T3 in depression

Thanks to Drs. Gih, Bostwick, and Casher for their valuable reminder about the use of triiodothyronine (T3) in treatment-resistant depression ("Augmenting antidepressants with triiodothyronine: An underutilized strategy," Current Psychiatry, July 2011, p. 43-44).

The authors note "If TSH [thyroid-stimulating hormone] is elevated, a free thyroxine (T4) level should be ordered to detect clinical hypothyroidism." I have found a significant number of patients with normal TSH levels but low free T4 levels, which is perhaps because of the number of traumatic brain injuries (TBI) in the veteran population I see. I realize a TSH screening alone is more cost-effective than both a TSH and free T4, but I wonder if this is the best course in evaluating treatment-resistant depression, particularly in patient populations where subtle brain damage may confound a normal TSH value. How many cases of hypothyroidism might be missed in the interest of economy?

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The authors respond

Thank you for your interest in our article. Our opinion is TSH alone is a sufficient screening laboratory in "routine" depressed populations. Although a case could be made for adding free T4 (with TSH), economics and clinical guidelines would argue otherwise. In patients who are asymptomatic but have abnormal thyroid values, referral to an endocrinologist is highly advised.

July 2011

Although we do not routinely see brain traumatized patients, a 2007 article by Rothman et al[1] affirms your astute clinical observations about TBI and associated neuroendocrine findings.

Many clinicians are checking and supplementing vitamin D levels, in addition to including omega-3 fatty acids in their psychotropic regimens. Although the jury remains out on these interventions, preliminary data suggest these may be helpful adjuncts for depressed patients and have a low burden of side effects. Let us not forget that evidence-based psychotherapies also should be included in the armamentarium for treating "resistant" depressed patients. Psychosocial interventions should be given the same "adequate dose and duration" guidance as psychotropics.

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Reserpine for schizophrenia

It seems unfortunate "Treatment-resistant schizophrenia: What can we do about it?" (Current Psychiatry, June 2011, p. 52-59) made no mention of reserpine, an alternative antipsychotic with a completely different mechanism of action. Many articles have reported augmentation when reserpine is combined with D2-blocking antipsychotics. Several articles also document a lack of convincing evidence for the common opinion that reserpine causes or worsens depression. Many psychiatrists may not know it is still available for prescription.

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Dr. Citrome responds

Thank you for bringing up an agent that has been forgotten but played a pivotal role in the early history of the psychopharmacology of schizophrenia. I could not locate a report of a randomized controlled study of reserpine specifically for treatment-resistant or refractory schizophrenia; therefore, I did not include this agent in my review. Christison et al[1] published a succinct summary of the use of reserpine in schizophrenia in which they reviewed the extant controlled studies for reserpine for psychosis. All were conducted more than 50 years ago using the standards for such trials as they existed at that time.

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The authors comment there is anecdotal and uncontrolled evidence that some patients who respond poorly to "neuroleptics" improve with reserpine. They suggest trials of reserpine may be warranted in some neuroleptic-resistant patients but effects such as severe depression, significant hypotension, exacerbation of asthma, peptic ulceration and hemorrhage, and extrapyramidal side effects can be problematic. There is evidence that a gradual increase to a full dose reduces some side effects.

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Treating family members

I enjoyed the article by Drs. Mossman, Farrell, and Gilday addressing the practice of physicians prescribing medications for relatives or friends ("Should you prescribe medications for family and friends?" Current Psychiatry, June 2011, p. 41-51). I would like to add additional reasons why physicians may accept or decline a relative's request for treatment.

Some doctors treat relatives out of a desire to reciprocate for financial or emotional support, or to compensate for deficiencies in other parts of their relationship.[1] Other reasons to treat include convenience for the relative by not having to wait for an appointment, or for the relative's physician by not wanting to bother them with a minor problem and associated paperwork.[2] A belief that the physician-relative can offer better care than what is available or currently provided has been given as a motivation for treatment.[3] The fear of misdiagnosis and a subsequent guilty conscience have been offered as reasons to refrain from treating family members.[1] Other doctors refrain from treating because of role conflict or the possibility of treatment noncompliance; a relative may not follow the treatment plan seriously because of familiarity with the physician.[2,3] Interestingly, a desire for confidentiality has been given as a reason to either treat or refrain from treating family members.[1]

Because most physicians will be solicited for treatment from family members or friends during their careers, I applaud the authors for addressing this topic. Increasing awareness of guidelines, reasons for and against treatment, and recommendations for treatment should be a priority in medical school curricula and graduate medical education.

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A complex subject

Thank you for your excellent article "Pharmacologic treatment of borderline personality disorder" (Current Psychiatry, August 2011, p. 30-40). This subject is very complex and poorly understood, both in primary diagnosis and the implications it has on other axis I conditions. Your attempts to educate and suggest possible treatment options are appreciated.

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