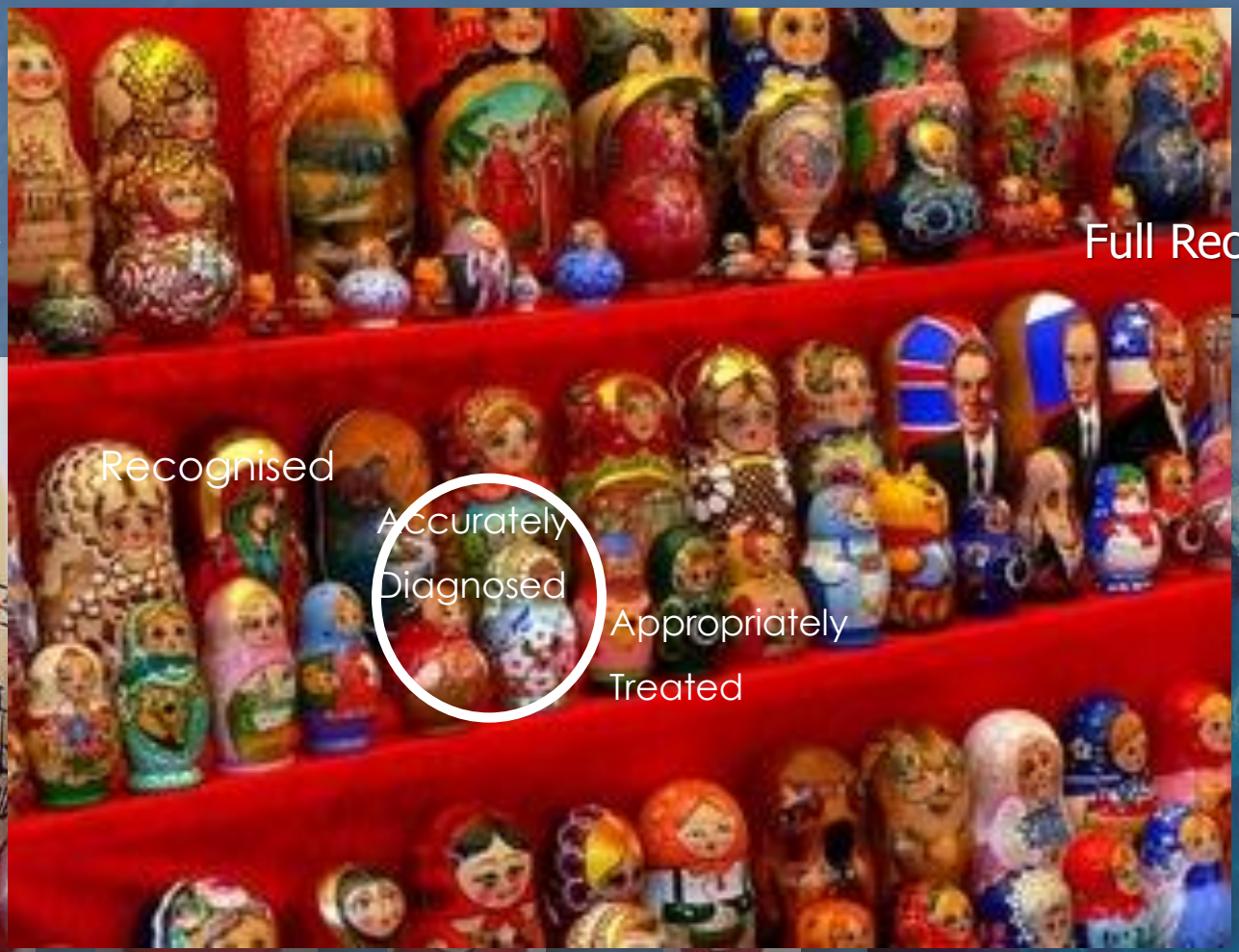
Mastering the Treatment of Depression in Primary Practice

Rob Shieff

Why is Depression challenging ?

Common
Covert
Chronic
Co-morbid
Crushing
Costly
Clingy
Contagious

Present for help



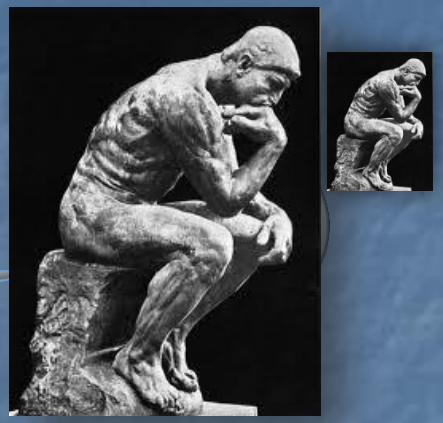
Recognised

Accurately Diagnosed

Appropriately Treated

Full Recovery

Whole Population



The Challenges
Of
Depression

Having the right attitude

Realistic hope

Patience vs Determination

Th Challenges Of Depression

Tolerate uncertainty

The Two Question PHQ-9 Screen

www.**Depression**.org.nz

Bruce Arroll

During the last month have you been feeling down, depressed or hopeless ?

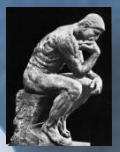
During the past month have you lost interest or pleasure in doing things ?

This is **96% sensitive**

(most people with depression will say YES)

BUT only **57% specific**

(a lot of people who say YES will not be suffering from depression)



Understanding it fully

refining the diagnosis

The Challenges Of Depression

making the diagnosis

assessing co-morbidity

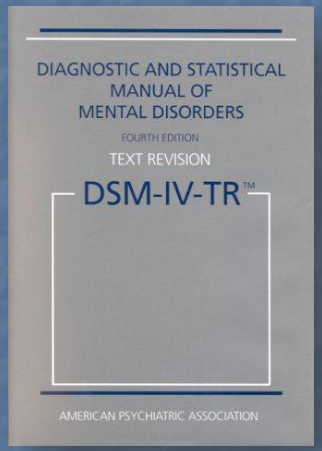
Depression – a diagnostic look

- At least 2 weeks

- Low mood
- Anhedonia

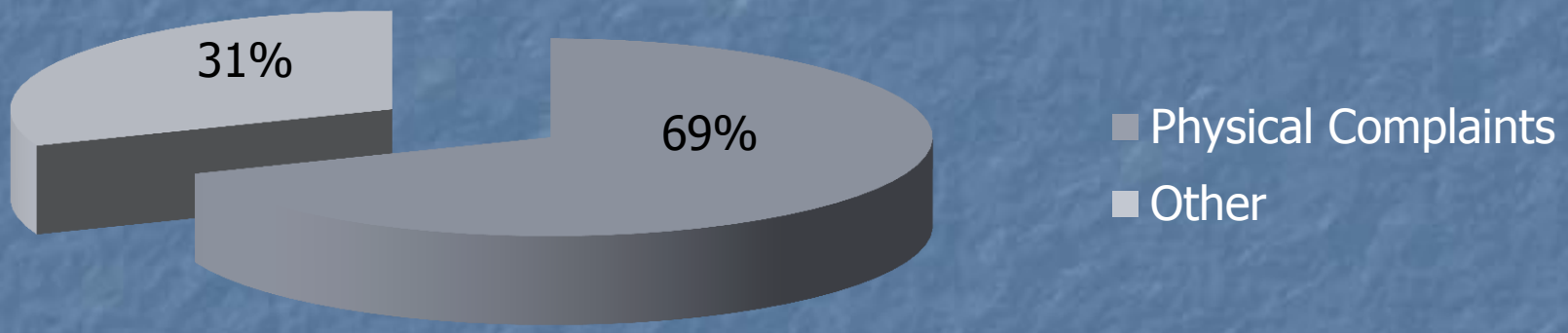
- Sleep
- Appetite / Weight
- Fatigue
- Activity
- Self-worth
- Suicidality
- Concentration

- Distress / Impairment
- No other explanation

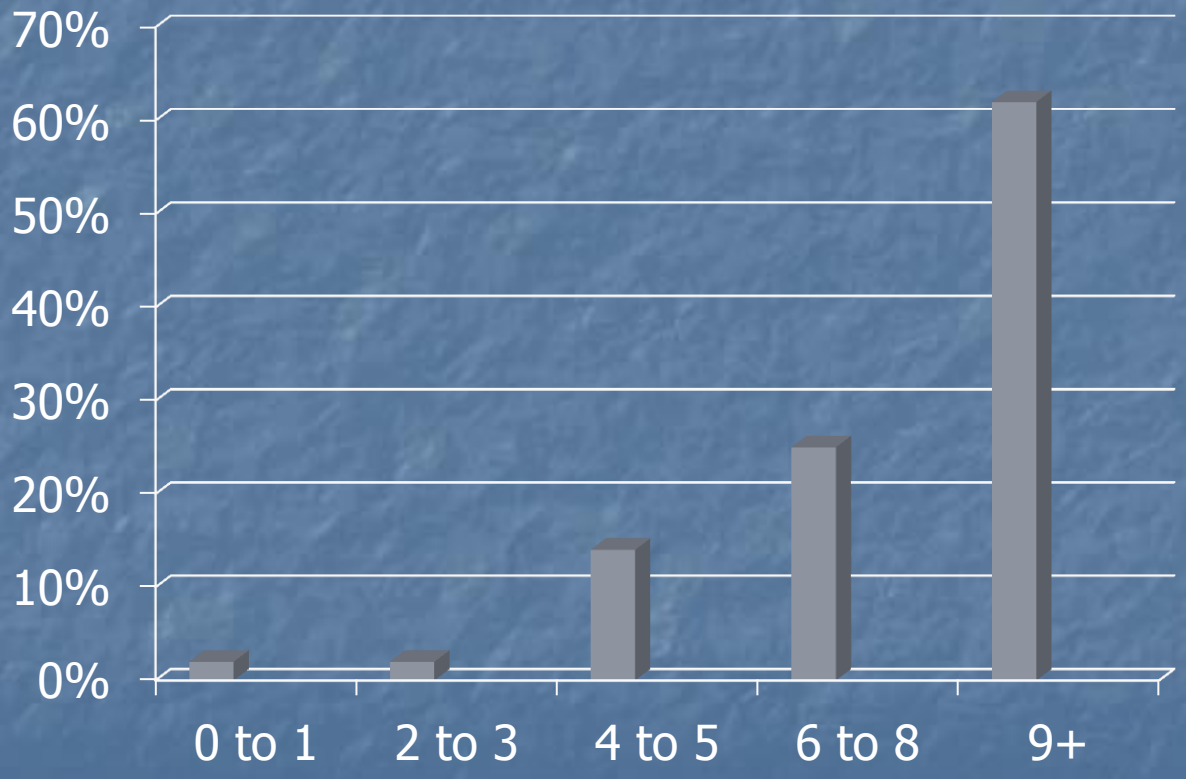



Sexual problems
D and A
Pain and MUS
Self-worth
Appetite
Concentration
Low mood
Anhedonia
Anger
Insomnia
Suicide
Relationship problems
Fatigue
Activity
Vocational Problems
Anxiety

Depressed patients most often present with physical complaints

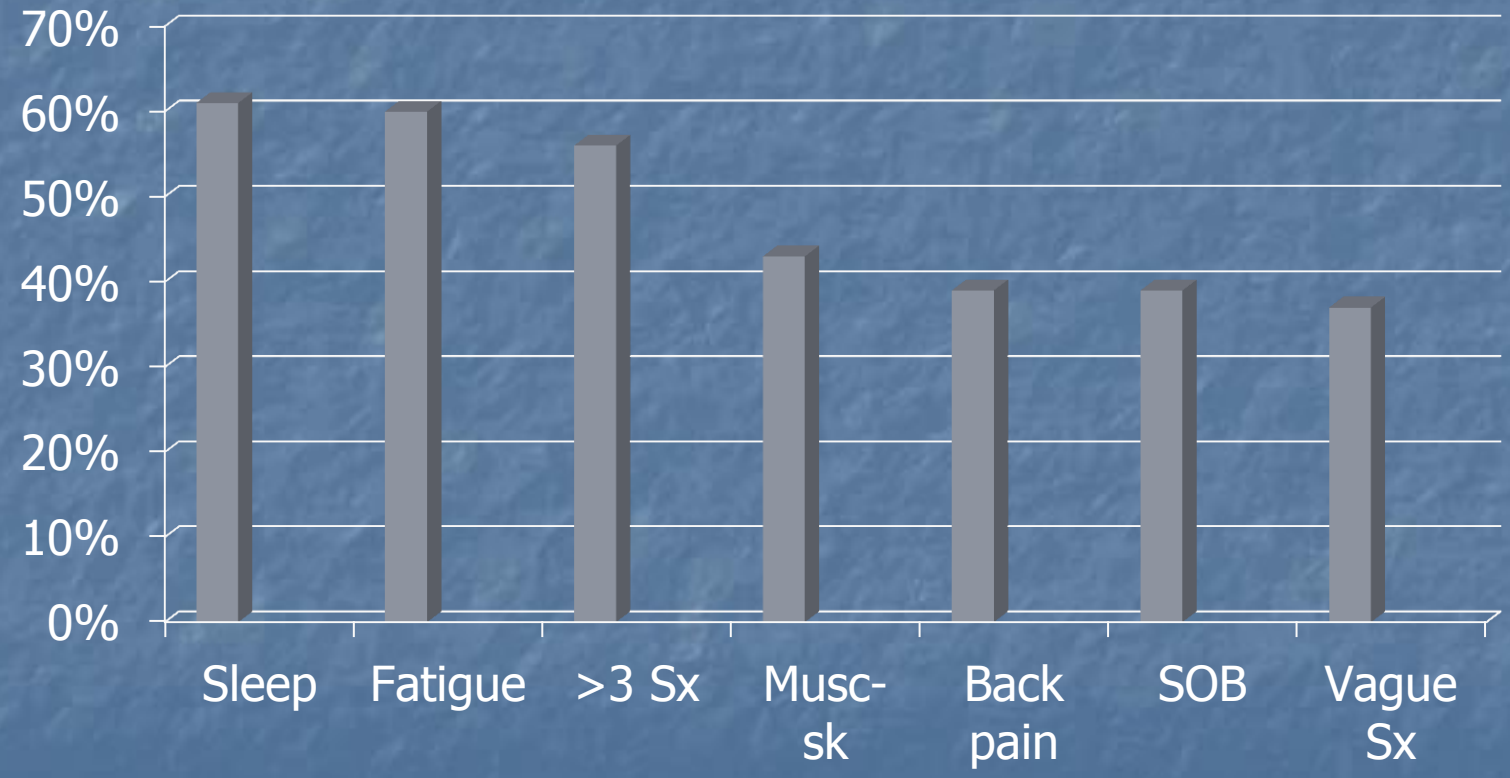


The likelihood of Depression increases with the number of physical complaints



Physical complaints as predictors of Depression

PPV



The better you know someone the more likely you will identify their depression

Number of prior consultations	RR
Never before	1
1 or 2	1.8
3 or 4	2.3
5 or more	2.9

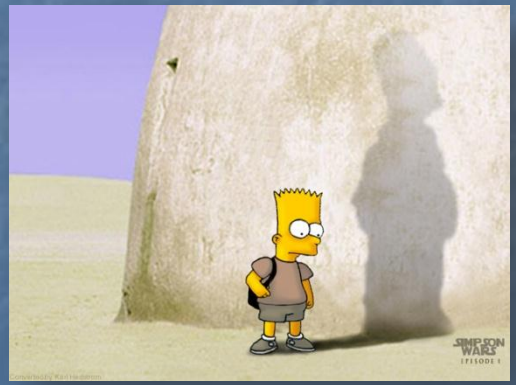
Medical Illness and Depression often occur together

Illness	% with Depression
Cancer	40 – 50%
Heart Disease	18 – 26%
Diabetes	33%
Stroke	30 – 50%

Forms of Depression

- Syndromal
  - Major Depression

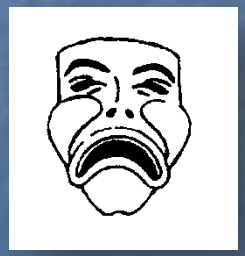
- Sub-syndromal
  - Minor Depression
  - Dysthymia

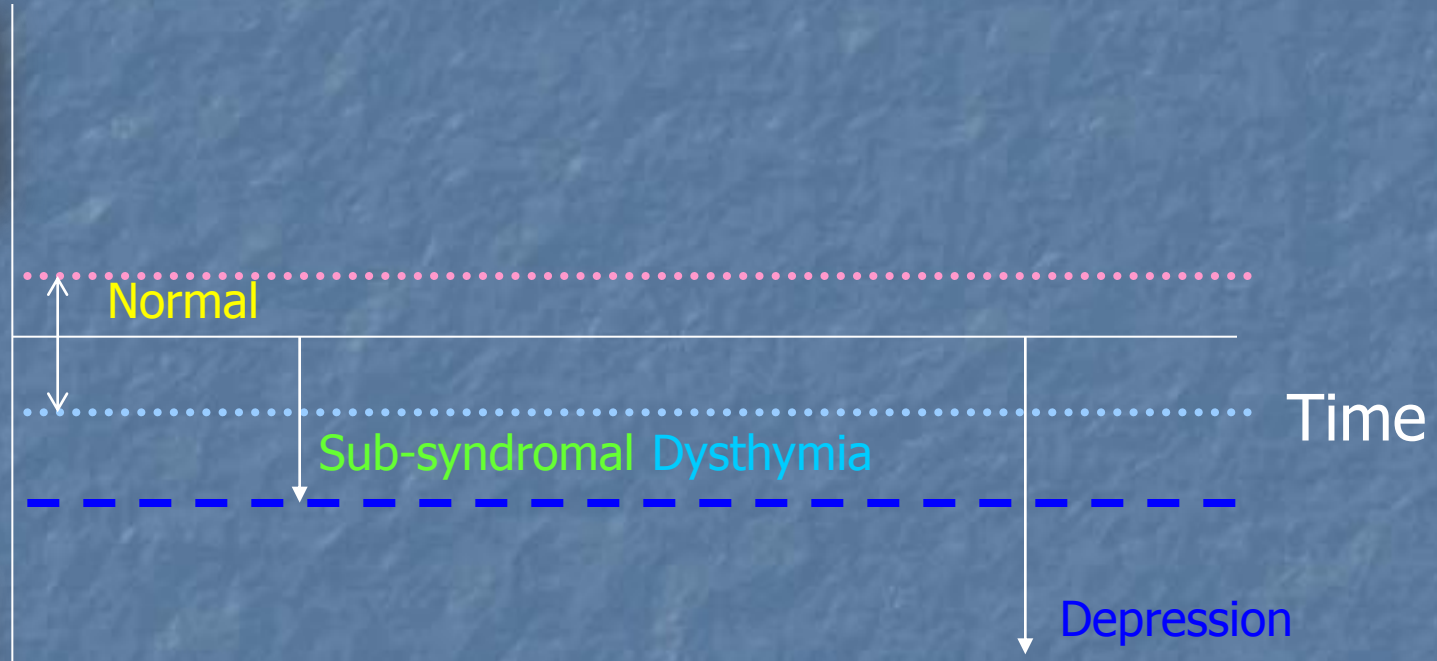


Sub-types of Depression

- Clinical ~ Biological
- Reactive ~ Endogenous
- Melancholic
- Atypical
- Psychotic
- Recurrent
- Chronic
- Refractory
- Aggitated
- As part of Bipolar Affective

Mood Chart

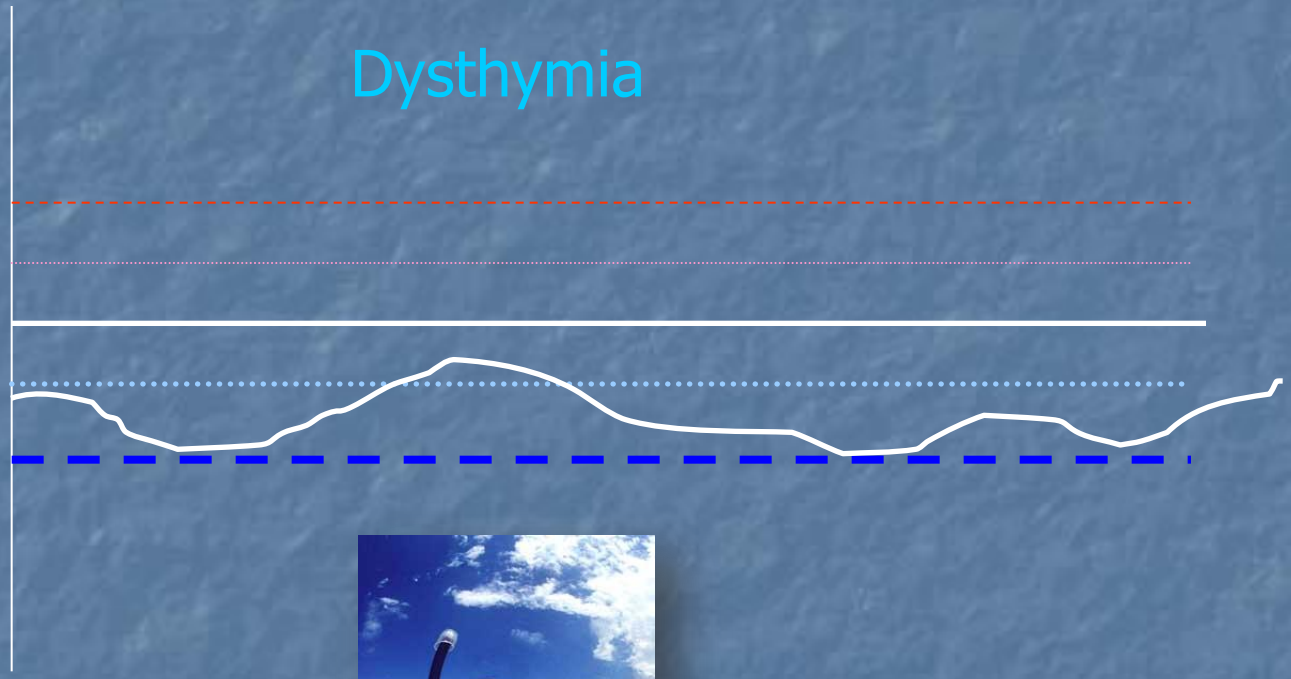




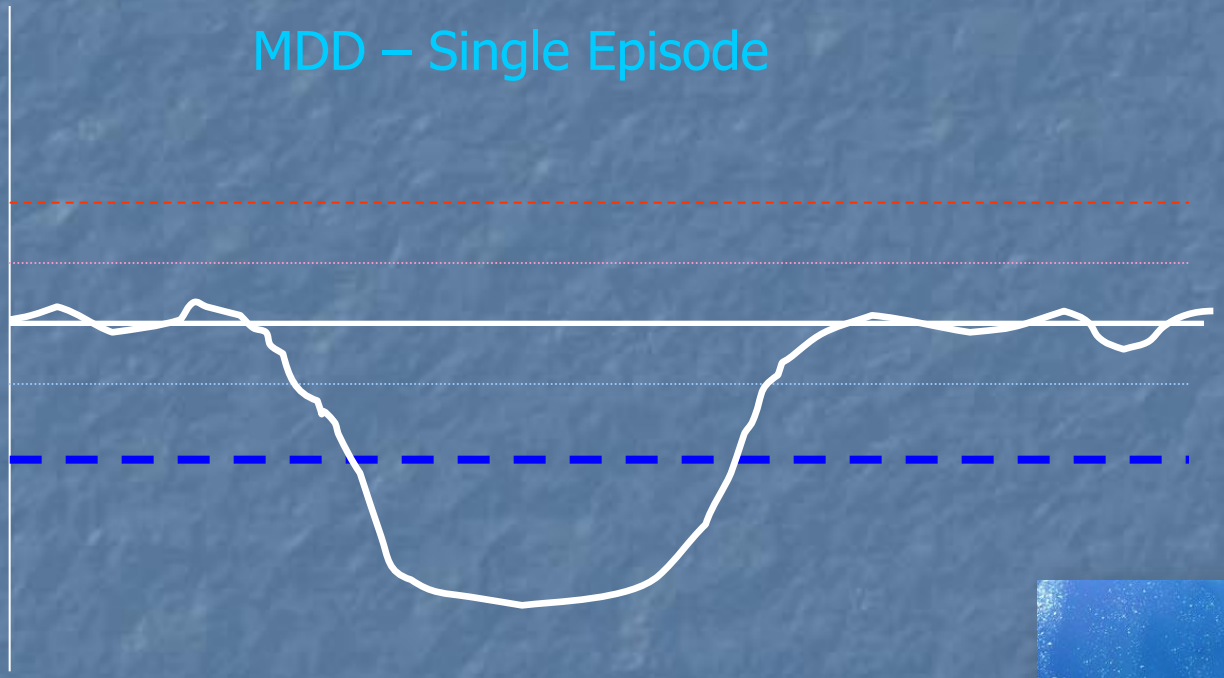
How it breaks down

Normal

Dysthymia



MDD – Single Episode



MDD – Recurrent

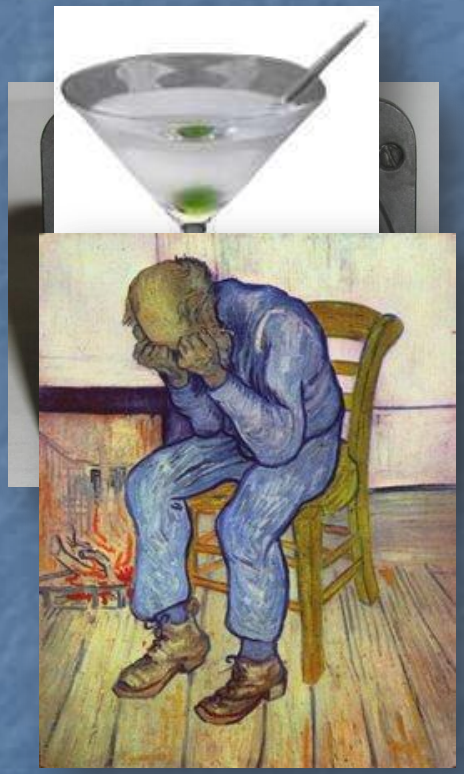
MDD – Partially Treated

Double Depression

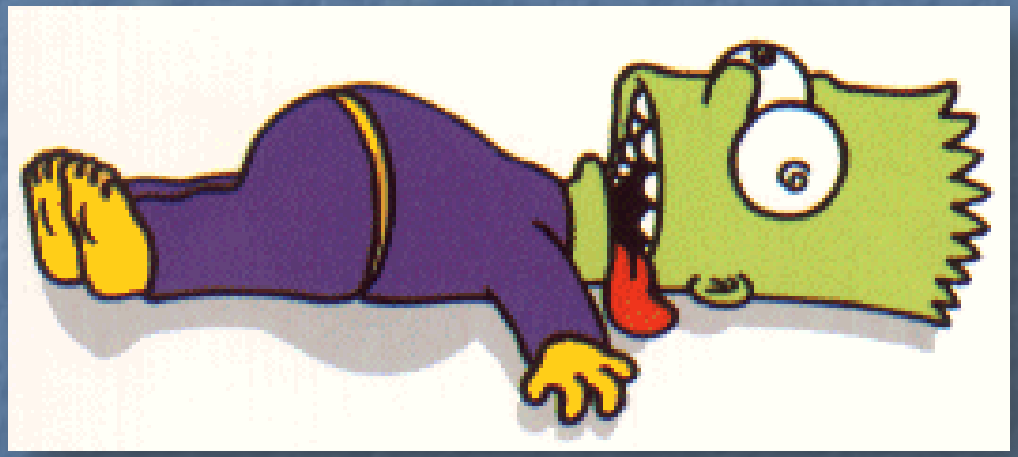
Lest we forget

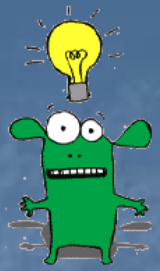
The Keys to Diagnosis

- Inclusion symptoms
- Duration
- Distress / Impairment
- Exclusion diagnoses
  - Medical Conditions
  - Alcohol and Drugs



When should I think about the possibility of a General Medical Condition ?





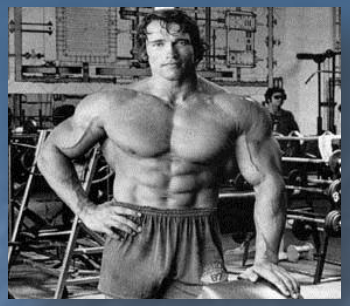
Clues

- Older presentation (> 45)

- Atypical

- Known disease history

Thinking about Substance Related Mental Health Problems



Connections

Due to : intoxication or withdrawl

Of : prescribed medications (Benzodiazepines, steroids)

poisons (mercury, arsenic, organophosphates)

alcohol and caffeine

drugs of abuse (MDMA , P , cocaine , THC)

Don't forget Substance Use ⟷ Psychological Problems

refining the diagnosis

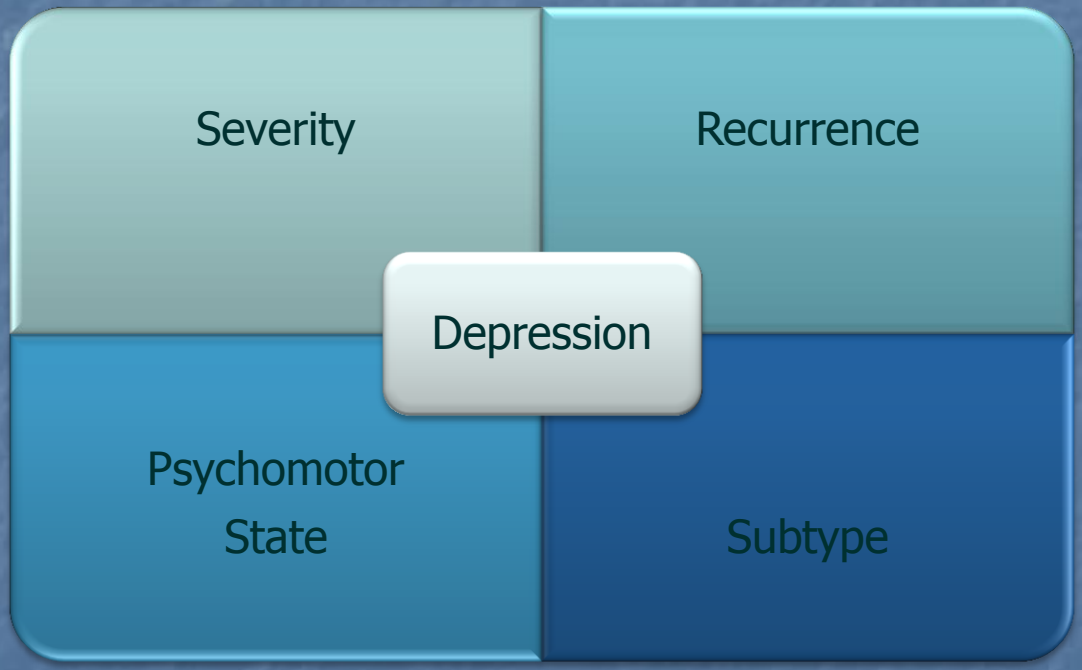
making the diagnosis

Understanding it fully

The Challenges Of Depression

Refine the diagnosis

Depression is not homogenous – different kinds respond to different treatments



Severity

Quick Inventory of Depressive Symptomatology Scale – Self Report

www.ids-qids.org/translations/english/QIDSoriq.pdf

Tracks progress

Guides treatment selection

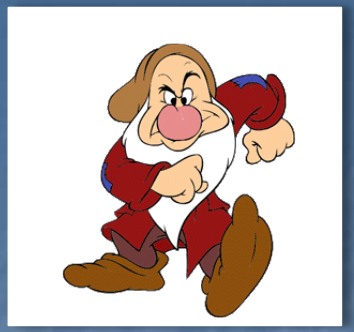
Mild to Moderate :

Skills rather than Pills

Moderate to Severe :

Pills and then Skills

Psychomotor State



Sluggish and Tired :

Select an activating antidepressant

eg SSRI , Bupropion , Venlafaxine

Activated and Agitated :

Select a sedating antidepressant

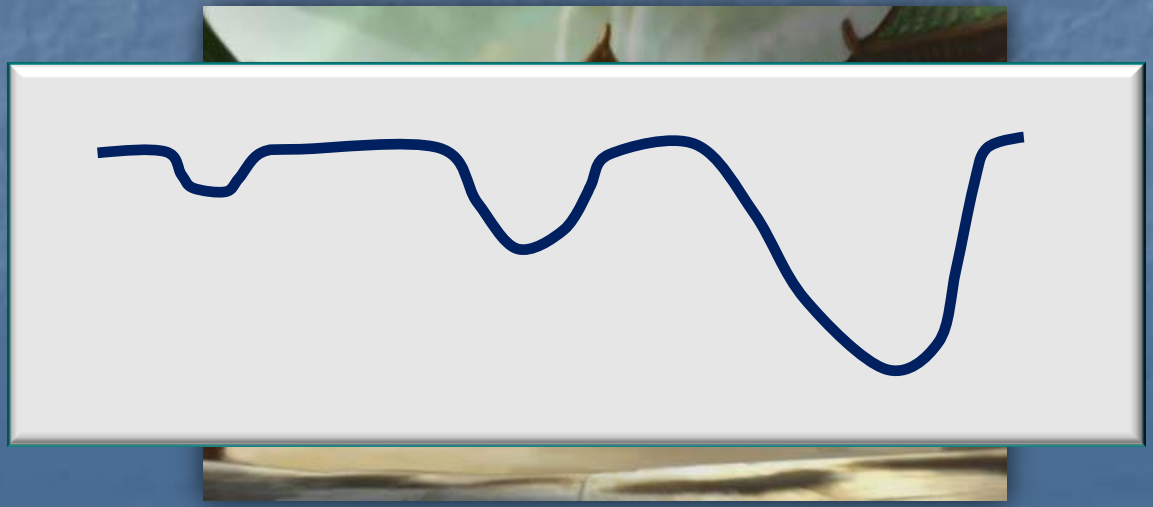
eg TCA , Mirtazapine

Recurrence

Episodes tend to become more intense and prolonged over time.

Work hard to prevent relapses

Be prepared for a bigger battle



Subtype

Melancholic

anhedonia
marked weight loss
early morning awakening
guilt

Atypical

over-eating
over-sleeping

Psychotic

Bipolar

TCA

Venlafaxine

Atypical Antipsychotic / Referral

Mood Stabiliser

Diagnosing Bipolar Depression is often difficult – but important

Treatment with antidepressant alone brings risk of :

- Provoking switch to mania
- Destabilising mood in the future

Clues that this episode of depression might be Bipolar:

History of significantly elevated or mixed mood

Family history of BPAD

Past history of brief hypomania / cyclothymia

Past history of very rapid response to antidepressants

Multiple prior episodes of depression – especially early onset

refining the diagnosis

making the diagnosis

Understanding it fully

The Challenges Of Depression

assessing co-morbidity

Co-morbidity

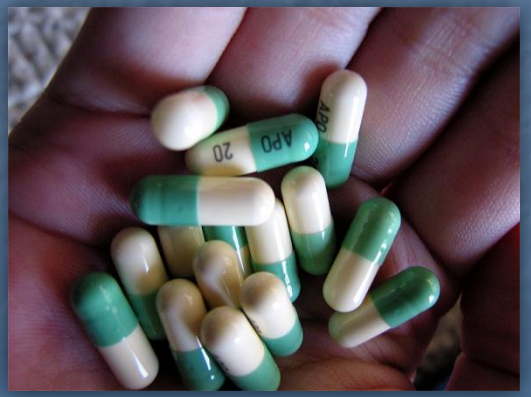
- The presence of more than one diagnosis at the same time
- RULE NOT THE EXCEPTION
  - If you make one diagnosis, look hard for the others

Common Co-morbidities

- Another Mood Disorder
  - Dysthymia
  - Any of the Anxiety Disorders
- A Substance Use Disorder
- A Personality Disorder
- Medical Problems

Why is Co-morbidity Important ?

- Amplifies severity, distress, impairment and hopelessness
- Increases burden of care (family, society)
- Compromises treatment if unidentified



general principles and goals

The Challenges Of Depression

pills

skills

Treating it completely

What is the goal?

Remission

Gone

or

Very few/ Very mild

Normal

Why is Remission so important?

- Partial response without remission is associated with :
  - Impaired Quality of Life
  - Higher Risk of Relapse
    - lower work productivity / worse social funct
    - intensification of other psychiatric / physical

Risk for Depression accumulates :

Lifetime risk for First Episode = 16%

Risk for recurrence after 1 episode = 50%
Risk for recurrence after 2 episodes = 65%
Risk for recurrence after 3 episodes = 70%

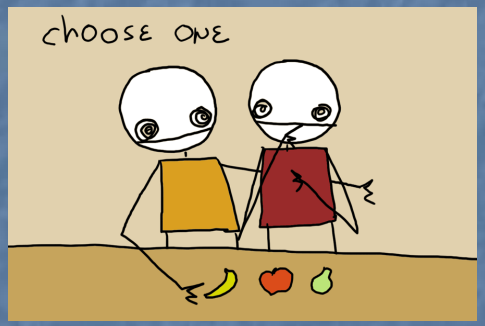
The Challenges Of Depression

Treating it completely

pills

skills

Key Determiners



Patient Choice
Severity

Mild

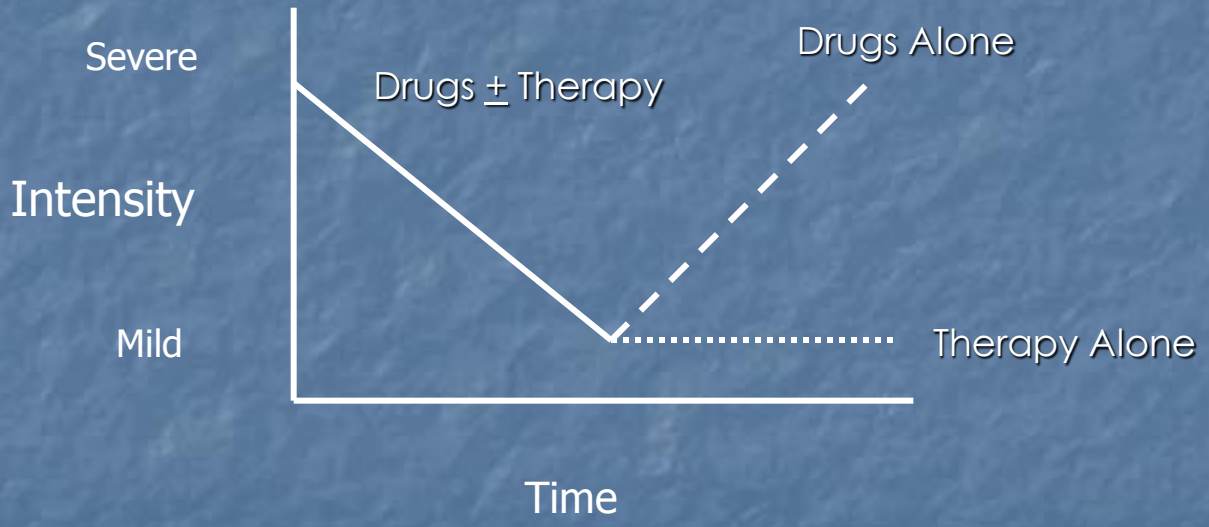
Ther erapy

2/3 of patients prefer psychological help

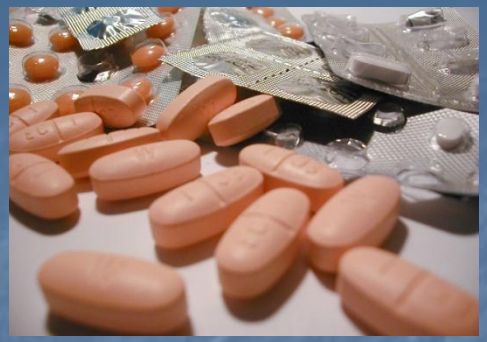
Adherence with medication is poor unless it is the patient's choice

The Other Key Determiner

The Recurrence Trap



Risks vs Benefits



Drug Therapies

Pros	Cons
Effective	Side-effects
Speed	Dependence
Severity	Abuse
Cost ±	Withdrawl
Effort	Tolerance
	Relapse
	Stigma
	Misattribution of gain

Talking Therapies

Pros	Cons
Effective	Effort
Enduring	Time
Cost ±	Cost ±
	Reliance

If the choice is medication

They won't work if they're not taken

We can increase compliance by offering :

1. Support
2. Information

benefit

side-effects

Realistical enefit and time-frame

Accurate a : type and management

Weeks

On the Medication Track

Is there a reason NOT to start with an SSRI ?

- Past history of responsiveness to an alternative
- Family history of responsiveness to an alternative
- If insomnia or agitation particularly prominent → TCA or Mirtazapine

Otherwise – start with an SSRI

First Choice

- Effective
- Well tolerated
- Few interactions
- Safe in overdose
- Cheap

Fluoxetine

Reliable and predictable. Long half life.
Odd number dosage.

1

Paroxetine

Weaker Generic. Short half-life.
Difficult withdrawl

Citalopram

Weaker Generic. Easy withdrawl.
More subtle action / side-effects

1.5

es-Citalopram

Newly introduced. Potent.
Favourable side-effect profile.
Little weight change

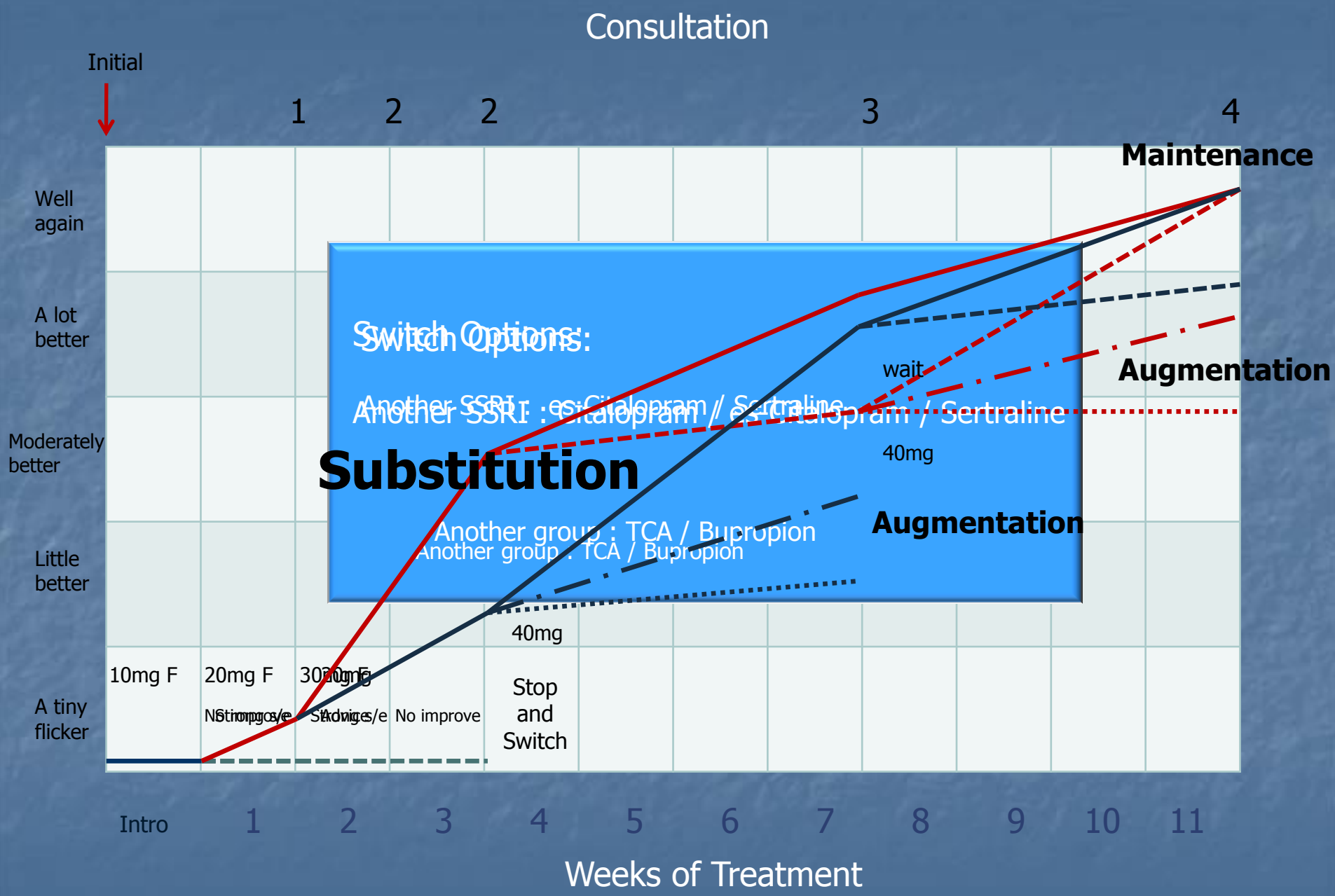
2

Setraline

A strategic approach to prescribing

response

dose


Consultation
Initial
1
2
2
3
4
Maintenance
Well again
A lot better
Moderately better
Little better
A tiny flicker
Switch Options:
Another SSRI : eg Citalopram / Sertraline
Another group : TCA / Bupropion
Substitution
wait
40mg
Augmentation
Augmentation
40mg
10mg F
20mg F
No improve
No improve
Stop and Switch
Intro
1
2
3
4
5
6
7
8
9
10
11
Weeks of Treatment

Remember to separate

- Full response
- No response or Strong side effects :
  - substitution
- Partial response :
  - augmentation

What next ?

Why might progress have stopped short of full recovery ?

Four possibilities to consider :

SSRI targets 5HT but not NA or DA

Low DA

Apathy
Anhedonia
Sleepy

Plan :

Add Bupropion
150 – 300mg

Low NA

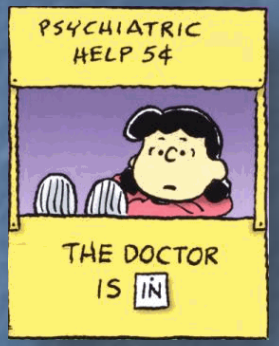
Anxious
Agitated
Insomnia

Plan :

Add Nortriptyline
25 – 75mg nocte

Still not right ?

- Very nearly but not quite :
  - Augment with Thyroid Hormone



- A long way to go :
  - Substitute for Venlafaxine or Mirtazapine
    Combine Venlafaxine with Mirtazapine
    Combine with Atypical Antipsychotic
    MAOI (Phenelzine)
    ECT / TMS / VNS / DBS

Venlafaxine Effexor and Mirtazapine Avanza

Effexor

Dual action : SNRI

Special authority

High potency
(antidepressant / anxiolytic : GAD)

Start 75mg mane
Increase to 300mg

Side-effects : Many / unpredictable

Difficult withdrawl

Avanza

Complex action : 5HT / NA / DA

Special authority

High potency
(antidepressant / anxiolytic)

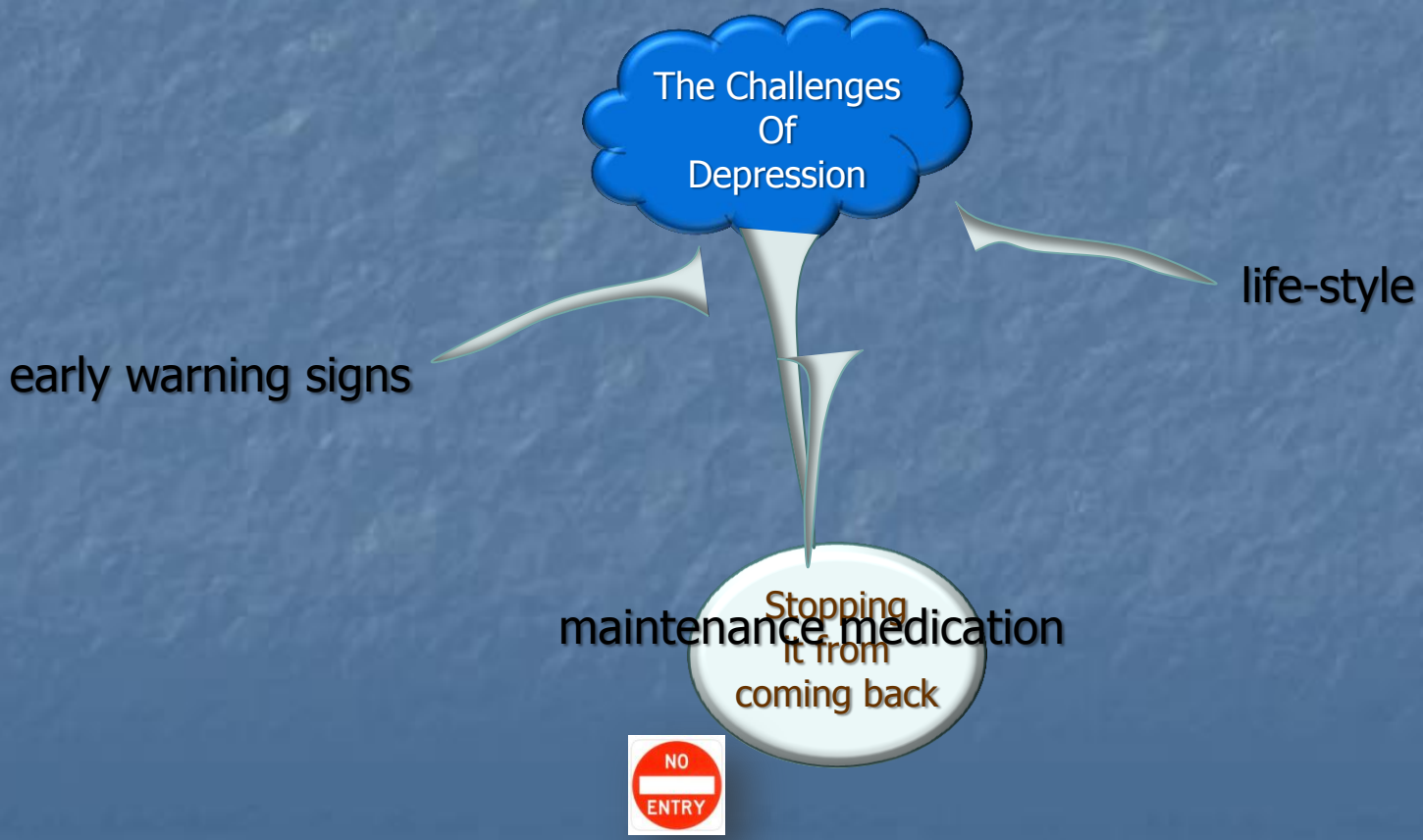
Start 15mg nocte
Increase to 45mg

Side-effects few: Sedation / Weight gain
Little sexual dysfunction

Easy withdrawl

Problems			Solutions
1. Dry mouth	→	Calories in drinks	Water or low calorie drinks
2. Calmer / less agitated	→	Burn fewer calories	Exercise
3. Hungrier / Lose the feeling of fullness			3 meals / smaller portions No snacks or seconds
4. Carbohydrate craving			Low GI carbs Limit carbs after lunch
5. Metabolic shift : Carbs to fat			Limit carbs Metformin

Eat your breakfast yourself , share your lunch with your friends and give your dinner to your enemies.


The Challenges
Of
Depression
life-style
early warning signs
maintenance medication
Stopping
It from
coming back
NO
ENTRY

Preventing Relapse

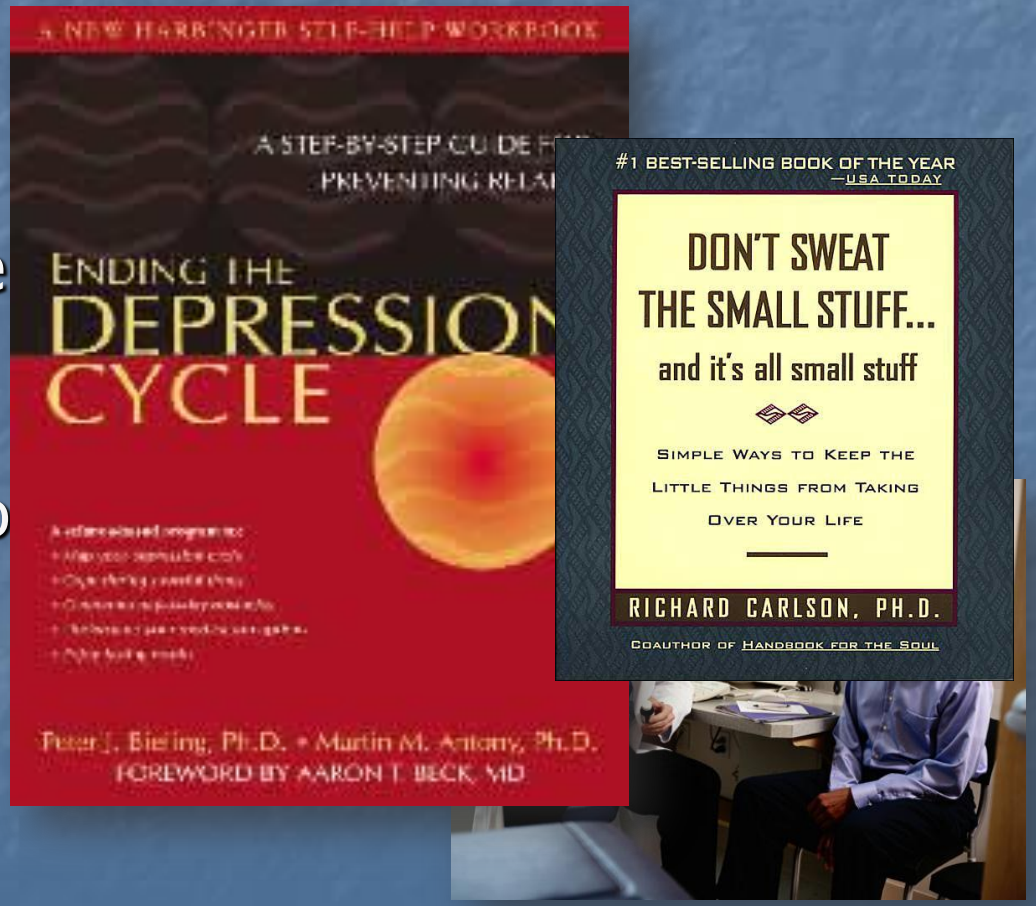
How might we prevent the slide ?

Non-Spec

ecific

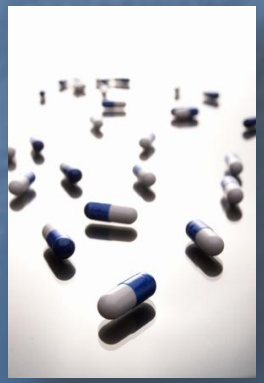
Non-Specific Factors

- Education
- Contact and Review
- Attention to Lifestyle
  - Structure
  - Balance
- Alcohol and Drug Mo
- Stress Management



Specific Factors

- Medication
- Meditation
- Early Warning Planning



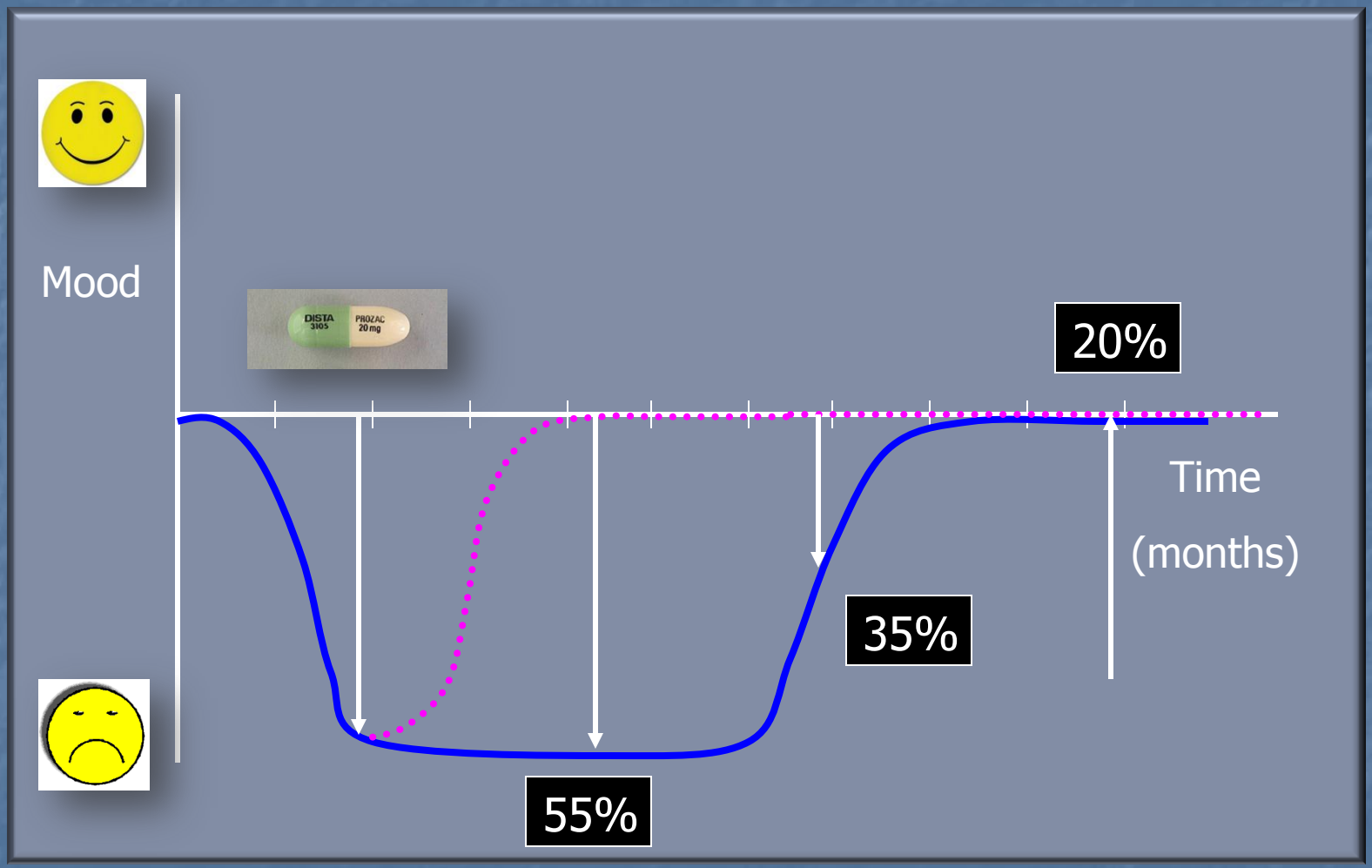
Managing Medication Into the Future

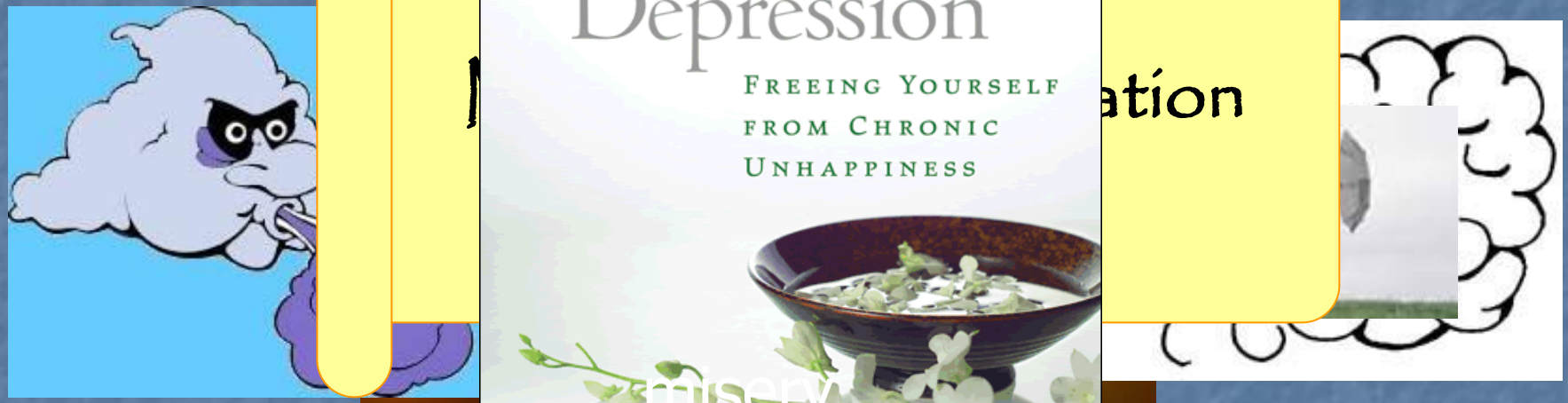
- How much?

Carry on with whatever it took to get fully better

- How long?

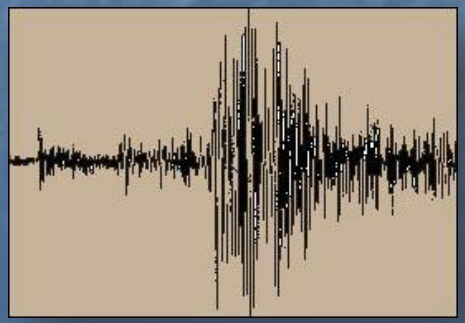
At least 6-9 mont


Mood
DISTA 3105
PROZAC 20 mg
20%
35%
55%
Time
(months)


A Proven Program From Leading Scientists
Including a CD of guided meditations by Jon Kabat-Zinn
The Mindful Way through Depression
Freeing Yourself from Chronic Unhappiness
Mark Williams, John Teasdale
Zindel Segal, and Jon Kabat-Zinn
misery
ation
The more you
he worse you feel

A Stitch in Time

- Early Warning Signs
- Action Planning



Early Warning Signs

sleeping pattern

y

f humour goes

in the shower stops

gym sessions

- Make a list and use it as a reference

Action Planning

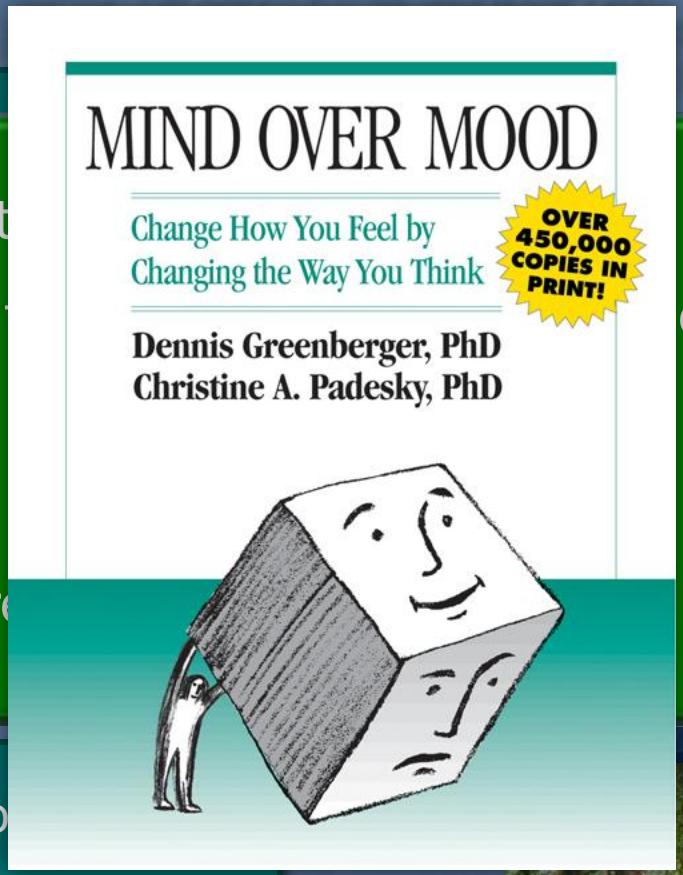
If yo

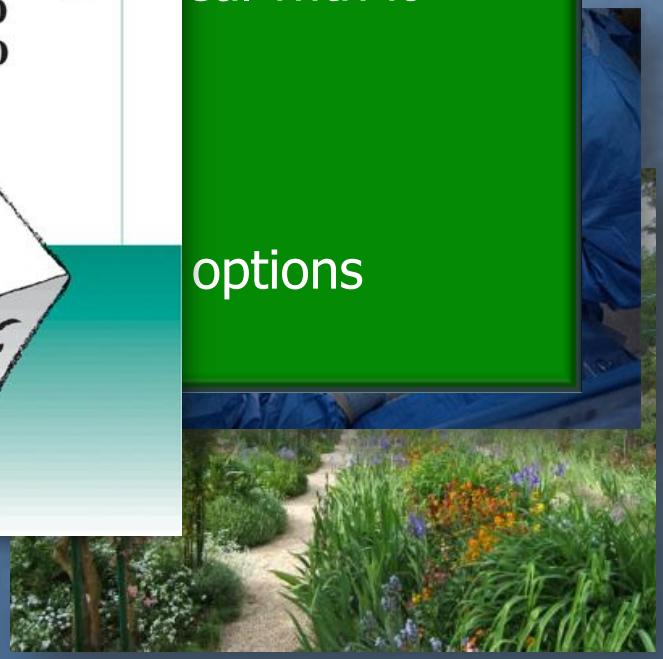
- Let ot
- Look
- Keep
- Fight
- Be pr

eal with it

options

You are more likely to





… that’s all from me