Short Communication

Evaluation of Treatments for both Epilepsy and Depression Patients

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Introduction

Although it is acknowledged that depression is a severe comorbidity of epilepsy, treating sadness and anxiety in those who have the condition can be difficult. This article's goal was to review published, carefully regulated clinical therapy studies of depression and anxiety in epilepsy patients. Cochrane, PsycINFO, and PubMed databases were searched for published controlled clinical trials, controlled psychosocial trials, or published controlled behavioural trials [1]. Cognitive behavioural therapy, antiepileptic drugs, and antidepressants were used as interventions. Despite the methodological flaws in the studies this analysis found, psychotherapy and medicine both reduced depression and anxiety in epilepsy patients. To establish adequate pharmaceutical and psychosocial co-management of depression and epilepsy, however, more investigation in the form of randomised controlled clinical studies is required [2].

It is commonly acknowledged that depression, which frequently coexists with anxiety, is a significant comorbidity of epilepsy. It not only results in a lower quality of life but also significantly raises medical expenses. Epilepsy patients are at a greater risk of experiencing depressed symptoms, and their suicide rates have been found to be up to ten times higher than those of the general population. There are conflicting statistics in the literature about the overall prevalence of depression in epilepsy patients, although it is generally believed that this number is around 30%.

Peri-ictal, ictal, post-ictal, and inter-ictal depression are several types of depression in patients with epilepsy. Peri-ictal depression has been defined as the existence of dysphoric, depressive, or anxious symptoms that appear before the seizure and go away with the ictus [3,4].

Patients with temporal lobe epilepsy frequently experience ictal depression, which has been reported to occur in this patient population at a rate of roughly 10% in the literature. Post-ictal depression, the second most frequent type of depression, is frequently related to the inhibitory processes that stop seizure activity and is seen with unilateral frontal or temporal foci.

Inter-ictal depression is characterised by episodes of significant depression, dysthymia, or affective mood disorder in between seizures. In people with epilepsy, it is the most typical type of depression. It can be difficult to treat comorbid depression in individuals with epilepsy. There is a lack of information on how these people with depression are treated for depression using medical, behavioural, or concurrent behavioural and medical treatments.

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Patients with persistent somatic disorders have shown positive results from psychotherapeutic techniques including Cognitive Behavioural Therapy (CBT). Despite the lack of evidence-based recommendations, doctors frequently prescribe SSRIs as part of medical treatment for depression. This is a systematic evaluation of the literature that has been written about therapy options for people who also have comorbid depression and epilepsy [1,2].

Prior to June 2012, controlled psychosocial or behavioural trials as well as prospective controlled clinical trials were looked for in the PubMed, Cochrane, and PsycINFO databases. Seizures, epilepsy, depression, psychotherapy, cognitive therapy, behavioural therapy, non-pharmacologic therapy, education, and stress management were utilised as search phrases.

In all investigations, the diagnosis of epilepsy was determined on the basis of clinical evidence. Epilepsy clinics recruited patients with an ICD9 diagnosis of epilepsy. Mazza et al. and Robertson et al. included patients with all forms of seizures, in contrast to Ettinger et al. who only included patients with primary generalised tonic-clonic seizures. Patients who had been diagnosed with epilepsy for one to two years or who experienced two seizures of any subtype each month before to the studies were eligible to participate in the psychotherapy trials [1,3]. The Epilepsy Self-Efficacy Scale, the Cornell Services Index, and the mean seizure frequency were utilised as outcome measures for epilepsy.

There is a dearth of information on how to treat patients who have concomitant epilepsy and depression. Although there have been more research published in recent years, few of them are randomised controlled clinical trials.

The generalizability of published studies to the general population of individuals with seizures and depression is constrained by a number of factors. First, the study sample sizes, which ranged from 17 to 80 patients, were modest. Underrepresented groups included women and non-Caucasians. Additionally, there were significant differences in the baseline characteristics and inclusion standards for epilepsy and depression between trials.

Similar to this, there were many different definitions of epilepsy, including individuals with a history of seizures, ICD9 diagnoses of seizures, and those who had two seizures each month [2]. The various studies also used varied methods for quantifying and evaluating seizure intensity, the effect on quality of life, and depressive symptoms. Despite the methodological flaws found in the research mentioned in this review, it does seem that treating depression and anxiety in epilepsy patients with both drugs and psychotherapy can be effective. Treatment for depression appears to improve quality of life in individuals with epilepsy and concomitant depression, which may lead to improved illness self-management. Improved medical treatment compliance and healthy lifestyle choices may be factors in enhancing positive health outcomes.

OXC and LTG, two distinct antidepressants, were utilised in the medication-based trials that are summarised here. Although the three controlled clinical trials took different methodologies, they all consistently shown that mood and sadness improved with drug use. Our review's conclusions highlight the need for head-to-head drug comparison studies comparing antidepressants to similar studies comparing AEDs to help doctors decide which drugs are most appropriate for patients with comorbid depression and epilepsy [2,3].

The most frequently researched therapy in this review was CBT, which had positive effects on outcomes for both epilepsy and depression. It is believed that CBT helps patients with epilepsy live better lives through at least two different mechanisms. These include a concentration on the treatment of depression as well as dealing with other crucial actions or ideas that could cause seizures.

The trials of CBT cited above did show improvement in depressive symptoms and quality of life, but the research were constrained by the absence of real controls [1,3]. Each study contrasted CBT with normal care, which was ill-defined. Psychotherapy, antidepressants, or a mix of psychotherapy and varying antidepressant use were the therapies in the control arm. Future research to evaluate the mechanistic components of care approaches might make use of a time and attentional control like general health education or spending time with a helpful volunteer.

Our analysis reveals that some antidepressant and antiepileptic medications, as well as standardised psychotherapies (particularly CBT), can improve

health outcomes for patients with comorbid epilepsy and depression, but our findings also point to other potential treatment options [3].

For instance, it is unclear if any particular antidepressants or AEDs may be more beneficial in those with comorbid epilepsy and depression. Depending on the type of epilepsy or the degree of the depression, preferred medications may change. Although CBT results are encouraging, it is unclear how techniques can or should be employed for implementation in typical clinical settings where there may be variations in patient cognitive capacities or willingness to engage in more intensive/prolonged treatments. Comparisons between studies are relatively challenging due to variation in the study measurement instruments used in the papers we identified through our evaluation.

Conclusion

The analysis indicates that pharmaceutical and behavioural therapies can help persons with epilepsy and depression by reducing both depression and seizure frequency. Better health outcomes are typically obtained by treating depressive symptoms. To establish acceptable pharmacological co-management of depression and epilepsy, standardise CBT delivery methods, and develop agreement on metrics for assessment of depression and other health outcomes, further research in the form of rigorous trials is required.

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