Depression: The Common Cold of Psychiatric Disorders in Primary Care?

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Learning Objectives

After the presentation, you should have increased your knowledge and enhanced your competence to …

1. Describe the DSM-5 diagnostic criteria for Depressive Disorders along with their etiology, epidemiology and differentials.
2. Perform an evidence based assessment of patients presenting with the symptom of depression.
3. Choose among therapeutic options in the treatment of patients who meet criteria for Depressive Disorders and subclinical depressive symptoms.

Disclosures

- No financial relationships to disclose
- Off label use of medications
- Adult psychopathology
- EBM……..as much as possible

Barriers to Care

- Availability
- Accessibility
- Affordability
- Acceptability

- Time
- Knowledge
- Comfort

Colorafi, K., Vanselow, J., & Nelson, T. (2017). Fam Pract Manag, 24(4), 11-16.

DSM-5 Criteria
Major Depressive Disorder

- ≥ 5/9 symptoms, 2-week duration, change from baseline and at least depressed mood or anhedonia·
- "The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning."
- No hypomania or mania
- Not a direct effect of a medical condition or substances
- Cannot be better explained by another psychiatric condition or bereavement

American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (DSM-5®). American Psychiatric Pub.

"SIGECAPS"

S	**S**leeping problems
I	Loss of **I**nterest in pleasurable activities (Anhedonia)
G	Feelings of **G**uilt, worthlessness, hopelessness
E	Decreased **E**nergy; fatigue
C	**C**oncentration difficulties
A	**A**ppetite/Weight changes
P	**P**sychomotor changes
S	**S**uicidal thoughts

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American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (DSM-5®). American Psychiatric Pub.
Martin, L. A., et al. (2013). JAMA Psychiatry, 70(10), 1100-1106.

Epidemiology of Depressive Disorders

- Prevalence
  - Point: ~7-9%
  - Lifetime: ~16%
    - 4.9 – 8.7% females
    - 3.2 - 4.4% males
  - Unrelated to ethnicity, income, marital status
- Gender differences:
  - Female:Male 1.5 - 3:1
- Age
  - Appears at any age
  - Onset in puberty
  - Peaks in the 20s
  - Late life first onset not uncommon
  - 18-29 yo (x3 higher prev than ≥60yo)
- Familial Pattern (40%, 2-4x risk)
- Comorbidity
  - Medical illness (11-36% I/P)
- Impairment (work, interpersonal)
- Common in primary care (up to 30%)

American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (DSM-5®). American Psychiatric Pub.
Kessler, R. C., et al. (2005). Arch Gen Psych, 62(6), 593-602.
Khouzam, H. R. (2007). Consultant, 47(8), 757-757.

Etiology of Depressive Disorders

- Environmental
  - Adverse childhood experiences
  - Stressful life events
- Genetic
  - 2-4 x risk to family w/ MDD
  - Higher risk for early onset and recurrent episodes
  - Heritability 40%
  - Personality trait: neuroticism (fear, moody, worry, lonely)
- Physiological
  - Neurotransmitter irregularities
  - Psychoneuroimmunology
  - *f*MRI, PET

American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (DSM-5®). American Psychiatric Pub.

Comorbidities and Differentials

- Medical
  - Autoimmune
  - Endocrine
  - Infectious
  - Neurologic
  - Malignancies
  - CAD
- Psychiatric
  - Adjustment Disorders
  - Bereavement
  - Other Depressive Disorders
  - Psychotic Disorders
  - Anxiety Disorders
- Substances
  - Recreational drugs
  - Iatrogenic

Medications that can cause depressed mood

Antivirals	Efavirenz
Cardiovascular Agents	Clonidine, Guanethidine, Methyldopa, Reserpine
Retinoic Acid Derivatives	Isotretinoin
Antidepressants	
Anticonvulsants	Levetiracetam, Phenobarbital, Primadone, Phenytoin, Tiagabine, Topiramate, Vigabatrin
Antimigraine Agents	Triptans
Antipsychotics	Aripiprazole, Quetiapine
Hormonal Agents	Corticosteroids, OCPs, GnRH agonists, Tamoxifen
Smoking Cessation Agents	Varenicline
Immunologic Agents	Interferon α, Interferon β

Tisdale, J. E., & Miller, D. A. (2010). *Drug-induced diseases: prevention, detection, and management*. ASHP.

Assessment

- Primary Care Assessment Approach
  - DSM-5 clinical criteria
  - Rating scales
  - R/O differentials and comorbidities
  - Safety evaluation

Siu, et al. (2016). JAMA, 315(4), 380-387.

Assessment

- Beck Depression Inventory (BDI II)
- Hamilton Depression Rating Scale (HAM-D)
- Montgomery Asberg Depression Rating Scale (MADRS)
- Hospital Anxiety and Depression Scale (HADS)
- Edinburgh Postnatal Depression Scale (EPDS)
- Geriatric Depression Scale (GDS)
- Patient Health Questionnaire (PHQ-2, PHQ-9)

Hospital Anxiety and Depression Scale (HADS)

Zigmond, A. S., & Snaith, R. P. (1983) Acta Psychiatr Scand, 67, 361-37o.

Hospital Anxiety and Depression Scale (HADS)

Tick the box beside the reply that is closest to how you have been feeling in the past week.
Don't take too long over you replies: your immediate is best.

D	A		D	A	
		I feel tense or 'wound up':			**I feel as if I am slowed down:**
	3	Most of the time	3		Nearly all the time
	2	A lot of the time	2		Very often
	1	From time to time, occasionally	1		Sometimes
	0	Not at all	0		Not at all
		I still enjoy the things I used to enjoy:			**I get a sort of frightened feeling like 'butterflies' in the stomach:**
0		Definitely as much		0	Not at all
1		Not quite so much		1	Occasionally
2		Only a little		2	Quite Often
3		Hardly at all		3	Very Often
		I get a sort of frightened feeling as if something awful is about to happen:			**I have lost interest in my appearance:**
	3	Very definitely and quite badly	3		Definitely
	2	Yes, but not too badly	2		I don't take as much care as I should
	1	A little, but it doesn't worry me	1		I may not take quite as much care
	0	Not at all	0		I take just as much care as ever
		I can laugh and see the funny side of things:			**I feel restless as I have to be on the move:**
0		As much as I always could		3	Very much indeed
1		Not quite so much now		2	Quite a lot
2		Definitely not so much now		1	Not very much
3		Not at all		0	Not at all
		Worrying thoughts go through my mind:			**I look forward with enjoyment to things:**
	3	A great deal of the time	0		As much as I ever did
	2	A lot of the time	1		Rather less than I used to
	1	From time to time, but not too often	2		Definitely less than I used to
	0	Only occasionally	3		Hardly at all
		I feel cheerful:			**I get sudden feelings of panic:**
3		Not at all		3	Very often indeed
2		Not often		2	Quite often
1		Sometimes		1	Not very often
0		Most of the time		0	Not at all
		I can sit at ease and feel relaxed:			**I can enjoy a good book or radio or TV program:**
	0	Definitely	0		Often
	1	Usually	1		Sometimes
	2	Not Often	2		Not often
	3	Not at all	3		Very seldom

Please check you have answered all the questions

Scoring:
Total score: Depression (D) _____ Anxiety (A) _____
0-7 = Normal
8-10 = Borderline abnormal (borderline case)
11-21 = Abnormal (case)

Edinburgh Postnatal Depression Scale (EPDS)

Cox. J. L, Holden, J. M., Sagovsky, R. (1987)
Br J Psychiat. 150, 782-786.

Life with a new baby is not always what you expect.

Please underline the answer that most accurately describes your feelings in the last 7 days.

1. **I have been able to laugh and see the funny side of things.**
   - As much as I always could
   - Not quite so much now
   - Definitely not so much now
   - Not at all

2. **I have looked forward with enjoyment to things.**
   - As much as I ever did
   - Rather less than I used to
   - Definitely less than I used to
   - Hardly at all

3. **I have blamed myself unnecessarily when things went wrong*.**
   - Yes, most of the time
   - Yes, some of the time
   - Not very often
   - No, never

4. **I have been anxious or worried for no good reason.**
   - No, not at all
   - Hardly ever
   - Yes, sometimes
   - Yes, very often

5. **I have felt scared or panicky for no very good reason*.**
   - Yes, quite a lot
   - Yes, sometimes
   - No, not much
   - No, not at all

6. **Things have been getting on top of me*.**
   - Yes, most of the time I haven't been able to cope at all
   - Yes, sometimes I haven't been coping as well as usual
   - No, most of the time I have coped quite well
   - No, I have been coping as well as ever

7. **I have been so unhappy that I have had difficulty sleeping*.**
   - Yes, most of the time
   - Yes, sometimes
   - Not very often
   - No, not at all

8. **I have felt sad or miserable*.**
   - Yes, most of the time
   - Yes, quite often
   - Not very often
   - No, not at all

9. **I have been so unhappy that I have been crying*.**
   - Yes, most of the time
   - Yes, quite often
   - Only occasionally
   - No, never

10. **The thought of harming myself has occurred to me*.**
    - Yes, quite often
    - Sometimes
    - Hardly ever
    - Never

2006

Geriatric Depression Scale (GDS)

Sheikh, J.I., & Yesavage, J.A. (1986). Clin Gerontologist 5(1-2): 165-173, 1986.

Geriatric Depression Scale (GDS) Short Form

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life?	Yes	No
2. Have you dropped many of your activities and interests?	Yes	No
3. Do you feel that your life is empty?	Yes	No
4. Do you often get bored?	Yes	No
5. Are you in good spirits most of the time?	Yes	No
6. Are you afraid that something bad is going to happen to you?	Yes	No
7. Do you feel happy most of the time?	Yes	No
8. Do you often feel helpless?	Yes	No
9. Do you prefer to stay at home rather than going out and doing new things?	Yes	No
10. Do you feel you have more problems with memory than most?	Yes	No
11. Do you think it is wonderful to be alive now?	Yes	No
12. Do you feel pretty worthless the way you are now?	Yes	No
13. Do you feel full of energy?	Yes	No
14. Do you feel that your situation is hopeless?	Yes	No
15. Do you think that most people are better off than you are?	Yes	No

Source: Sheikh, J.I., and Yesavage, J.A. Geriatric Depression Scale (GDS): Recent evidence and development of a shorter version. *Clinical Gerontologist* 5(1-2): 165-173, 1986.

Patient Health Questionnaire (PHQ -2)

The Patient Health Questionnaire-2 (PHQ-2)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Kroenke, K, Spitzer, R. L., Williams, J. B. (2003). *Medi Care,* 41, 1284-92.

Patient Health Questionnaire (PHQ-9)

Kroenke, K, Spitzer, R. L., & Williams, J. B. (2001). *J Gen Int Med*, 16(9), 606-613.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ **Date:** _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems? *(use "√" to indicate your answer)*

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2. Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
3. Trouble falling/staying asleep, sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add Columns:		_____ +	_____ +	_____
TOTAL:	_____			

If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

Mood Disorder Questionnaire (MDQ)

Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

Hirschfeld, R. M. (2002). *J Clin Psychiat*, 4, 9–11.

Assessment

- Primary Care Assessment Approach
  - DSM-5 clinical criteria
  - Rating scales
  - R/O differentials and comorbidities
  - Safety evaluation

Treatment Options

Treatment Options

- Non-Pharmacological (e.g. Cognitive Behavioral Interventions).
- Psychopharmacology
- Complimentary and Alternative therapy
- Electroconvulsive Therapy (ECT)
- Light Therapy
- Repetitive Transcranial Magnetic Stimulation (rTMS)
- Vagus Nerve Stimulation
- Psychosurgery
- Referral

Components of Cognitive Behavioral Interventions

- Identifying maladaptive thoughts, beliefs, expectations, assumptions
- Challenging these faulty cognitions

Cognitive

- Identify environmental or external factors/triggers that precipitate, perpetuate depression
- Learning new habits and behavioral skills

Behavioral

Treatment Options

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Treatment Options – 1st Line

SSRI*	Fluoxetine	Prozac, Prozac Weekly, Sarafem
	Paroxetine	Paxil, Paxil XR, Pexeva
	Sertraline	Zoloft
	Citalopram	Celexa
	Escitalopram	Lexapro
SNRI*	Venlafaxine	Effexor, Effexor XR
	Desvenlafaxine	Pristiq, Khedezla
	Duloxetine	Cymbalta
	Levomilnacipran	Fetzima
NDRI*	Bupropion	Wellbutrin, Wellbutrin SR, Wellbutrin XL, Budeprion SR, Budeprion XL, Aplenzin, Forfivo XL
Serotonin antagonist*	Mirtazapine	Remeron, Remeron SolTab
Mixed serotonin activity (5HT modulators)*	Nefazodone	Serzone (not often used as 1st line)
	Trazodone	Desyrel, Oleptro (not often used as 1st line)
	Vilazodone	Viibryd
	Vortioxetine	~~Brintellix~~ renamed: Trintelix

* FDA Approved for Major Depressive Disorder or Depression

Treatment Options – 2nd Line

TCA*	Amitriptyline	Elavil
	Amoxapine	use to be Asendin
	Chlordiazepoxide/Amitriptyline	Limbitrol, Limbitrol DS
	Desipramine	Norpramin
	Doxepin	use to be Sinequan
	Imipramine	Tofranil, Tofranil PM
	Maprotiline	use to be Ludiomil
	Nortriptyline	Pamelor
	Perphenazine/Amitriptyline	use to be Etrafon
	Protriptyline	Vivactil
	Trimipramine	Surmontil
MAOI*	Isocarboxazid	Marplan
	Phenelzine	Nardil
	Selegiline	Emsam (transdermal)
	Tranylcypromine	Parnate

* FDA Approved for Major Depressive Disorder or Depression (w/ or w/o anxiety)

Safety, Tolerability, Adverse Effects

Class	Safety, Tolerability, Adverse Effects
SSRI	• QT prolongation (citalopram, escitalopram) • Increased risk of bleeding, glaucoma • Nausea, diarrhea, headache, fatigue, activating • Weight gain, insomnia, sexual SE, activating (fluoxetine)
TCA	• Orthostatic hypotension, arrhythmia, seizure • Anticholinergic • Weight gain, sexual SE, somnolence
SNRI	• Incr. BP, Incr. QT interval (venlafaxine) • Drug:Drug interactions (less with desvenlafaxine) • Nausea, headache, sweating, tachycardia, urinary retention • Insomnia, sexual SE, activating
Mixed 5-HT	• Orthostatic hypotension, liver failure (nefazodone), priapism (trazodone) • Nausea, diarrhea, headache, dizziness, somnolence (trazodone) • Weight gain and sexual SE (vilazodone)
Bupropion	• Seizure • Nausea, dry mouth, tremor, insomnia, activating
Mirtazapine	• Dry mouth, constipation, weight gain, somnolence
MAOI	• Serotonin syndrome, hypertensive crisis, postural hypotension • Sexual dysfunction

Treatment Options - Augmentation

Second Generation· Antipsychotic*	Aripiprazole, Brexpiprazole, Olanzapine, Quetiapine	Abilify, Rexulti, Seroquel, Zyprexa
Novel†	Lithium	Lithobid
	Stimulants	Methylphenidate Amphetamine mixes
	Modafinil & Armodafanil	Provigil, Nuvigil
	Triiodothyronine, Liothyronine (T3)	Cytomel, Triostat
	Anticonvulsants	Carbamazepine, Lamotrigine, Valproate
Other†	St. John's Wort	Drug interactions , photosensitivity
	S-adenosylmethionine (SAM-e)	Some evidence
	L-methylfolate	Some evidence
	Omega-3 fatty acid	Prolongs bleeding time
	Celecoxib	Small – Mod effects, w/ & w/o other Rx
Newest (FDA approved)	Esketamine	Spravato
	Brexanolone	Zulresso

* FDA Approved for the adjunctive treatment or acute treatment resistant Major Depressive Disorder
† Used but not FDA approved

2nd Gen Antipsychotics

Table 3. Some Relative Adverse Effects of Second-Generation Antipsychotics

Drug	Diabetes	Weight Gain	Extrapyramidal Symptoms	QTc Interval Prolongation	Elevated Prolactin
Aripiprazole	+/–	+	++	+/–	–
Asenapine	+	++	++	+	++
Brexpiprazole*	+	++	+	–	+/–
Cariprazine*	+/–	+	+++	–	–
Clozapine	++++	++++	+/–	+	+/–
Iloperidone	++	++	+/–	++	+/–
Lurasidone	+/–	+/–	++	+/–	+/–
Olanzapine	++++	++++	+	+	+
Paliperidone	++	+++	+++	+	+++
Quetiapine	++	+++	+/–	+	+/–
Risperidone	++	+++	+++	+	+++
Ziprasidone	+/–	+/–	+/–	++	+

*Limited experience

Med Lett Drugs Ther. 2016;58(1510):163.

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Esketamine (Spravato)

- Nasal Spray
- Combination w/ antidepressant
- Treatment resistant depression
- 2x weekly in first month, every 1-2 weeks until remission
- “may result in significantly rapid improvement in depressive symptoms”
- Risk Evaluation and Mitigation Strategy (REMS)

$590 - $885
for clinics

Canuso, C. M., et. al. (2018). *Am J Psychiat*, 175(7), 620-630.
Daly, E. J., et al. (2018). JAMA Psychiat, 75(2), 139-148.

Brexanolone (Zulresso)

- "Post-Partum Depression"
- 1:9 w/in 12 mo, 1:500-1000 psychotic features
- Indication: Moderate-Severe Post-Partum Depression
- Schedule IV
- 60-hour continuous IV infusion
- Reduction in symptoms as early as 24 hours
- Risk Evaluation and Mitigation Strategy (REMS)

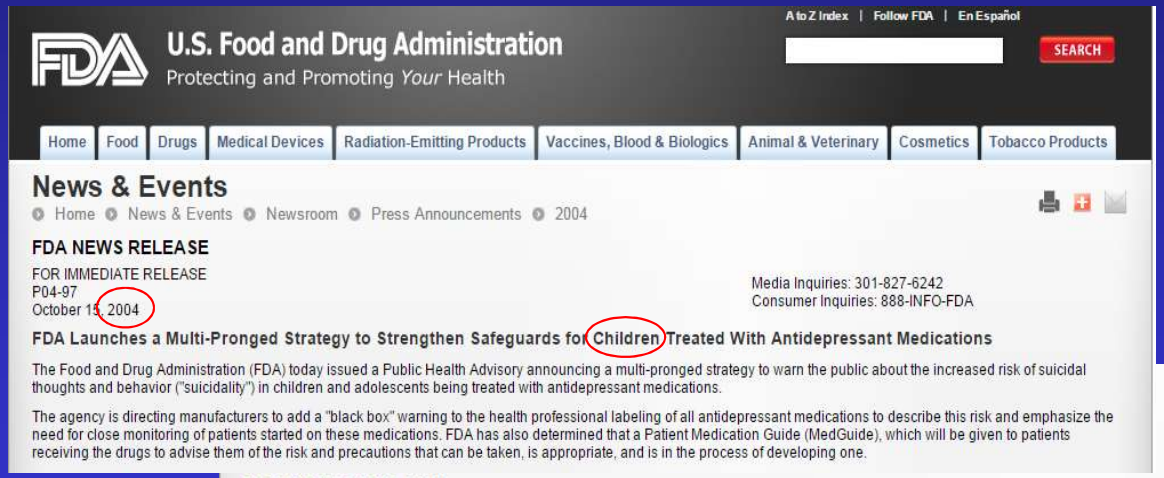
$20,000 - $35,000 **+**
for full course of treatment

Selection of an Initial Antidepressant

- Consider safety·
- Consider efficacy
- Consider cost
- Consider previous experience, patient preference
- Consider side effects/tolerability - tailor to patient
  - fluoxetine, bupropion: stimulating
  - SNRIs: avoid in HTN
  - mirtazapine: most sedating, wt gain
  - citalopram/escitalopram: Incr QT
  - citalopram: decr Rx-Rx SE
  - TCAs: avoid in HTN, ↑ age, suicidal, ortho hypotension, seizure, arrhythmia
  - bupropion: least sexual SEs, less wt gain
  - bupropion, TCA: lowers seizure threshold
  - SSRIs: insomnia, sexual SE, wt gain

Suicidality - All Antidepressants

Black Boxed Warning: Increased risk of suicidal thinking or behavior in children, adolescents, and adults



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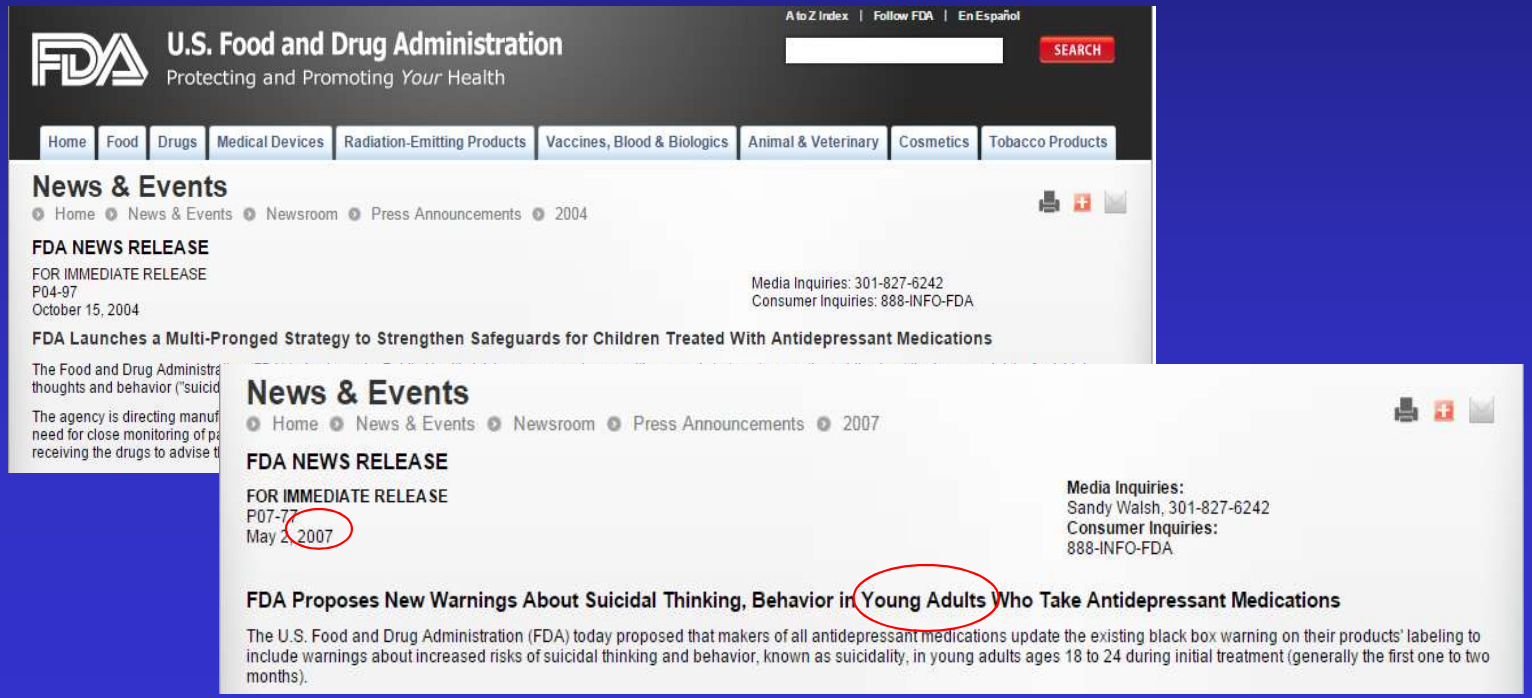

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FOR IMMEDIATE RELEASE
P04-97
October 15, 2004

Media Inquiries: 301-827-6242
Consumer Inquiries: 888-INFO-FDA

FDA Launches a Multi-Pronged Strategy to Strengthen Safeguards for Children Treated With Antidepressant Medications

The Food and Drug Administra
thoughts and behavior ("suicid

The agency is directing manuf
need for close monitoring of pa
receiving the drugs to advise t

News & Events

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FDA NEWS RELEASE

FOR IMMEDIATE RELEASE
P07-77
May 2, 2007

Media Inquiries:
Sandy Walsh, 301-827-6242
Consumer Inquiries:
888-INFO-FDA

FDA Proposes New Warnings About Suicidal Thinking, Behavior in Young Adults Who Take Antidepressant Medications

The U.S. Food and Drug Administration (FDA) today proposed that makers of all antidepressant medications update the existing black box warning on their products' labeling to include warnings about increased risks of suicidal thinking and behavior, known as suicidality, in young adults ages 18 to 24 during initial treatment (generally the first one to two months).

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  - TCAs: avoid in HTN, ↑ age, suicidal, ortho hypotension, seizure, arrhythmia
  - bupropion: least sexual SEs, less wt gain
  - bupropion, TCA: lowers seizure threshold
  - SSRIs: insomnia, sexual SE, wt gain

Selection of an Initial Antidepressant

- ~~Consider safety~~
- ~~Consider efficacy~~
- ~~Consider cost~~
- Consider previous experience, patient preference
- Consider side effects/tolerability - tailor to patient
  - fluoxetine, bupropion: stimulating
  - SNRIs: avoid in HTN
  - mirtazapine: most sedating, wt gain
  - citalopram/escitalopram: Incr QT
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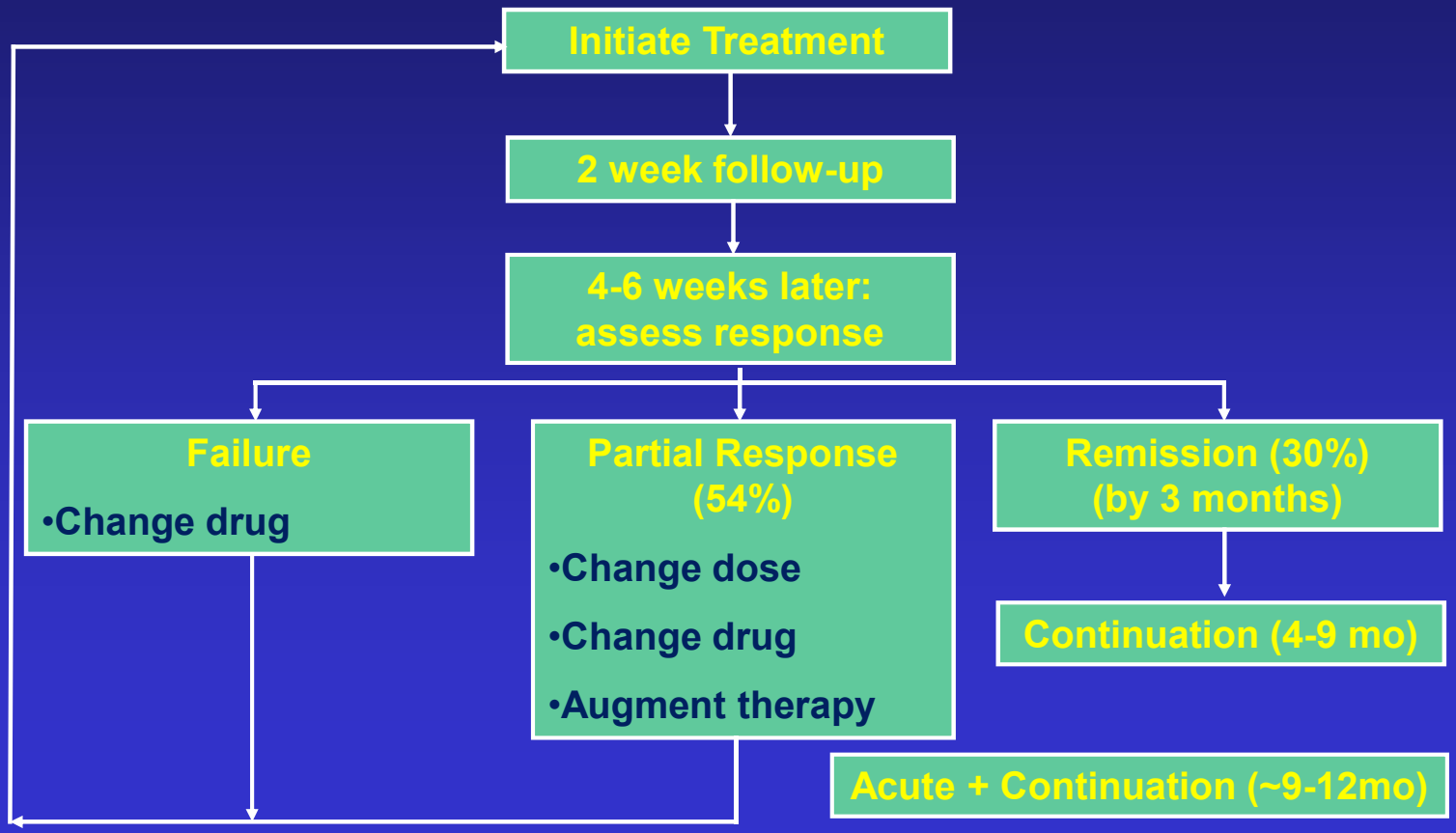
Treatment Algorithm



Psychopharmacology Tips and tricks

- Frequency of follow-up
- Switching antidepressants
- Dual Rx therapy
- Length of treatment
- Serotonin Syndrome
- Discontinuing treatment
- Treatment resistance
- MDD recurrence

	Serotonin Syndrome	Neuroleptic Malignant Syndrome
Inciting Agent	Serotonin Agonist SSRI SNRI TCA buspirone mirtazapine anticonvulsants cyclobenzaprine dextromethorphan linezolid meperidine odansetron trazodone tramadol others (MAOIs)	Dopamine antagonists (or w/drawal of dopamine agonist antipsychotics chlorpromazine metoclopramide bromocriptine (ag) pramiprexole (ag) ropinirole (ag)
Onset	Abrupt (hours)	Days to weeks
Neuromuscular Sx	Hyperreflexia, tremor, myoclonus	Bradyreflexia, led-pipe rigidity
GI symptoms	Nausea, vomiting, diarrhea	Not common
Pupils	Dilated	Normal
Treatment	BZD, cyproheptadine	bromocriptine
Course	Rapid (w/in 24 hours) *fluoxetine – longer 2^o > t(1/2)	Days to weeks

Psychopharmacology Tips and tricks

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- MDD recurrence

Serotonin **Discontinuation** Syndrome - FINISH

Flu-like symptoms

Insomnia

Nausea

Imbalance

Sensory disturbances

Hyperarousal

Berber, M. J. (1998). J Clin Psychiat, 59(5), 255..

Psychopharmacology Tips and tricks

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Fava, M., et. al. (2006). *Am J Psych*, *163*(7), 1161-1172.
Shelton, R. C., Osuntokun, O., Heinloth, A. N., & Corya, S. A. (2010). CNS Drugs, 24(2), 131-161.

Pseudo-resistance (insufficient treatment)

- Misdiagnosis
- Not addressing comorbidities
- Type of treatment is wrong or not optimal
- Dose is wrong
- Treatment delivery issues
- Non-adherence

Psychopharmacology Tips and tricks

- Frequency of follow-up
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STAR*D
- ~37% remission with 1st Rx
- ~33% did not reach remission even after 4 sequential Rx trials

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Shelton, R. C., Osuntokun, O., Heinloth, A. N., & Corya, S. A. (2010). CNS Drugs, 24(2), 131-161.

Treatment Resistance

- Risk Factors
  - Comorbid general medical disorders
  - Chronic pain
  - Medications (sub therapeutic 20%)
  - Comorbid psychiatric disorders
  - Severe intensity of depressive symptoms
  - Suicidal thought and behavior
  - Adverse life events
  - Early age of onset
  - Longer or recurrent depressive episodes
  - Low SES
  - Enzyme inducers, rapid metabolizers?
  - Increased inflammatory markers (CRP)
- Responses
  - Manage medical disorders
  - Manage chronic pain
  - Adherence (40%), AEs (20-30%)?
  - Diagnose and treat comorbidities
  - Change/augment treatment
  - Assess and treat/refer appropriately
  - Stay the course
  - Children/adolescents are referred
  - Change/augment treatment
  - CBI (for all of these risk factors)
  - Pharmacokinetics, Laboratory testing
  - 2nd line tx w/ anti-inflammatories (~EBM)
  - Refer to psychiatry/psychology for any of the above

Lynch, T., Price, A. (2007). Am Fam Physician.76(3):391-396.
Thase, M., & Connolly, K. R. (2015). UpToDate, Waltham, MA, 2016

Pharmacological Options for Treatment Resistance*

- T3 hormone
- Anticonvulsants
- Stimulants
- Lithium

* None of these drugs are FDA approved for MDD or “Depression”.

Psychopharmacology Tips and tricks

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Treatment Options

- Non-Pharmacological (e.g. Cognitive Behavioral Intervention)
- Psychopharmacology
- Complimentary and Alternative therapy
- Electroconvulsive Therapy (ECT)
- Light Therapy
- Repetitive Transcranial Magnetic Stimulation (rTMS)
- Vagus Nerve Stimulation
- Psychosurgery
- Referral

Treating Major Depressive Disorder (APA Guidelines)

Managing Depression

- Therapeutic alliance
- Psychiatric Assessment
- Evaluate safety
- Appropriate treatment setting
- Functional impairments & QOL
- Coordinate with other clinicians
- Monitor psychiatric status
- Integrate measures
- Enhance treatment adherence
- Provide education to Pt/family

American Psychiatric Association. (2015). Treating major depressive disorder: a quick reference guide. 2010.

Treating Major Depressive Disorder (APA Guidelines)

Acute Phase Treatment

- Initial treatment choice →
- Evaluating response
- Addressing inadequate response

Continuation Phase

- Reduce relapse

Maintenance Phase

- Monitoring

Discontinuation of Treatment

- Monitoring

- History of illness
- Type & severity of symptoms
- Co-occurring illnesses/conditions/situations
- Response to prior treatments
- Patient preference
- Availability of mental health resources

American Psychiatric Association. (2015). Treating major depressive disorder: a quick reference guide. 2010.
Qaseem, A., Barry, M. J., Kasagara, D. (2016). Ann Intern Med, 164(5), 350-359.

A Practical Management Strategy for Depressive Disorders in Primary Care

- Screen all patients at annual exam or if symptomatic (PHQ9)
- Consider differentials and comorbidities
- Determine acuity of impairment or distress
- Assess previous therapies
- Refer for, or provide CB interventions yourself
- Consider and prescribe psychotropics responsibly
- Develop a depression care/follow-up process·
- Refer when appropriate

Colorafi, K., Vanselow, J., & Nelson, T. (2017). *Fam Pract Manag, 24*(4), 11-16.

Time-Limited Appointments (15-20 min)

- Pre work - PHQ9
- Review depression symptoms, assess/document suicidality
- Brief ROS including substance use
- Review adherence & ask about side effects
- Use evidence based treatments (CBI & Rx)
- Limit changes to one at a time
- Verbally encourage pt & support others involved in pt's care

Strakowski, S., & Nelson, E. (2015). Major depressive disorder. Oxford University Press.

A Practical Management Strategy for Depressive Disorders in Primary Care

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Thanks for Listening

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