Antidepressant use in gastroenterology

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LETTER TO THE EDITOR

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Antidepressant use in gastroenterology: Overcoming hurdles

I read with interest the article by Yan et al.[1] addressing an important topic in clinical gastroenterology practice: the stigma associated with the prescription of antidepressants. In their conclusions, the authors recommend "physicians should help patients establish the right knowledge to defeat stigma [...] toward antidepressant agents."

In fact, this all comes down to the way doctors communicate with patients about the use of antidepressants. This, however, is easier said than done. It requires the sufficient amount of time (which we may not readily have at our disposal) and the appropriate communication skills. In addition, there are considerable hurdles on the side of the physicians (in particular non-psychiatrists), who might not feel comfortable or competent in prescribing psychoactive drugs for gastrointestinal symptoms.

Interestingly, Yan et al. also state that "prescribing antidepressants to patients without psychological symptoms might lead to ethical issues in our hospital." This further highlights another obstacle, that is, the fact that antidepressants are prescribed off-label. In fact, at least in UK primary practice, two-thirds of all antidepressants are prescribed off-label. For TCAs, the prevalence of off-label indications is 81% (93% for amitriptyline).[2] It is a peculiar situation when a drug is almost universally used off-label rather than on-label. Guidelines indeed advocate for the use of TCAs in both IBS[3] and FD,[4] and the medical-scientific community should engage with regulatory authorities to resolve this unorthodoxy by drug repurposing. It is unrealistic to expect randomized clinical trials being conducted for off-label drug indications, especially for an old (and inexpensive) drug such as amitriptyline that is no longer owned by an innovator company.

In addition, when initiating discussion on starting an antidepressant in gastroenterology clinics, one should be aware of the following:

1. Gastroenterologists should consider functional disorders as being disorders of the gut-brain interaction. The term "functional" has a negative connotation, and many colleagues still use this as a synonym for psychiatric comorbidity.
2. Antidepressants in the context of treating gastrointestinal disorders should be referred to as neuromodulators.[5]
3. Inappropriate communication on side effects can introduce nocebo effects and decreased adherence to therapy. Symptoms presumed to being side effects may in fact have already been present prior to starting treatment and can be interpreted as verbalization of the patient's anxiety about side effects.[6]

Adhering to such communication strategies has the potential to increase therapeutic efficacy, thereby contributing to satisfaction with treatment at both ends: patients *and* physicians.

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