Ir J Psych Med 1998; 15(1): 41-42

RE: Cogito ergo sum? - refocusing dementia ethics in a hypercognitive society. Ir J Psych Med 1997; 14(4): 121-3.

Sir – I wonder if I might make two comments on the excellent editorial on the treatment of dementia by Desmond O'Neill (Vol 14 (4) December 1997). The first concerns the way in which decisions are made regarding drugs which can improve cognition. Curiously. although few would doubt that our cognitive skills are the most important aspect of our bodily functions, it seems to take very low priority in terms of treatment. When L-dopa was introduced for the treatment of Parkinson's disease it was clear that it would not alter the prognosis of the condition, but its capacity to help people become more mobile was quickly recognised and became a universal treatment. The same now applies to the use of cholinesterase-inhibitors in the treatment of dementia but, because the outcome of the condition remains the same and because it is more difficult to establish cognitive improvement even though it is of the same level as the improvement in mobility with Parkinson's disease, Health Authorities are refusing to allow the drug to be prescribed. As your editorial says, this is cognitivism.

My other comment concerns the end stages of dementia where relatives sometimes have very inappropriate ideas about the preservation of life. Although I entirely agree that any decision as to treatment must involve discussions with relatives, it is important to recognise that our loyalty must primarily lie with the patients themselves and if relatives appear to demand painful and largely futile technological intervention, we have a duty to protect the patient. Secondly, it is extremely difficult for many relatives to suggest to a doctor that their parent be allowed to die. In my view, the onus is on the doctor to introduce this option after which the ice is broken and relatives and carers appreciate the opportunity to discuss the issue frankly.

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The use of SSRIs in depressed patients with Parkinson's disease.

Sir – A recent case report by Mannion *et al*[1] described two depressed patients with Parkinson's disease (PD) who each received paroxetine and developed subsequent exacerbations of their PD. I believe several comments are necessary to address this important issue more completely.

First, depression in PD has recently become an important treatment consideration. An estimate by Cummings, based on 26 studies, places its "frequency" at approximately 40% (range = 4%-70 %); the true prevalence rate has yet to be determined.[2] In their report, Mannion *et al*[1] note that antidepressants have demonstrated efficacy in relieving depressive symptoms in patient's with "presymptomatic" PD. While there may be anecdotal evidence to support this, a search for literature addressing the use of any antidepressant in patients with PD finds three things. First, there are few published investigations, and those which do exist employ inconsistent and nonrigorous methodologies. Second, many of these studies do not evaluate antidepressants as treatments for depression in patients with PD. Third, there are no published investigations evaluating the efficacy and safety of any selective serotonin reuptake inhibitor (SSRI) as a treatment for depression in patients with PD. This has been formally documented by a recently published meta-analysis which conveys an urgent need for further study in this area.[3] Thus, the available efficacy and safety data for the pharmacotherapy of depression in Parkinson's disease is quite deficient.

Second, in both patients, paroxetine was initiated at 20 mg/day which may have been an excessive starting dose. It is generally well accepted that in patients who are either neurologically compromised or who are older, that psychotropic medications be commenced at lower doses than what is typical. Thus, it is plausible to consider that a different outcome may have occurred had paroxetine been commenced at 10 mg/day.

A third point of comment involves information from the first patient for whom paroxetine and selegiline, a type-B specific monoamine oxidase inhibitor (MAOI), were co-prescribed. In patients who have concurrently received fluoxetine and a non-specific MAOI (eg., tranylcypromine, phenelzine), symptoms reflecting the serotonin syndrome (eg., tremor, agitation, confusion) have been reported.[4] Selegiline, in doses of 10 mg/day, has previously been reported to be used safely when co-prescribed with fluoxetine.[5] However, since selegiline may lose its specificity for monoamine oxidase type-B at 20 mg/day, the safety of using selegiline at this dose with an SSRI is uncertain and not recommended.

A final comment involves the extent to which extrapyramidal reactions (EPRs) have been reported to be associated with SSRIs; there at least 28 reports involving a minimum of 42 patients.[6] For those patients without PD, a full range of EPRs have been reported including what appears to be a reversible (tardive-like) dyskinesia. Important risk factors for developing EPRs after starting an SSRI may include concurrent antipsychotic use, using a rapid SSRI dose escalation strategy, treating with high daily SSRI doses, older patients, and female patients. Unfortunately, most available information is from anecdotal reports and thus there is a need for definitive risk factor guidelines.

Reports of patients with PD who have received an SSRI and experienced and exacerbation of their PD have typically been receiving standard pharmacotherapy for their PD. Patients involved have experienced exacerbations of tremor, rigidity, gait, postural instability and bradykinesia; all exacerbations were reported to have been reversible.

One possible reason why patients with PD develop depression may be due to disrupted central serotonin activity.[7] The SSRIs would then appear to be ideal antidepressants for these patients. However, the anticholinergic properties of the TCAs may also make these antidepressants desirable since medications with this pharmacologic property are commonly used in the treatment of PD. Potential drawbacks of the TCAs might include sedation, postural hypotension and dizziness which may all place PD patients at a higher risk for falls. The addition of a TCA to an existing anticholinergic may cause obvious complications for the patient, and TCAs have also been reported to cause EPRs.[8-10]

Regardless of the antidepressant selected, there remains limited published information detailing the efficacy and safety of antidepressants as treatments for depression in patients with PD. Consequently, selecting an antidepressant for a depressed patient with PD should include considering conservative dosing strategies and being aware of potential adverse effects and drug interactions.

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