Mood disorders are common among the medically ill and tend to worsen, as illness becomes more severe. Major depressive disorder (MDD) occurs in 4–6% of the general population, in 5–10% of medically ill outpatients, and in 10–30% of hospitalised medical inpatients. Rheumatic diseases such as fibromyalgia, chronic fatigue/pain syndromes, rheumatoid arthritis, systemic lupus erythematosus (SLE), scleroderma, and Sjögren’s syndrome (SS) are associated with psychiatric disorders or symptom states. Depression is associated with increased functional disability, pain, and stressors like low autonomy, low income, marital status and high demands.

There are other approaches to diagnosing depression in the medically ill. The substitutive approach emphasises impaired concentration and indecisiveness rather than loss of energy. The exclusive approach eliminates anorexia and loss of energy from the list of nine symptoms; in addition, it requires five of the seven remaining DSM criteria to diagnose depression in a medically ill patient. Because this approach leads to false-negative results, its sensitivity is poor.

Self administered scales (for example, Beck Depression Inventory, Zung Self-Rating Depression Scale) are helpful in screening for depression and following the improvement of depressive symptoms after starting treatment. Dependent on the scale used, rates of mood disorders in rheumatological patients are different. We recommend that the diagnosis should be made by the applications diagnostic criteria using the inclusive approach.

In SLE patients, careful identification of neuropsychiatric phenomena and generation of a differential diagnosis are crucial. Miguel et al made organic diagnoses of depressive symptoms in patients with concomitant lupus and depression. Utset and colleagues showed that patients with CNS lupus and secondary SS have higher rates of depression than patients with other organ involvement, suggesting an organic cause for depression.

The treatment of mood disorders includes use of psychopharmacological agents, talking therapies, electroconvulsive therapy (ECT), and neurosurgery. With recent advances in psychopharmacology, drug treatment of depression succeeds in up to 80% of cases.

Although no more efficacious than tricyclic antidepressants, selective serotonin reuptake inhibitors (SSRIs) are first line treatment for depression in rheumatological patients because of their safety record and tolerability. SSRIs lack the anticholinergic, orthostatic, and cardiac-
conduction-prolonging effects common with tricyclic antidepressants, but commonly cause gastrointestinal symptoms, headache, nervousness, and sexual dysfunction.

To treat depression you should aim for the therapeutic dose of the drug (for example, 20 mg of fluoxetine, paroxetine, or citalopram) as soon as the patient can tolerate it, and maintain this level for four to six weeks. If the response is positive but partial, the dose should be raised (for example, to 30 mg) and treatment continued for two to four additional weeks. In unresponsive cases, augmentation and combination strategies may be beneficial if the patient has not responded by eight weeks. If these fail, psychiatric consultation may be very helpful. If the depression tends to recur, it is important for patients and physicians to recognise recurrent symptoms so that treatment can be resumed immediately.

Patients with fibromyalgia require a combined treatment approach. Improvement will come faster if they can accept that restoration of function (for example, to move, walk, work, play), not pain relief, is the primary goal of treatment. Improvement of sleep, regular exercise, and treatment of depression (when present) are indispensable. Moreover, they stimulate appetite and weight gain in anorexic, cachectic patients and permit reduced doses of opioid analgesics while reducing their sedative effects and leaving the patient more alert. Although stimulant use must be monitored in patients with severe hypertension and ventricular irritability, clinical experience shows these agents to be remarkably benign.15

ECT is preferred for severe, life threatening depression, psychotic depression, and when drug treatment is judged more dangerous. Even patients with increased intracranial pressure have been safely treated.16

Two major psychotherapies have demonstrated effectiveness in the treatment of major depression in rheumatological patients: cognitive behavioural therapy (CBT), which deals with relations among affect, behaviour, and cognition, and interpersonal therapy (IPT), which deals with interpersonal relationships. In CBT, the patient learns to identify how the negative view of self, world, and future escalates to unwarranted generalisations (for example, “she snubbed me” to “nobody loves me”) and worsens mood. Patients learn to challenge and change this sequence. IPT is an equally commonsense process that deals with the current problem (for example, functional disability) and its impact on the patient’s relationships both at home and at work and how these relationships affect to mood.

Education about the symptoms and signs of depression is a major component of any psychotherapy for a depressed patient. During a mood episode, the patient should not make major life changes. Spouses and other family members benefit from periodic education and reassurance that they are not responsible for their loved one’s illness. Treatment continues until recovery is complete. As depression tends to recur, it is important for patients and physicians to recognise recurrent symptoms so that treatment can be resumed immediately.

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is resistant and the depression does not respond to two or more adequate trials of antidepressants, referral to a psychiatrist would be appropriate.

Although rheumatic diseases and psychiatric disorders are commonly comorbid, depression may not be recognised. Timely recognition and determined treatment can reduce the distress, despair, and dysfunction that cripple these patients’ lives.

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Diagnosis and treatment of mood disorders in patients with rheumatic disease

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