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ALLERGIC REACTIONS - OUTCOME OF SERTRALINE AND ESCITALOPRAM TREATMENTS

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SUMMARY

The treatment of dysthymia in itself poses a problem in the everyday psychiatric practice and it can be further hindered when accompanied by pronounced personality traits (which are indicative of disorder). Due to its pathology and duration dysthymia interferes with the patient's quality of life and the ability to function in some segments of everyday life. These interferences enticed our patient to opt for psychiatric treatment.

During a three-year period, despite all the efforts made by psychiatrists in this comprehensive and challenging dysthymia treatment (psychotherapy, group psychotherapy, psychopharmacotherapy), the expected outcomes of the treatment did not occur. The patient's goals and expectations included lifestyle change, achieving life satisfaction and mood improvement. The patient was refusing suggested psychopharmaca until confronted, in psychotherapy, with the fact that she is the one prolonging her own helplessness and directing her passive aggression at the members of the group.

In the end the patient agreed to take psychopharmaca. Therefore, sertraline was introduced in the treatment, but the patient experienced a severe allergic reaction (Quincke's oedema). After four months the second attempt was made and escitalopram was introduced, which resulted in urticaria. Due to these allergic reactions to antidepressants, the patient decided not to pursue the psychopharmacological treatment.

Key words: dysthymia- antidepressants- allergic reactions

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INTRODUCTION

Dysthymic disorder is a condition characterised by chronic depressive mood that lasts for most of the day, more days than not, for at least 2 years. People who suffer from dysthymia describe their mood as sad or dispirited (desponded) (American Psychiatric Association 2000, World Health Organization 1999). Sufferers can exhibit appetite disorder (increased or decreased), low energy, low self-esteem, difficulties making decisions, and feeling of hopelessness.

Dysthymia interferes with the person's ability to function in everyday life, it reduces self-satisfaction and significantly decreases the quality of life. Recovery from dysthymia often takes a long time, and the symptoms often return.

The literature clearly shows that medications that are effective in treating major depressive disorder are also effective in dysthymic disorder. A systematic review of antidepressant treatment in dysthymia suggests that SSRIs, tricyclic antidepressants and monoamine oxidase inhibitors (MAOIs) are all equally effective, but SSRIs may be slightly better tolerated (Kilts et al. 2009).

Sertraline and escitalopram have comparable antidepressant efficacy in the treatment of major depressive disorder (Ventura et al. 2007).

Psychotherapy is also recommended alongside medication treatment. The effectiveness of several types of therapy, including psychodynamic, cognitive behavioral, and interpersonal therapy, has been demonstrated in controlled studies to be effective in the treatment of depression and dysthymia. Supportive psychotherapy and psychoeducation (teaching patients and their families about this illness) significantly improve patient compliance and family cooperation.

CASE REPORT

41-year-old female patient started receiving psychiatric treatment after the retirement. Prior to this she sporadically sought psychiatric help but did not use psychopharmaca. The psychiatric treatment was initiated with the intent of claiming disability pension.

The patient stated that she is the elder child. She described her father as being authoritative and mother as emotionally unavailable (lacking emotional warmth). She denied having any personal difficulties during her school years and described herself as a sociable person with a number of female friends (but no male ones). She did not have emotional relationships prior to getting married at the age of 36, following the short relationship and a mutual decision to start a family. Both spouses

were highly educated and employed, hence economically well situated. They did not have children.

At the first psychiatric appointment the patient refused psychopharmacotherapy, and was insistent in doing so for a lengthy period of time. However, she readily accepted other forms of treatment such as group and individual therapy which she attended regularly and with sufficient motivation. Dominant disturbances were related to her mood, which was predominantly depressive but not on a daily basis, and they were accompanied by poor concentration, neglect of physical appearance, sexual intimacy avoidance (the patient did not engage in sexual intercourse for more than 13 months, but she did often think about having children). Over an extended period of time she suffered from low self-esteem and was dissatisfied both her familial and professional life.

During the 36-month period after the patient started receiving psychotherapy there was an increase in body weight of approximately 20 kg, which the patient was reluctant to talk about. She also exhibited sleep difficulties.

The patient occasionally (once or twice a week) used alprazolam at a dose that did not exceed 0.5 mg/day. After 36 months of psychotherapy, which showed no significant improvement, the patient was persuaded by the group therapy members and the therapist to start antidepressant treatment. Sertraline was introduced at the initial dose of 25 mg due to the patient's reluctance and sensitivity to psychopharmacotherapy.

After the administration of the first dose, that is 2 to 3 hours after taking 25 mg of sertraline the patient experienced an allergic reaction and was forced to seek medical help. Due to suffocation symptoms, tongue oedema and facial flushing Quincke's syndrome was diagnosed by the dermatologist. The allergic reaction inevitably led to termination of the sertraline treatment.

After four months the second attempt at introducing antidepressants was made and once again the members of the group therapy and the therapist played an important role in persuading the patient (which was not an easy task). The patient reluctantly agreed to therapy and escitalopram was introduced, with extreme caution due to the previous negative experience, at the initial dose of 5 mg. After a couple of hours the patient experienced rash and whole body flushing as well as itching and diarrhoea. Consequently, she sought immediate medical help. A dermatologist diagnosed urticaria and prescribed a corresponding treatment. The antidepressant treatment was promptly stopped.

Since the two attempts at treating dysthymia with antidepressants resulted in severe allergic reactions, the patient decided not to pursue the antidepressant treatment.

Currently the patient does not receive psychopharmacology and the intensity of dysthymia symptoms is the same as it was at the beginning of the psychiatric treatment. The patient still receives psychotherapy.

DISCUSSION

Dysthymia is a disorder characterised by the chronic depressive mood. It can occur during adolescence, but can also develop later in life. When dysthymia occurs after the age of 21 it is diagnosed as a late-onset dysthymia, as was the case with the patient presented in this paper.

Duration of dysthymia is a diagnostic criterion that differentiates dysthymia from other mood disorders. Due to the nature of its symptoms, dysthymia interferes with the person's ability to function in everyday life. The person loses self-confidence and *joie de vivre*.

The treatment of dysthymia is similar to other mood disorder treatments. The basis of the treatment are antidepressants. In order for the treatment of dysthymia to be successful the patient has to actively participate in it. Avoiding psychopharmacology is unfavourable, and psychotherapy as the only method of treatment turned out to be ineffective in this particular case.

Sertraline is a selective serotonin reuptake inhibitor (5-HT). In accordance with its selective inhibition of reuptake of 5-HT, sertraline does not increase catecholaminergic activity nor it shows affinity towards muscarinic (cholinergic), serotonergic, dopaminergic, adrenergic, histaminergic, GABA or benzodiazepine receptors (Ventura et al. 2007).

Even though, according to our estimate, the antidepressant used in the treatment was safe, and there was a clear indication for it, the administration of the same resulted in Quincke's oedema. Prior to this, the patient was neither allergic to food or other allergenic substances.

When the next antidepressant which was indicated for the treatment and which we successfully used in the past, escitalopram, was introduced, the patient once again experienced dermatological side-effects. As a result we were forced to stop the escitalopram treatment.

The antidepressant action of escitalopram is presumably linked to the potentiation of serotonergic activity in the central nervous system resulting from its inhibitory effect on the reuptake of 5-HT from the synaptic cleft (Lalit et al. 2004). Escitalopram is a highly selective serotonin reuptake inhibitor. Escitalopram has no, or minimal effect on noradrenaline, dopamine and gamma-amino butyric acid (GABA) uptake (Llorca et al. 2005).

Despite the intensive psychotherapy, the patient remained passive-aggressive, which enabled her to control the members of the group and to impose both herself and her illness on the people around her. If she had consented to the recommended medication treatment earlier, she would have lost her position within the group. Moreover, the improvement of her psychological condition would inevitably lead to acquiring a new status in the group.

The case clearly shows that the patient experienced the same side effects when administered two different antidepressants. Considering the patient's strong ambivalence toward psychopharmaca, we wonder whether the side effects were not in fact defense mechanisms created so that the patient could perpetuate her passive-aggressive helplessness?

CONCLUSION

Each antidepressant, regardless of its administration safety and the positive clinical experiences, can pose a potential risk of side effects.

The administration of the antidepressants used in the treatment of dysthymia resulted in severe side effects. If we start with the premise that the allergic reactions are psychosomatic, is it not plausible that the side effects presented in this case are, in effect, patient's psychosomatic reaction to psychopharmacotherapy, which she refused for years?

Even though it is our belief that the combined methods of treatment (psychopharmacotherapy and psychotherapy) are more successful than individual ones, we cannot but conclude that each treatment has to be suited to patient's individual needs. In other words, the course of treatment has to be individualised.

REFERENCES

1. *American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, IV edition.* Washington DC: American Psychiatric Association, 2000.
2. Kiltz CD, Wade AG, Andersen HF & Schlaepfer TE. Baseline severity of depression predicts antidepressant drug response relative to escitalopram. *Expert Opin Pharmacother.* 2009;10:927-936.
3. Lalit V, Appaya PM, Hegde RP, Mital AK, Mittal S, Nagpal R, Palaniappun V, Ramsubramaniam C, Rao GP, Roy K, Trivedi JK, Vankar GK, Karan RS, Shah S & Patel RB. Escitalopram versus citalopram and sertraline: A double-blind controlled, multi-centric trial in Indian patients with unipolar major depression. *Indian J Psychiatry.* 2004; 46:333-341.
4. Llorca PM, Brousse G & Schwan R. Escitalopram for treatment of major depressive disorder in adults. *Encephale.* 2005; 31:490-501.
5. Ventura D, Armstrong EP, Skrepnek GH & Erder HM. Escitalopram versus sertraline in the treatment of major depressive disorder: a randomized clinical trial. *Curr Med Res Opin.* 2007; 23:245-250.
6. *World Health Organization. International statistical classification of disease and related health problems. 10th revision.* Geneva: World Health Organization; 1999.

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