

**Mythbusting**

In “10 delirium myths debunked,” (Pearls, CURRENT PSYCHIATRY, October 2006, p. 45-6) Dr. Mitchell Levy promulgates a dangerous myth about psychiatric illness. He states that a patient—a postoperative middle-aged attorney with psychotic symptoms—“is not mentally ill, but has delirium.”

Delirium, like schizophrenia, is a mental disorder. The idea that a mental syndrome with an identifiable physical cause is not a psychiatric disorder is antiquated and obviously incorrect but is not understood by many medical personnel. We need to educate our colleagues about this misconception.

This myth dehumanizes mentally ill individuals. By distinguishing the middle-aged attorney from what might be considered a typical schizophrenia patient, Dr. Levy propagates the idea that mentally ill persons come from a class beneath successful professionals. This mistaken idea contributes to misdiagnosis and inadequate treatment and disproportionately low financial allocation for treating mentally ill patients.

Ira Handler, MD  
Butler Memorial Hospital  
Butler, PA

**Dr. Levy responds**

As a psychiatrist in a large university hospital, I advocate for the mentally ill daily and would never denigrate their condition.

A differential diagnosis via DSM-IV-TR, however, requires determining that “symptoms are not due to the direct physiological effects of a substance or general medical condition.” The best way to advocate for our patients is to render proper treatment, and the standard of care for treating delirium addresses causative medical issues.

Delirium is a mental disorder just as depression is a physical disorder caused by disrupted



neurobiological mechanisms. However, as most psychiatrists—but not all internists—are aware, a high-functioning person rarely suffers a first schizophrenic break in middle age. Conversely, bypass patients are at risk for cognitive and perceptual changes—which mimic schizophrenia—caused by delirium.

My article described a situation I encounter frequently in consultation-liaison psychiatry when non-psychiatrists attempt to admit their delirious patients to the psych unit instead of treating the underlying medical cause. I hope that we can advocate for our patients across multiple venues and not at the expense of any group or population.

Mitchell Levy, MD  
Assistant professor in psychiatry  
University of Washington, Seattle

**SGAs for resistant depression**

Thanks to readers who commented on the October Instant Poll concerning my article on use of second-generation antipsychotics (SGAs) in treatment-resistant unipolar depression (CURRENT PSYCHIATRY, October 2006, p. 30-44). Let me respond to several comments:

*“Using SGAs in resistant depression is an unusual strategy, though they can be used as mood stabilizers.”*

This reader raises an important point I would like to clarify on using SGAs for mood disorders. SGAs have acute antimanic effects and are effective for treating mixed bipolar states, rapid cycling, and psychotic features. Long-term data support use of some SGAs as mood stabilizers.<sup>1</sup> Olanzapine (as combined with fluoxetine) and quetiapine (as monotherapy) are FDA-approved for treating bipolar depression, suggesting that both SGAs—and perhaps others—work across the full bipolar disorder spectrum (mania, mixed states, depression).

continued

## Letters

Alternatively, findings from several randomized, placebo-controlled trials suggest that SGAs add value in treating unipolar major depression.<sup>2</sup>

*“No solid evidence supports using atypicals in unipolar depression, and there are known metabolic risks.”*

The Center for Evidence-Based Medicine at Oxford University ranks the validity and value of medical interventions based on levels of evidence ([www.cebm.net/levels\\_of\\_evidence.asp](http://www.cebm.net/levels_of_evidence.asp)). These levels range from 5 (lowest support) to 1a (highest support). Data supporting SGA use in resistant depression meet level 1a criteria, which has support from multiple, homogeneous clinical trials.

Some trials do not support SGAs' value in resistant depression. These studies are not “negative” trials, but rather “failed” trials. Given the typical design of studies in treatment-resistant depression, a “negative” (ie, nonsupportive) trial means that all outcomes were poor—that is, the primary test agent and comparison agents yielded low relative effects.

By contrast, a “failed” trial means that:<sup>1</sup>

- The primary test agent (the SGA) did not separate from a comparator drug and/or placebo<sup>2</sup>
- The comparator or placebo also produced a large effect. This indicates that some subjects were not treatment-resistant, in that they responded to another intervention during the study.

Further, SGAs showed approximately equivalent beneficial effects for resistant depression in all supportive and nonsupportive placebo-controlled trials. That is, the effectiveness of the combinations varied little, and the determining factor was the relative effect of the comparative agent.

Some SGAs can cause metabolic syndrome. As discussed in my article (October, p. 38), weight gain and attendant metabolic syndrome as well as tardive dyskinesia and hyperprolactinemia temper enthusiasm for SGA use. Of note, at least two SGAs—aripiprazole<sup>3,4</sup> and ziprasidone<sup>5</sup>—have not shown problematic metabolic effects,

although evidence supporting the use of these drugs for resistant unipolar depression is limited. Taken together, these risks warrant reserving SGAs for unipolar depression that has not responded to antidepressants.

*“After two failed SSRI trials, I would try a serotonin-norepinephrine reuptake inhibitor (SNRI) and/or bupropion. Then it would depend on symptoms and risk factors.”*

Compared with SNRI monotherapy or combination SSRI/bupropion therapy, a higher level of evidence supports SGAs' benefits in resistant depression. Given the risks associated with SGAs, however, try an SNRI and SSRI/bupropion therapy before adding an SGA for most patients.

*“I would not use an SGA in resistant depression without evidence of psychosis.”*

SGAs' benefit in nonpsychotic, unipolar major depression resistant to two classes of antidepressants is reasonably well-established. Psychotic depression, however, is one of the few diagnostic groups for which an SGA added to an antidepressant should be considered first line.

Richard C. Shelton, MD  
James G. Blakemore Research Professor  
Vanderbilt University  
Nashville, TN

## References

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