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LETTERS TO THE EDITORS

Maintenance use of ketamine for treatment-resistant depression: an open-label pilot study

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Singh et al.[1] reported that two or three weekly 40 min i.v. infusions of ketamine (0.5 mg/kg) are safe and effective for maintaining an acute response to ketamine during one month of treatment for resistant depression (TRD).

We present herein the results of an open label pilot study of 8 TRD patients who received 40 min infusions of ketamine (0.5 mg/kg) for 7 weeks after a positive acute response to three ketamine infusions. We employed a maintenance protocol at a lower frequency as follows: three initial infusions every other day for a week, an infusion 7 days after the last initial infusion and infusions every two weeks thereafter. This lower frequency was based on the 18-day median time to loss of response reported by Murrough et al.[2]

In this study, those who did not respond adequately to appropriate courses of at least two antidepressants were considered TRD patients. The subjects were two men and six women, aged 25-53 years, diagnosed with major depressive disorder. They had no unstable clinical diseases and they were not acutely psychotic. Three patients had a comorbid diagnosis of generalized anxiety disorder, one of whom also had a diagnosis of fibromyalgia. Two of the individuals had been hospitalized once after attempting suicide. The mean duration of illness in this sample was 16 years. At the time of the study, four of the patients were in polytherapy, three were in monotherapy and one had chosen to discontinue antidepressants because he considered them ineffective.

They signed an informed consent form and completed a Beck Depression Inventory (BDI) three times: pretreatment (mean BDI scores = 33.75), 3 days after the initial infusions (mean BDI scores = 10.25) and on day 60 (mean BDI sores = 10.75). All eight patients sustained the response until day 60.

During the infusions all of the patients had some degree of dissociative symptoms, ranging from a feeling of lightheadedness to feelings of being outside the body or in another dimension. These symptoms began after 15 to 20 min of infusion and quickly reduced in intensity after the end of the infusions. All the patients could be discharged with no complications 30 min after the end of the infusions. Like Singh et al.,[1] we also observed that the dissociative symptoms decreased with repeated doses. Two patients complained of nausea, which was successfully treated with intravenous ondansetron. Despite this, seven of the patients described the infusion experience as pleasant and only one as unpleasant. No delusions or hallucinations were reported during the study. There were no clinical emergencies.

Thus, the use of multiple infusions of ketamine to maintain its acute effects might be an effective and well-tolerated treatment approach for TRD patients. An infusion every two weeks appears to suffice. This may represent a simple, quick way to bring longer term benefits for TRD patients with an acute ketamine response. Hence, this may be an alternative as we await eventual FDA approval of intranasal esketamine or new drugs targeting the glutamatergic system.[3] However, controlled studies with larger samples are required to replicate our findings.

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Disclosure

The authors report no conflicts of interest.

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Skin picking disorder comorbid with ADHD successfully treated with methylphenidate

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Skin picking disorder (SPD) is characterized by repetitive picking and scratching of the skin, leading to tissue damage and substantial distress.[1] The few pharmacological studies on SPD treatment have yielded conflicting results[2] and more pharmacological evidence is needed to guide clinicians.

Attention deficit hyperactivity disorder (ADHD) is characterized by symptoms that express varying levels of inattention, hyperactivity and impulsivity. Case reports of ADHD treatment with psychostimulants suggest they can also act on comorbid disorders with impulsive features (kleptomania, pathological gambling and bulimia nervosa).[3] Erdogan et al.[4] reported that SPD patients had a high prevalence of comorbid ADHD, but this has not been investigated in other studies. The only case report of ADHD comorbid with SPD, by Lane et al.,[1] described