

Monitor HIV Patients for Anxiety, Depression

BY SHERRY BOSCHERT

SAN FRANCISCO — Substance abuse is such a common cause of anxiety or depression in HIV-infected patients that Dr. Robert B. Daroff Jr. advises getting a toxicology screen in every patient with HIV and a mood disorder.

"It's one of the only objective measures I have in psychiatry. I might as well use it," said Dr. Daroff, director of the HIV Psychiatry Program at the San Francisco VA Medical Center. Social factors also may cause or contribute to mood disorders. Feelings of helplessness and dependency, social isolation, or difficulty communicating with significant others can lead to anxiety or depression, he said at a meeting on the medical management of HIV and AIDS sponsored by the University of California, San Francisco.

Biologic factors such as metabolic or endocrine abnormalities and side effects from antiretroviral therapy can also cause psychiatric disorders in patients with HIV. When anti-HIV drugs may be causing the mood disorder, consider possibly subtracting a drug instead of adding one, he said. (See box.)

Approximately 36% of patients with HIV had major depression and 16% had generalized anxiety disorder, one study found (*Arch. Gen. Psychiatry* 2001;58:721-8). Mood disorders may impair compliance with antiretroviral therapy in patients with HIV.

In a survey of psychiatrists with AIDS expertise, the top choices for first-line treatment of depression in patients with HIV who had not yet started antiretrovirals were escitalopram, citalopram, sertraline, and mirtazapine, Dr. Daroff said. For patients already on highly active antiretroviral therapy with a ritonavir-boosted protease inhibitor, the top choices for an antidepressant were unchanged, but Dr. Daroff would not generally initiate treatment with escitalopram be-



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cause the other agents were available in generic form.

Few psychiatric drugs are contraindicated in patients on antiretrovirals. Patients taking protease inhibitors should avoid pimozone, midazolam, triazolam, and St. John's wort. Patients taking non-nucleoside reverse transcriptase inhibitors should avoid alprazolam, midazolam, triazolam, and St. John's wort.

If a patient may have bipolar depression, avoid tricyclic antidepressants and dual-acting medications such as venlafaxine or duloxetine to decrease the risk of switching to mania. Quetiapine or lamotrigine may be a better choice than an antidepressant in these patients, he said.

Treatment for anxiety disorders most often involves SSRIs, venlafaxine, benzodiazepines, or buspirone. Start at a quarter to half of normal dosing and increase the dose slowly because patients with HIV and anxiety are often "exquisitely sensitive to side effects," he advised.

Psychotherapy should be part of the therapeutic approach, he said. "I think we're underprescribing psychotherapy in HIV."

Psychotherapy was associated with decreased HIV levels and improved CD4 counts in 7 of 14 randomized, controlled trials in patients with HIV, a review found.

The review (*Psychosom. Med.* 2008;70:575-84) and other studies suggest that psychotherapy reduces mental distress associated with HIV, and that different forms of psychotherapy may be equally effective in these patients, Dr. Daroff said.

The kind of psychotherapy seems to be less important than the quality of the relationship between the therapist and the patient, "which suggests that there is great power in the relationship you build with your patients," added Dr. Daroff.

He reported having no relevant disclosures. ■

Side Effects of Antiretrovirals

Didanosine: Nervousness, anxiety, confusion, insomnia.

Lamivudine: Insomnia, mania.

Stavudine: Confusion, depression, anxiety, mania, insomnia.

Zidovudine (AZT): Mania, depression, anxiety, insomnia, confusion.

Raltegravir: May worsen preexisting depression.

Efavirenz: Stepped-up dosing reduces neuropsychiatric side effects seen in clinical trials.

Source: Dr. Daroff

Marijuana Self-Medication Might Prompt Mood Disorders, Stress

BY SHERRY BOSCHERT

SAN FRANCISCO — The "medical" use of marijuana, which is common among patients diagnosed with illnesses such as HIV or cancer, might lead to depression or anxiety disorders. However, data suggesting that marijuana use is a risk factor for throat and neck cancers are weak, two experts say.

Evidence that marijuana use might play an etiological role in the development of psychotic disorders and schizophrenia has been mounting (*Eur. Arch. Psychiatry Clin. Neurosci.* 2009;259:413-31, *Am. J. Psychiatr.* 2009;166:1251-7). The relationship between marijuana (or "pot") and anxiety or mood disorders, however, is less clear, Dr. Robert B. Daroff Jr., director of the HIV Psychiatry Program at the San Francisco VA Medical Center, said at a meeting on the medical management of HIV sponsored by the University of California, San Francisco.

Patients with HIV often contend that they are self-medicating to symptoms and that the most common "diagnosis" associated with medical marijuana use is "stress," he said.

"I usually advise—and this doesn't always go smoothly—that depressed or anxious patients take a trial off of pot before I treat their depression or their anxiety," he said. If patients are willing to try interrupting marijuana use, often they will find that the drug was a major contributing factor to their psychiatric symptoms.

"At least for patients who have treatment-resistant depression and anxiety, we ought to be pushing harder for them to give a trial off of pot to see if that's related" to their psychiatric problem, he said.

Deborah Greenspan, D.Sc., professor and chair of orofacial sciences and distinguished professor of dentistry at the university, said anecdotal reports that the practice of using marijuana contributes to the development of oral squamous cell carcinoma

(SCC) prompted her to review studies related to this topic.

A large, population-based case-control study with 407 subjects found no association between marijuana use and SCC either in the cohort as a whole or in any subgroup based on age, cigarette smoking status, or alcohol consumption (*Cancer Research* 2004;64:4,049-54).

An analysis of five case-control studies with 4,029 cases of head and neck cancer, and 5,015 control patients found no significant association between cancer and marijuana use in patients who did not smoke cigarettes (*Cancer Epidemiol. Biomarkers Prev.* 2009;18:1544-51).

"There may have been some dual activity going on" from cigarette use by marijuana smokers that contributed to suggestions that marijuana increased cancer risk in some earlier small studies, Dr. Greenspan said.

Dr. Daroff and Dr. Greenspan reported having no relevant disclosures. ■

Comorbid Depression Lifts Heart Risks for Women

MONTREAL — In women with documented cardiovascular risk factors, those with comorbid depression have a greater risk of clinical events, compared with their nondepressed counterparts, according to findings from the Women's Ischemic Syndrome Evaluation (WISE), trial sponsored by the National Heart, Lung, and Blood Institute.

"Many studies have associated depression with an increased risk of cardiovascular disease incidence," reported Thomas Rutledge, Ph.D., of the department of psychiatry at the University of California, San Diego. "We wanted to know whether the added presence of depression would statistically worsen the relationship between cardiac risk factors and outcome," he said at the annual meeting of the Society of Behavioral Medicine.

Dr. Rutledge examined the association of cardiovascular disease (CVD) risk factors with actual CVD events in 153 depressed and 718 nondepressed women who were enrolled in the WISE trial. The women were a mean age of 60 years and all of them had been referred for coronary angiography.

CVD risk factors were assessed, including smoking, dyslipidemia, hypertension, obesity, diabetes, and level of physical activity. Depression was defined as self-reported current use of antidepressants to treat depression.

Over a mean follow-up period of 5.9 years, the CVD mortality rate was higher in depressed women with CVD risk factors than it was in nondepressed women with the same risk factors (11.5% vs. 9.2%, respectively). Similarly, depressed women experienced more cardiovascular events such as stroke, myocardial infarction, and heart failure (23.9% vs. 13.3%).

—Kate Johnson