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Uvođenje psihofarmakoterapije kod pacijentice s epilepsijom – prikaz slučaja

/ Initiation of Psychopharmacotherapy in a Patient With Epilepsy – A Case Report

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Uvod: Osobe oboljele od epilepsije imaju značajno višu prevalenciju psihičkih poremećaja u usporedbi s općom populacijom. Psihijatrijski komorbiditet prisutan je u više od trećine osoba s epilepsijom, znatno narušava kvalitetu života, povećava rizik od suicida te otežava adherenciju i optimalno doziranje antiepileptičke terapije. Dvosmjerni odnos epilepsije i psihičkih poremećaja, zajedno s potencijalnim psihotropnim nuspojavama antiepileptika, zahtijeva multidisciplinarni pristup liječenju. Prikaz slučaja: Prikazujemo pacijenticu u ranim tridesetim godinama koja se od epilepsije liječi 11 godina. Unatoč terapiji levetiracetamom u visokoj dozi, bilježi do šest epileptičkih napa-

Introduction: Individuals with epilepsy have a significantly higher prevalence of mental disorders compared to the general population. Psychiatric comorbidity is present in more than one-third of people with epilepsy, markedly impairs quality of life, increases suicide risk, and complicates adherence and optimal dosing of antiepileptic therapy. The bidirectional relationship between epilepsy and mental disorders, together with the potential psychotropic adverse effects of antiepileptic drugs, requires a multidisciplinary treatment approach. Case report: We present a female patient in her early thirties who has been treated for epilepsy for 11 years. Despite high-dose levetiracetam therapy, she still experiences up to six

daja godišnje. Upućena je na psihijatrijski pregled zbog anksiozno-depresivnih smetnji, pri čemu treba uzeti u obzir i poznati psihotropni potencijal levetiracetama koji u dijela pacijenata može inducirati ili pogoršati depresiju, anksioznost i afektivnu labilnost. U kliničkoj slici dominiraju sniženo raspoloženje, tjeskoba, afektivna labilnost, socijalno povlačenje te povremene kompulzije i nametnute misli. Inicijalno je preporučeno uvođenje vortioksetina i kvetiapina, međutim, nadležni neurolog isključuje navedenu terapiju zbog zabrinutosti oko utjecaja na epileptogeni prag. Pacijentica je potom upućena kliničkom farmakologu. Rasprava: Ovaj slučaj otvara nekoliko ključnih pitanja koja će se detaljnije obraditi u radu: 1. koliko su SSRI antidepresivi doista sigurni kod osoba s epilepsijom i postoji li njihov mogući protektivni učinak putem serotoninergičnih mehanizama; 2. kakav je stvarni epileptogeni potencijal kvetiapina u usporedbi s drugim antipsihoticima; 3. u kojoj mjeri psihijatrijske nuspojave antiepileptika pridinose kliničkoj slici i treba li razmotriti zamjenu antiepileptika; 4. kako uspostaviti učinkovit model multidisciplinarne suradnje psihijatra, neurologa i kliničkog farmakologa u svakodnevnoj praksi. Zaključak: Visoka prevalencija psihijatrijskih komorbiditeta kod epilepsije i složenost farmakokinetičkih interakcija zahtijevaju sustavan, multidisciplinarni pristup. Razvoj jasnih interdisciplinarnih smjernica omogućio bi sigurnije i učinkovitije liječenje psihičkih poremećaja bez kompromitiranja kontrole epilepsije.

epileptic seizures per year. She was referred for psychiatric evaluation due to anxiety–depressive symptoms, with the need to take into account the known psychotropic potential of levetiracetam, which in some patients can induce or worsen depression, anxiety, and affective lability. The clinical picture is dominated by low mood, anxiety, affective lability, social withdrawal, and occasional compulsions and intrusive thoughts. The initial recommendation was to introduce vortioxetine and quetiapine; however, the treating neurologist rejected this therapy due to concern about its impact on the epileptogenic threshold. The patient was then referred to a clinical pharmacologist. Discussion: This case raises several key questions that will be addressed in more detail in the paper: How safe are SSRI antidepressants actually in people with epilepsy, and is there a possible protective effect via serotonergic mechanisms?

What is the true epileptogenic potential of quetiapine compared with other antipsychotics? To what extent do psychiatric side effects of antiepileptic drugs contribute to the clinical picture, and should a change of antiepileptic medication be considered? How can an effective model of multidisciplinary collaboration between psychiatrist, neurologist, and clinical pharmacologist be established in everyday practice? Conclusion: The high prevalence of psychiatric comorbidities in epilepsy and the complexity of pharmacokinetic interactions require a systematic, multidisciplinary approach. The development of clear interdisciplinary guidelines would allow for safer and more effective treatment of mental disorders without compromising seizure control.