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DEPRESSION AND ANXIETY IN PATIENTS WITH RHEUMATOID ARTHRITIS

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Rheumatoid Arthritis (RA) is a chronic progressive autoimmune disease, with a worldwide adult prevalence of 0.2 - 1.2%. Rheumatoid arthritis is in 2-3 times more common in middle-aged women than in men. The spread of rheumatoid arthritis of women over 65 years old is about 5%. The problem of the relationship of rheumatoid arthritis and mental disorders, according to current research, causes the interest. We aimed to study evaluation of depression and its correlation with anxiety and duration of disease in patients with rheumatoid arthritis.

One hundred and twenty patients with a diagnosis of Rheumatoid arthritis, according to the criteria of International Classification Disease 10 (ICD), who attended clinics for follow-up visits, were included in this study. Patients with a diagnosis of RA and aged between 20 and 60 years were included. Exclusion criteria were as follows: age less than 20 years and over 60 years, trauma and/or history of a severe heart failure, malignancy, additional connective tissue disease, previously diagnosed peripheral nervous system involvement. According the studies, patients are inherited two groups. Group one (GA) included participants with duration of RA 1-5 years, group two (GB) included those with duration of RA 5-10 years and group three control (GC) included people without mental and somatic pathology. The remaining demographic variables, age, sex, education, relationship status, place of residence were comparable among the two basic groups and group of control.

Mood status was evaluated using Hamilton Rating Scale for Depression (HRSD) and Hamilton Rating Scale for Anxiety (HRSA). HRSD and HRSA are both 35-questioned multiple-choice self-report inventories. For depression, 21 points and over are significant; for anxiety, 14 points and over are significant.

Of total, 160 patients, 131 were female and 29 were male; the mean age was 37.9±1.82 years; group A: 46 were female (83.6%) and 9 were male (16.4%); group B 52 were female (80.0%) and 13 were male (20.0%); group control: 33 were female (82.5%) and 7 were male (17.5%); the mean age was 27.78±6.38 years.

In group A depression included mild depressive disorders (34,5%), anxiety-depressive disorders (29,1%), anxiety-phobic disorders (20,0%), depressive-hypochondriac disorders (7,3%), emotional-labile (asthenic disorders) (18,2%); in group B included mild depressive disorders (6,2%), anxiety-depressive disorders (40.0%), depressive-hypochondriac disorders (18.5%), anxiety-phobic disorders (4,6%), emotional-labile (asthenic disorders) (36,9%).

Patients group A with duration of RA 1-5 years often had mild depressive disorders, anxiety-depressive disorders, anxiety-phobic disorders, but patients group B with duration of RA of RA 5-10 years often had emotionally labile (asthenic) disorders, depressive-hypochondriac disorders, anxiety-depressive disorders. Physicians should be aware of such findings and, therefore, apply proper treatmenting strategies.

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THE NEUROLOGIC MANIFESTATIONS PRESENTED IN THE ENDOCRINE DISORDERS

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Diagnosing the endocrine disorder as the cause of the neurologic impairment is essential, as treating the underlying hormonal dysfunction will often rapidly reverse the neurologic symptoms. Better understanding of the interaction between the endocrine system and the nervous system, combined with the knowledge about the pathophysiology of the neurologic manifestations presented in the endocrine disorders might allow earlier diagnosis and better treatment of the endocrine disorders.

Headache may be a nonspecific sign, but it can be caused by pathologic conditions including idiopathic intracranial hypertension. Idiopathic intracranial hypertension (pseudotumor cerebri syndrome, PTCS) is the presence of elevated intracranial pressure in the setting of normal brain parenchyma and cerebrospinal fluid. Headache, vomiting, vision changes, abducens nerve palsy, and papilledema are commonly presented. If it is untreated, it may progress to optic atrophy and vision will be lost rapidly. Therefore, early diagnosis and treatment are crucial. The exact mechanism of PTCS is unclear, but it may occur associated with a variety of conditions, including various endocrine disorders such as adrenal insufficiency, diabetic ketoacidosis on treatment, hyperadrenalism, hyperthyroidism, and hypoparathyroidism.

Muscle weakness, pain, and stiffness are common symptoms of endocrine disorders. Systemic characteristic symptoms of specific endocrine disorders usually precede the onset of weakness, but muscle weakness may be the initial symptom. Endocrine myopathy should be considered as one of the etiology of muscle weakness, because specific treatment is available in endocrine myopathy.

Thyroid dysfunction, parathyroid disorders, and adrenal diseases may cause endocrine myopathies. Weakness is usually much more prominent in the legs than in the arms, and abnormal gait can be the initial symptom of either proximal or distal leg weakness. Electrolyte imbalances such as hyper- or hyponatremia, hyper- or hypokalemia, hypophosphatemia, hypocalcemia, and hypomagnesemia can all be the cause of myopathies accompanied with endocrine disorders. Deep tendon reflexes may be normal or diminished but generally not absent. The serum creatine kinase is usually normal. However it can be elevated which does not correlate with the severity of muscle weakness.