DEPRESSION AS THE FIRST SYMPTOM IN AIDS PATIENT

SANJAY BANERJEE¹, RAVI KANT ARYA²

A patient experienced depression before being diagnosed as AIDS positive. He was well accepted by family members despite being aware about the infectivity and fatality of the disease.

The overwhelming psychological trauma and sense of threat experienced by those who have contracted AIDS are undoubtedly intensified by the frightening and often misleading media comments and by the irrational fears and negative discriminatory responses of the public. Taking into account the psychological stresses occasioned by awareness of being infected and the interpersonal, intrafamilial, social and occupational consequences of the disease together with high incidence of neurological complications, accompaniments of AIDS is matter for no surprise (Fenton, 1987a). The American experience appears to have been that psychiatric consultations are most frequently requested to evaluate depressive symptoms, suicidal risk, and disturbed behaviour related to CNS impairment and associated with dementia or delirium (Dilley et al., 1985, Holland and Tross, 1985). Mood disorder is a very common psychiatric complication (Rundell et al., 1986), and it is said that this has been most commonly diagnosed as an adjustment reaction with depression or anxious mood (Holland & Tross, 1985). A mood of sadness, hopelessness and helplessness is characteristic often associated with guilt, low self esteem and feeling of worthlessness, social withdrawal and isolation and also anticipatory grief are common accompaniment. Suicidal ideas may become prominent as the disease progresses (Fenton, 1987a).

Initial complaints of poor concentration and mental slowing, impairment of recent memory, lack of co-ordination and unsteady gait, and social withdrawal and apathy may be overlooked or regarded as feature of depressive disorder (Navia & Price, 1986). In India, 44 cases of full blown AIDS have been detected till March 1990 (ICMR Bulletin, 1990). It seems that no AIDS patient with depression as the first symptom, has been reported from India.

CASE

A 30 years old Hindu Male was referred from the department of Medicine, P.S. Medical College, Karamsad. He was diagnosed as AIDS positive two weeks ago. On admission in the psychiatric ward, he complained of disturbed sleep, did not feel like working, sadness of mood, suicidal ideas gradually increasing for last two months, even before diagnosis of AIDS. When the patient was explained about prognosis of the illness, his symptoms aggravated. The patient was the youngest of two brothers and one sister. He described a happy childhood and denied any difficult or painful childhood experience. There was no prior history of similar complaint. He described his marriage as being happy. Family history was negative for psychiatric disease. On admission, his heart rate was 70/min, respiration rate was 20/min and blood pressure 110/70 mm of Hg. Physical examination revealed nothing abnormal. He was an alert young man who looked somewhat older than his age. He had a low-tone speech. He was well oriented to time, place and person.

His affect was sad and reported depression. He exhibited ideas of worthlessness and hopelessness. He had ideas of committing suicide but never attempted. His fund of general information was normal. He correctly recalled four words immediately and after five minutes. His digit span was five forwards and three backwards. His associations were coherent and relevant. He was able to copy designs on paper and his ability to perform abstract thinking was normal. Cerebrospinal fluid findings were normal and computerised tomography was normal.

Initially, he was given 75 mg of Imipramine orally which was later increased to 150 mg. He responded well to treatment. All depressive symptoms disappeared within four weeks. He was transferred back to Department of Medicine after three weeks, for complaints of loose motions and candida infection of the tongue. Imipramine was gradually tapered in ten weeks. The patient was followed up till his death six months later. He never developed depression or dementia.

DISCUSSION

Faulstich (1987), Fenton (1987a, 1987b), Goldmacher (1987) and Perry & Markowicz (1986) have described that from the time a patient learns that he is infected (and sometimes before) to the time that he is...
near death with full blown AIDS, psychological and psychiatric problems are common. It is of interest to note that the patient described above and depression even before he had any knowledge of his own illness and he became further depressed on knowing the diagnosis of AIDS. Mood disturbance is common among suffers from AIDS and this may mask the onset of dementia for some time (Fenton, 1987a). The patient responded well to Imipramine within four weeks. He did not develop dementia till death, six months after diagnosis. Rundell et al. (1986) have also reported a case where severe depression appeared to be the most appropriate diagnosis.

Fenton (1987a) in a review article, reported frequent social isolation resulting from inability to follow occupation, diminution of sexual contact and social withdrawal. Patient's fear that family members and friends avoid him. There is a sense of time running out and of unfinished business in relation to interpersonal and family problem and the possibilities of solving or easing these inevitably intensifies the depressed mood. Unlike cases reported from western countries the above case had good familial support. Despite the awareness of the infectivity and fatality of the disease, the patient was well accepted by the family members.

REFERENCES

Dilley, J.W.; Ochiltree, H.N.; Perl, M. and Wolberdlng, F.A. (1985). Findings in Psychiatric consultations with patients with acquired immunodeficiency syndrome. American Journal of Psychiatry, 142, 82-86.

Paulslich, M.E. (1987). Psychiatric aspects of AIDS. American Journal of Psychiatry, 144, 351-356.

Fenton, T.W. (1987a). AIDS related psychiatric disorder. British Journal of Psychiatry, 151, 579-588.

Fenton, T.W. (1987b). Practical problems in the management of AIDS related psychiatric disorder. Journal of the Royal Society of Medicine, 80, 271-274.

Goldmeier, D. (1987). Psychosocial aspects of AIDS. British Journal of Hospital Medicine, 37, 232-240.

Holland, J.C. and Tross, S. (1985). The psychosocial and neuropsychiatric sequelae of the acquired immunodeficiency syndrome and related disorders. Annals of Internal Medicine, 103, 760-764.

Indian Council Of Medical Research Editorial Board (April 1990). Surveillance for HIV infection - An Update. ICMR BULLETIN, 20/4, 34 - 35.

Navia, B.A. and Price, R.W. (1986). Clinical features of the AIDS dementia complex. Abstract (poster 319) in Programme of the international Conference on AIDS, Paris, France, Paris : Voyage Conseil.

Perry, S.W. and Markowitz, J. (1986). Psychiatric interventions for AIDS spectrum disorders. Hospital and Community Psychiatry 37, 1001 - 1006

Rundell, J.R.; Wise, M.G. and Ursano, R.J. (1986) Three cases of AIDS - related psychiatric disorders. American Journal of Psychiatry, 143, 777 - 778.