Государственный медицинский университет г Семей.
Кафедра фармакологии и доказательной медицины.

Клинический случай.

Выполнила: Кажыкенова Г.Т.

Врач-резидент психиатр 201 группа.

Клинический случай:

- Впервые амбулаторно обратилась женщина пожилого возраста. Был выставлен диагноз: Инволюционная депрессия средней степени тяжести. Перед врачом стал вопрос назначить антидепрессант флуоксетин или амитриптилин.

Формулировка вопроса Пико:

Пациент (проблема, население)	**Пациент пожилого возраста с инволюционной депрессией**
Вмешательство	СИОЗС (флуоксетин)
Вмешательство сравнение	амитриптилин
Исход	Эффективность препарата

Лечение

РКИ,

Вопрос:

- Является ли для пациента пожилого возраста с инволюционной депрессией назначение антидепрессанта флуоксетина эффективным по сравнению с амитриптилином?


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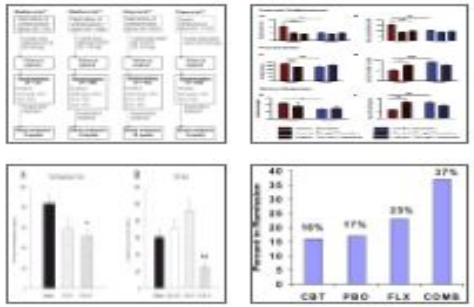

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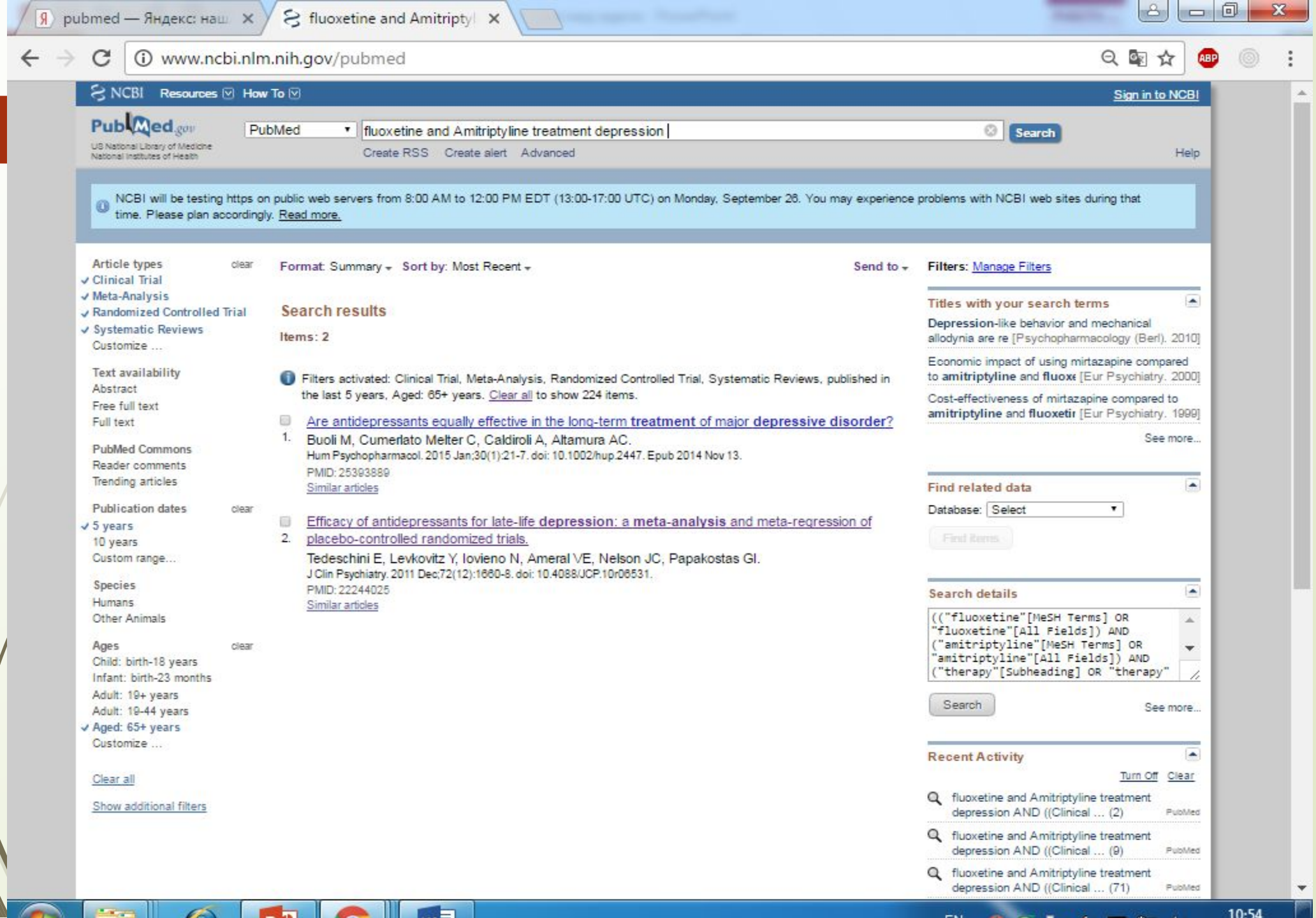
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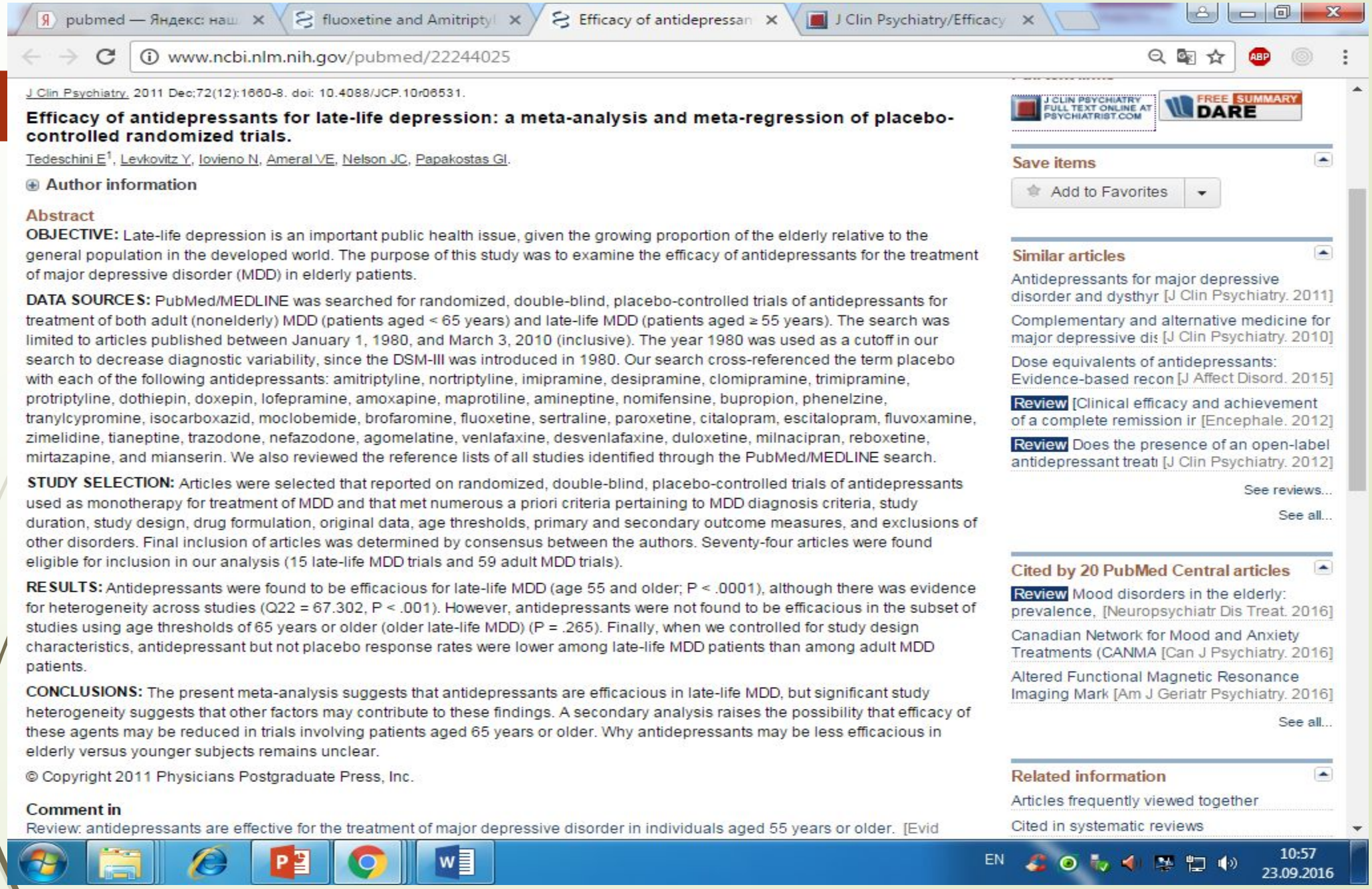
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J Clin Psychiatry. 2011 Dec;72(12):1660-8. doi: 10.4088/JCP.10r06531.
Efficacy of antidepressants for late-life depression: a meta-analysis and meta-regression of placebo-controlled randomized trials.
Tedeschini E[1], Levkovitz Y, Iovieno N, Ameral VE, Nelson JC, Papakostas GI.
Author information
Abstract
OBJECTIVE: Late-life depression is an important public health issue, given the growing proportion of the elderly relative to the general population in the developed world. The purpose of this study was to examine the efficacy of antidepressants for the treatment of major depressive disorder (MDD) in elderly patients.
DATA SOURCES: PubMed/MEDLINE was searched for randomized, double-blind, placebo-controlled trials of antidepressants for treatment of both adult (nonelderly) MDD (patients aged < 65 years) and late-life MDD (patients aged ≥ 55 years). The search was limited to articles published between January 1, 1980, and March 3, 2010 (inclusive). The year 1980 was used as a cutoff in our search to decrease diagnostic variability, since the DSM-III was introduced in 1980. Our search cross-referenced the term placebo with each of the following antidepressants: amitriptyline, nortriptyline, imipramine, desipramine, clomipramine, trimipramine, protriptyline, dothiepin, doxepin, lofepramine, amoxapine, maprotiline, amineptine, nomifensine, bupropion, phenelzine, tranylcypromine, isocarboxazid, moclobemide, brofaromine, fluoxetine, sertraline, paroxetine, citalopram, escitalopram, fluvoxamine, zimelidine, tianeptine, trazodone, nefazodone, agomelatine, venlafaxine, desvenlafaxine, duloxetine, milnacipran, reboxetine, mirtazapine, and mianserin. We also reviewed the reference lists of all studies identified through the PubMed/MEDLINE search.
STUDY SELECTION: Articles were selected that reported on randomized, double-blind, placebo-controlled trials of antidepressants used as monotherapy for treatment of MDD and that met numerous a priori criteria pertaining to MDD diagnosis criteria, study duration, study design, drug formulation, original data, age thresholds, primary and secondary outcome measures, and exclusions of other disorders. Final inclusion of articles was determined by consensus between the authors. Seventy-four articles were found eligible for inclusion in our analysis (15 late-life MDD trials and 59 adult MDD trials).
RESULTS: Antidepressants were found to be efficacious for late-life MDD (age 55 and older; P < .0001), although there was evidence for heterogeneity across studies (Q22 = 67.302, P < .001). However, antidepressants were not found to be efficacious in the subset of studies using age thresholds of 65 years or older (older late-life MDD) (P = .265). Finally, when we controlled for study design characteristics, antidepressant but not placebo response rates were lower among late-life MDD patients than among adult MDD patients.
CONCLUSIONS: The present meta-analysis suggests that antidepressants are efficacious in late-life MDD, but significant study heterogeneity suggests that other factors may contribute to these findings. A secondary analysis raises the possibility that efficacy of these agents may be reduced in trials involving patients aged 65 years or older. Why antidepressants may be less efficacious in elderly versus younger subjects remains unclear.
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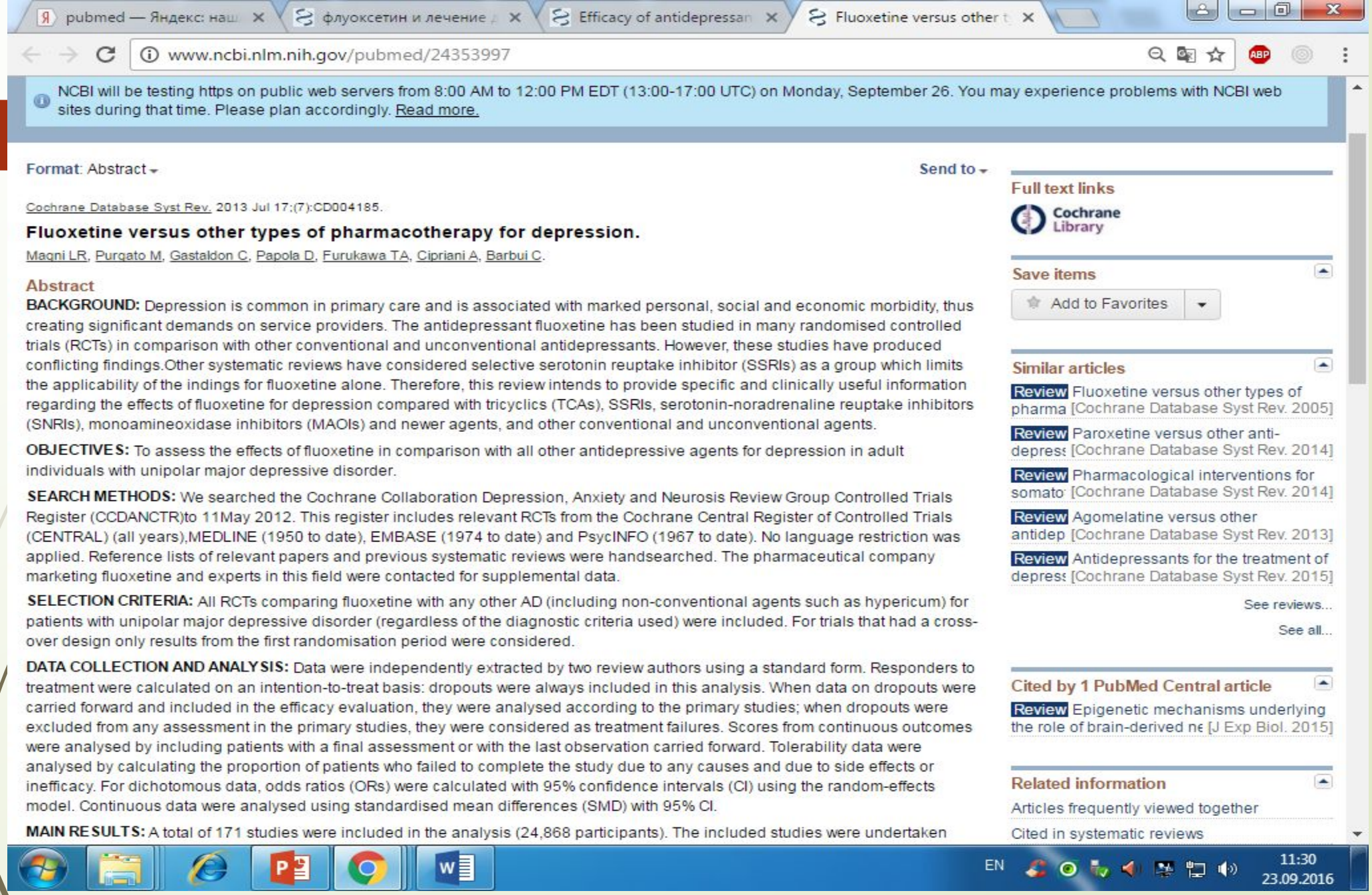
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Fluoxetine versus other types of pharmacotherapy for depression.
Magni LR, Purgato M, Gastaldon C, Papola D, Furukawa TA, Cipriani A, Barbui C.
Abstract
BACKGROUND: Depression is common in primary care and is associated with marked personal, social and economic morbidity, thus creating significant demands on service providers. The antidepressant fluoxetine has been studied in many randomised controlled trials (RCTs) in comparison with other conventional and unconventional antidepressants. However, these studies have produced conflicting findings.Other systematic reviews have considered selective serotonin reuptake inhibitor (SSRIs) as a group which limits the applicability of the indings for fluoxetine alone. Therefore, this review intends to provide specific and clinically useful information regarding the effects of fluoxetine for depression compared with tricyclics (TCAs), SSRIs, serotonin-noradrenaline reuptake inhibitors (SNRIs), monoamineoxidase inhibitors (MAOIs) and newer agents, and other conventional and unconventional agents.
OBJECTIVES: To assess the effects of fluoxetine in comparison with all other antidepressive agents for depression in adult individuals with unipolar major depressive disorder.
SEARCH METHODS: We searched the Cochrane Collaboration Depression, Anxiety and Neurosis Review Group Controlled Trials Register (CCDANCTR)to 11May 2012. This register includes relevant RCTs from the Cochrane Central Register of Controlled Trials (CENTRAL) (all years),MEDLINE (1950 to date), EMBASE (1974 to date) and PsycINFO (1967 to date). No language restriction was applied. Reference lists of relevant papers and previous systematic reviews were handsearched. The pharmaceutical company marketing fluoxetine and experts in this field were contacted for supplemental data.
SELECTION CRITERIA: All RCTs comparing fluoxetine with any other AD (including non-conventional agents such as hypericum) for patients with unipolar major depressive disorder (regardless of the diagnostic criteria used) were included. For trials that had a cross-over design only results from the first randomisation period were considered.
DATA COLLECTION AND ANALYSIS: Data were independently extracted by two review authors using a standard form. Responders to treatment were calculated on an intention-to-treat basis: dropouts were always included in this analysis. When data on dropouts were carried forward and included in the efficacy evaluation, they were analysed according to the primary studies; when dropouts were excluded from any assessment in the primary studies, they were considered as treatment failures. Scores from continuous outcomes were analysed by including patients with a final assessment or with the last observation carried forward. Tolerability data were analysed by calculating the proportion of patients who failed to complete the study due to any causes and due to side effects or inefficacy. For dichotomous data, odds ratios (ORs) were calculated with 95% confidence intervals (CI) using the random-effects model. Continuous data were analysed using standardised mean differences (SMD) with 95% CI.
MAIN RESULTS: A total of 171 studies were included in the analysis (24,868 participants). The included studies were undertaken
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MAIN RESULTS: A total of 171 studies were included in the analysis (24,868 participants). The included studies were undertaken between 1984 and 2012. Studies had homogenous characteristics in terms of design, intervention and outcome measures. The assessment of quality with the risk of bias tool revealed that the great majority of them failed to report methodological details, like the method of random sequence generation, the allocation concealment and blinding. Moreover, most of the included studies were sponsored by drug companies, so the potential for overestimation of treatment effect due to sponsorship bias should be considered in interpreting the results. Fluoxetine was as effective as the TCAs when considered as a group both on a dichotomous outcome (reduction of at least 50% on the Hamilton Depression Scale) (OR 0.97, 95% CI 0.77 to 1.22, 24 RCTs, 2124 participants) and a continuous outcome (mean scores at the end of the trial or change score on depression measures) (SMD 0.03, 95% CI -0.07 to 0.14, 50 RCTs, 3393 participants). On a dichotomousoutcome, fluoxetine was less effective than dothiepin or dosulepin (OR 2.13, 95% CI 1.08 to 4.20; number needed to treat (NNT) =6, 95% CI 3 to 50, 2 RCTs, 144 participants), sertraline (OR 1.37, 95% CI 1.08 to 1.74; NNT = 13, 95% CI 7 to 58, 6 RCTs, 1188 participants), mirtazapine (OR 1.46, 95% CI 1.04 to 2.04; NNT = 12, 95% CI 6 to 134, 4 RCTs, 600 participants) and venlafaxine(OR 1.29, 95% CI 1.10 to 1.51; NNT = 11, 95% CI 8 to 16, 12 RCTs, 3387 participants). On a continuous outcome, fluoxetine was more effective than ABT-200 (SMD -1.85, 95% CI -2.25 to -1.45, 1 RCT, 141 participants) and milnacipran (SMD -0.36, 95% CI-0.63 to -0.08, 2 RCTs, 213 participants); conversely, it was less effective than venlafaxine (SMD 0.10, 95% CI 0 to 0.19, 13 RCTs,3097 participants). Fluoxetine was better tolerated than TCAs considered as a group (total dropout OR 0.79, 95% CI 0.65 to 0.96;NNT = 20, 95% CI 13 to 48, 49 RCTs, 4194 participants) and was better tolerated in comparison with individual ADs, in particular amitriptyline (total dropout OR 0.62, 95% CI 0.46 to 0.85; NNT = 13, 95% CI 8 to 39, 18 RCTs, 1089 participants), and among the newer ADs ABT-200 (total dropout OR 0.18, 95% CI 0.08 to 0.39; NNT = 3, 95% CI 2 to 5, 1 RCT, 144 participants), pramipexole(total dropout OR 0.12, 95% CI 0.03 to 0.42, NNT = 3, 95% CI 2 to 5, 1 RCT, 105 participants), and reboxetine (total dropout OR0.60, 95% CI 0.44 to 0.82, NNT = 9, 95% CI 6 to 24, 4 RCTs, 764 participants).

AUTHORS' CONCLUSIONS: The present study detected differences in terms of efficacy and tolerability between fluoxetine and certain ADs, but the clinical meaning of these differences is uncertain.Moreover, the assessment of quality with the risk of bias tool showed that the great majority of included studies failed to report details on methodological procedures. Of consequence, no definitive implications can be drawn from the studies' results. The better efficacy profile of sertraline and venlafaxine (and possibly other ADs) over fluoxetine may be clinically meaningful,as already suggested by other systematic reviews. In addition to efficacy data, treatment decisions should also be based on considerations of drug toxicity, patient acceptability and cost.

Update of

Fluoxetine versus other types of pharmacotherapy for depression. [Cochrane Database Syst Rev. 2005]

PMID: 24353997 DOI: 10.1002/14651858.CD004185.pub3

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КЛИНИЧЕСКИЙ ПРОТОКОЛ ДИАГНОСТИКИ И ЛЕЧЕНИЯ

ДЕПРЕССИИ БЕЗ ПСИХОТИЧЕСКИХ СИМПТОМОВ

I. ВВОДНАЯ ЧАСТЬ:

1. **Название протокола:** Депрессии без психотических симптомов.

2. **Код протокола**:

3. **Код МКБ-10:**

F31.3 Биполярное аффективное расстройство, текущий эпизод легкой или умеренной депрессии.
F31.4 Биполярное аффективное расстройство, текущий эпизод тяжелой депрессии без психотических симптомов.
F32.0 Депрессивный эпизод легкой степени.
F32.1 Депрессивный эпизод средней степени.
F32.2 Депрессивный эпизод тяжелой степени без психотических симптомов.
F33.0 Рекуррентное депрессивное расстройство, текущий эпизод легкой степени.
F33.1 Рекуррентное депрессивное расстройство, текущий эпизод средней

возрасте (хлорпротиксен, тиоридазин)

14.2.1 Медикаментозное лечение, оказываемое на амбулаторном уровне[4-7,9,12-18]**:**

Таблица 2 – Основные медикаменты:

Рекомендуется монотерапия: одно из нижеперечисленных препаратов.

МНН	Терапевтический диапазон	Курс лечения
Дулоксетин (УД – А)	60 мг\сутки внутрь	Не менее 3-6 месяцев с момента исчезновения проявлений депрессии
Агомелатин (УД – А)	25-50мг\сутки внутрь	
Венлафаксин (УД – А)	37,5-150 мг\сутки внутрь	
Амитриптилин (УД – А)	75-150мг\сутки внутрь	
Сертралин (УД – А)	50-100мг\сутки внутрь	
Флувоксамин (УД – А)	50-100 мг\сутки внутрь	
Миртазапин (УД – А)	15-30 мг\сутки внутрь	
Флуоксетин (УД – А)	20-60 мг\сутки внутрь	
Топирамат (УД – В)	50-150 мг\сутки	

Вывод:

- По итогам поиска в базе данных PubMed препарат флуоксетин наиболее эффективен по сравнению с амитриптилином. Согласно клиническим протоколам – уровень доказательности А.