Letters to the Editor

Interest-Activity Dimension and Response to Aripiprazole

To the Editor: A recent study published in JCP by Uher et al1 presented an important finding of clinical relevance. Although the interest-activity dimension is known as an important predictor of treatment response in major depressive disorder, the report provided the first evidence for its utility as a measure of response to aripiprazole.

The authors thoroughly examined various aspects to establish their findings, but some issues require further attention. Calculation of an interest-activity symptom score using the sum of 6 items is one such issue. Usually, for formulating a composite index, using a weighted sum is preferred and is a statistically more valid approach.2 In the process of summing items from 2 different scales, there is always a possibility of overrepresentation of a certain variable. Furthermore, the authors could have run a sensitivity analysis by using interest activity scores from individual scales (Montgomery-Asberg Depression Rating Scale and Quick Inventory for Depressive Symptomatology, Self-Report). This, in addition to substantiating their finding, would also have provided insight about which method (self-rated vs clinician rated) better predicts response and should be preferred in clinical settings.

In addition, some clinical variables were not compared between the groups, such as number of prior episodes, number of trials of medication, personality, and plasma level of escitalopram, which could have influenced the results. Although patients with psychotic symptoms were excluded, those with a history of psychotic symptoms are not mentioned. Such patients may respond poorly to an antidepressant trial. Details regarding patients with stable medical conditions such as hypothyroidism, which may affect treatment response and persistence of symptoms, are also missing. It would also have been interesting to know of any association with suicidality, considering the public health importance. If patients with suicidality respond with introduction of aripiprazole, this would strongly favor its early introduction in treatment. Inclusion of partial responders also could have provided a better interpretation of the results as to which group actually benefits, nonresponders or partial responders. Inclusion of patients with up to 3 adequate trials of antidepressants (a deviation from clinical trial registry, which exclude those with 3 trials3) suggests that some of the patients can be classified as having “resistant depression.” This information could provide some insight regarding differential response.

REFERENCES

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