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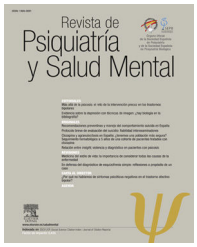

LETTER TO THE EDITOR

Cardiovascular safety profile of tianeptine☆

Perfil de seguridad cardiovascular de la tianeptina

Dear Editor,

Having read with interest the recent article ''Tianeptina, un abordaje farmacológico atípico de la depresión'' (Tianeptine, an atypical pharmacological approach to depression''[1] we would like to make a number of comments. Firstly, we would like to highlight the complete and thorough nature of this article, which illustrates a mechanism of action that to date has been incompletely and even contradictorily described in the available literature. However, the article does not expand on the drug's safety profile, therefore we performed a literature review using the Pubmed database, the results of which we considered would be of interest to report.

There are a series of Russian papers dated between 2002–2009 that analyse in depth the use of Tianeptine as a treatment for depression in patients with hypertension and ischaemic heart disease that show, in addition to the efficacy and safety of the drug as an antidepressant, additional benefits on blood pressure levels and even on parameters such as left ventricle remodelling after myocardial infarction.

The first paper we found regarding the cardiovascular safety of tianeptine dates from 1990, that shows that tianeptine did not cause orthostatic hypotension or increased heart rate. No changes could be observed on the electrocardiogram, and the cardiac conduction time remained unchanged.[2] A second paper from 1991, concluded that the drug was well tolerated by depressed patients and did not induce significant cardiovascular changes in patients with cardiovascular anomalies or in alcoholic patients (including the elderly), fewer cases of orthostatic hypotension were observed than with other antidepressants, and suicide attempts with drug overdose did not result in death due to cardiovascular complications.[3]

Focussing now on the series of Russian papers, in 2004 a study found a decrease in the Beck Depression Inventory Scale associating 37.5 mg of tianeptine compared to basic treatment of stable ischaemic heart disease only (control group), which also resulted in a decrease in the number and severity of cardialgias, better control of blood pressure in patients with hypertension, an increase in exercise time during the exercise test, and an increase in the overall quality of life index.[4]

In 2006, a study on patients with ischaemic heart disease and coronary arteriosclerosis found a negative correlation between the difference in the weighted average variation on the rythmogram before and after treatment with tianeptine, and the difference in the relevant depression indices, with a high correlation coefficient (—.74; p = .03[5]). Also from this same year, another study on 376 patients concluded that the addition of tianeptine to the treatment of patients with arterial hypertension and concomitant coronary artery disease improved the effectiveness of antihypertensive treatment, in addition to being effective in depressive symptoms.[6]

In 2009, another study that used tianeptine found a reduction in affective symptoms, contributing to a positive impact on intracardiac and structural and geometric haemodynamic parameters of the left ventricle.[7]

There are at least three other Russian publications from this time (2002–2009) that appear in the Pubmed database, but in Russian and they are not accessible, although they also look at the cardiovascular safety of the drug and its efficacy.[8–10]

In summary, the cardiovascular safety profile of the drug seems very attractive, also in elderly patients, and the perspective of the potential to improve efficacy of the treatment of arterial hypertension in cardiac patients is extremely interesting, in addition to the different mechanism of action it presents, which opens the door to use in combination that could be useful in resistant depression. In bipolar depression, to date we have identified a single, very recent study that has not shown significant differences with placebo, but it is still early, therefore, to discount it for this purpose.[11]

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Importance of training in de-escalation techniques for the prevention and management of agitation☆

Importancia de la formación en técnicas de desescalado para la prevención y tratamiento de los episodios de agitación

Dear Editor,

Psychomotor agitation is a nonspecific syndrome of multifactorial aetiology that entails impaired motor behaviour and a state of uncontrolled and unproductive physical and mental hyperactivity, associated with internal stress.[1] Agitation can lead to violent,[2] verbal or physical behaviour towards the person themselves or their families, healthcare personnel and the environment. This frequent clinical picture, which is extremely serious, most often presents in a rapidly progressive manner. It should be noted that there are warning signs or prodromal signs, which usually precede agitation.[3] These symptoms include hostile or suspicious discourse, a disproportionate approach to a context or tense and angry facial expression.

Assessing the severity of agitation and predicting possible aggressive behaviour[2] by detecting and addressing alarm signals, could enable control of potentially dangerous behaviour.[4] Therefore, this assessment must guide therapeutic decisions,[2] attempting to promote the use of tools that could be beneficial for the patient. However, there are coercive measures such as mechanical restraint and seclusion that are potentially negative for the therapeutic relationship and harmful to both patients and healthcare personnel,[5] although they are used when the patient's life is at risk and while awaiting therapeutic response.

The treatment of agitation includes the use of drugs and non-pharmacological techniques. It could be said that enough has been studied on psychopharmacological treatment in agitated patients. On the contrary, to date there has been little discussion about verbal de-escalation techniques, despite the increasing evidence of their efficacy, throughout health training in our environment, we have no regulated learning on de-escalation techniques or on the management of agitated patients beyond pharmacological treatment.

The guidelines of the Best Practices in Evaluation and Treatment of Agitation project, seek to standardise verbal de-escalation techniques and ensure that they are undertaken with the best safeguards,[6] and in the best possible way. These techniques have the potential to reduce levels of restlessness and agitation, and to reduce the potential for associated violence.[7] In addition, they provide benefits in terms of safety, outcomes and patient satisfaction,[7] and are clearly beneficial for the doctor-patient relationship, among

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