Editöre mektup / *Letter to editor*

Resistant depressive disorder in a patient treated with antiretroviral drugs for HIV
(Antiviral ilaç tedavisi gören HIV (+) hastada dirençli depresif bozukluk)

Filiz İZCİ[1]

To the Editor,

Recognizing the psychiatric manifestations of HIV disease can be complicated by the complex biologic, psychologic and social circumstances associated with this illness, and psychiatric symptoms often go unrecognized and untreated. The most common psychiatric manifestations are depressive spectrum disorders.[1] Also, some antiviral drugs used for the treatment of infection diseases like HIV may cause mood disorders such as depression and resistance to treatment.[2] A 39 year old male patient admitted with reluctance, anhedoina, insomnia, loss of appetite. It was learned that the patient had been recieving regular psychiatric treatment for 6 months but his complaints were increased for the past 1 month and he had started to make suicide plans. The patient was hospitalized with a preliminary diagnosis of depressive disorder. Treatment with emtricitabine + tenofovir disoproxil and efavirenz was administered to the patient. There was no special findings other than this in the patient and family history. In the psychiatric examination, speed of his speech and intonation was low, psychomotor activity was decreased, his mood and affect were depressive, anhedonia, insomnia, anorexia, anxiety, anergy, avolition and suicidal thoughts were present. HAM-D and HAM-A scores were 24 and 14, respectively. Paroxetine 20 mg/day, lorezepam 1 mg/day, quetiapine 200 mg/day was administered. Blood parametres were at normal range. Substance metabolites were negative in urine analysis. Because there was no significant decrease in HAM-D scores during the 1st and 2nd week of treatment paroxetine dose was increased up to 30 mg/day and quetiapine dose was increased up to 300 mg/day. During the 4th week of the treatment it is thought that the current anti-HIV drugs were increasing his depressive symptoms and the patient was consulted to infectious diseases department for drug selection. It was said that continuation of current drugs was required. Partial improvement was seen in the patient's complaints during the 6th week of the treatment. Lamotrigine 25 mg/day was added and increased up to 100 mg/day. In the outpatient follow up, HAM D scores were decreased to 8 and remission was achieved. Depressive symptoms are common among individuals living with HIV/AIDS; nationally representative data suggest that 36% of these individuals are likely to screen positive for clinical depression.[3] Also, Depression in HIV patients was most overt in the first six months when they were aware of the infection.[4] Mood disorders, anxiety, and substance use disorders can be seen in HIV(+) patients undergoing antiretroviral therapy. Antiretroviral treatment can exacerbate depressive symptoms and complicate treatment response. Emtricitabine has been used clinically in combination with tenofovir in HIV/HBV-coinfected patients.[5] The adverse effects of emtricitabine include some psychiatric symptoms as headache, depression, insomnia, nightmare.[6] The neuropsychiatric side effects of an efavirenz, such as; insomnia, fatigue, depression, suicide attempt, headache and dizziness, have been reported between 20-40%.[7] Besides, the adverse effects of tenofovir include gastrointestinal symptoms, dizziness, fatigue, and headache.[8] In our patient and in this group of patients, it should be considered that drugs used for the treatment of infectious diseases may complicate treatment response.

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[1] İstanbul Bilim University, School of Medicine, Department of Psychiatry, İstanbul
E-mail: filizizci@yahoo.com