A Case of Subacute Onset Dementia Due to Sertraline

Sir,

Sertraline has been extensively used as SSRI in the use of affective disorders for nearly a decade now.

It has been overall safe and effective in regular practice. However like other SSRI it has also been associated with side effects. In our clinical practice we have regularly used the drug. The present study was on a middle aged gentleman who had been on several antidepressive medications and finally switched on to sertraline. However he developed disturbances in his memory and behavioural disorders which included delusions and sexual outbursts. When seen by neurologist he was worked up for dementia although no definite cause could be identified. Finally when the drug was withheld he showed rapid improvement.

Thus we are reporting this case of a subacutely developing dementia with behavioural problems which were reversible, and mainly associated with Sertraline use.

Sertraline is a selective serotonin reuptake inhibitor known to have curative effects in a number of affective disorders. However it is also known to cause a number of side effects. In out presently reported case we have seen a subacutely developing dementia developing in a case of sertraline use.

A 52 year old gentleman, resident of New Delhi, Professor by occupation and not a known diabetic or hypertensive, presented for the first time to a general physician with c/o lethargy, insomnia and lack of interest in his activities. He was referred to a Psychiatrist who after examination felt him to be a case of reactive depression related to work stress. He was counseled but failed to respond adequately.

On further interviews he was put on tricyclic antidepressants. He responded well initially but c/o of drowsiness and inability to concentrate. He was asked to withhold the drug and was started on Sertraline.

After a brief period of about a week, he developed increased lethargy and abnormal behaviour along with incontinence of urine. He was more irritible, with poor communication skill and increased and aberrant sexual desires as complained by his wife. He was however having no insight. He was asked to take a neurological opinion at this stage.

O/e he was found to be having a normal general examination. CNS examination revealed an alert state with disorientation to time, place and person. He was having severe bradykinesia, psychomotor retardation. He was apathetic and reluctant to cooperate for a higher mental function assay. However he had profound impairment of recent and remote memory but his immediate recall was present. Calculation and reasoning skills were poor. Speech was monotonous and nonfluid and content was abusive and very much unlikely his background ethical senses. Reading, naming, copying and spontaneous writing were all profoundly impaired. Motor examination showed normal power, slightly increased tone generally, brisk jerks, B/L downing planters. He had significant release reactions and asymmetrically. Bladder was catheterised. Sensory system and cordination were difficult to assess due to lack of co-operation. Gait was of short stepping type without any tendency to fall.

His blood counts, Sugar, Liver and renal functions including electrolytes and ammonia levels were normal. CPK, Thyroid functions were in range. An MRI scan of the brain showed diffuse cerebral atrophy. EEG was normal without any seizure activity. A SPECT study of the brain was done and there was no perfusion defects. CSF studies, HIV, VDRL were negative.

Based on these clinical and diagnostic work up he was thought to be having a subacute type of onset of dementia. However the cause was not too sure. But keeping in mind of the remote possibility of drug induced dementia was suspected. SERTRALINE was withheld.

About a week later he started improving and his insight started returning. The social disinhibition was removed and he became continent. Gradually over a period of time of around two weeks he had significantly improved and started taking feed by himself. His memory recovered slowly and he was remarkably better after a period of one month.

Sertraline is a selective serotonin reuptake inhibitor chemically different from other SSRI. The common central nervous system side effects of this drug include hypertonia, hypoesthesia.1 Infrequent complications are confusion, Hyperkinesia, Vertigo, Ataxia, Migraine, Hypersesthesia, Cramps, Hypokinesia, Abnormal gait, Choreoathetoid movements, Dyskinesias and nystagmus, tremors, impaired concentration.7

Frequent psychiatric disorders associated are sexual dysfunction,7 depression, teeth grinding, paranoid reactions abnormal drams, hallucinations, depersonalisation, aggressive reactions, suicidal tendencies, increased libido and withdrawal features.

Thus we have observed that in the case discussed above a subacutely precipitated dementia in a previously depressed subject, due to no other antecedent cause other than therapy with Sertraline. The response to the withdrawal of the drug and absence of any other documentary cause for the same probably established the diagnosis of Sertraline induced dementia.
REFERENCES

