An M.A.O.I. Specific Affective Disorder. The "Too Much" Syndrome.

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This paper has presented a depressive syndrome occurring mainly in premenopausal women which is atypical in that it is characterized by too much sleep, too much eating, too much weight, and possibly too much libido. Treatment with an M.A.O.I. antidepressant is indicated and is always effective. It is important to distinguish other depressive syndromes which may show too much sleep, or too much appetite and too much weight, which may respond to treatment with either M.A.O.I. antidepressants or tricyclic antidepressants.

I believe that this clinically depressive syndrome is the first described to indicate specific chemotherapy. It is very possible that there may be other syndromes that may be recognized clinically that will also indicate a specific drug treatment. Careful clinical descriptions may well therefore lead to more specific indications for chemotherapy in, the affective disorders.

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Introduction

For some years the M. A.O. I. antidepressants have been known to be useful at times in the treatment of affective disorders. However, the lack of clear-cut clinical indications, and the possibility of potentially serious side effects or untoward reactions with other substances, has limited their use and has even given rise to the suggestion that the use of M.A.O.I. should be discontinued as a treatment modality in depression (Hollis-ter, 1970). This paper describes a clearly defined clinical syndrome that appears to respond to M.A.O.I. antidepressants exclusively. I believe this is the First description of a clinically distinguishable subgroup of affective disorders that indicates a specific chemotherapy.

Description

In clinical practice, it has become apparent to me that many of the depressions that respond to treatment with M.A.O.I. antidepressants vary in their clinical pattern from the classical description of endogenous depression. Many depressed patients, with either increased appetite and weight gain rather than the more usual anorexia and weight

loss, or hypersomnia rather than the more usual insomnia, show a better response to treatment with M.A.O.I. antidepressants than to treatment with tricyclic antidepressants or ECT. However, although these clinical findings provide a clue which one might follow in choosing the most effective drug for the patient, it is not invariable that these types of patients respond best to M.A.O.I. However, I have observed that there is an atypical depressive syndrome that, without exception, responds to treatment with M.A.O.I. antidepressants.

In such an M.A.O.I. -specific depression, the following features are present. The patient has a depressed affect although this is rarely the presenting complaint. It is unusual for them to be so depressed as to express suicidal ideas. They are more likely to complain of excessive irritability, but there is no diurnal variation of mood. These patients usually complain of anxiety and agitation. They may present with complaints of somatic symptoms, most commonly headaches or vague abdominal symptoms. However, in addition they exhibit the following specific symptom complex.

These patients present with a history of recurrent depressive episodes without any precipitating causes. They describe hypersomnia, sleeping for much longer periods of time than is normal for them, sleeping during the day as well as night time, and never feeling sufficiently rested. Their appetite is marked by compulsive eating and snacking between meals, and there is marked weight gain. That is, they sleep too much, eat too much, and weigh too much. Several of these patients have also described an increase in libido. Others have also described cold intolerance in spite of euthyroid status. Besides these rather atypical symptoms in depression, they have the more typical depressive symptoms of lack of energy and drive, together with loss of interest and ambition. Although most of these patients presented themselves for treatment in the 20-to 40-year-old age group, a history can usually be obtained of the first episode occurring in their adolescence. All of the women with this syndrome have been postmenarche and premenopausal. In the past few months I have recognized eight cases of this syndrome and have retrospectively identified 12 other cases. On this basis I would estimate that about one in 40 patients, in my practice, present with this syndrome, or about 10 new patients in one year.

The most important aspect of this syndrome is that, without exception, all have responded to treatment with M.A.O.I. antidepressants with complete recovery, usually within one month. Both tranylcypromine and phenelzine have proved effective in these patients. Where tricyclic antidepressants have been tried, these patients have shown little or no improvement.

Case History

Mrs. I.M. is a 33-year-old married Registered Nurse. She was first seen in 1970 with complaints of marital problems. She is married to a man who has an inadequate psychopathic personality pattern, and their marriage has never been very satisfactory to the patient. However, she decided to seek some help after eight years of marriage because her husband was showing less and less interest in sexual relationships with her and she had become aware of increased libido. She also described a sleep pattern of hypersomnia. She was sleeping approximately 10 hours at night and also sleeping for an hour or two in the day whenever she had the opportunity. Her appetite was increased, and she felt she was never satiated. She had a pattern of compulsive eating throughout her life. She had gained weight. She had no energy or drive and had to force herself to do anything. She had lost interest in her hobbies. She had always been a very artistically inclined person and had found that she had completely lost any desire to continue any of her hobbies. She had also become very withdrawn and was avoiding any social contact with other people.

On examination, she appeared as a very anxious and depressed-looking woman

who burst into tears easily. She described her mood as being very depressed and low, and she tended to feel worse in the mornings.

She had noted that she had become very irritable. She felt that life was not really worth living, but had never contemplated suicide. There was no evidence of any thought disorder, and there was no confusion.

She had had no previous psychiatric treatment, but did describe several episodes of depression during her life. The first severe episode that she recalled was at about 16 years of age. There was no family history of mental illness.

She was treated initially with tranylcypromine 10 mgms t.i.d., and she did respond well to this treatment. However, this drug had to be discontinued because of severe insomnia which developed as a side effect. She was then placed on amitriptyline 25 mgms t.i.d. which relieved her depressed mood to a limited extent. This medication was then replaced by phenelzine 15 mgms t.i.d., which was later increased to 30 mgms b.i.d. with good response. Her mood improved dramatically, and she no longer complained of depression. She regained her interest in her hobbies and her social life. She felt that she had plenty of energy and drive. She found that she could control her appetite and began to lose weight. She needed to sleep only about seven hours at night, and she was not sleeping in the daytime. She felt that her marriage problems had ceased to be a major problem, and she felt that her relationship with her husband was the best that it had been for many years. The Nardil was discontinued in the spring of 1972, approximately one year after it was commenced.

She returned in October, 1972, with complaints of depression once again. She had the same pattern of vegetative symptoms as noted before. She again responded well to treatment with phenelzine 30 mgms b.i.d. The medication was again discontinued in the spring of 1973, and she remained well throughout the summer. However, in September,
1973, she again returned with identical symptoms and was again placed on phenelzine 30 mgms b.i.d. She again showed marked improvement on this medication.

This patient is a typical example of the "Too Much" Syndrome.

Discussion

Since the advent of antidepressant chemotherapy, attempts have been made to delineate specific syndromes that would indicate treatment with a specific drug. Using the traditional classification of affective disorders, the attempts have mostly failed. The only exception would appear to be the use of Lithium Carbonate in the treatment of the manic phase of the manic-depressive psychosis.

Vague recommendations that tricyclic antidepressants are indicated in the endogenous type of depression or that M.A.O.I. antidepressants are more likely to be effective in reactive or exogenous depression have been of little practical use. There does seem to be some evidence to suggest that the closer the patients' symptoms are to the classical endogenous depressive picture, that is, complaints of depression with psychomotor retardation, late insomnia, appetite, and extreme weight loss, as well as loss of energy, drive, and libido and loss of interest and ambition, the more likely they are to respond to treatment with tricyclic antidepressants.

Presented here is an atypical depressive syndrome that is easily recognized and responds specifically to treatment with M.A.O.I. antidepressants. A depressive episode that occurs in a premenopausal woman and is characterized by too much sleep, too much eating, and too much weight together with the more usual depressive symptoms, indicates treatment with an M.A.O.I. antidepressant and, to date, will always respond to such treatment.

I believe that this depressive syndrome is often misdiagnosed. Throughout under-graduate medical training and postgraduate psychiatric training, it is generally taught that affective depressive disorders are characterized by insomnia, loss of

appetite, weight loss, and loss of libido. Therefore, when a patient complains of depression, but shows none of these symptoms and in fact appears to sleep well, to eat well, and to be gaining weight, the true diagnosis of depression may well be overlooked. In perusing histories that I took from patients five to 10 years ago, I find that, in retrospect, there are many with the "too much" pattern that I failed to diagnose correctly.

It is intriguing that all except one patient with this syndrome in my sample of cases are premenopausal women. It is perhaps even more intriguing that this one exception is a well-adjusted homosexual. There is no indication that his homosexuality has any connection with his being depressed.

REFERENCES

HOLLISTER, LE: Toxicology of Psychotherapeutic Drugs in Principles of Psychopharmacology,first ed., CLARK, W.G., DEL GIUDICE, J. New York, Academic Press, p.543, 1970.