Evidence-based pharmacological treatment recommendations for managing depression in persons living with HIV (PLWH)

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BACKGROUND

Clinical depression is common among Persons Living with HIV (PLWH) and untreated depression is associated with risk behaviors that may lead to HIV transmission, non-adherence to antiretroviral (ARV) medications, frequent hospitalizations, and decreased survival.[1]

The pathology of depression in PLWH is multi-factorial and management can be complex. Diagnosis of HIV may directly or indirectly lead to depression in PLWH. The initial shock of the diagnosis and coping with the disease may be a direct psychological stressor or further complicate pre-existing depression. Neuropsychological changes as the disease progresses, HIV-related medical conditions, anti-retroviral side effects, as well as the socioeconomic burden of PLWH are among the many factors that can lead to depression in this patient population.[1-3]

RECOMMENDATION FOR TREATMENT

Guidelines for HIV treatment recommend screening for depression as part of the annual mental health assessment and base the diagnosis on the criteria established in the ***Diagnostic and Statistical Manual of Mental Disorders-IV Text Revision (DSM-IV-TR***).[2] Screening should also take place whenever symptoms of depression are present. Psychotherapy in combination with antidepressant medications has proven to be more effective than medications alone, specifically among PLWH. Physicians should start medication and psychotherapy treatment for patients with moderate to severe clinical depression or mild depression not resolving in a 2-4 week period. Antidepressant medications should be individualized for each patient considering drug-drug interactions with HIV-related medications and side-effect profile.

Because of potential side effects and drug-drug interactions, health care providers should become familiar with the safety profiles and interactions of antidepressants and HIV-related medications. When an antidepressant is indicated, the choice can be guided by patient history, family history, target symptoms, and the side effects and safety profiles of the medications. For example, if a patient has responded to a specific medication in the past, he/she probably will again. If a patient has a relative who responded well to a specific medication, the patient may do the same. Drug characteristics and side effects may also guide medication choice. For example, a patient whose main complaint is insomnia may benefit from antidepressants with more sedative effects.[1,3-4]

PHARMACOLOGIC TREATMENT OF CHOICE

A meta-analysis and two systematic reviews have supported selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants (TCAs) as agents of choice for PLWH.[5] TCAs, while proven to be effective, are no longer treatments of choice because of the increase in side-effects and potential for drug-drug interactions with ARVs.[6] Few studies and no large-scale randomized controlled trials have looked at the efficacy of serotonin norepinephrine reuptake inhibitors (SNRIs) for the treatment of depression in patients with HIV. A meta-analysis of randomized controlled trials in the general population showed SNRIs to be as effective as SSRIs for treatment of non-complicated depression .[7]

Current HIV guidelines recommend to start with SSRIs or SNRIs due to their efficacy in treating depression, lower side-effect profile, and less potential for drug-drug interactions with ARVs.[6] A full course of initial treatment is considered 4-6 weeks. If a patient fails a full course of treatment or response to therapy is incomplete at a therapeutic dose, then referring to a psychiatrist for antidepressant medication management is recommended.[1]

Some antidepressants are contraindicated with certain ARVs. ARVs, protease inhibitors (PIs) in particular, affect the metabolism of antidepressants via cytochrome P450.

Ritonavir can increase serum levels of TCAs resulting in potential toxicity. In general, ARVs, other than PIs, have no clinically significant drug interactions and do not require drug level monitoring. Antidepressants used concomitantly with PIs should be started at a low dose and titrated to a safe and effective dose. On the other hand, PIs may decrease serum levels of paroxetine, sertraline and bupropion. Efavirenz may lower sertraline and bupropion levels. In these instances, the antidepressants may need to be titrated for effectiveness. St. John's Wort is a common herbal medication used widely as an alternative to treatment for depression and has an absolute contraindication for use in patients with ARVs. It has been known to decrease serum concentrations of all classes of ARVs.[6-8]

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