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Case study

A CASE OF HYPOTHYROIDISM INDUCED RECURRENT DEPRESSIVE DISORDER

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ABSTRACT

Recurrent depressive disorder is a lifelong illness with relapses and remissions. The aetiology is biopsychosocial, genetic factors contributing and life stressors exaggerating the disease. Due to recurrent episodes the morbidity is quite high both for the patient and the family members. The poor compliance of drugs during the euthymic period acts as a trigger for relapse. The identification of comorbid physical conditions adding fuel to the disease process has to be identified and treated promptly. This case is reported to show the significance of undetected hypothyroidism in a patient with recurrent depressive disorder.

Keywords: Recurrent depressive disorder, Hypothyroidism, Mood stabilizer, Biopsychosocial cause.

INTRODUCTION

Recurrent depressive disorder is a long-term, mostly lifelong illness, presenting as bouts of depressive episodes separated by periods of normalcy. 50 to 60 % of those with a single episode of depression are prone to develop a second episode, 70 % of those with a second episode are prone to develop a third, and 90 % of those with a third episode are prone to develop further episodes of depression. These patients need to be treated with maintenance therapy in order to prevent relapses. Patients who have ongoing psychosocial stressors, comorbid illnesses, residual symptoms of depression are potential candidates for maintenance therapy [1]. The comorbid physical conditions which act as causative or aggravating factors are to be identified and treated effectively for long-term remission.

CASE REPORT

Mrs X, 60 yr. old married woman, studied up to 11thgrade, housewife was brought by her husband with complaints of low mood, feeling tired, crying spells, not able to do household work, sleep disturbance, suicidal ideas for past 2 mo. This was the 5th episode, insidious in onset, progressive in nature. Patient's husband reported that she started complaining of sadness, sleep disturbance 2 mo back. She stopped communicating with family members gradually, stayed alone in a room, had to be persuaded to eat, sleep, bath and take care of her daily needs. She had to be persuaded to change clothes and take care of her personal hygiene. She would take the bath once in 2 to 3 d and would do it in a hurry and come back and lie down. She had to be persuaded to do household activities and she would complain of tiredness and lie down. She would get irritated and shout at her husband if repeatedly asked to do any work. She was found to be awake in the middle of the night staring at the walls, at times crying alone for no reason. She was preoccupied of her illness and whether she would be cured of her illness or not. She would express her wish to live like a normal human being who is able to work, laugh, spend time happily with family, etc. She was found lamenting about her illness to herself and her relatives or neighbours who visit her. At times, she reported to her husband of having suicidal ideas and death wishes. She expressed fear that her mental illness might worsen and she might have to live with it her entire life. No history of any other psychotic symptoms, heads injury, seizures.

Patient was a known case of diabetes mellitus, diagnosed 10 y back, on treatment with oral hypoglycaemic agents and her blood glucose level and HbA1c were found to be within normal limits.

1st episode of depression started when the patient was 24 y old, when she was 3 mo pregnant with her second child. She was ambivalent about proceeding with the pregnancy because her first child was 8 mo old and she felt that it was too early for a second child. She was worried that her husband and in-laws might not approve of her decision and force her to continue with the pregnancy. She went to a private practitioner, medical termination of pregnancy was done without her husband's consent, but she developed excessive bleeding at home and she had to explain her pregnancy to her family members which created conflict among them. Subsequently she developed sleeplessness, complained of sad mood, communicated less with family members, did not take care of her first child properly. She felt guilty of the abortion. No treatment was given. She gradually became alright over a period of 5 to 6 mo. She attained premorbid level of functioning.

2nd episode of depression was when she was 45 y old, about a year after attaining menopause. She and her husband were about to relocate to new neighbourhood when she started expressing fear that she might not accommodate well in the new area and she might feel lonely. After shifting to the new house, her husband noted that she was becoming dull, withdrawn, crying on and off and sleepless at night. This continued for about 3 to 4 mo, as she did not improve she was taken to a private practitioner and was given sleeping pills. Her sleep improved but her depressive symptoms worsened. She started complaining of suicidal ideas and death wishes; she was taken for magico-religious treatment. She felt no improvement of the illness, and one day at 11 am when her husband went for work she removed all her jewels, locked the house and jumped in a well in the backyard. She was rescued by her neighbours who heard the sound. She felt bad about being rescued. Her husband gave voluntary retirement in order to look after her. She was taken to a private psychiatrist and was started on antidepressants and she improved and attained premorbid level of functioning after about 5 mo.

3rd and 4th episode, when she was 48 and 50 y of age, during the marriage of her first and second son respectively. She relapsed while on antidepressants on both the occasions. Each episode lasted for about 4 to 5 mo and she was on continuous treatment during these episodes. She was taken to her psychiatrist immediately after relapse on both the occasions and she improved.

Premorbidly, she was a hyperthymic person, extrovert, loves to be with people, had strong will power, tackled family problems with confidence, and looked after her family in a responsible and caring way.

On mental state examination during the 5th episode, she was alert, oriented, and kempt. Rapport established with difficulty. Talk was relevant and coherent. Preoccupations about her illness, ideas of worthlessness, hopelessness and low self-esteem were present. Suicidal ideas and death wishes were prominent. She was depressed and tearful. No psychotic symptoms were noted. No disturbance in memory noted. Intelligence was within normal limits. Haemoglobin, Blood cell counts, Blood sugar, Liver function test, renal function tests, Computerised topography of the brain were normal. T3 and T4 were low and TSH was high.

Psychological tests Rorschach test, HAM-D (Hamilton Rating Scale for depression) and HAM-A (Hamilton Rating Scale for anxiety) were administered. Patient was found to be having significant scores of depression in the areas of depressed mood, suicidal ideation, helplessness, hopelessness and worthlessness.

She was diagnosed as a case of recurrent depressive disorder, currently severe depressive episode without psychotic features with comorbid diabetes mellitus and hypothyroidism. Patient's consent was obtained for publishing without revealing her identity.

She was started on the mood stabilizer Sodium valproate and antidepressant SSRI Sertraline and the doses titrated. She was started on thyroxine supplementation. Treatment of comorbid illness diabetes continued. Patient improved gradually and attained euthymic state over a period of 3months. Patient was followed up over a period of 1 y during which she was both euthymic and euthyroid.

DISCUSSION

This case is reported for the significance of hypothyroidism induced mood disorders especially in females [2]. Biopsychosocial aetiology of this case has to be borne in mind while treating all psychiatric disorders and a holistic approach towards the patient has to be done [3]. Continuation therapy is intended to prevent the relapse, that is, to suppress the symptoms of a current depressive episode from which the patient has not fully recovered[4]. Usually, continuation therapy lasts 4 to 6 mo after a patient has responded in the acute phase of treatment [5]. Maintenance therapy is a designed to prevent recurrence, or the development of a new episode, once an acute episode and the continuation treatment phase are over [6]. According to guidelines established by Hirschfeld, the duration of maintenance therapy is 6 to 24 mo [7]. If other more curative treatment options are not available, maintenance therapy may be needed for an indefinite amount of time for certain patients; maintenance therapy may translate into lifelong treatment. The key characteristics that qualify a patient with major depression for maintenance therapy are the number of prior episodes the patient has had and the frequency of recurrence. Patients who have had 2 episodes within several years or a lifetime history of 3 or more episodes would be likely to show the greatest benefit from longer-term, preventive therapy. Psychotherapies like cognitive behaviour therapy (CBT), mindfulness-based cognitive therapy (MBCT), and interpersonal therapy (IPT), short-term psychodynamic psychotherapy (STPP) should be chosen and tailored according to the needs of the patient [8].

Patient has to be taught about the signs of relapse and the advantages of early identification and treatment of depression by the health care specialist. Psycho education should be given both to patient and caregiver about how the severity of depression and the number of episodes can be curtailed effectively with appropriate and timely treatment [9]. The need for compliance of treatment has to be highlighted and can be ensured by home visits by the psychiatric social worker.

Supportive psychotherapy during the period of remission is important. Coping skills should be taught to patients to deal with ongoing psychosocial stressors.

Family members should be taught about the importance of expressed emotion and how much the love and care of family members helps in reducing the morbidity and mortality [10].

The need for treatment of the comorbid illnesses like diabetes mellitus and hypothyroidism and the influence of comorbid illness on depression severity and relapse are to be explained to the patient [11].

The inclusion of biological, psychological and social triggers and its role in the course and prognosis of the disease is to be taken into account while treating.

CONFLICT OF INTERESTS

Declared None

REFERENCES

1. Coryell W, Endicott J, Keller M. Predictors of relapse into major depressive disorder in a nonclinical population. Am J Psychiatry 1991;148:1353–8.
2. Dayan CM, Panicker V. Hypothyroidism and depression. Eur Thyroid J 2013;2:168-79.
3. Chris KW. Schotte. A biopsychosocial model as a guide for psychoeducation and treatment of depression. Depression and Anxiety. 2006;23:312–24.
4. Kupfer DJ. Long-term treatment of depression. J Clin Psychiatry 1991;52(Suppl 5):28–34.
5. Keller MB. The long-term treatment of major depression. J Clin Psychiatry 1999;60(Suppl 17):41–5.
6. Keller MB, Boland RJ. Implications of failing to achieve successful long-term maintenance treatment of recurrent unipolar major depression. Biol Psychiatry 1998;344:348–60.
7. Robert MA. Hirschfeld. The comorbidity of major depression and anxiety disorders: recognition and management in primary care. Prim Care Companion J Clin Psychiatry 2001;3:244–54.
8. Cuijpers Pim, Van Straten, Annemieke Andersson, Gerhard van Oppen, Patricia. Psychotherapy for depression in adults: a meta-analysis of comparative outcome studies. J Consulting Clin Psychol 2008;76:909-22.
9. Kae Shimazu, Shinji Shimodera, Yoshio Mino, Atsushi Nishida, Naoto Kamimura, Ken Sawada, Hirokazu Fujita, *et al*. Furukawa, Shimpei Inoue. Family psychoeducation for major depression: randomised controlled trial. Br J Psychiatry 2011;198:385-90.
10. H Hayhurst, Z Cooper, ES Paykel, S Vearnals, R Ramana. Expressed emotion and depression. A longitudinal study. Br J Psychiatry 1997;171:439-43.
11. How land R. General Health, health care utilization, and medical comorbidity in dysthymia. Int J Psychiatry Med 2005;23:211-38.