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CASE REPORT

Antidepressant discontinuation syndrome – a case report

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Antidepressant discontinuation syndrome (ADDS) is often an under-recognised cause of multiple unpleasant symptoms upon stopping antidepressant. It requires a high index of suspicion to not miss this elusive diagnosis. This case will look at a common scenario of a nursing home resident forgetting to refill his antidepressant prescription which lead to the above syndrome. This will lead to discussion on how to treat this syndrome and subsequently allow the patient to carry on their daily life.

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Introduction

Antidepressant discontinuation syndrome usually occur within a few days of stopping the causative drug.[1] It is usually short-lived and mild but in certain severe cases, it can lead to many unpleasant symptoms and incorrectly diagnosed as other condition, thereby leading to more non adherence by the patient.[1]

The symptoms vary and can include different systems and can be rather vague and general such as flu-like illness, headache and lethargy making it unique as it is not directly related to the treating psychiatric illness. Therefore, the condition can be mistaken as other neurological conditions, infectious diseases or adverse effects of other medications taken by the patient.[2]

All antidepressant groups including monoamine oxidase inhibitors (MAOI), selective serotonin reuptake inhibitors (SSRI) and tricyclic antidepressant (TCA), have the potential to cause this syndrome.[1,3] As compared to longer acting antidepressant such as fluoxetine, shorter acting antidepressant such as paroxetine and venlafaxine have higher potential to cause antidepressant discontinuation syndrome.[3]

Case Report

Mr. K is a 49-years-old Chinese man who presented with history of crying spells for the past 3 days. He was accompanied by his caretaker in the nursing home. He claimed he has been crying without any apparent reason or control. It was associated with nightmares and insomnia. There was also increase in salivation, rhinorrhoea, nausea and dizziness. There was no blurring of vision or syncope. There is no suicidal ideation or aggressive behaviour.

Premorbid, he has hypertension, type 2 diabetes mellitus and suffered 2 episodes of right middle cerebral infarct in 2005 and 2013. As a consequent of his recurrent stroke which left him dependant on wheelchair, he developed depression a year later and was started on paroxetine 10mg daily which managed to control most of his depressive symptoms which included low mood, feeling of worthlessness, anxiety and irritability with the absence of crying spells. He is on 8 types of medications for his hypertension, diabetes, stroke and depression.

Physical examination showed an alert middle-aged man who was crying in between the consultation. He maintained good eye contact and had slurred speech. His vital signs were stable. He is orientated to time, place and person. Neurological examination revealed hypersalivation with presence of gag reflex. The power over his left upper and lower limbs was 3/5 with normal power on the opposite limb.

Mr K is a divorcee with no children and no contact with his former wife. He has been in the nursing home since his second episode of stroke. He has no siblings. His parents are his only close relative who kept regular contact with him. On further history, patient has not been taking his antidepressant for the past one week as the medicine has finished and he missed his last hospital appointment. He also complains of feeling irritated by his friends in the nursing home as they keep asking him the reason for his persistent crying.

He was treated as a case of antidepressant discontinuation syndrome. His differential diagnosis was relapse of his previous depression. As paroxetine was not available in the clinic, he was started on another selective serotonin reuptake inhibitor (SSRI), sertraline.

He was given an appointment in 2 weeks in which he reported to be well and cheerful with no more crying spells and insomnia. His salivation and flu-like symptoms also had resolved. He, along with his caretaker were advised to not stop his antidepressant without prior consultation with the treating physician and to be more adherent to his hospital appointments.

Discussion

Antidepressant Discontinuation Syndrome (ADDS) occurs after abrupt discontinuation of medications that has been taken for a minimum of six weeks. The symptoms last for one to two weeks and is rapidly halted by the re-initiation of the drug taken. There is limited data on the prevalence or burden of this condition due to several factors including issues with diagnosis, and its transient nature. It is said around 20% of patients will develop this syndrome if the use is abruptly stopped.[1]

There are also classifications according to the type of treatment used, for example the SSRI discontinuation syndrome which is caused by the halt of SSRI usage.[4]

As many as 50 symptoms have been reported to occur in ADDS.[5] SSRI and TCA usually share the symptoms shown in Table 1:[5]

Table 1 Common symptoms related to ADDS.[5] SSRI and TCA

Symptom group	Example of specific symptoms	Common in SSRI	Common in TCA
Sensory	Paraesthesia, numbness, visual trails	Yes	No
Disequilibrium	Dizziness, light-headedness, vertigo	Yes	No
General somatic	Lethargy, headache, sweating, tremor, anorexia	Yes	Yes
Affective	Irritability, anxiety, low mood, tearfulness	Yes	Yes
Gastrointestinal	Nausea, diarrhoea, vomiting	Yes	Yes
Sleep related	Insomnia, excessive dreaming, nightmares	Yes	Yes

This includes general somatic, gastrointestinal, affective and sleep-related symptoms.[5] Sensory and disequilibrium symptoms are however more with the use of SSRI.[5]

However, reactions to MAOI discontinuation seems to be the most severe with worsening of even baseline depressive symptoms, manifestations of acute confusional state with paranoid delusions and hallucinations, and anxiety symptoms including hyperacusis and depersonalization.[5]

In order to rapidly remember these symptoms, the mnemonic FINISH is used; **F**lulike symptoms, **I**nsomnia, **N**ausea, Imbalance, **S**ensory disturbance and **H**yperarousal (anxiety/agitation), which are the six core symptoms. It has been reported to be experienced by up to 40% of patients who have abruptly stopped their treatment.[1,6-7]

There has been other suggestions to identify symptoms and use it for the basis of diagnosis, in order to help with management of these patients. For example, in 2000, a range of symptoms were suggested for the SSRI discontinuation syndrome which involves two or more of the following symptoms:[4]

Dizziness, light-headedness, vertigo or feeling faint; shock-like sensations or paraesthesia; anxiety; diarrhoea; fatigue; gait instability; headache; insomnia; irritability; nausea or emesis; tremor; and visual disturbances.

Also taking into consideration is the symptom developing within 1-7 days of stopping or reduction of medication after 1 month of use, the symptoms cause significant distress and not cause by other medical conditions.

However, to our knowledge these criteria has not been formally validated.[1,4,6]

Diagnosis is usually established based on history of stopping the antidepressant. This will usually require a high index of suspicion to look out for discontinuation symptoms.[1]

Management mainly involve restarting treatment and symptomatic management of troubling symptoms. As is well said, "prevention is better than cure". Therefore, pre-emptive advice and education for both treating clinicians and patients before starting antidepressant about the possibility of discontinuation symptoms on suddenly stopping antidepressant should be emphasised.[1,5]

However, this step alone, still does not solve the problem. Hence there has been several proposed methods in the literature regarding this issue. One of which suggests to slowly taper down the dose. The rate would depend on the medication, so for example those with a shorter half- life such as venlafaxine and paroxetine should be tapered down more gradually within weeks to months.[3,8] Sometimes switching to a longer half-life antidepressant; fluoxetine may be warranted.[8] However, switching antidepressants needs to be done with caution.[3]

Other methods of management have suggested alternative management which may include a short course of benzodiazepines for symptomatic treatment, antimuscarinic agents that may help with gastrointestinal symptoms and cholinergic rebound in TCA withdrawals, and also antipsychotic treatment with patients experiencing withdrawal mania.[1,8]

Depression is a common presentation in primary care and part of the management is stopping the treatment once the patient is cured, hence primary care physicians should be made aware of ADDS and its management. The repercussions of the treating clinician not familiar with this condition can lead to heavy consequences such as medical and psychiatric misdiagnosis, and may lead to patient unwilling to use psychotropic medications and lead to difficult treatment of such patients.[1]

Although the symptoms of ADDS was related to the non-compliance of this patient, it has taught both the authors and patient a valuable lesson on this syndrome. This patient is more likely to experience ADDS, when trying to taper down his antidepressants. Therefore, better preparation can be made should this decision be agreed upon later on in his course of treatment.

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