Tidur pada pasien depresi suatu penelitian pada pasien depresi mengenai tidur, REM dan Phasic-REM, dengan pendekatan psikiatri biologik

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Abstrak

Depresi merupakan penyakit yang terbanyak didapati baik pada praktik spesialis maupun umum. Gangguan psikiatrik ini dapat bersifat ringan atau penyakit yang berat.

Gangguan penyakit yang berat dapat fatal, karena biasanya penderita mencoba untuk bunuh diri (suicidium). Diagnosis penyakit tidak mudah. Gangguan yang ringan, sering bermanifestasi sebagai penyakit fisik, dan gangguan emosional tersamar oleh keluhan somatiknya. Pada masa akut sering gangguan yang berat menyerupai gangguan lain seperti skizofrenia.

Banyak sarjana di bidang psikiatri mencari markah biologik sebagai alat untuk membantu diagnosis depresi. Salah satu markah biologik adalah gambaran poligrafik tidur. Hasil yang positif dari laboratorium tidur sulit dipakai di klinik, karena mahal dan sangat memakan waktu, baik penilaian maupun interpretasi.

Kelompok Studi Psikiatri Biologik Jakarta (KSPBJ) telah melakukan modifikasi dari teknik standar dengan teknik yang dinamakan Teknik KSPBJ. Pada teknik ini hanya merekam satu menit dari lima menit selama perekaman yang berlangsung tujuh jam.

Dari penelitian kami dengan sukarelawan normal dan pasien depresi didapatkan bahwa Teknik KSPBJ mempunyai agreement yang tinggi dengan teknik standar. Lebih lanjut didapatkan bahwa dengan teknik itu, seperti juga pada teknik standar didapatkan markah biologik untuk depresi.

Penderita depresi mempunyai latensi REM yang rendah, yang berbeda dengan normal (P<0,001). Selaln itu ternyata pula pada penderita depresi terjadi shifting p-REM ke 1/3 awal malam dan pada perbaikan depresi terjadi shifting ke 1/3 akhir malam. Penelltian ini konsisten dengan hipotesis adanya ketidak-seimbangan sistem kolinergik - noradrenergik pada mekanisme latency REM, dan ketidak-seimbangan noradrenergik-serotonergik pada phasic REM.<hr>Sleep In Depressed Patient (A Study On Sleep, REM, and Phasic REM In Depressed Patients)Up to 10 % of all patients seeing a doctor are depressed. This conclusion emerged from an enquiry conducted in 1973 by over 10.000 physicians practicing in Austria, Federal Republic of Germany, France, Italy and Switzerland.

Approximately 15% of the severely depressed commit suicide, whereas the moderate and mild forms usually cause reduction in the quality of life of these patients.

The diagnosis of depression is not easy. Depressive states often escape diagnosis because these patients are so overwhelmed by the impact of their physical symptoms, particularly since they can more easily accept the idea that their illness is of physical, as opposed to mental origin.

By referring only to their physical complaints, and deliberately failing to disclose their slate of mind, they lead the unwary physician up the wrong diagnostic path.

In most mental hospitals, or departments of psychiatry, the diagnosis of depression is also not easily made. In the acute and severe forms these condition sometimes are wrongly diagnosed as schizophrenia.

Numerous scientists are presently searching for a biological marker of depression. The Ideal biological marker must be sensitive, specific, easy to identify and relatively Inexpensive In its operation.

Research over the past two decades has led to the development of a standardized sleep EEG methodology, which has been proven useful for the identification of characteristic

sleep abnormalities of depressed patients.

Application of REM abnormalities as a biological marker has produced an accurate, reliable and objective laboratory method for a diagnostic aid in the identification of depression.

Even though this is proven to be a useful tool, in clinical practice it is not presently practical as a routine screening test in depressed patients. One of the drawbacks of these methods is the limited number of and the access to standard sleep laboratories. Expenses of EEG sleep studies run high, approximately US$ 500.00 per night. The other factor is that it is time consuming to evaluate 1200 pages of EEG sleep records.

In 1980 KSPBJ (Study Group for Biological Psychiatry) developed a modification of the Rechtschaffen and Dales method. The KSPBJ technique records only one minute in every five minutes. That is one minute on and four minutes off for a period of seven hours.

In this dissertation a comparison was made between the KSPRJ technique and the standard technique. With 18 normal volunteers, 14 new cases of depression, and 13 medicated depressed patients, the conclusion can be made that the KSPBJ technique has a statistically high agreement with the standard technique. (Po m 0.78 - 0.82, Kappa - 0.71 - 0.75).

Another result of these studies with 91 depressed patients and 50 normal volunteers is finding that depressed patients have shortened REM Latency (<60 minutes). This shortened REM Latency could be used in predicting the diagnosis of depression with a quite high level of sensitivity (73-76%), and specificity (over 90%).

Yet another conclusion with this KSPBJ technique is that in depressed patients, there seem to be a shifting to the left of phasic REM (to one third of initial night), and on recovery a shifting to the right (to one third of terminal night).

These findings are consistent with the hypothesis, of choilnergic - noradrenergic balance mechanism in the forming of latency REM, and the balance of noradrenergic - serotonergic mechanism in the forming of phasic REM.

When comparing this technique with the standard technique, there is an 80% reduction of the cost of sleep EEG recording, and an 80% saving in time for evaluation.

In conclusion, the KSPBJ technique can be considered as a biological marker for depression which is reasonably sensitive and specific, easy to identify, and in addition relatively inexpensive.