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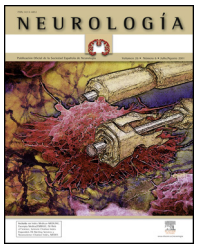

REVIEW ARTICLE

Post-stroke depression: an update☆

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KEYWORDS
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Abstract
Introduction: Post-stroke depression (PSD) is the most common mood disorder following a stroke, and also the main factor limiting recovery and rehabilitation in stroke patients. In addition, it may increase mortality by up to ten times.
Development: PSD occurs in 1 in 3 stroke patients and more than half of all cases are neither diagnosed nor treated. Several mechanisms, including biological, behavioural, and social factors, are involved in its pathogenesis. Symptoms usually occur within the first three months after stroke (early onset PSD), and less frequently at a later time (late onset PSD). Symptoms resemble those of other types of depression, although there are some differences; PSD patients experience more sleep disturbances, vegetative symptoms, and social withdrawal. For PSD diagnosis, we recommended vigilance and use of specific diagnostic tools such as the Patient Health Questionnaire-2 (PHQ-2). The treatments of choice are selective serotonin reuptake inhibitors (SSRI). However, there are still many unanswered questions in the treatment of PSD, such as the best time to start treatment or the effects of antidepressants on cognition and motor function, among others.
Conclusions: Neurologists play a pivotal role in the care and management of patients recovering from stroke. They must be familiar with methods for early detection and treatment of PSD, as this can facilitate a patient's functional recovery and social reintegration, and improve quality of life for patients and their families.
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PALABRAS CLAVE
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Inhibidores selectivos de la recaptación de serotonina

Depresión post ictus: una actualización

Resumen
Introducción: La depresión post ictus (DPI) es el trastorno afectivo más frecuente tras un ictus y el principal factor que limita la recuperación y rehabilitación de los pacientes, además de poder incrementar su mortalidad hasta 10 veces.
Desarrollo: La DPI se presenta en uno de cada 3 pacientes con ictus y en más de la mitad de los casos no se diagnostica ni se trata. En su etiopatogenia son varios los mecanismos implicados: biológicos, conductuales y sociales. Los síntomas suelen aparecer en los primeros 3 meses tras el ictus (DPI «precoz») y menos frecuentemente más tarde (DPI «tardía»). Los síntomas son similares a los de otras depresiones, aunque con algunas diferencias, como presentar más trastornos del sueño, síntomas vegetativos e introversión para las relaciones sociales. Para su diagnóstico se recomienda mantener una actitud vigilante y emplear herramientas diagnósticas específicas, como el *Patient Health Questionaire-2* (PHQ-2). Finalmente, el tratamiento de elección son los inhibidores selectivos de la recaptación de serotonina (ISRS). No obstante, aún son muchas las cuestiones por resolver en el tratamiento de la DPI, como cuándo es el mejor momento para iniciar el tratamiento o el efecto de los antidepresivos sobre la cognición y la función motora, entre otros.
Conclusiones: Los neurólogos desempeñan un papel fundamental en la recuperación de los enfermos con ictus. Es necesario que estén familiarizados con la detección temprana y el tratamiento de la DPI, para así facilitar la recuperación funcional del paciente, su reinserción social y la mejora en la calidad de vida del enfermo y su familia.
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Introduction

Stroke has traditionally been considered a disease mainly affecting motor performance; as a result, approaches to hospital care, rehabilitation, and follow-up focus almost exclusively on this area. However, studies have recently demonstrated that there are other aspects such as cognition, behaviour, and emotion that greatly affect the impact that stroke will have on a patient's life.

Within the emotional-cognitive sphere, depression will be a determining factor for these patients. We currently know that depression is the most frequent neuropsychological complication of stroke.[1,2] Nevertheless, in addition to post-stroke depression (PSD), many other neuropsychological symptoms may be present after stroke: anxiety, irritability, agitation, and emotional incontinence; changes in emotional experience; sleep disturbances; behavioural disorders such as disinhibition; apathy and fatigue; and psychotic symptoms such as delusions and hallucinations.[1–3]

We also know that PSD is the main predictor of poor functional outcome after stroke. Presence of PSD is associated with poorer functional and cognitive recovery, increased limitations on daily life activities, and social and interpersonal activities, poorer quality of life, and higher mortality rates (up to 10 times higher than in patients without PSD).[3,4]

Furthermore, we know that there are many risk factors for developing PSD, including more severe motor deficit, a higher degree of disability, and a poorer social support network. Identifying these factors permits early application of prevention and treatment strategies.[1]

However, although prevalence of PSD is high, it is generally underdiagnosed and usually undertreated, as we will discuss in a later section.

PSD is a frequent complication with severe negative repercussions for both patients and their carers, and yet it is clearly predictable and treatable. Therefore, it is essential to understand the risk factors for PSD and identify it in patients as soon as possible.

Prevalence of PSD

Estimating the real prevalence of PSD is not an easy task due to the methodological differences between the studies that have been conducted.[1,2] First, the diagnostic criteria for depression are not the same in all studies, although it must be said that most of them conducted structured interviews and followed the criteria from the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV).

Second, the scales applied to assess the results also vary from one study to the other. Some use PSD-specific scales whereas some other studies use general scales, such as the Hamilton Rating Scale for Depression (Ham-D); furthermore, some studies use self-evaluation scales and others do not.

Third, inclusion criteria vary considerably. In fact, some studies excluded patients that other studies included (for example, patients with aphasia or dementia), and inclusion criteria also differed with regard to the target populations, age groups, or phases of the disease (acute- vs chronic-phase stroke).

Lastly, it has been demonstrated that prevalence rates of PSD depend on the setting where patients are examined.[5]

In general, prevalence rates of PSD range from 25% to 79% depending on the patient selection criteria used by each of the different studies.[5,6]

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