Case Report

# Paroxetine in the treatment of recurrent brief depressive disorder

**Sathya Prakash, Piyali Mandal, Rajesh Sagar**

*Department of Psychiatry, All India Institute of Medical Sciences, New Delhi, India*

ABSTRACT

Recurrent brief depressive disorder is now a well-recognized type of depressive disorder. However, there is still no clear evidence base for its treatment. The efficacy of several drugs including antidepressants and mood stabilizers in this disorder has been controversial. Methodological limitations need to be considered when interpreting the results of studies on efficacy of drugs in this disorder. We report a case of recurrent brief depressive disorder that responded dramatically to paroxetine. However, there is a need for larger, methodologically sound, double-blind, placebo-controlled studies.

**Key words:** Antidepressants, mood stabilizers, paroxetine, recurrent brief depression

## INTRODUCTION

Recurrent episodes of brief depressive symptoms not lasting 2 weeks is not an uncommon clinical presentation. Typically, they last only for a few days, but are associated with much morbidity. Significant suicidal behavior has also been noted with such episodes.[1] Descriptions of brief depressions have been found historically in the work of a number of authors,[2] but have been accepted as a diagnostic entity only in the latest editions of ICD[3] and DSM.[4] Treatment of recurrent brief depressive disorder (RBDD) has been controversial with evidence largely from case reports and series. Double-blind, placebo-controlled studies have yielded largely negative findings.[1] We present a case of RBDD successfully treated with paroxetine.

| Access this article online | |
|---|---|
| Quick Response Code: | Website: www.jpharmacol.com |
| | DOI: 10.4103/0976-500X.119718 |

## CASE REPORT

Our patient was a 48-year-old lady who was a local politician and who was carrying out her duties satisfactorily for the past several years. About a year and a half prior to her presenting to us, she developed symptoms characterized by low mood, anhedonia, easy fatigability, decreased concentration, hopelessness, and decreased sleep and appetite. These symptoms developed following a minor stressor at work and were clearly disproportionate to the stress. The symptoms had developed abruptly and the patient had never experienced such symptoms earlier. She had been an emotionally strong and confident lady earlier and was herself surprised at her current condition. She also developed prominent suicidal ideations and tried to kill herself by setting herself on fire, but was incidentally found and rescued by her maid. These symptoms continued for 4-5 days and were spontaneously remitted. Similar episodes occurred on almost a monthly basis for the next 18 months, each lasting 3-5 days. The interval varied between 15 and 40 days. They were unrelated to her menstrual cycles. There was no history of mania or psychosis. In the inter-episodic period, the patient was fully functional and carried out all her duties satisfactorily. Initially, the patient did not realize that it was a

**Address for correspondence:**
Sathya Prakash, Department of Psychiatry, All India Institute of Medical Sciences, Ansari Nagar, New Delhi - 110 029, India.
E-mail: dr.sathyaprakashtbts@gmail.com

psychiatric illness, but after several such episodes, she consulted a private psychiatrist who started her on escitalopram (10 mg). It was continued for 4 months with no improvement. She changed psychiatrists and was tried on mirtazapine (15 mg) irregularly for 3 months without improvement. She did not follow-up with one psychiatrist and therefore full doses were not tried. She eventually presented to us during an episode and was off all psychotropics at that time. We made a diagnosis of RBDD as per ICD 10 and started her on paroxetine (10 mg). She scored 24 on Hamilton depression rating scale[5] at the time of presentation. Although her symptoms resolved in about 4 days time, the dose was gradually increased to 25 mg/day, but, in the following month, she again had an episode lasting for about 4 days. She scored 20 on Hamilton depression rating scale this time and had somewhat less frequent suicidal ideation. Paroxetine dose was further increased to 50 mg. About 25 days later, the patient again developed depressive symptoms in the form of mild fatigue and some decrease in self-confidence, which lasted for 3-5 days. She now scored only 7 on Hamilton depression rating scale during the episode. There were no ideas of hopelessness, helplessness, worthlessness, or suicidal ideation. However, the lack of confidence still prevented her from carrying out her duties in those 3-5 days, although otherwise she was symptomatically much better. However, with one session of supportive counseling, she managed to get back to work as well. In the subsequent month, although she complained of mild fatigue, there were no other symptoms and she started doing her duties satisfactorily. The patient was continued on the same dose and is on regular follow-up. Thereafter, for the subsequent 9 months, she maintained the full symptomatic improvement.

## DISCUSSION

As mentioned earlier, treatment of RBDD has been controversial. Three different double-blind, placebo-controlled trials of paroxetine in patients suggestive of episodes of RBDD have been negative.[6-8] Similar studies with fluoxetine, flupenthixol, citalopram, and mianserin have been negative, but small samples tried on carbamazepine, verapamil, and nimodipine have shown positive results.[1] Open trials with fluoxetine have yielded encouraging results. Case reports of successful treatment have been published for lamotrigine,[9] tranylcypromine, carbamazepine,[1] lithium,[10] mirtazapine,[11] and olanzapine.[12] Negative case reports have been published for amitryptiline, clomipramine, and maprotiline.[1] The above discussion suggests that there is no unequivocal evidence of efficacy of any drug from methodologically sound studies. It needs to be highlighted that studies have tended to use samples with comorbid personality disorders, somatic illnesses, or frequent suicidal behavior. Below, we have provided examples of methodological limitations of studies on paroxetine to illustrate this point.

In a study of 91 patients treated with paroxetine, there was some effect in reducing suicidal behavior, but none on depressive mood, hopelessness, and anger.[7] But 74 of these patients had at least one cluster B personality disorder. Paroxetine was also significantly more effective in patients who met fewer than 15 criteria for cluster B personality disorders than in those who met more than 15 criteria. Thus, the presence of personality disorder might have led to the treatment of resistance and therefore might not paint the true picture of pharmacological treatment of this condition. This is also the case with some other studies,[6,8] on paroxetine. Similar observations have been made by pioneering researchers in the field.[1]

It is therefore worthwhile considering antidepressants as the first choice in the treatment followed by mood stabilizers as second-line agents.[1] Including the current report, paroxetine, and fluoxetine are the only selective serotonin reuptake inhibitor (SSRI) drugs that have yielded positive results. Interestingly, these are the only two SSRIs that have additional noradrenergic properties at higher doses that can contribute additional antidepressant effects.[13] Unfortunately, there are hardly any reports of serotonin norepinephrine reuptake inhibitors, whether successful or otherwise, in this disorder. Given the lack of clarity on distinct features of neurobiology of RBDD, this hypothesis is worth considering. While interpreting the results of this report, one must also remember that there are reports of recurrent brief depression going into spontaneous remission. One way to test this would be to suspend treatment and re-challenge if the episode returns. But, for ethical reasons, we did not try the same. However, the present report being only a case report, needs replication in larger trials with representative samples.

## REFERENCES


1. Pezawas l, Angst J, Kasper S. Recurrent brief depression revisited. Int Rev Psychiatry 2005;17:63-70.
2. Angst J. The history and concept of recurrent brief depression. Eur Arch in Psychiatry Clin Neurosci 1994;244:171-3.
3. World Health Organisation. The International statistical classification of diseases and related health problems. 10th ed. vol. 1., Geneva: World Health Organization; 1992.
4. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4th ed. Washington, DC: American Psychiatric Association; 1994.
5. Hamilton M. A rating scale for depression. J Neurol Neurosurg Psychiatry 1960;23:56-62.
6. Kocmur M, Dernovsek M, Tavcar R. Effect of paroxetine on intermittent brief depression episodes and suicide attempts among patients with personality disorders. A doubleblind, placebo-controlled study. Psychiatria Danubina 1998;10:283-6.
7. Verkes RJ, Van Der Mast RC, Hengeveld MW, Tuyl JP, Zwinderman AH, Van Kempen GM. Reduction by paroxetine of suicidal behavior in patients with repeated suicide attempts but not major depression. Am J Psychiatry 1998;155:543-7.
8. Kasper S, Stamenkovic M, Pezawas L. Recurrent brief depression: Diagnosis, epidemiology and potential pharmacological options. In: Palmer KJ, editor. Managing Depressive Disorders. Auckland, NZ and Philadelphia: Adis International; 2000.

9. Ravindran LN, Ravindran AV. Lamotrigine in the treatment of recurrent brief depression. Int Clin Psychopharmacol 2007;22:121-3.
10. Corominas A, Bonet P, Nieto E. Recurrent brief depression successfully treated with lithium. Biol Psychiatry 1998;44:927-29.
11. Stamenkovic M, Pezawas L, de Zwaan M, Aschauer HN, Kasper S. Mirtazapine in recurrent brief depression. Int Clin Psychopharmacol 1998;13:39-40.
12. De la Fuente JM. Case report: Excellent response to long-term higher dose single olanzapine in a case of recurrent brief depression. Pharmacopsychiatry 2008;41:156-8.
13. Stahl SM. Antidepressants. In: Stahl SM, editor. Stahl's essential psychopharmacology. 3rd ed. Cambridge: Cambridge university press; 2008.

**How to cite this article:** Prakash S, Mandal P, Sagar R. Paroxetine in the treatment of recurrent brief depressive disorder. J Pharmacol Pharmacother 2013;4:288-90.
**Source of Support:** Nil, **Conflict of Interest:** None declared.