*Case Report*

# SUCCESSFUL TREATMENT OF RECURRENT BRIEF DEPRESSION

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**ABSTRACT**

Recurrent brief depressive disorder (RBD) is a well-defined and significantly prevalent affective disorder with an increased risk of suicidal behaviour and significant clinical impairment in the community and general practice. RBD is characterized by depressive episodes occurring at least once a month and lasting for only few days and the lack of a successful treatment represents one of the main challenges of this disorder. We report on a 21-years-old married woman who presented with a three years history of sudden depressive episode with a twenty days recurrences lasting 7-10 days of depressive symptoms such as psychomotor retardation and mutism. The patient was treated with imipramine and fluoxetine for a while and in spite of maintaining the treatment, recurrence of depressive episodes were continued but since sodium valporate therapy was added, she has remained euthymic without any recurrence of depressive symptoms. The absence of recurrence for a year since sodium valporate treatment was started, suggest a prophylactic effect of this agent on RBD.

**KEY WORDS:** Depressive disorder, Recurrence, Mood stabilizer medication.

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## INTRODUCTION

Recurrent brief depression (RBD) is an affective disorder with periodic episodes occurring almost every month that are unrelated to the menstruation cycle and last only a few days. The diagnostic criteria for RBD requires the presence of at least five out of nine depressive symptoms analogous to the symptoms of major depression, yet a duration of less than two weeks, according to DSM-IV and ICD-10 diagnostic criteria. RBD is a well-defined and significantly prevalent affective disorder with an increased risk of suicidal behavior and significant clinical impairment in the community and general practice. Suicide attempts have been reported in 7.8% of RBD patients.[1-4]

Available data indicate that the 10-year prevalence rate for this disorder is estimated to be 10 percent for people in their 20s and the 1-year prevalence in the general population is about 5%. These numbers indicate that RBD is most common among young adults.[1,5] Further epidemiological and clinical studies are needed to develop preventation strategies and specific treatment.[1,6-8] The DSM-IV criteria for RBD specify that the symptom duration for each episode is less than 2 weeks. Otherwise, the diagnostic criteria for RBD and major depressive disorder are essentially identical. One subtle difference is that the lives of patients

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with RBD may seem more disturbed or chaotic because of the frequent changes in their moods than are the lives of patients with major depressive disorder.[1]

RBD in adolescence tend to show a near-monthly rhythm and psychotic features. Most appear to be manifestations of affective illness and may be treated and prevented as such.[9] Results of another study showed that episodes of sleep disturbances closely coincide with the episodes of depression and thus helping clinicians establish the periodicity of the depressive episodes.[1] We should view RBD as a severe condition, not as a mild form of mood disorder. Furthermore, the validity of a diagnostic entity depend on the diagnostic criteria and the outcome but also on family history, laboratory studies and specific therapeutic response. Taking this into account the lack of a successful treatment represents one of the main challenges for this disorder.[10] The therapeutic value of lithium in RBD has been suggested by Montgomery (1992), considering its usefulness in emotionally unstable character disorder, but the specific efficacy of this agent has not been tested yet in the case of patients with RBD.[3]

## CASE REPORT

The patient was a 21-years-old female who following a stress, developed hypoactivity, drowsiness, hyperphagia, anxiety and mutism for the first time at the age of 14. This episode lasted about 7-10 days and reoccurred after almost 20 days without any stress. Between episodes the patient was almost completely well without experiencing any psychological symptoms. Despite using adequate dose of TCA and SSRI medication depressive episodes reoccurred for about 3 years but interval of episodes became longer and severity of depressive symptoms was also decreased. In the second step, by adding 600mg of sodium valporatc to her previous medication (50mg imipramine and 20mg fluoxetin) recurrence of depressive episodes was almost controlled but the patient became mildly depressed for 2-3 days every 3-4 months and these depressive episodes were completely subsided when 10mg Ritalin was added to previous medications. Adding Ritalin to tricyclic antidepressant is a kind of augmentive therapy in depression.[11,12] Since in augmentive therapy we have to use half or 1/3 dose, maximum dose of fluoxetine prescribed to this patient was 20 mg for at least one month.[11]

The patient was symptom free for a year and then her medication were tapered and discontinued during a period of 3 months. The patient was also symptom free 6 months after discontinuation of medication but after a normal vaginal delivery developed depression again which subsided after 20 days without using any medication. Depression has not reoccurred during the last four years.

## DISCUSSION

The clinical relevance of RBD has not received sufficient attention to date.[6] RBD has been written about mostly in the European literature, but with its introduction as research category in the appendix of DSM-IV. The diagnosis is likely to gain rapid acceptance in the United States. This acceptance will be further facilitated by clinicians' increasing awareness that RBD is relatively common and associated with significant morbidity.

One study showed that patients with RBD share several biological abnormalities with patients with major depressive disorder as compared with control subjects who are mentally healthy. RBD is closely related to major depressive disorder in its cause and pathophysiology.[1] In a study on 15 patients with RBD, authors showed that fluoxetine treatment with 20-40mg daily was more effective, also frequency of depressive episodes showed a significant decrease during fluoxetine treatment. Duration and severity of the single depressive episodes also decreased but did not reach statistical significance. The study shows the effectiveness of fluoxetin in RBD but to confirm this, more study is necessary.[8] Another study on a 38-year-old man who presented with a 10-month history of sudden depressive episodes, with monthly recurrences lasting

2-4 days. This showed that clomipramine is effective in treatment of RBD but the recurrence of the disorder was observed. Since lithium therapy was added, there has been no recurrence of depressive symptoms. Lithium's mechanism of action in preventing depressive recurrence might play a major role in the therapeutic approach of RBD, especially since recurrence is the main feature that defines the severity of this disorder.[4] A prospective follow-up study on nine patients with RBD showed there were no recurrence in eight out of nine patients while on lithium therapy. Of nine patients followed up 5-14 years after the first onset, three had been well.[9]

The course of disease in this patient shows clearly the three main characteristics of this disorder: brevity, recurrence and severity of depressive symptoms. Depressive episodes never lasted more than 10 days and the patient was completely symptom free between episodes and symptoms were severe enough that she was dysfunctioned due to psychomotor retardation and mutism.

Euthymic mood between episodes argues against dysthymia or bipolar type II disorder and depressive episodes lasting less than 10 days argues against major depressive disorder. The absence of recurrence for a year after starting sodium valporate treatment suggests a prophylactic effect of this agent on RBD. Considering this case and other studies, mood stabilizer medication might play a major role in the therapeutic approach to RBD, especially since recurrence is the main feature that defines the severity of this disorder.

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