

DAS Geriatrie-Update in der Region:



Johanniskraut, Quelle: Internet-search,
Google-Bilder, Wikipedia

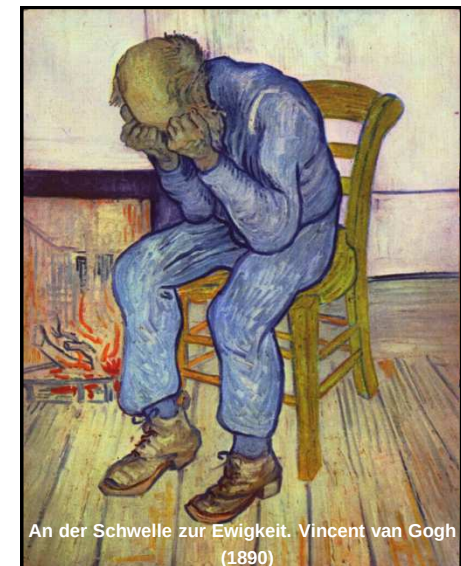
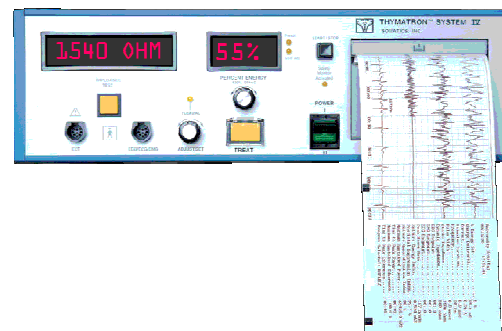
- Psychiatrie -

Behandlung der Depression

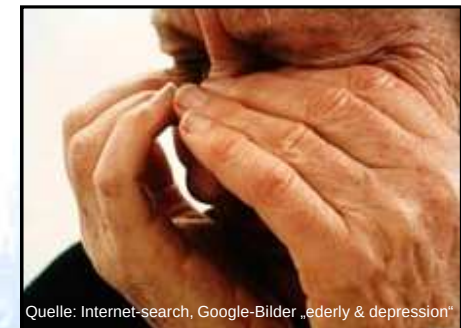
Prof. Dr. med. C. Schönfeldt-Lecuona
Klinik für Psychiatrie und Psychotherapie III
Universitätsklinikum Ulm



Klinik für Psychiatrie und Psychotherapie III. Safranberg (Ulm)



An der Schwelle zur Ewigkeit. Vincent van Gogh
(1890)



Quelle: Internet-search, Google-Bilder „elderly & depression“

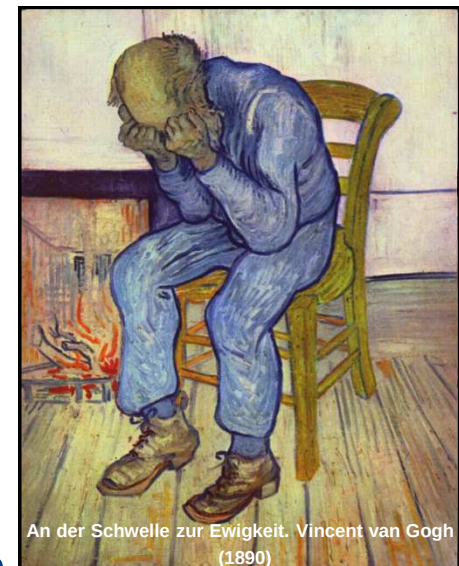
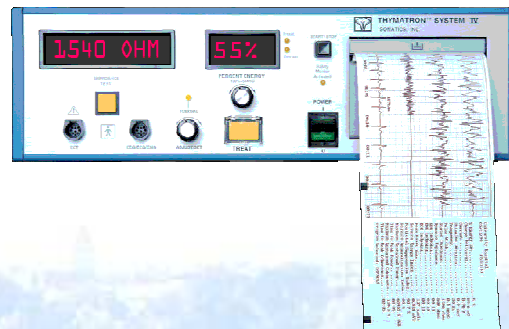
DAS Geriatrie-Update in der Region:

- Pflanzliche Antidepressiva sind (nicht) besser



Johanniskraut, Google, Internet search,
Google-Bilder, Wikipedia

- Elektrokonvulsionstherapie (EKT) ist (nicht) gefährlich



An der Schwelle zur Ewigkeit. Vincent van Gogh
(1890)



- Psychopharmakologie und biologische Verfahren
 - **Medikamente**
 - Schlafentzug
 - biologisch aktives Licht
 - **EKT**, VNS, TMS (DBS / TDCS ?)
- Psychotherapie
 - supportive Gesprächstherapie
 - Verhaltenstherapie
 - analytische Therapie
- Entspannungsverfahren
- Co-Therapie
 - Ergotherapie
 - Kunsttherapie
 - Physio-, Sporttherapie
- Soziotherapie
 - Psychoedukation



Pflanzliche Antidepressiva sind nicht besser



- Antidepressiva (AD), on-lable
 - Unterschiedliche Wirkmechanismen
 - Tri- und Tetrazyklische AD (Amitriptylin, Doxepin, Trimipramin, Clomipramin, Desipramin, Milnacipran // Maprotilin, Mianserin....)
 - Spezifische Serotonin-Wiederaufnahmehemmer (SSRI) (Fluoxetin, Paroxetin, Fluvoxamin, Citalopram, Es-cit, Sertralin)
 - Monoamino-oxidase(MAO)-Hemmer (Tranylcypromin, Moclobemid)
 - Noradrenalin-Wiederaufnahmehemmer (NARI) (Reboxetin, Atomoxetin)
 - Dopamin-Wiederaufnahmehemmer (DARI) (Bupropion)
 - Duale AD (NA/SRI, NA/DARI) (Venlafaxin, Duloxetine)
 - Alpha 2-Antagonisten (Mirtazapin)
 - Melatonin-Agonisten (Agomelatin)
 - Tianeptin (Serotonin-Reuptake-Enhancer)
 - Phytopharmaka (Johanniskraut)
- Antipsychotika (SGA), off-lable (oft als add-on)
 - Unterschiedliche Wirkmechanismen
 - Quetiapin (Olanzapin, Risperidon, Ziprasidon, Aripiprazol)
- Sedativa/Hypnotika/Anxiolytika, vorübergehend
 - Benzodiazepine
 - niedrigpotente Antipsychotika
 - Benzodiazepin-Analoga/ GABA-A Analoga



Pflanzliche Antidepressiva sind nicht besser



- Antidepressiva (AD), on-label
 - Unterschiedliche Wirkmechanismen
 - Tri- und Tetrazyklische AD (Amitriptylin, Doxepin, Trimipramin, Clomipramin, Desipramin, Milnacipran // Maprotilin, Mianserin....)
 - Spezifische Serotonin-Wiederaufnahmehemmer (SSRI) (Fluoxetin, Paroxetin, Fluvoxamin, Citalopram, Es-cit, Sertralin)
 - Monoamino-oxidase(MAO)-Hemmer (Tranylcypromin, Moclobemid)
 - Noradrenalin-Wiederaufnahmehemmer (NARI) (Reboxetin, Atomoxetin)
 - Dopamin-Wiederaufnahmehemmer (DARI) (Bupropion)
 - Duale AD (NA/SRI, NA/DARI) (Venlafaxin, Duloxetine)
 - Alpha 2-Antagonisten (Mirtazapin)
 - Melatonin-Agonisten (Agomelatin)
 - Tianeptin (Serotonin-Reuptake-Enhancer)
 - **Phytopharmaka (Johanniskraut)**
- Antipsychotika (SGA), off-label (oft als add-on)
 - Unterschiedliche Wirkmechanismen
 - Quetiapin (Olanzapin, Risperidon, Ziprasidon, Aripiprazol)
- Sedativa/Hypnotika/Anxiolytika, vorübergehend
 - Benzodiazepine
 - niedrigpotente Antipsychotika
 - Benzodiazepin-Analoga/ GABA-A Analoga

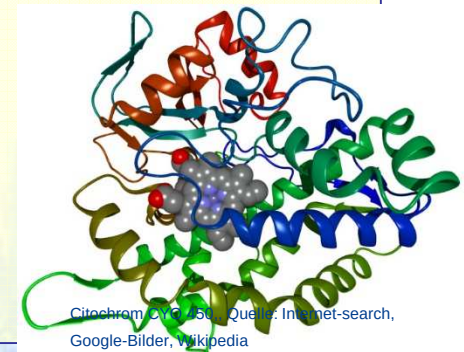
Johanniskraut

(Hypericum perforatum)

• Johanniskraut

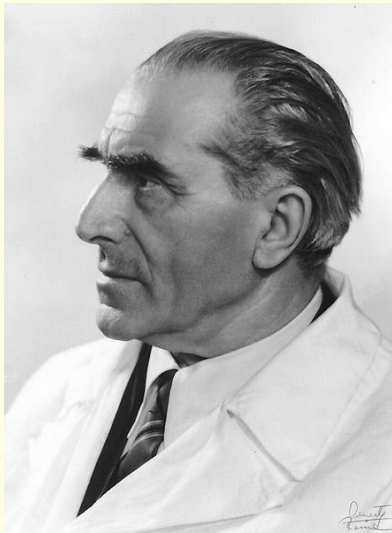
– Macht eine enzymatische Induktion des CYP 450 der Leber
(*Iso-Enzyme des Zytochroms P 450 (CYP 1A2, 2C9, 3A4)*)

- Antikoagulantien (Marcumar)
- Antibiotika (Makrolide)
- Immunsuppressiva (Cyclosporin A, Sirolimus, Tacrolimus)
- HAART-Medikamente (highly active antiretroviral therapy)
- Antihypertonika (Kalziumantagonisten, Sartane)
- Antiemetika (Ondansetron)
- Antidiabetika (Glimepirid, Rosiglitazon, Tolbutamid)
- Antiphlogistika (NASR: Diclofenac, Ibuprofen...)
- Antidementiva (Tacrin)
- Statine (Atorvastatin, Lovastatin, Simvastatin)
- Malaria-Mittel (Halofantrin, Mefloquin)
- Steroide (Ethinylestradiol)
- Tamoxifen (Antitumor-Medikamente)
- Antimykotika (Terfenadin)
- Potenzmittel (Sildenafil)





Elektrokonvulsionstherapie (EKT) ist (nicht) gefährlich



Ugo Cerletti
(1877-1963)

&

Lucio Bini
(1908-1964)



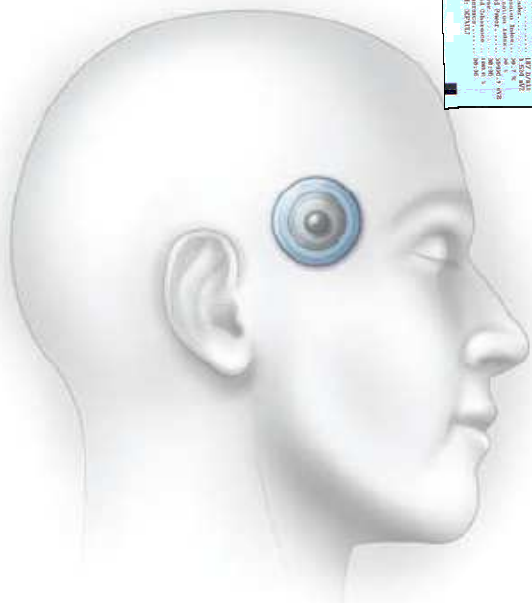
Uno Nuovo Metodo di Shock Terapia: "L'Elettroshock".
Boll Acad Med Roma 64 (1938)

Elektrokonvulsionstherapie (EKT) ist (nicht) gefährlich

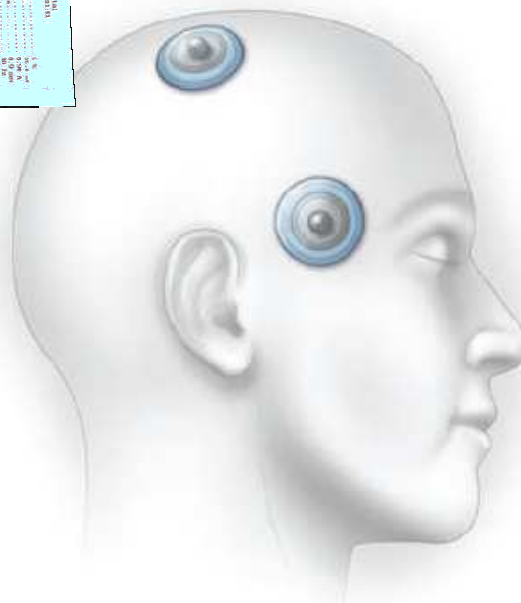


Die modifizierte EKT:

- Anästhesiologische Abklärung
- Kurze Narkose (ohne Tubus, wenige Minuten)
- Muskelrelaxation
- Ständige anästhesiologische Überwachung



Bilateral



Right unilateral



Bifrontal

d'Elia & Raotma 1975



Elektrokonvulsionstherapie (EKT)

ist (nicht) gefährlich

EKT: Wirksamkeit

Articles

Efficacy and safety of electroconvulsive therapy in depressive disorders: a systematic review and meta-analysis

*The UK ECT Review Group**

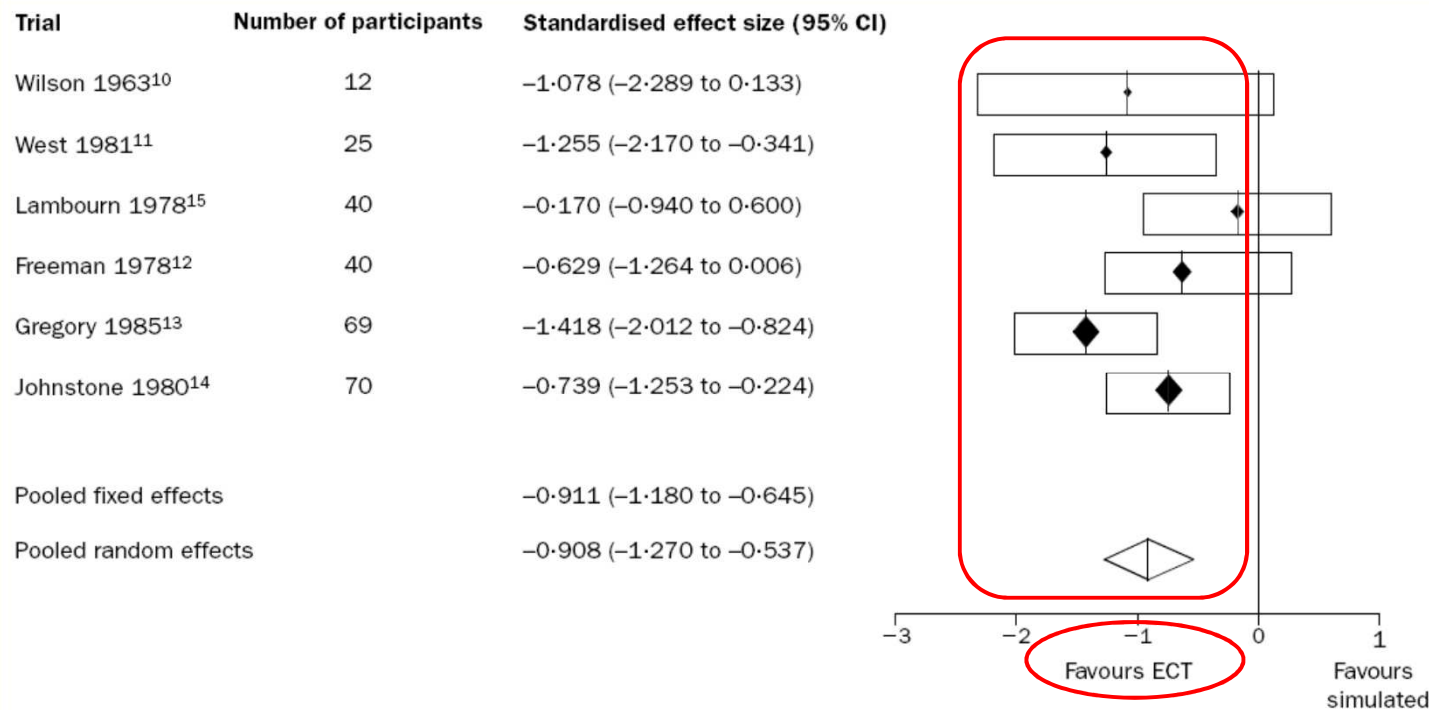
Lancet 2003; 361: 799–808

- EKT vs Schein - EKT: 6 Studien, 256 Patienten
- EKT vs Pharmakotherapie: 18 Studien, 1144 Patienten
- EKT bilateral vs unilateral: 22 Studien, 1408 Patienten

Elektrokonvulsionstherapie (EKT)

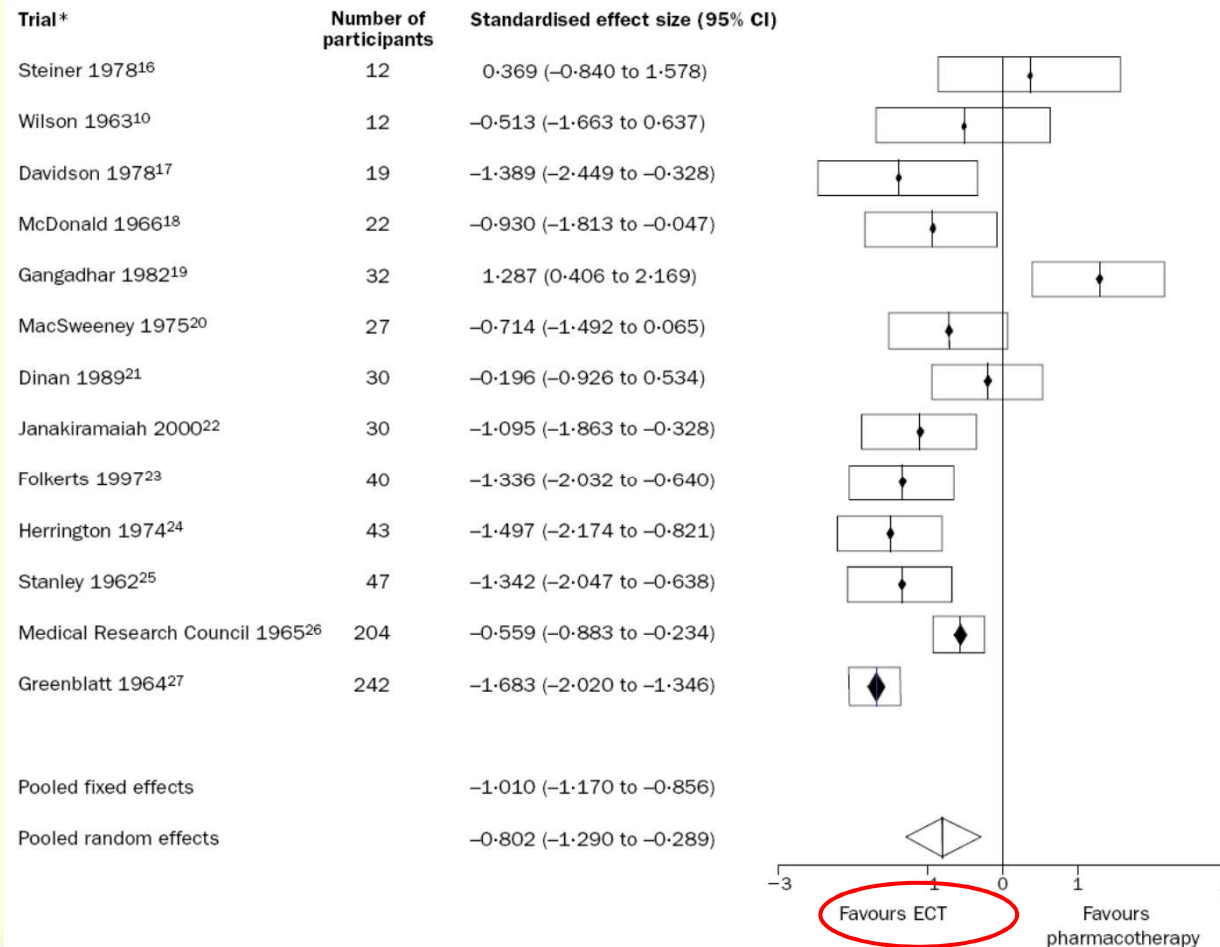
ist (nicht) gefährlich

EKT vs Schein - EKT



Elektrokonvulsionstherapie (EKT) ist (nicht) gefährlich

ECT vs Pharmakotherapie





ELSEVIER

The American Journal of Geriatric Psychiatry

Volume 23, Issue 3, March 2015, Pages 274-282



Regular Research Article

Older Age Is Associated with Rapid Remission of Depression After Electroconvulsive Therapy: A Latent Class Growth Analysis

Didi Rhebergen M.D., Ph.D. ^{a, b, c, d, e}, Anne Huisman M.D. ^b, Filip Bouckaert M.D. ^c, King Kho M.D., Ph.D. ^d, Rob Kok M.D., Ph.D. ^d, Pascal Sienaert M.D., Ph.D. ^c, Harm-Pieter Spaans M.D. ^d, Max Stek M.D., Ph.D. ^{a, b}

[Show more](#)

<https://doi.org/10.1016/j.jagp.2014.05.002>

[Get rights and content](#)

Objectives

This study aims to empirically identify latent course trajectories of depressive symptoms during electroconvulsive therapy (ECT) within a cohort of patients suffering from a depressive disorder and to examine putative predictors of course.

Methods

Using a prospective cohort multicenter collaborative ECT design, 120 patients fulfilling the Mini International Neuropsychiatric Interview criteria for major depressive disorder and referred for ECT were selected. Ratings of the 17-item Hamilton Rating Scale for Depression (HRSD) were obtained weekly during the course of ECT. Latent class growth analysis was used to identify trajectories of course during 6-week follow-up, based on weekly total HRSD scores. Characteristics of the identified classes were examined, and putative predictors for class membership were tested.

Results

Data-driven techniques identified distinct course trajectories during 6-week follow-up ECT treatment, consisting of "rapid remission," "moderate response," and "nonremitting" course trajectories. Remission rates were as high as 80.1% in the rapid remission class. Older age was associated with rapid remission, even after adjustment for putative confounders.

Conclusion

Our results strongly confirm the favorable outcome of ECT among elderly depressed inpatients.

Volume 212, Issue 2 February 2018, pp. 71-80

Prediction of electroconvulsive therapy response and remission in major depression: meta-analysis

Linda van Diermen ^(a1), Seline van den Amelee ^(a2), Astrid M. Kamperman ^(a3), Bernard C.G. Sabbe ^(a2) ... 

<https://doi.org/10.1192/bjp.2017.28> Published online: 01 February 2018

Abstract

Electroconvulsive therapy (ECT) is considered to be the most effective treatment in severe major depression. The identification of reliable predictors of ECT response could contribute to a more targeted patient selection and consequently increased ECT response rates.

To investigate the predictive value of age, depression severity, psychotic and melancholic features for ECT response and remission in major depression.

A meta-analysis was conducted according to the PRISMA statement. A literature search identified recent studies that reported on at least one of the potential predictors.

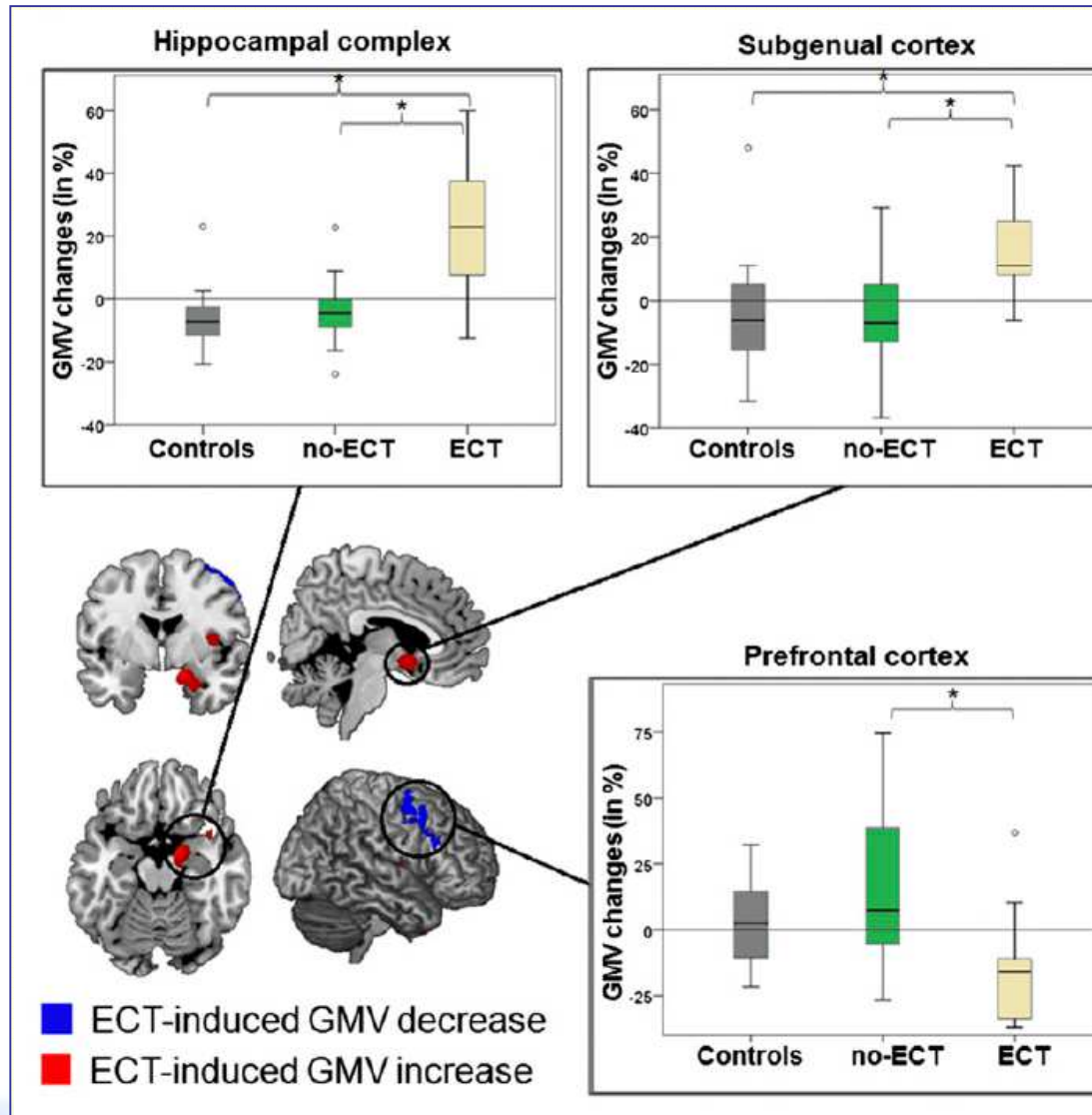
Of the 2193 articles screened, 34 have been included for meta-analysis. Presence of psychotic features is a predictor of ECT remission (odds ratio (OR) = 1.47, $P = 0.001$) and response (OR = 1.69, $P < 0.001$), as is older age (standardised mean difference (SMD) = 0.26 for remission and 0.35 for response ($P < 0.001$)). The severity of depression predicts response (SMD = 0.19, $P = 0.001$), but not remission. Data on melancholic symptoms were inconclusive.

ECT is particularly effective in patients with depression with psychotic features and in elderly people with depression.

More research on both biological and clinical predictors is needed to further evaluate the position of ECT in treatment protocols for major depression.

Elektrokonvulsionstherapie (EKT)

ist (nicht) gefährlich



EKT-Effekte:
(Voxel-based morphometry)

Zunahme des
Hippokampus-Volumens
nur nach ECT, nicht nach
medikamentöser
Therapie

Dukart et al. (2014)

Geriatrisches Zentrum Ulm

&

Klinik für Psychiatrie und Psychotherapie III,
Universitätsklinik Ulm

Pico del Teide, Teneriffa, 3.718 m

Vielen Dank für Ihre Aufmerksamkeit

carlos.schoenfeldt@uni-ulm.de