار شوند چه اتفاقی می افتد؟

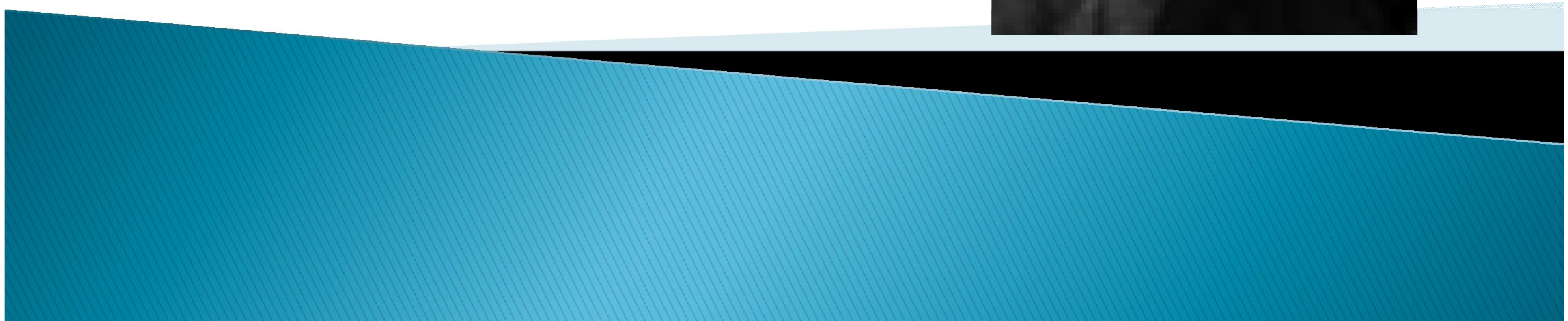
یک بیمار افسرده چند مدت دارو استفاه کند؟ باپپولار چطور؟

وجه افتراق فاز مانیا در باپپولارها از فاز حاد اسکیزوفرنی چیست؟

چه توصیه هایی برای جلوگیری از عود افسردگی و مانیا دارید؟

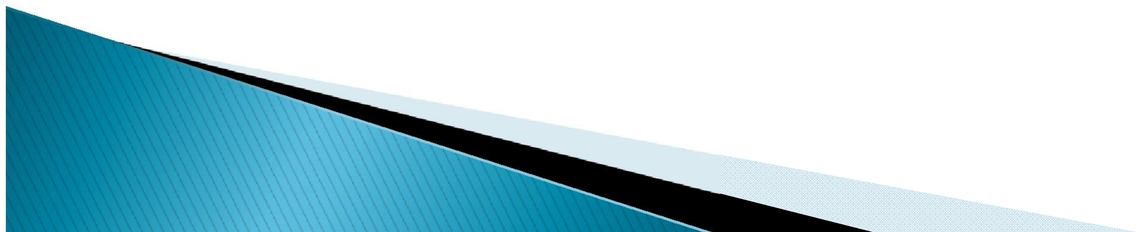
احتمال دارد بیمار افسرده به باپپولار تبدیل شود؟

depression

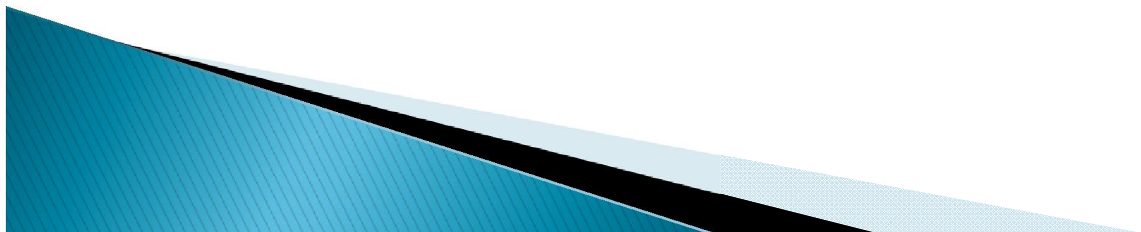


- twofold greater prevalence of major depressive disorder in women than in men. Depression is more common in rural areas than in urban areas

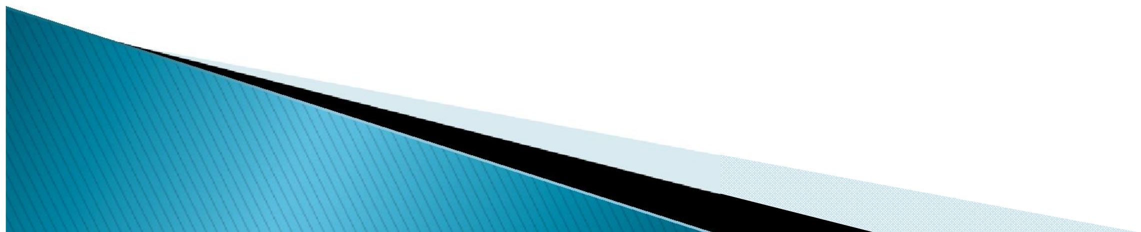
- norepinephrine and serotonin



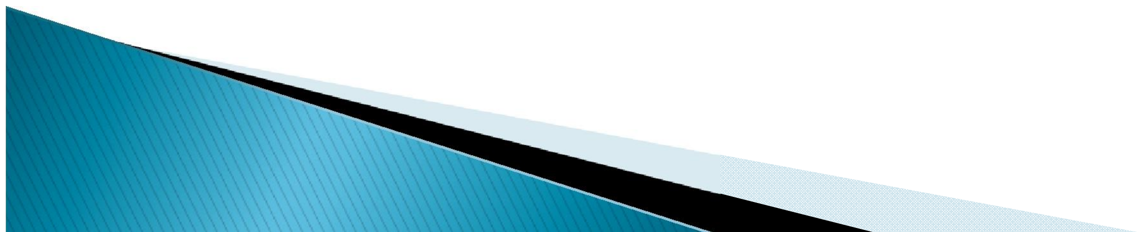
- Family Studies
- if one parent has a mood disorder, a child will have a risk of between 10 and 25 percent for mood disorder. If both parents are affected, this risk roughly doubles(20-50)



- genes explain only 50 to 70 percent of the etiology of mood disorders. Environment or other nonheritable factors must explain the remainder(30–50)



- Recent stressful events are the most powerful predictors of the onset of a depressive episode
- The environmental stressor
- loss of a spouse.
- unemployment three times more likely to major depression
- losing a parent before age 11



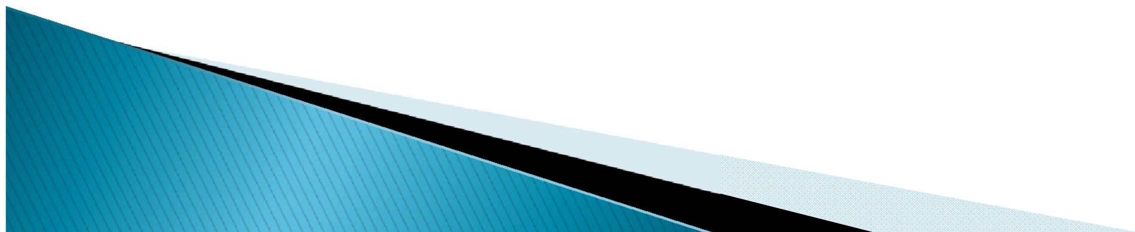
Diagnosis

DSM-5 Criteria for M D D

Five (or more) of symptoms during t2-week
at least one of the symptoms is either:

(1) depressed mood or

(2) loss of interest or pleasure



- 3-significant weight loss (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day

- 4-insomnia or hypersomnia nearly every day

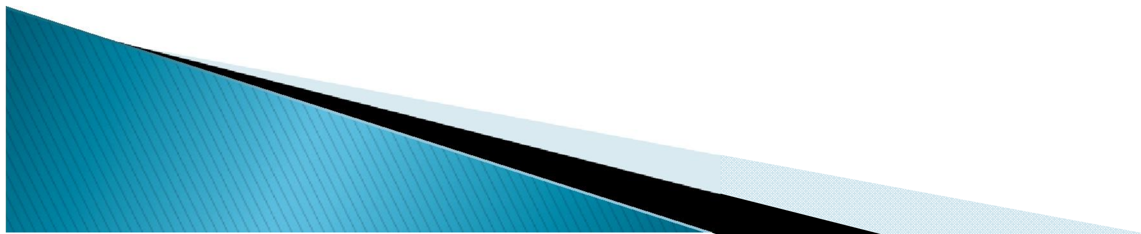
- 5-psychomotor agitation or retardation

- 6-fatigue or loss of energy feelings of worthlessness or

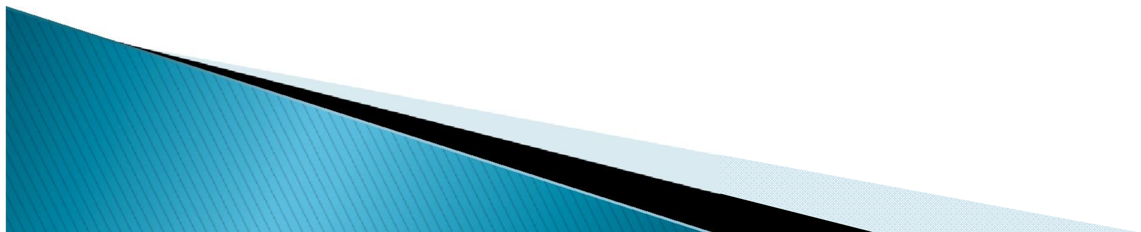
- 7-excessive or inappropriate guilt

- 8-diminished ability to think or concentrate
- 9-recurrent thoughts of death- recurrent suicidal ideation

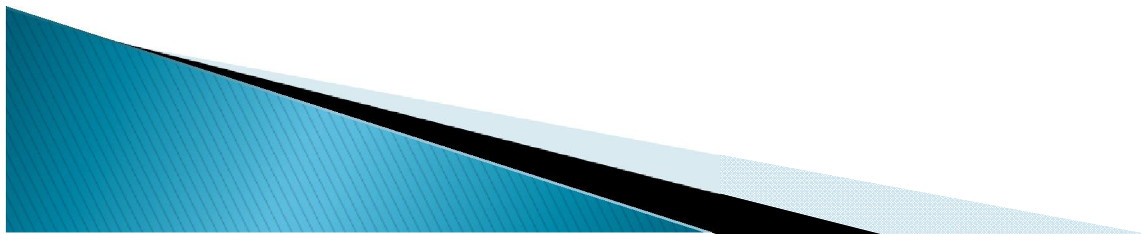
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.



- 97 Anxiety, a common symptom of depression,
- 90 percent of all depressed patients complain about reduced energy
- 80 percent of patients complain of trouble sleeping, especially early morning
- 70 percent of all depressed patients contemplate suicide, and 10 to 15 percent commit suicide.

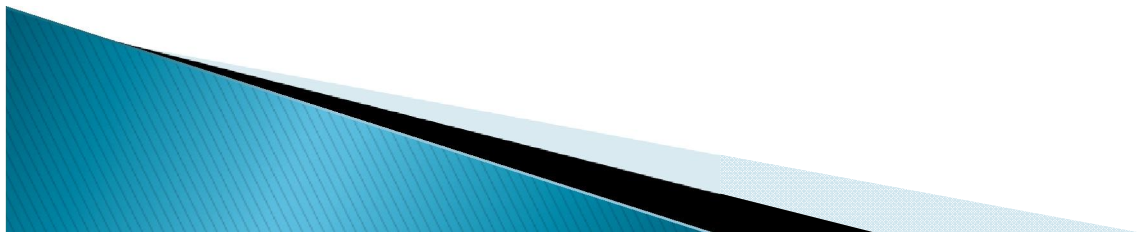


- abnormal menses and decreased interest
  * constipation and headaches
- diabetes, hypertension, chronic obstructive lung disease, and heart disease.



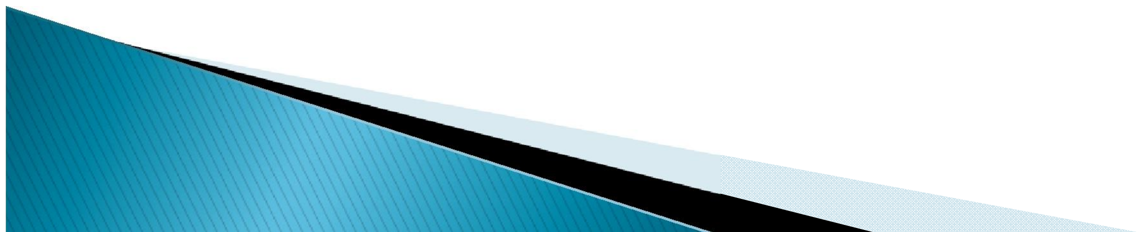
- Course & Onset

- An untreated depressive episode lasts 6 to 13 months;
- most treated episodes last about 3 months.

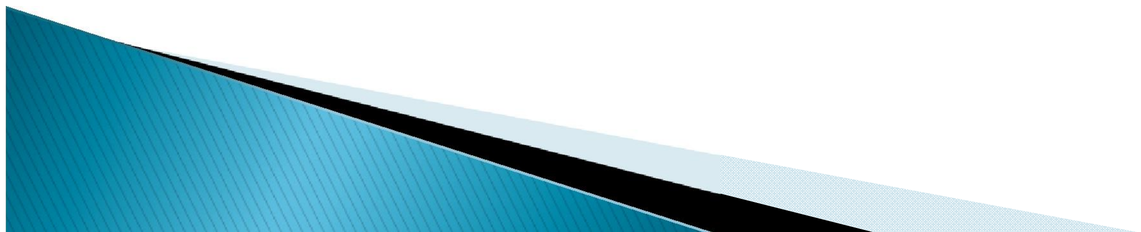


- ***Treatment***

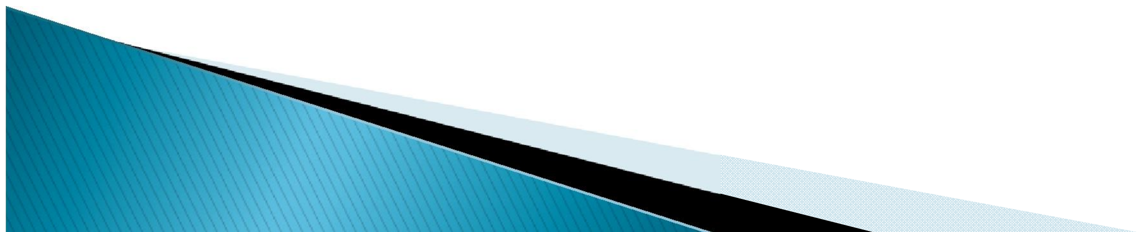
- Desipramine 75–300
- Protriptyline 20–60
- Nortriptyline 40–200
- Maprotiline 100–225



- Amitriptyline 75-300
-
- Doxepin 75-300
- Imipramine 75-300
-
- Trimipramine 75-300
- Clomipramine 75-300



- Citalopram 20–60.
-
- Escitalopram 10–20
- Fluoxetine (Prozac) 10–40
-
- Fluvoxamine (Luvox)[b] 100–300
- Paroxetine (Paxil) 20–50
- Sertraline (Zoloft) 50–150

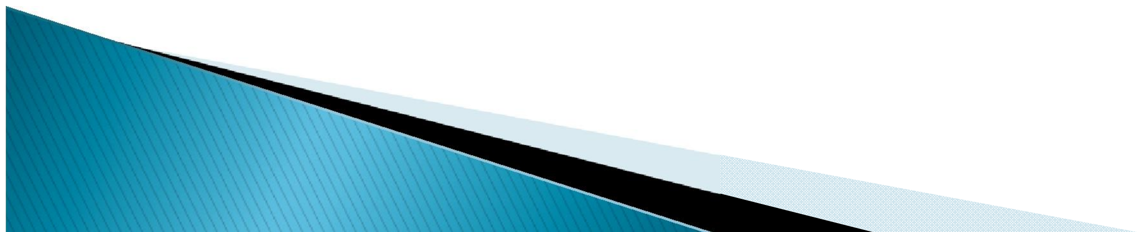


- Venlafaxine (Effexor) 150-375

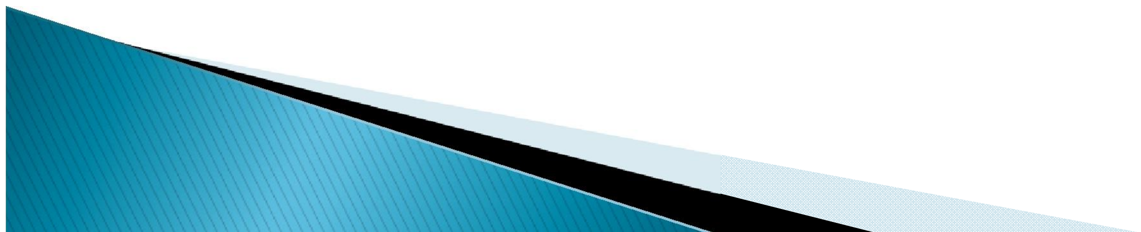
Duloxetine (Cymbalta) 30-60

- Bupropion (Wellbutrin) 200400

- Trazodone 150-600

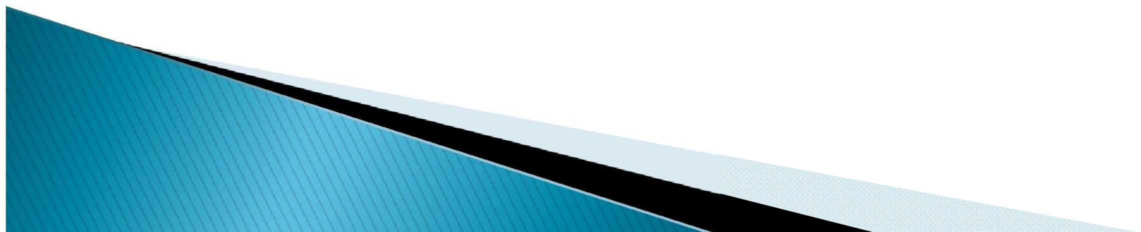


- ***Side effects of TCAs***
- Drowsiness,
- hypotension,
- CA
- weight gain. Dose titration is needed. [A]
- Dry mouth, blurred vision, urinary hesitancy, and constipation
- Overdose may be fatal

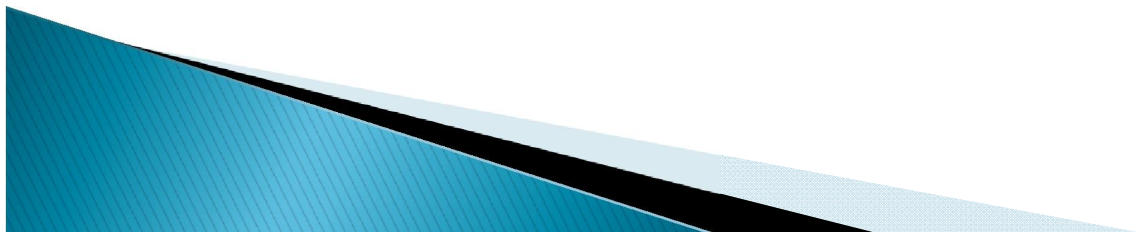


- Side effects of SNRIs
- Sleep changes,
- GI distres
- discontinuation syndrome Higher doses may cause hypertension.
- Dose titration is needed.

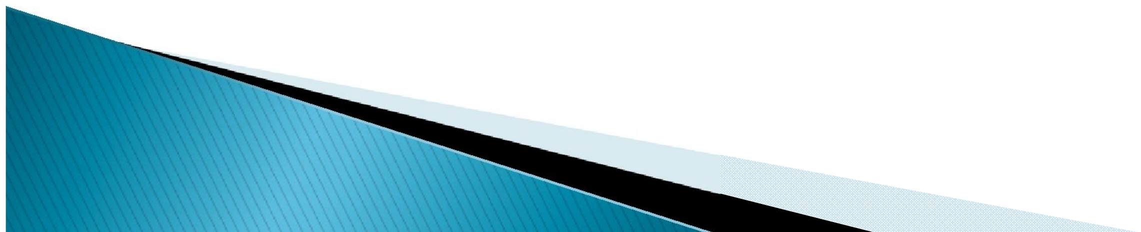
- Abrupt discontinuation may result in discontinuation symptoms.



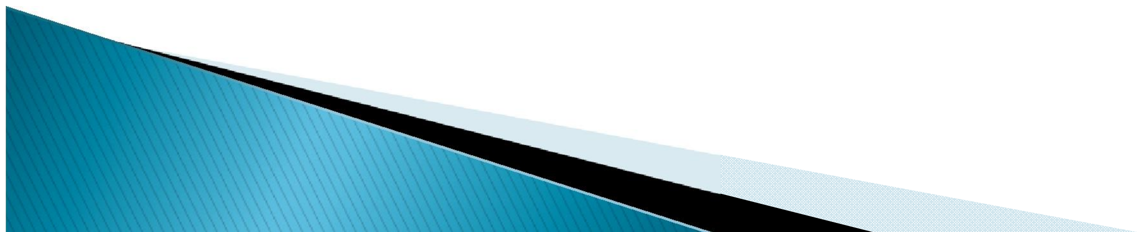
- All SSRIs may cause insomnia, agitation, sedation, GI distress, and sexual dysfunction Many SSRIs inhibit various cytochrome P450 isoenzymes. They are better tolerated than tricyclics and have high safety in overdose. Shorter half-life SSRIs may be associated with discontinuation symptoms when abruptly stopped



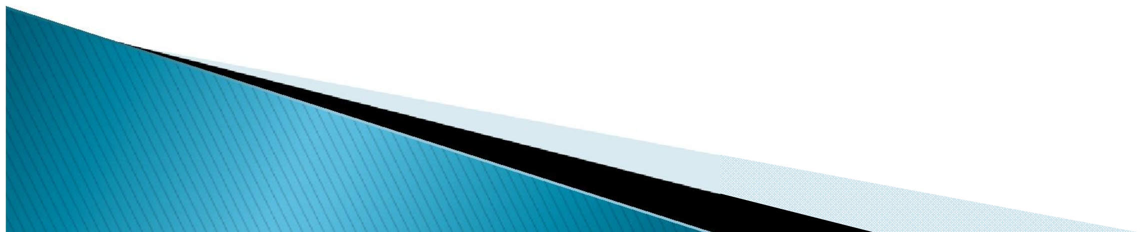
- Bipolar I Disorder
- Course
- Bipolar I disorder most often starts with depression (75 percent)
- The manic episodes typically have a rapid onset (hours or days), but may evolve over a few weeks. An untreated manic episode lasts about 3 months



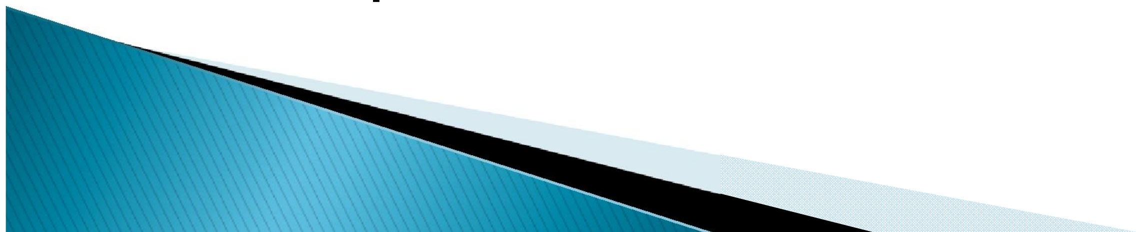
- Bipolar II disorder is a chronic disease
- Treatment
- Overall, the treatment of mood disorders is rewarding for psychiatrists.



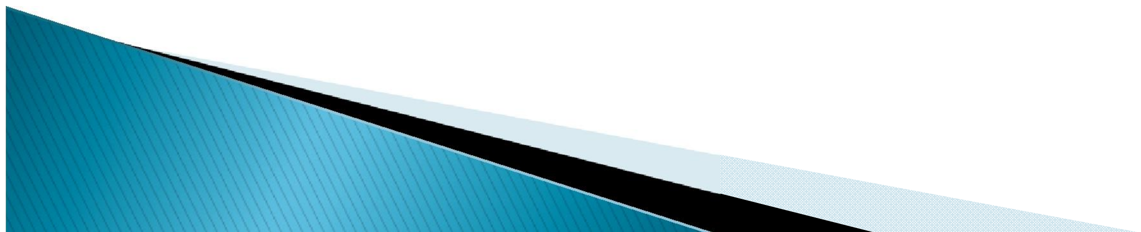
- indications for hospitalization are the risk of suicide or homicide, a patient's grossly reduced ability to get food and shelter, and the need for diagnostic procedures. A history of rapidly progressing symptoms and the rupture of a patient's usual support systems



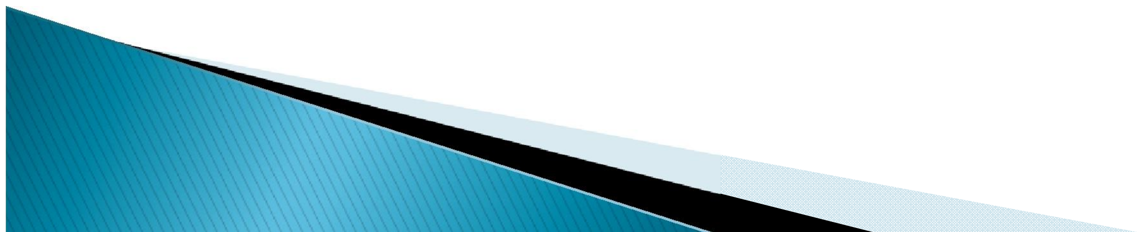
- antidepressants may take up to 3 to 4 weeks The most common clinical mistake leading to an unsuccessful trial of an antidepressant drug is the use of too low a dosage for too short a time. Unless adverse events prevent it, the dosage of an antidepressant should be raised to the maximum recommended level and maintained at that level for at least 4 or 5 weeks before a drug trial is considered unsuccessful. Alternatively, if a patient is improving clinically on a low dosage of the drug, this dosage should not be raised unless clinical improvement stops before maximal benefit is obtained.to exert significant therapeutic effects



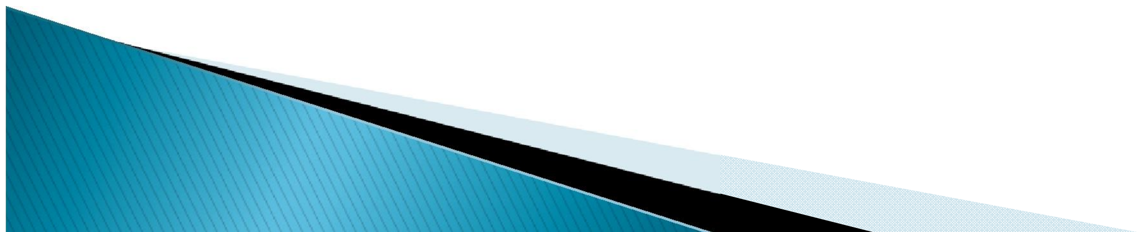
- Duration and Prophylaxis
- Antidepressant treatment should be maintained for at least 6 months

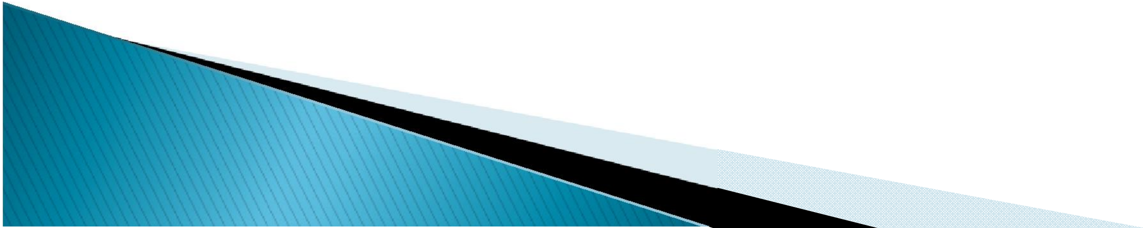


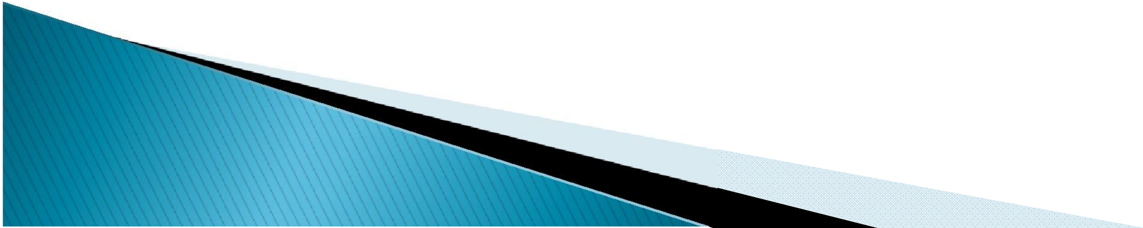
- Initial Medication Selection
- The available antidepressants do not differ in overall efficacy, speed of response, or long-term effectiveness. Antidepressants, however, do differ in their pharmacology, drugâ€“drug interactions, short- and long-term side effects, likelihood of discontinuation symptoms, and ease of dose adjustment.



- approximately 45 to 60 percent of all outpatients with uncomplicated (i.e., minimal psychiatric and general medical comorbidity), nonchronic, nonpsychotic major depressive disorder who begin treatment with medication respond (i.e., achieve at least a 50 percent reduction in baseline symptoms); however, only 35 to 50 percent achieve remission







- Treatment of Acute Mania
- The treatment of acute mania, or hypomania, usually is the easiest phases of bipolar disorders to treat.

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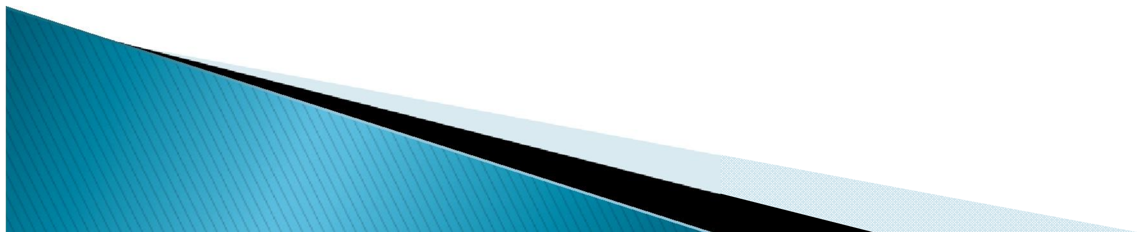
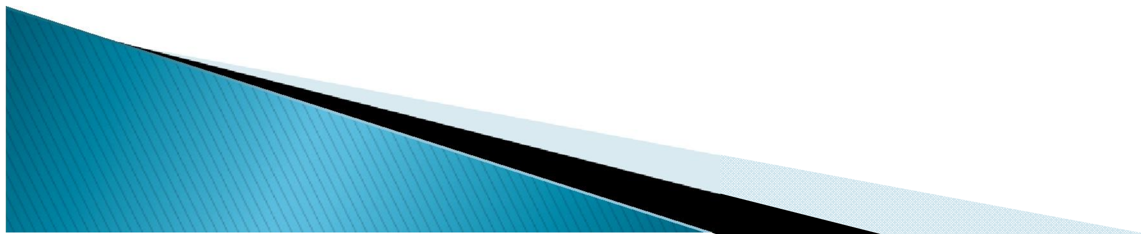
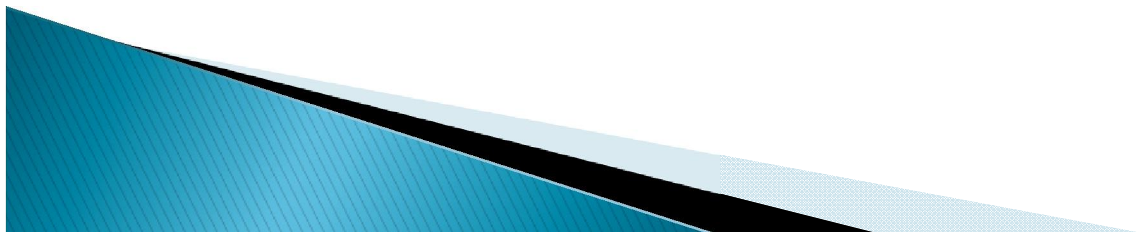


- Patients with severe mania are best treated in the hospital where aggressive dosing is possible and an adequate response can be achieved within days or weeks.

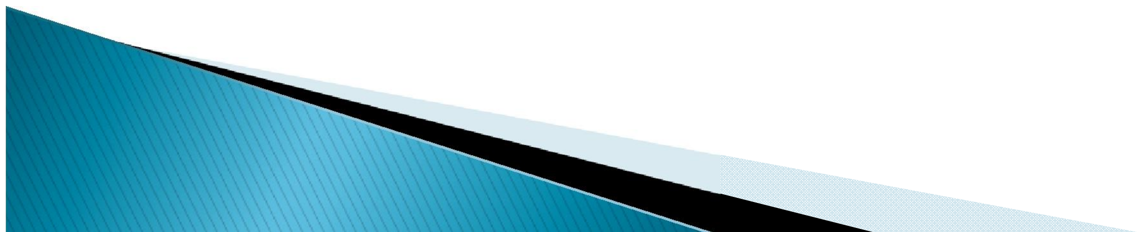


- Lithium Carbonate
- Valproate
- Carbamazepine
- Clonazepam and Lorazepam

- Atypical and Typical Antipsychotics



- Treatment of Acute Bipolar Depression
- a mood stabilizer in the first-line treatment for a first or isolated episode of bipolar depression. A fixed combination of olanzapine and fluoxetine (Symbyax) has been shown to be effective in treating acute bipolar depression for an 8-week



- Electroconvulsive therapy may also be useful for bipolar depressed patients who do not respond to lithium or other mood stabilizers and their adjuncts, particularly in cases in which intense suicidal tendency presents as a medical emergency.