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HIV-Related Mood Disorders

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PRESIDENT (2006-2007)
AMERICAN PSYCHIATRIC ASSOCIATION

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WORLD PSYCHIATRIC ASSOCIATION
Overview

• Mood disorders are the most frequent psychiatric complications associated with HIV disease
• Mood disorders may be secondary to HIV complications or its treatment
• Multiple effective therapeutic strategies are available to manage the psychiatric complications of HIV-mood disorders
• Suicide risk is elevated across the trajectory of HIV disease
Probable Risk Factors for Depression in HIV

- Personal history of prior mood disorders
- Personal history of alcoholism, substance use, suicide attempt, anxiety disorders
- Family history of the above conditions
- Current alcohol or drug use
- Inadequate social support
Probable Risk Factors for Depression in HIV (Cont’d)

- Non-disclosure of HIV status
- Multiple losses
- Advancing illness
- Treatment failure (or success)
Affective vs. Somatic Symptoms

**AFFECTIVE**
- Depressed mood
- Loss of interest
- Guilt, worthlessness
- Hopelessness
- Suicidal ideation

**SOMATIC**
- Appetite/Weight loss
- Sleep disturbances
- Agitation/retardation
- Fatigue
- Loss of concentration
Agents Used for Depression in Patients with HIV

- Antidepressants
  - Selective Serotonin Reuptake Inhibitors (SSRIs)
  - Novel antidepressants
  - Tricyclic Antidepressants (TCAs)
- Psychostimulants
- Hormonal treatment
Antidepressants

- SSRIs: All are equally effective, no change on CD4 count
  - Fluoxetine (10-60 mg/day)
    - Highly protein bound, long half-life, inhibits 2D6
  - Paroxetine (10-40 mg/day)
    - Highly protein bound, induces its own metabolism, most potent inhibitor of 2D6
  - Sertraline (25-200 mg/day)
    - High protein bound, shortest half life of all SSRIs
  - Citalopram (20-40 mg/day)
    - Least protein bound and least P-450 affinity of all SSRIs
Antidepressants (Cont’d)

• Novel antidepressants
  – Bupropion (75 - 150 mg bid)
    • Avoid in persons with advanced HIV or dementia
  – Nefazodone (50 - 200 mg bid)
    • Highly protein bound, 3A4 significant interactions (ketoconazole, protease inhibitors)
  – Venlafaxine (75 - 150 mg bid)
    • Low protein binding, low affinity for P-450
  – Mirtazapine (7.5 - 45 mg)
    • Low affinity for P-450, sedating, weight gain
Potential Useful Properties of Tricyclic Antidepressants

- Anti-diarrhea
- Weight gain
- Sedation
- Anti-nausea
- Anti-anxiety
- Anti-neuropathic pain
- Meaningful therapeutic blood levels
Psychostimulants

- Methylphenidate and dextroamphetamine
- Often useful in depression among medically ill patients (adult equivalent of failure to thrive)
- Ameliorates mild cognitive dysfunctions
- Use with caution in patients with seizures
- Avoid in psychotically ill patients
- Most helpful in patients with significant fatigue
Psychostimulants (Cont’d)

• Try antidepressants first
  – Early HIV disease
  – Previous history of depression
  – No cognitive impairment
  – History of substance abuse

• Try psychostimulants first
  – Mid to late HIV disease
  – Depression coexisting with cognitive impairment
  – Significant fatigue
  – Cognitive impairment whether or not depression is present
Hormonal Treatment

• Testosterone
• Dehydroandrosterone (DHEA)
Antidepressant Studies: Psychotherapy and Medication

- Interpersonal therapy (46% response)
- Cognitive behavioral therapy (30%)
- Supportive therapy + imipramine (50%)
- Supportive therapy (20%)
- Group + fluoxetine (64%) vs group + placebo (48%)
Psychotherapies

- Insight-oriented
- Interpersonal therapy
- Cognitive behavioral
- Supportive
- Group/family/couples
- Combination of the above
Common Themes in Psychotherapy with HIV Patients

- Loss
- Anger
- Control issues (decision making)
- Death and dying
- Impact on partners, children, etc.
- Fear (rejection, dependency, dementia, pain)
- Disclosure of HIV
Common Themes in Psychotherapy with HIV Patients (Cont’d)

- Sexuality
- Spirituality
- Guilt, regret
- Low self-esteem, self-criticism
- Stigma and discrimination
- Suicide
  - Rational vs impulsive
  - Physician assisted
Inpatient Care

- Suicide risk
- Inability to care for self at home
- Need to start pharmacotherapy in a controlled environment
- Medically frail person
- History of bipolar disease with rapid cycling
Electroconvulsive Treatment

- Used successfully in HIV infected individuals
- May be especially useful for patients who are too medically ill to tolerate antidepressants, severely suicidal patients, psychotic patients or treatment resistance patients
- May be associated with increased confusion
- Worse in the presence of coexisting CNS diseases
Treatment of HIV Related Mania

• Lithium carbonate
  – Poorly tolerated
  – Monitor closely for neurotoxicity and GI side-effects
  – Serum levels may easily change due to diarrhea or poor fluid intake
  – HIV nephropathy
Treatment of HIV Related Mania (Cont’d)

• Valproic acid
  – Effective
    • Edged out lithium in patients with organic mania
  – Fewer GI side effects
  – May need to monitor liver functions more often
  – Co-administration with zidovudine will raise zidovudine levels
  – Recent reports of increase viral replication worrisome
Treatment of HIV Related Mania (Cont’d)

- Carbamazepine
  - Elevated risk of pancytopenia in HIV infected patients receiving marrow toxic therapies
  - Must check CBC weekly when given concomitantly with zidovudine
  - Induces its own metabolism via induction of hepatic enzyme system
  - May decrease its own levels as well as that of other drugs
Treatment of HIV Related Mania (Cont’d)

• Clonazepam
  – Often effective as second or third agent for added stabilization
  – Relatively safe
    • Caution with protease inhibitors
      – May decrease its effectiveness
    – Good adjuvant for sleep disturbance in acute mania
Treatment of HIV Related Mania (Cont’d)

• Gabapentin
  – Up to 900 mg bid (1800/day maximum)
  – Effective as other agents
  – Excellent with patients who also suffer from neuropathy

• Lamotrogine and topiramate
  – No reports
Treatment of HIV Related Mania (Cont’d)

• Neuroleptics
  – Caution is warranted with traditional neuroleptics
  – HIV patients extremely sensitive to side effects
    • Severe Parkinsonism (in some cases irreversible)
    • Low potency neuroleptics: anticholinergic effects may worsen cognitive dysfunction
    • High potency neuroleptics: increased incidence of neuroleptic malignant syndrome (NMS)
  – Atypicals (olanzepine, risperidone)
    • All tried with good results
Risk Factors

• Prior attempt
• African American, Hispanic Men
• Ages 25-54
• Personal/Family history of suicide attempts
• Family history of psychiatric disorders
• History of psychiatric disorders
• History of drug/alcohol abuse or dependence
• Higher levels of distress, hopelessness
Suicide Risk Factors (Cont’d)

- Presence of more HIV symptoms
- Multiple losses
  - Including loss of employment and insurance
- Lack of social support
- Conflicts around sexual orientation
- Poorly controlled pain
- Stage of HIV disease
- Presence of cognitive dysfunction
Completed Suicide

- There is an increased rate of completed suicides in AIDS patients compared to other populations.
- Studies have demonstrated 3-6 fold increase in this population.
- Since development of antiretroviral treatment, suicide rates are only moderately elevated and comparable to other medical illnesses.
Summary

• Mood disorders are the most frequent psychiatric complication associated with HIV disease
• Mood disorders may be secondary to HIV complications or its treatment
• Suicide risk could be elevated across the trajectory of HIV disease
Summary (Cont’d)

• Multiple effective therapeutic strategies are available to manage the psychiatric complications of HIV-mood disorders

• Timely treatment of mood disorders may slow progression of cognitive impairments and enhance the quality of life

• Aggressive treatment of any mood disorder or other psychiatric conditions should be offered to the patient as psychiatric disorders profoundly impact patients’ decisions regarding treatment
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in cooperation with
The Carter–Jenkins Center
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