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5 Things You Need to Know About Epilepsy & Depression

Announcer:
Welcome to CME on ReachMD. This activity, titled “5 Things You Need to Know About Epilepsy & Depression” is provided by Prova Education.

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Dr. Munger Clary:
Patients with epilepsy commonly have comorbid mental health disorders such as depression, yet some clinicians may not be fully aware of the combined prevalence of these two disorders, the bidirectional relationship between them, or the importance of screening for and treating comorbid depression. Today, we're looking for answers and exploring how implantable therapies such as vagal nerve stimulation, or VNS devices, can effectively treat both epilepsy and depression. This is CME on ReachMD, and I'm Dr. Heidi Munger Clary.

Dr. Salpekar:
I'm Dr. Jay Salpekar.

Dr. Munger Clary:
So, Jay, let's talk first about prevalence and underdiagnosis. From your perspective, how do clinicians think about depression associated with neurological disorders like epilepsy and depression?

Dr. Salpekar:
Well, Dr. Munger Clary, clinicians have a hard time with depression, especially associated with epilepsy. Back in the old days, people used to think, “Well, you have epilepsy, of course you're going to be depressed.” Now we know that it's not quite that simple. And you don't necessarily have to have depression if you have epilepsy, but there are different subtypes of epilepsy that might lead to more depressive symptoms. What we do know is that it can be very serious, and it's something that clinicians need to pay attention to.

Dr. Munger Clary:
And, you know, it's really interesting how long that relationship can last; it can be before epilepsy and after. Now, how do clinicians decide to assess and treat for depression?

Dr. Salpekar:
Well, I think clinicians really have to follow the lead of the patient when it comes down to it. A patient will tell them that they're not doing well, they may not understand why, they might not feel energetic, they might be unmotivated. So, a lot of times, what a clinician will have to do is decide is there something iatrogenic going on? Is there some sort of reaction to the depression medicine? Is there some reaction to the anti-seizure medicine that is causing low energy, depression, cognitive problems? So, clinicians are pretty good at that. But what they may not be able to appreciate is the bidirectional relationship between depression and epilepsy. Now, just like in the old days, we might be able to accept that epilepsy, for many years having epilepsy could lead to having depression. But what is less

appreciated is that having depression can actually lead to epilepsy. Now that is a whole sea change in how we understand pathophysiology and what's happening in the brain between these two conditions. It means that there's a real overlap chemically, biologically, physiologically, between depression and epilepsy. So, if a clinician is not addressing depression, then we may not be addressing comprehensive treatment of epilepsy.

Dr. Munger Clary:
Agree. And, it's interesting to think about what is it that might tip off a clinician to, you know, look for depression in one of their patients? Could you speak to what types of signs or symptoms that clinicians should be looking for?

Dr. Salpekar:
Sure. Well, the clearest example is a departure from someone's usual state of health, from their usual ability to function, if there's something different. Energy is a big thing. Motivation, being able to accomplish tasks through the course of a day. A lot of times people will complain about being listless or unenergetic, can't concentrate. And then sometimes if it gets severe, people will have low mood or tearful spells, crying spells. But a lot of times with epilepsy, what we see more often than what we call dysphoria, is we see irritability, people who are just impatient, frustrated easily, snapping at people that they don't want to be getting irritated with. And just having a real difficulty tolerating the regular frustrations of day-to-day activities. Those can be signs of depression that can be very significant.

Dr. Munger Clary:
That's really helpful. I think it's also, you know, challenging when we think about those clinical encounters for neurologists in their everyday care, whether or not you have time or the right tools and questions to ask patients about all those different things in your day-to-day care. I think that can be really challenging. And a lot of neurologists also might have challenges with what to do next if they identify these kinds of symptoms.

When we consider the prevalence of depression among people with epilepsy, which you mentioned is, you know, quite high and that potential is, you know, present throughout much of the course of epilepsy – what kinds of screeners can be used to detect these symptoms? And then, what's your opinion about why they're underutilized since there are screeners out there that clinicians could use?

Dr. Salpekar:
That's true. There are a lot of available tests. There's some very, very good ones. But I think even before using a test, a neurologist has to be comfortable with the subject. I think that neurologists should not be shy about asking patients if they're depressed. And for any of our screening tools, and I'll talk about a few of them that are very useful, but the first thing is to ask a patient, “How's your mood? Are you depressed?” That can be very telling. Anything besides a very confident, “No, my mood is fine,” or “No, I'm not depressed,” that warrants another question. Now, if there are a few questions that come up, or a few answers that come up that suggest depressive symptoms, then it might be useful to actually use a tool such as a screening questionnaire, like a Beck's Depression Inventory, or a Hamilton Depression Inventory. Those are some very good ones. The Patient Health Questionnaire is also a good one, PHQ-9. One of my favorites actually is the NDDI-E, Neurologic Disorders Depression Inventory for Epilepsy, N-D-D-I dash E. And that's a very straightforward test, it's only 6 questions. And people can talk about things like: Are they doing what they need to do? Do they take pleasure in activities? Do they – all the way to the point of: Do I question whether I should be alive or not? And those are things that are on people's mind already. Sometimes, if a clinician opens the door and says, “Yes, it's okay to talk about it,” then they'll answer the question and they'll tell how they're actually doing. So, those are the types of screening strategies, I'll say, not even screening tools, but strategies that can be very helpful to identify depression in patients.

Dr. Munger Clary:
That's really helpful. A lot of times, if I don't have time to use a screening instrument, I'll ask a question like, “How's your mood lately?” And the NDDI-E, being the most widely validated depression instrument in epilepsy, is really useful. One thing that could be useful to clinicians as well within that 6-question questionnaire, are the two questions that have some validation data as an ultra brief screener, the item about having difficulty finding pleasure, and then the item about suicidality, “I'd be better off dead.” So, that's something that could be a smaller version that people could also use in their practice. But 6 questions is pretty quick and easy to complete as well. So that's great. Thank you.

For those just tuning in, you're listening to CME on ReachMD. I'm Dr. Heidi Munger Clary, and here with me today is Dr. Jay Salpekar. We're discussing five things you need to know about epilepsy and depression.

Jay, now let's put this into context for our audience. Tell me about some best practices when it comes to management and the potential role of implantable devices for depression in people with epilepsy.

Dr. Salpekar:
Sure. Implantable devices are a very important topic. I think that there are a lot of different treatments and it's usually best to go from

simple to difficult. I would start by saying: What are the existing medicines to treat seizures? The anti-seizure medicines can sometimes help with depression. We have pretty robust data for lamotrigine, in fact, as a treatment for depression in the context of epilepsy, or even independent of epilepsy. A lot of our anti-seizure medicines are pretty good as adjuncts to treat mood disorder and even primary bipolar disorder. So, keep that in mind.

And then other antidepressants can be useful too. I think it's a good idea for a neurologist to learn one or two antidepressants that they can get comfortable with, that they're familiar with dosing, titration, potential side effects, and then responses.

But if those things are not effective, then we should consider implantable devices like the vagal nerve stimulator. The vagal nerve stimulator has a long history. And there's actually very robust data for long-term benefit from the vagal nerve stimulator. So, it should be considered, particularly in a person who has refractory epilepsy to the usual medicines. So, something about implantable devices, other types of treatments for seizures, overlaps with our treatment for depression. And it makes sense to consider all the options.

Dr. Munger Clary:
Yeah, I think when we think about care of people with epilepsy, if there's any way that we can manage or potentially improve both the comorbid mental health disorder, the depression symptoms, as well as the epilepsy at the same time, that can be a nice approach to think about using anti-seizure medications or VNS. I know a lot of times in our practice, when we think about candidates for different surgical therapies is, especially among the neurostimulation options, if somebody has existing depression, that's often an extra plus, you know, when we're thinking about different options or potential ways they might be able to benefit from a therapy that can help with both of those conditions at the same time.

Dr. Salpekar:
I agree. That makes a lot of sense. I guess the only thing I would add is that VNS is actually FDA indicated for depression. It's the neurostimulation device that is FDA indicated. So, there is a track record for that. And neurologists should not be shy about using whatever tool they have available to treat depression comorbid with epilepsy.

Dr. Munger Clary:
Well, this has certainly been a fascinating conversation. But before we wrap up, Jay, can you share one take-home message with our audience?

Dr. Salpekar:
Wow, it’s going to be hard to boil it down to just one message. But I think if there is one message, it is screen for depression, ask the question. Don't be shy about it. People are going to be depressed whether you ask or not, you might as well ask, and put it out there, and then do something about it.

Dr. Munger Clary:
That's great. I was going to say something very similar for my take-home message. But what I would add to that is that doing something about it, there are many tools available, and some of which include things that all neurologists are very familiar with within the realm of epilepsy treatment. And so, there's always something at your fingertips that you can do to try to take a step and address these impactful symptoms for people with epilepsy.

Dr. Munger Clary:
Unfortunately, that's all the time we have for today. So, I want to thank our audience for listening in. And thank you, Dr. Jay Salpekar, for joining me and for sharing all of your valuable insights. It was great speaking with you today.

Dr. Salpekar:
Thank you, it was a pleasure to be here.

Announcer:
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