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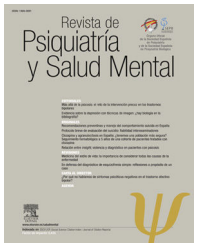

LETTER TO THE EDITOR

Involuntary outpatient treatment: A proposal of regulation☆

Tratamiento ambulatorio involuntario: una propuesta de regulación

Dear Editor,

An article appeared recently in *Diario Médico*[1] debating the need to regulate involuntary outpatient treatment (IOT).

IOT is aimed at patients with severe mental disorders, with no insight, multiple hospital admissions, who stop their treatment when they leave hospital resulting in physical and mental deterioration, and who display auto and hetero-aggressive behaviours.

Its application could reduce the number of readmissions and days in hospital, violent behaviours and arrests. However, studies based on meta-analyses[2,3] indicate that there is no significant reduction in health service use, or improvement in clinical outcomes in terms of social function or quality of life; although there are fewer victims of violence and non-violent crime.

Due to this apparent lack of clarity,[4] which also implies a reduction in fundamental rights, the legitimacy of IOT is now being debated. Those who reject it maintain that: (1) it is a discriminatory and stigmatising measure; (2) there are no conclusive studies that assess its pros and cons, its reliability and efficacy are dubious; and (3) the lack of resources available in the community to achieve maximum coverage and enable a comprehensive plan constitutes the essential issue.

Its defenders claim: (1) the treatment is necessary for the health of the patient; (2) it can reduce auto and hetero-aggressive behaviours, drug and alcohol abuse; (3) it could be a less restrictive option than admission to hospital, and (4) it is a protective measure of the person's legal safety, and it promotes continuity of treatment and recovery of autonomy and competence.

Attempts were made to regulate IOT by an extension to the Code of Civil Procedure (art. 763.5), about which there was much debate. Furthermore, the Constitutional Court, by court ruling STC 132/2010, declared paragraphs 1 and 3 of article 763 unconstitutional. Although it could seem that involuntary admissions are ''illegal'' because they are unconstitutional, the Constitutional Court did not declare the measure null and void, but asked for an amendment to avoid this legal vacuum. This was resolved with ''Organic Law 8/2015, of 22 July, amending the system for the protection of children and adolescents'', rendering article 763 organic in nature, and therefore no longer unconstitutional.

As has been debated recently,[5] we want to discuss the proposal of article 763.5, and develop it further with the following clarifications:

1. The rights to non-discrimination, equality and dignity, protection of integrity, right to life and health, and habilitation and rehabilitation,[6] must be taken as the cornerstone, thus respecting the ''Convention on the Rights of Persons with Disabilities''.[7]
2. A maximum application period of 18 months is set but no mention is made of a minimum. Swartz et al.[8–10] argue that application for less than 6 months does not achieve good outcomes.
3. Its target patient ''profile'' should be specified.
4. The proposal argues that IOT should be applied ''when the patients' health requires it''; however, mention should be made of the deterioration of an untreated person, avoidance of auto/hetero-violent behaviours, etc.
5. Although it encourages reporting the progress and follow-up of the process to the Court every 3 months, it is also advisable to indicate the need for the patient to be given a hearing.

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Precautions in prescribing serotonin reuptake inhibitors☆

Precauciones en la prescripción de inhibidores de la recaptación de serotonina

Dear Editor,

There are a considerable number of psychotropic drugs today that can cause endocrinological and metabolic changes which may affect both treatment adherence and the patient's quality of life and health status. Thus hyperprolactinaemia secondary to antipsychotics[1] — with its effects on gonadal function and bone metabolism —, or therapy with lithium and other antidepressants, with their effects on the thyroid function are just a few examples of this significant issue

Fluoxetine is a powerful selective serotonin reuptake inhibitor (SSRI) which is widely prescribed and indicated in the treatment of episodes of major depression, obsessive-compulsive disorder (OCD), and bulimia nerviosa.[2] The syndrome of inappropriate secretion of ADH (SIADH) consists of the secretion maintained by ADH failing to have its usual stimuli, in particular hypovolaemia and hyperosmolarity, and is characterised by the presence of hypoosmolar hyponatremia, urine sodium (NaU) above 40 mmol/l and urine osmolarity (OsmU) above 100 mOsm/kg, in absence of the effective reduction of volaemia (heart failure, ascities, hypovolemia,...), once thyroid and suprarrenal failure have been ruled out.[3]

Tumours, infections and very exceptionally drugs[4] are the most common causes. Antidepressants and in particular the SSRI have been frequently involved. Although not totally clarified, their physiopathological mechanism may depend on an increased secretion of ADH due to the stimulus of serotoninergic receptors and alpha-adrenergic receptors by the serotonin and noradrenaline.[5]

Pedrós et al.[6] reviewed 44 spontaneous reports of hyponatraemia and/or SIADH suspected of having been caused by SSRI between 1983 and 2003. Of these, 11 were attributed to fluoxetine. As a result, we present the case of a woman who developed hyponatraemia due to the use of this drug.

A woman aged 76 with a history of high blood pressure, Sjögren's syndrome and osteoporosis. She had been treated with 16 mg/day candesartan and 20 mg/day fluoxetine for the previous 4 months. She presented due to instability when walking, dizziness and mental torpidity of one month onset. Physical examination revealed the absence of oedema and signs of dehydration. Analysis highlighted a plasma NA of 125 mmol/l, plasma Osm 266 mOsm/l (vn: 280–300 mOsm/l), NaU 47 mmol/l and OsmU233 mOsm/l. Cortisol and thyrotophin (TSH) levels were normal.

On suspected SIADH secondary to fluoxetine, the drug was suspended and treatment was initiated with hypertonic saline solution and water deprivation. Clinical and analytical evolution was favourable, with normalisation of the natraemia.

According to its specification sheet[1] SIADH by fluoxetine is a serious and rare adverse effect (≥1/10,000 to <1/1000). Both Pedrós and Gandhi et al.[7] found there to be a higher risk of hyponatraemia due to SSRI in women over 65 years of age, in concomitant treatment with diuretics and a history of chronic kidney disease or heart failure. One cohort study of the British population[8] demonstrated a significant increase in the risk of hyponataemia with citalopram, fluoxetine and escitalopram compared with sertraline and paroxetine. The latter was found to be more frequently implicated in the Pedrós study.

To conclude, we believe that caution should be taken when prescribing SSRIs, especially in women over 65 years of age, where there is concomitant use of diuretics or a history of kidney or health failure. In these cases natraemia should be monitored and clinical follow-up should be performed at least in the first three months of treatment.

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