Authors' objectives
To review the clinical management of the psychiatric aspects of Huntington's Disease (HD) namely the mood disorders, psychotic disorders, anxiety symptoms, sleep disorders, disorders of sexuality, and the behavioural changes of apathy, irritability, and aggression using pharmacological and psychotherapeutic interventions and to explore the role of psychiatric intervention in presymptomatic testing.

Searching
English language articles were sought from MEDLINE (1976 to 1996), from the American Psychiatric Press Electronic Library (1992 to 1997) and from 16 U.S. textbooks. Bibliographies of identified articles were scanned.

Study selection
Study designs of evaluations included in the review
Single case studies, case series and clinical trials pertaining to the clinical management of psychiatric aspects of HD were included.

Specific interventions included in the review
The following interventions were included: mood disorders treated with electro convulsive therapy (ECT), tricyclic antidepressants (including desipramine, imipramine, amitriptyline), chlorpromazine, amoxapine, phenelzine, isocarboxazid, clozapine, sulpiride, lithium, haloperidol and unspecified phenothiazines; and aggression treated with propranolol, pindolol, haloperidol and lithium, and buspirone.

Participants included in the review
Participants included patients with Huntington's Disease experiencing the following symptoms: depression; chorea; psychosis; dysarthria; labile mood, apathy; paranoia; mania; anxiety; verbal/physical aggression; impulsivity; and irritability. Some patients with organic brain syndrome and aggression were also included.

Outcomes assessed in the review
Outcomes included the following: depression; functional capacity; affect; speech; aggression; chorea; general health questionnaire (GHQ); and neurovegetative functions. Outcomes included objective and non objective rating scales.

How were decisions on the relevance of primary studies made?
All identified studies were included.

Assessment of study quality
Some aspects of validity were discussed including study design, objectivity of rating scales, definition of diagnosis, and completeness of intervention detail. However, this was not done systematically and methods used for assessment were not described. The authors do not state how the papers were assessed for validity, or how many of the authors performed the validity assessment.

Data extraction
The following data were extracted: author; agent used; condition treated; study design and sample size; outcome; and side effects. The process of data extraction was not described.
Methods of synthesis
How were the studies combined?
The studies were combined in a narrative review.

How were differences between studies investigated?
Differences between the studies were discussed.

Results of the review
Treatment of mood disorders: 14 studies including 5 single case studies, 8 case series/open trial/retrospective chart review (43 patients), and 1 double-blind placebo crossover (6 patients).

Treatment of aggression: 7 studies including 4 single case studies, 1 case series open trial (3 patients), and 2 double blind/placebo-controlled cross-over.

Management of mood disorders: Clinical trials of treatment of mood disorders were scarce, lacked robust design and involved small numbers.

Psychotic features: Almost no trials specifically addressed the treatment of psychosis in HD.

Aggression and irritability: there were few systematic attempts to quantify the types and degrees of aggression. No trials were identified relating to the effectiveness of neuroleptics, mood stabilizers, anti-convulsants, tricyclic anti-depressants, SSRIs, and psychosocial interventions. There was conflicting evidence for the effectiveness of beta-blockers (5 studies).

Sexual disorders: no studies systematically examined the management of inappropriate sexual behaviours. Sleep disorders: no specific studies were identified.

Apathy: there were no reports of specific pharmacological interventions.

Anxiety: there were no specific references to the treatment.

Ethical, social and psychological management of genetic testing: there were very few data on the impact that genetic testing has on psychiatric services and the availability of psychiatric care, besides the specific pre- and post test counselling, to people who have tested positive for the HD gene.

Authors' conclusions
The clinical management of the psychiatric manifestations of HD requires much more complete and systematic study before any definite conclusions can be drawn as to the efficacy of various approaches.

CRD commentary
The aims were clearly stated. The following aspects of validity were discussed: lack of consistent definition of diagnosis; lack of objective outcome ratings; small sample size; lack of objective rating scale; incomplete details of interventions; and lack of wash-out period in cross-over trials.

By restricting the literature search to English language studies some other relevant studies may have been omitted. Fuller details of the literature search, such as keywords, would have been welcome. No details were given of the criteria used in the individual studies to define Huntington's Disease and no details given of methods used to extract data.

Results from this review are, as the author states, limited by the paucity and poor quality of retrieved studies. The authors conclusions are supported by the evidence presented.

Implications of the review for practice and research
Practice: The author considers that until better studies are complete each patient should be treated on a case-by-case
Research: The author considers that more rigorous trials of psychotropic medications in Huntington's disease are needed.

**Bibliographic details**

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This is a critical abstract of a systematic review that meets the criteria for inclusion on DARE. Each critical abstract contains a brief summary of the review methods, results and conclusions followed by a detailed critical assessment on the reliability of the review and the conclusions drawn.