Management of Major Depressive Disorder in Adults

1. Screening – Routine in primary care.
   ('yes' to either Q below = positive screen)
   - ➢ YES/NO: During the past month, have you often been bothered by feeling down, depressed, or hopeless?
   - ➢ 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 (↓), Guilt, Energy (↓), Concentration (↓), 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.
   - ■ Jointly choose: appropriate treatment is matter of patient preference.
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.

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

POCKET GUIDE

Positive Depression Screen

↓

Emergencies?

↓

Depressive Episode?

↓

Contributing Factors?
("DSM") Disease, Substances, Meds

↓

Optimize Managment 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 access to full guidelines: http://www.oqp.med.va.gov/cpg/cpg.htm

DoD access to full guidelines: http://www.cs.amedd.army.mil/Qmo

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Medical Conditions Related to Depression

Pathology	Disease
Cardio/vascular	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	Presbyopia, Presbycusis, Alzheimer's disease, Parkinson's disease, Huntington's disease, Other Neurodegenerative diseases
Immune	HIV (both primary and infection-related), Multiple Sclerosis, Systemic Lupus Erythematosis (SLE), Sarcoidosis
Infection	Systemic Inflammatory Response Syndrome (SIRS), Meningitis
Metabolic/ Endocrine Conditions (include renal and pulmonary)	Malnutrition, Vitamin deficiencies, Hypo/Hyperthyroidism, Addison's Disease, Diabetes Mellitus, Hepatic disease (cirrhosis), Electrolyte disturbances, Acidbase disturbances, Chronic Obstructive Pulmonary Disease (COPD) or Asthma, Hypoxia
Neoplasm	Of any kind, especially pancreatic or central nervous system (CNS)

Medications That Can Cause Depression

Evidence

QE	SR	Drug/Drug Class
I	B	Amphetamine withdrawal, Anabolic Steroids, Digitalis, Glucocorticoids
I	C	Cocaine withdrawal
II-1	C	Reserpine
II-2	A	Gonadotropin-releasing agonists, Pimozide
II-2	B	Propanolol (Beta Blockers)
II-2	C	ACE inhibitors, Antihyperlipidemics, Benzodiazepines, Cimetidine, Ranitidine, Clonidine, Cycloserine, Interferons, Levodopa, Methyldopa, Metoclopramide, Oral contraceptives, Topiramate, Verapamil (Calcium channel Blockers)

ANTIDEPRESSANT MEDICATION TABLE – Refer to pharmaceutical manufacturer's literature for full prescribing information

SEROTONIN SELECTIVE REUPTAKE INHIBITORS (SSRIs)

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Citalopram	Celexa	20 mg	60 mg	Reduce dose for the elderly & those with renal or hepatic failure	No serious systemic toxicity even after substantial overdose. Drug interactions may include tricyclic antidepressants, carbamazepine & warfarin.	Nausea, insomnia, sedation, headache, fatigue dizziness, sexual dysfunction anorexia, weight loss, sweating, GI distress, tremor, restlessness, agitation, anxiety.	Response rate = 2 - 4 wks	AM daily dosing. Can be started at an effective dose immediately.
Fluoxetine	Prozac	20 mg	80 mg					
Paroxetine	Paxil	20 mg	50 mg					
Sertraline	Zoloft	50 mg	200 mg					

First Line Antidepressant Medication

Drugs of this class differ substantially in safety, tolerability and simplicity when used in patients on other medications. Can work in TCA nonresponders. Useful in several anxiety disorders. Taper gradually when discontinuing these medications. Fluoxetine has the longer half-life.

SEROTONIN and NOREPHINEPHRINE REUPTAKE INHIBITORS (SSRIs)

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Venlafaxine IR	Effexor IR	75 mg	375 mg	Information Not Available	No serious systemic toxicity. Downtaper slowly to prevent clinically significant withdrawal syndrome. Few drug interactions.	Comparable to SSRIs at low dose. Nausea, dry mouth, insomnia, somnolence, dizziness, anxiety, abnormal ejaculation, head-ache, asthenia, sweating.	Response rate = 2 - 4 wks (4 - 7 days at ~ 300 mg/day)	BID or TID dosing with IR. Daily dosing with XR. Can be started at an effective dose (75 mg) immediately.
Venlafaxine XR	Effexor XR	75 mg	375 mg					

Dual action drug that predominantly acts like a Serotonin Selective Reuptake inhibitor at low doses and adds the effect of an Norepinephrine Selective Reuptake Inhibitor at high doses. Possible efficacy in cases not responsive to TCAs or SSRIs. Taper dose prior to discontinuation.

SEROTONIN (5-H2A) RECEPTOR ANTAGONIST and WEAK SEROTONIN REUPTAKE INHIBITORS

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Nefazodone	Serzone	200 mg	600 mg	Reduce dose for the elderly & those with renal or hepatic failure	No serious systemic toxicity from OD. Can interact with agents that decrease arousal/impair cognitive performance and interact with adrenergic agents that regulate blood pressure.	Somnolence dizziness, fatigue, dry mouth, nausea, headache, constipation, impaired vision. Unlikely to cause sexual dysfunction.	Response rate = 2 - 4 wks	BID dosing. Requires dose titration.
Trazodone	Desyrel	150 mg	600 mg					

Corrects sleep disturbance and reduces anxiety in about one week.

DOPAMINE and NOREPHINEPHRINE REUPTAKE INHIBITORS (DNRIs)

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Bupropion - IR	Wellbutrin - IR	200 mg	450 mg	Reduce dose for the elderly & those with renal or hepatic failure	Seizure risk at doses higher than max. Drug/drug interactions uncommon.	Rarely causes sexual dysfunction.	Response rate = 2 - 4 wks	BID/TID dosing. Requires dose titration.
Bupropion - SR	Wellbutrin - SR	150 mg	400 mg					

Least likely antidepressant to result in a pt becoming manic. Do not use if there is a history of seizure disorder, head trauma, bulimia or anorexia. Can work in TCA nonresponders.

TRICYCLIC ANTIDEPRESSANTS (TCAs) – Mainly Serotonin Reuptake Inhibitors

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Amitriptyline *	Elavil, Endep *	50 - 100 mg	300 mg	Reduce dose for those with renal or hepatic failure	Serious toxicity can result from OD. Slow system clearance. Can cause multiple drug/drug interactions.	Sedation, increased anticholinergic effects, orthostatic hypotension, cardiac conduction disturbances, arrhythmia & wt gain, dizziness, sexual dysfunction.	Response rate = 2 - 4 wks Therapeutic Levels: Imipramine 200-350 ng/ml	Can be given QD. Monitor serum level after one week of treatment
Imipramine *	Toframil *	75 mg	300 mg					
Daxepin *	Sinequan *	75 mg	300 mg					

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).

TRICYCLE ANTIDEPRESSANTS (TCAs) – Mainly Norepinephrine Reuptake Inhibitors

GENERIC	BRAND NAME	ADULT STARTING DOSE	MAX	EXCEPTION	SAFETY MARGIN	TOLERABILITY	EFFICACY	SIMPLICITY
Desipramine *	Norpramin *	75 - 200 mg	300 mg	Reduce dose for the elderly & those with renal or hepatic failure	Serious toxicity can result from OD. Reserve Maprotiline as a second-line agent due to risk of seizures at therapeutic & nontherapeutic doses.	Generally Good	Response rate = 2 - 4 wks Therapeutic Levels: Desipramine 125-300 ng/mL Nortriptyline 50-150 ng/mL	Can be given QD. Can start effective dose immediately. Monitor serum level after one week of treatment.
Notriptyline *	Avently/Pamelor	50 mg	150 mg					

Consider Desipramine or Nortriptyline first in the elderly if TCAs are necessary.

* Secondary Amine Tricyclic Antidepressants (SATCAs)