

Update to your Mental Health Tool Kit Managing Depression in chronic disease

adapted from
The MacArthur Foundation
Depression Education Program

OUTLINE

- u The 'common' problem
- u Types of depression
- u PHQ-9
- u McArthur Tool Kit
- u Decision support

DEPRESSION IS COMMON

- u 10-50% of patients with diabetes, cardiac disease, or asthma have major depression
- u Depressed patients visit primary care physicians 3 times more often than patients not depressed

DEPRESSION IS SIGNIFICANT

- u Increased morbidity and mortality in medical conditions
- u Increased utilization
- u Increased costs
- u **Leading cause** of disability worldwide

DEPRESSION IN DIABETES

- u ↑ non-adherence
- u ↑ GHb
- u ↑ retinopathy; ↑ neuropathy; ↑ nephropathy
- u ↑ macrovascular complications (CAD, etc)

- Groot et al Psychosom Med 2001
- Van Tilburg et al Psychosom Med 2001

DEPRESSION IN CARDIAC DISEASE

- u ↑ risk of hypertension; ↑ CVA; ↑ CAD
- u ↑ risk of death after MI (independent of other risks)
- u ↑ HPA activation
- u ↑ sympatho-medullary activity
- u ↑ platelet aggregation; ↑ coagulation; ↓ fibrinolysis; ↓ BP variability

- Musselman et al Archives Gen Psych 1998
- van Kanel et al Psychosom Med 2001

DEPRESSION IN ASTHMA

- u Depression associated with nonadherence, increased symptoms/decreased function
- u 50% of mothers of asthmatic children have depression
- u Depression in mothers associated with 40% ↑ in ER visits of children

UNDER-RECOGNITION/ UNDERTREATMENT

- u 30%-70% of depression is missed during outpatient visit/treatment of chronic disease
- u 50% of patients stop medication within first 3 months, first 2 weeks most critical follow-up

TYPES OF DEPRESSION

- u Major depression
- u Chronic depression (dysthymia)
- u Minor depression
 - o adjustment disorder
 - o depressive disorder nos

MAJOR DEPRESSION

Four Hallmarks:

- u Depressed mood
- u Anhedonia
- u Physical symptoms
- u Psychological symptoms

CHRONIC DEPRESSION (DYSTHYMIA)

- u Characterized by 2 years of depressed mood, occurring more days than not
- u Persists with at least 2 other symptoms of depression
- u Increases risk of major depressive episodes

MINOR DEPRESSION

- u Adjustment disorder
- u Depressive disorder nos
- u Significant disability

PATIENT HEALTH QUESTIONNAIRE: (PHQ)

- u 9-item, self-administered questionnaire
- u Page 17 of Handout (McArthur Toolkit)
- u Validated for diagnostic assessment
- u Validated for follow up of outcomes
- u Clinically significant depression (“CSD”): PHQ = 10 or greater

USE OF THE PHQ

- u Assess high-risk, ‘red flag’ patients
 - Chronic illness
 - Unexplained physical complaints
 - Patients who appear sad or stressed
 - Patients who have lost interest or pleasure in their lives

Scoring The PHQ: Severity

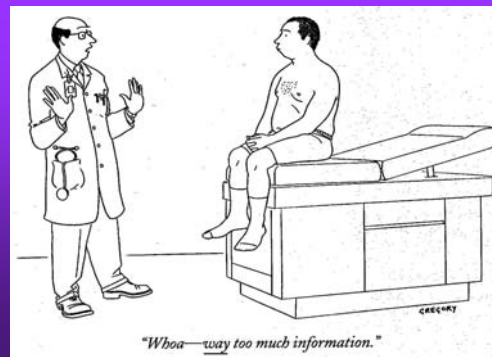
- u Count numerical values of symptoms
 - 0-4 not clinically depressed
 - 5-9 mild depression
 - 10-14 moderate depression
 - >14 severe depression

PHQ-9 Compared to Clinician Assessment of MDD

Result	Sensitivity	Specificity
Using DSM-IV criteria method	73%	98%
Score ≥ 10	88%	88%
Score ≥ 15	68%	95%

BARRIERS TO RECOGNITION

- u Culture and stigma
- u Somatization
- u Comorbidity
- u Fallacy of ‘good reasons’
- u ‘Pandora’s box’
- u Discomfort with emotional issues



DECISION SUPPORT: ACUTE DEPRESSION

- u Treatment selection
 - Consider four options
- u Referral
- u Support/office counseling

REFERRAL

- u Suicidality
- u Psychosis
- u Bipolarity
- u Chemical dependency
- u Personality disorder

OFFICE COUNSELING

- S** *schedule regular activities*
- P** *plan pleasant events*
- E** *exercise*
- A** *assertiveness*
- K** *kind thoughts about self*

Christensen et al: Psychiatry for Primary Care, 1998

FOUR TREATMENTS

- u Watchful waiting
- u Psychotherapy
- u Antidepressant medication
- u Combination therapies

WATCHFUL WAITING (WW)

- u Many depressions remit spontaneously
- u WW is an acceptable “treatment plan”
- u Initial treatment of choice for minor depression
- u Intensity of WW
 - Low: repeat PHQ only (mild depression)
 - Moderate: w/care management (mod. depression)

PSYCHOTHERAPY

- u **Effective**
 - Mild to moderate major depression
 - Adjunct to antidepressants
- u **Possibly effective**
 - Dysthymia (chronic depression)
 - Minor depression
 - For patients in life transitions or with personal conflicts

PHARMACOTHERAPY

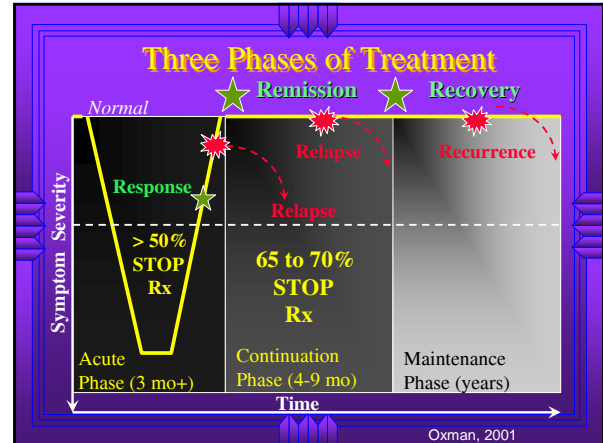
- u Effective
 - Major depression
 - Dysthymia (chronic depression)
- u Possibly effective
 - Minor depression

MEDICATION ALGORITHM

- u Start with SSRI or new agent
- u Increase every 2-4 weeks
- u If no response, switch class
- u If partial response at maximum dose, consider augmentation or consultation

TREATMENT GUIDELINES

- u Titrate agent to achieve therapeutic dose or remission
- u Full effect may take 2-4 weeks
- u Continue for 4-9 months after full remission
- u Use maintenance medication for recurrent depressions



ANTIDEPRESSANTS

- u TRICYCLICS
- u SSRIs
 - o citalopram (Celexa)
 - o fluoxetine (Prozac)
 - o paroxetine (Paxil)
 - o sertraline (Zoloff)
 - o escitalopram (Lexapro)
- u OTHER AGENTS
 - o bupropion (Wellbutrin) - DA/NE
 - o mirtazapine (Remeron) - NE/5HT
 - o nefazodone (Serzone) - SRI/5HT
 - o venlafaxine (Effexor) - SRI/NRI
 - o cymbalta/prestiq - SNRI/NE

TRICYCLIC ANTIDEPRESSANTS

Side Effects:

- u anticholinergic
- u antihistaminergic
- u antiadrenergic
- u quinidine-like effects
- * nortriptyline and desipramine least toxic

ADVANTAGES OF SSRI_s AND OTHER NEW AGENTS

- u Fewer side effects
- u Safety profile
- u Increased patient satisfaction
- u Improved adherence to therapy
- u Cost savings

CHOOSING AMONG SSRI_s AND OTHER NEW AGENTS

Evaluate

- u half-life
- u drug interactions
- u side effects
- u time to onset of effect

HALF-LIFE

- u *Long* (longer than 1 day)
 - o fluoxetine (Prozac)
- u *Short*
 - o other SSRI_s (once a day)
 - o Effexor XR (once a day)
 - o Wellbutrin SR (1-2x/day)
 - o other new agents (2x/day)

DRUG INTERACTIONS

- u Obtain medication history
- u Be aware that all drugs can affect the action and serum levels of other drugs
- u Monitor the clinical effects and serum levels of all medications

DRUG INTERACTIONS (ANTIDEPRESSANT INHIBITION OF CYTOCHROME P450)

- u IID₆
 - Moderate inhibition (fluoxetine, paroxetine)
 - Low inhibition (citalopram, sertraline)
 - Low inhibition (other new agents)
- u IIIA_{3/4}
 - use nefazodone with caution

USE CAUTION WITH:

- u COUMADIN
- u DIGOXIN
- u ANTICONVULSANTS
- u ERTHYROMYCIN
- u KETACONAZOLE
- u ALPRAZOLAM
- u CODEINE
- u DEXTROMETHORAPHAN
- u BETA/CALCIUM CHANNEL BLOCKERS
- u TYPE 1C ANTIARRHYTHMIC AGENTS

SIDE EFFECTS (SSRIs)

- u Agitation/insomnia
- u GI distress – take at qhs
- u Sexual dysfunction – may be due to other meds, pre-existed
- u Weight gain – don't forget other causes

SIDE EFFECTS (OTHER NEW AGENTS)

- u bupropion - agitation
- u mirtazepine - sedation, weight gain
- u nefazodone - sedation
- u venlafaxine - GI distress, elevated BP

MANAGING SIDE EFFECTS

- u Insomnia/agitation
 - Use adjunctive sedating agent – discuss possibility of OSA first
 - Switch to mirtazapine, nefazodone
- u Sexual dysfunction
 - Switch to bupropion, mirtazapine, nefazodone
 - Add bupropion, sildenafil, yohimbine

MANAGING SIDE EFFECTS

- u Sedation
 - Give medication HS
- u GI distress
 - Give medication after meals/ qhs
- u Anticholinergic effects
 - Bulk in diet, lemon drops
- u Postural hypotension
 - Hydration, change position slowly, support hose

COMORBID ANXIETY/PANIC

- u Educate patient
- u Give low dose SSRI, titrate slowly
- u Consider benzodiazepine
- u Use buspirone for anxiety, not panic
- u Consider venlafaxine, nefazodone, or mirtazepine monotherapy

PARTIAL OR NO RESPONSE

- u Check for adherence
- u Re-evaluate diagnosis
- u Adjust dosage
- u Change antidepressant
- u Augment (with another class)
- u Consider dual action agent
- u Add psychotherapy
- u Refer for expert consultation

WHEN DO YOU STOP?

- u Maintain dose 4-9 months after remission
- u Chance of relapse
 - 50% if 1 prior episode
 - 75% if 2 prior episodes
 - 90% if 3 prior episodes
- u Patient may need lifetime therapy
- u Maintenance should be full dose

Summary

- Recognize depression as a co-morbid condition, treat it like any other disease
- Consider your own biases/feelings
- Be willing to listen and respond
- Use the tools that are available – PHQ-9
McArthur tool kit and patient Handouts
- Refer when needed, you are not alone....

Questions/Comments

