Management of Major Depressive Disorder in Adults

(‘yes’ to either Q below = positive screen)
1. YES/NO: During the past month, have you often been bothered by feeling down, depressed, or hopeless?
2. YES/NO: During the past month, have you often been bothered by little interest or pleasure in doing things?

2. Consider for emergent triage: Delirium, acute or marked psychosis, severe depression (e.g. catatonia, malnourishment), acute danger to self or others, or unstable acute medical conditions.

3. Assess for “red flags”. High index of suspicion for depression if:
- unexplained symptoms, chronic illness, decreased function, hx of abuse/neglect, family hx, significant losses, other psychiatric problems

4. Assess for depressive episode:
• 5 or more of “sig-e-caps”
• Sleep (✓ or □), Interests (✓ or □), Guilt, Energy (✓ or □), Concentration (✓ or □), Appetite (✓ or □), Psychomotor changes (✓ or □), Suicidal ideas.

5. Assess for possible medical contributors (“DSM”) and optimize management.
• Diseases: any exacerbating depression?
• Substance misuse: any problems present?
• Medications: any depressogenic prescription medicines?

6. Provide education, discuss options, and jointly choose therapy.
• Educate on depression, tx options, self-management, & possible contributors.
• Discuss risks and benefits of psychotherapy, meds, both or neither.

7. Determine locus of care — primary care vs. mental health

8. Course of therapy.
• Monitor adherence & side-effects every 1-2 weeks; assess response at 4 to 6 weeks and adjust therapy as indicated: reassess response at 12 weeks
• Consider consultation/referral for an incomplete response

INQUIRING ABOUT SUICIDAL IDEATION

• When a patient describes a depressive episode the Primary Care Provider can empathize and explore for the presence of suicidal ideation by saying: “You sound as if you have been feeling pretty miserable (or sad or low or dismal or despondent or down). Has life ever seemed not worth living?”

• If the patient acknowledges suicidal ideation but does not state how active the contemplation is, follow-up by asking: “So, you have felt life is not worth living. Have you ever thought about acting on those feelings?”

• If the patient acknowledges that s/he has, explore if the patient has a plan. If so, what is it, is it realistic, has s/he acted on it, if so, how recently?

• If the patient has made a plan, has the means or has recently acted on it, then hospitalization is needed. If the patient is in a gray area, decide how impulsive the patient is and whether a good faith agreement can be made to contact the Provider or come to an emergency care facility if suicidal ideation becomes intrusive, persistent or compelling.

INQUIRING ABOUT SELF- HARM

• If the patient has made a plan, has the means or has recently acted on it, then hospitalization is needed. If the patient is in a gray area, decide how impulsive the patient is and whether a good faith agreement can be made to contact the Provider or come to an emergency care facility if suicidal ideation becomes intrusive, persistent or compelling.

INQUIRING ABOUT SUBSTANCE USE

• Consider consultation/referral for an incomplete response

INQUIRING ABOUT ALCOHOL USE

• Consider consultation/referral for an incomplete response

POCKET GUIDE

Positive Depression Screen

Emergencies?

Depressive Episode?

Contributing Factors? (“DSM”) Disease, Substances, Meds

Optimize Management of “DSMs”

Provide Education, Discussion Options

Jointly Choose Therapy

Determine Locus of Care

Initiate Therapy Monitor every 1-2 weeks

Assess Response at 4-6 weeks Adjust Therapy

Reassess Response at 12 Weeks

Consider Consultation/Referral for Incomplete Response

VA/DoD Clinical Practice Guideline for Management of Major Depressive Disorder in Adults: Primary Care

VA access to full guidelines: http://www.CPR.edu/VA/OPG/OPG.htm
DoD access to full guidelines: http://www.cs.army.mil/CPQO
Sponsored & produced by the VA Employee Education System in cooperation with the Offices of Quality & Performance and November 2001

Evidence

<table>
<thead>
<tr>
<th>QE</th>
<th>SR</th>
<th>Drug/Drug Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>B</td>
<td>Amphetamines withdrawal, Anabolic Steroids, Diazepines, Oxiceptocin</td>
</tr>
<tr>
<td>II-1</td>
<td>C</td>
<td>Reserpine</td>
</tr>
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<td>II-2</td>
<td>A</td>
<td>Gonadotropin-releasing agonists, Gonaditele</td>
</tr>
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<td>Propanolol (Beta Blockers)</td>
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<td>II-2</td>
<td>C</td>
<td>ACE inhibitors, Antihypertensives, Benzoxazepines, Cinniferine, Rauofside, Clonidine, Clonidine, Cyclosine, Interferons, Levodopa, Methylxyl, Metamitamine, Oral contraceptives, Topirimate, Venamlanil (Calcium channel Blockers)</td>
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Medical Conditions Related to Depression

Pathology | Disease
---|---
Cardiovascular | Coronary artery disease, Congestive heart failure, Uncontrolled hypertension, Anemia, Stroke, Vascular Dementias
Chronic Pain | Fibromyalgia, Reflex sympathetic
Syndrome | dystrophy, Low back pain (LBP), Chronic pelvic pain, Bone or disease related pain
Degenerative | Palsy, Muscular dystrophy, Alzheimer’s disease, Parkinson’s disease, Huntington’s disease, Other Neurodegenerative diseases
Inflammatory | HIV (both primary and infection-related), Multiple Sclerosis, Systemic Lupus Erythematosus (SLE), Sarcoidosis
Infection | Systemic Inflammatory Response Syndrome (SIRS), Meningitis
Metabolic | Malnutrition, Vitamin deficiencies, Hypoparathyroidism, Addison’s Disease, Diabetes Mellitus, Hepatic disease (cirrhosis), Electrolyte disturbances, Acid-base disturbances, Chronic Obstructive Pulmonary Disease (COPD) or Asthma, Hypoxia
Endocrine | HIV (both primary and infection-related), Multiple Sclerosis, Systemic Lupus Erythematosus (SLE), Sarcoidosis
Neoplasia | Of any kind, especially pancreatic or central nervous system (CNS)

Medications That Can Cause Depression

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**TRICYCLIC ANTIDEPRESSANTS (TCAs) – Mainly Serotonin Reuptake Inhibitors**

<table>
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<tr>
<th>GENERIC BRAND NAME</th>
<th>MAX ADULT STARTING DOSE</th>
<th>SAFETY MARGIN</th>
<th>TOLERABILITY</th>
<th>EFFICACY</th>
<th>SIMPLICITY</th>
</tr>
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<tr>
<td>Amitriptyline *</td>
<td>50 - 150 mg</td>
<td>No serious toxicity from OD. Can interact with agents that decrease arousal/impair cognitive performance and interact with adrenergic agents that regulate blood pressure.</td>
<td>Seizure risk at doses higher than max. Drug/drug interactions uncommon.</td>
<td>Rarely causes sexual dysfunction.</td>
<td>AM daily dosing. Can be started at an effective dose immediately.</td>
</tr>
<tr>
<td>Nortriptyline *</td>
<td>50 - 150 mg</td>
<td>No serious toxicity from OD. Can interact with agents that decrease arousal/impair cognitive performance and interact with adrenergic agents that regulate blood pressure.</td>
<td>Seizure risk at doses higher than max. Drug/drug interactions uncommon.</td>
<td>Rarely causes sexual dysfunction.</td>
<td>AM daily dosing. Can be started at an effective dose immediately.</td>
</tr>
<tr>
<td>Imipramine *</td>
<td>75 mg</td>
<td>No serious toxicity from OD. Can interact with agents that decrease arousal/impair cognitive performance and interact with adrenergic agents that regulate blood pressure.</td>
<td>Seizure risk at doses higher than max. Drug/drug interactions uncommon.</td>
<td>Rarely causes sexual dysfunction.</td>
<td>AM daily dosing. Can be started at an effective dose immediately.</td>
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**Note:** These antidepressants are not recommended for use in the elderly. Highest response rates. TATCAs useful in chronic pain, migraine headaches & insomnia. * Tertiary Amine Tricyclic Antidepressants (TATCAs). * Secondary Amine Tricyclic Antidepressants (SATCAs)