COMMENT & CRITIQUE

Deanxit-associated tardive dyskinesia and tardive akathisia in a depressed patient

Deanxit is a mixture of the tricyclic antidepressant melitracen (10 mg) and the classical antipsychotic flupentixol (0.5 mg). It has been approved in 30 countries for the indication of treating mild depression (1). Side effects of this medication for short-term use include dizziness, dry mouth, constipation, tiredness, changes in appetite or weight, blurred vision, headache and weight gain (1). Many physicians and neurologists prescribe this medication for their patients with anxiety, depression, or neurosis. We report here an unusual case of a patient with recurrent major depression who developed tardive dyskinesia (TD) and tardive akathisia (TA) after taking one tablet of deanxit per night for 25 consecutive years.

A 75-year-old married woman visited our outpatient clinic because of complaints including persistent head shaking, repetitive and involuntary movements over her bilateral oral-buccal-lingual areas, resting tremors over both hands, subjective feeling of restlessness, non-stop daytime anxiety, rapid alternation of sitting and standing and chronic insomnia over the past two years. The patient had her first episode of depression at age 44 but did not receive any treatment at that time. Her second episode of depression occurred at the age of 50, and she was treated with deanxit 1# hs, lorazepam 1 mg hs and oxazolam 10 mg hs. In the 25 years that followed, the patient continued to take these medications. In the past one year, the patient developed symptoms of TD and TA. They became exacerbated in the past month and even made her become suicidal. Therefore, she was transferred to our hospital for help.

During the outpatient interview, she had mild depression and anxiety. She had no delusions or hallucinations. No impairment of her cognitive function was noted. Her Abnormal Involuntary Movement Scale (AIMS) score was 22, and her Barnes Akathisia Rating Scale (BARS) score was 9. She admitted to having fleeting suicidal ideas. Physical and laboratory examinations including a computed tomography scan of her brain were unremarkable.

After her initial assessment, we discontinued her deanxit and started her with lorazepam 0.5 mg bid & qn, propranolol 10 mg qd & qn, midazolam 7.5 mg hs, zolpidem 10 mg hs, clonazepam 2 mg hs and sertraline 50 mg hs. These medications were maintained for 4 months. Her movement symptoms were gradually remitted. Her current AIMS score is 2 and BARS score 1. She does not show residual deanxit-associated movement side effects. There is no evidence of recurrence of insomnia, anxiety or depression.

Our reported case is unique because it concerns a depressed patient who developed TD and TA after taking deanxit for 25 years, rather than a schizophrenic patient who developed movement side effects after receiving an antipsychotic for a long period of time (2,3). Deanxit was initially used to treat the patient's recurrent major depression. However, the patient depended on this medication and took it continuously because of her chronic insomnia, anxiety and depression. This case is also unusual for the patient's development of TA in addition to TD.

Most physicians have the knowledge that classical antipsychotics can lead to the side effect of TD. However, they may not know that depressed or neurotic patients treated with deanxit for a long time can also develop TD and TA. Furthermore, they may not know exactly what patients with TA look like. Based on the definition hypothesised by Bluke (4), there are four criteria for making the diagnosis of TA. First, the patient must have akathisia. Second, the akathisia must occur during neuroleptic treatment or within 3 months of discontinuing neuroleptic treatment. Third, it must last at least 1 month after discontinuation of neuroleptics. Fourth, the patient must have no other neurological illness that might cause akathisia, such as encephalitis or Parkinson's disease. Our case met the above diagnostic criteria of TA.

Regarding the management of TD and TA, we treated this patient with lorazepam and a beta-blocker for 4 months. She responded to these medications well and the symptoms remitted gradually. Notably, we also used the long-acting hypnotic, clonazepam and the selective serotonin reuptake inhibitor, sertraline to handle her chronic insomnia and depression. No insomnia or depression was noticed since starting her with these two medications and the doses of these medications have also been gradually tapered.

In conclusion, this unusual case developed TD and TA after taking deanxit for 25 consecutive years. It highlights the importance of being aware that movement side effects can be induced by this combined antidepressant/antipsychotic medication after long-term use in depressed patients and that these side effects can be avoided by simply using an antidepressant alone.

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