DEPRESSION

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Overview[1]

Major Depressive Disorder (MDD) is recognized as a leading cause of disability worldwide. Annual rates of MDD in Canada are estimated to be 4.0%. In addition to psychosocial morbidity, MDD is associated with physical morbidity. Depressive disorders are characterized predominately by depressive features.

Diagnostic Considerations[1,2,3,6]

DSM-IV criteria for a Major Depressive Episode.

Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either depressed mood or markedly diminished interest or pleasure.

(1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.
(2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others). Additional criteria are derived from the following symptoms:
(3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.
(4) Insomnia or hypersomnia nearly every day
(5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
(6) Fatigue or loss of energy nearly every day
(7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
(8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
(9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

DSM-IV (American Psychiatric Association, 2000).

Management considerations[2,4,6,7,11,14,15]

1) The primary care physician should screen the following patient populations: post-partum women, PMHx of depression, anxiety disorders, chronic pain, multiple somatic complaints, past history of abuse, elderly with behavioural changes/dementia, people with substance abuse issues.
2) At each visit consider imminent risk: Screen for suicidal and homicidal ideation. Consider a Form 1 if indicated.
3) Obtain collateral history from family members.
4) Discuss confidentiality limitations with patient.
5) Consider organic causes: Hypothyroidism, diabetes mellitus, anemia, B12/folate deficiency, metabolic conditions, medications (beta blockers, pegalated interferon, steroids), bipolar disorder, anxiety disorders, psychosis, and substance abuse.
6) The physical exam: look for signs for trauma and organic causes of depression (i.e. hypothyroidism and anemia)
7) Investigations: CBC, electrolytes, TSH, Ferritin, folate, Calcium, Magnesium, and B12. Consider tox screen +/- ECG if clinically indicated.
8) Prior to initiating pharmacotherapy offer therapeutic counseling alone or in adjunct with medication. Ensure follow up within 1-3 weeks to reassess mood and treatment efficacy.

Pharmacotherapy[17-20]

Drug Name and Class	Initial Dose (Max. dose)	Most Common Side Effects	Additional Comments
1st Line Agents (one example from each class)			
Citalopram (SSRI-Selective Seratonin Reuptake Inhibitor)	10-20mg qam **(60 mg/day)**	CNS effects, drowsiness, anxiety, tremor, headache, nausea, GI intolerance, dry mouth, sweating, anorgasmia, decreased libido Rare: Seratonin syndrome, SiADH, and Extra Pyramidal Side Effects (Paroxetine, Sertraline)	Never stop abruptly due to discontinuation syndrome (flu like illness). Employ tapering strategy. Citalopram, Escitalopram, and Sertraline are reported to have fewest drug-drug interactions. All SSRI's have equal efficacy and anxiolytic effects.
Venlafaxine (SNRI- Seratonin Norepinephrine Reuptake Inhibitor)	37.5 mg of extended release (XR) capsule can titrate up by 37.5 mg qweekly **(225mg/day)** Maintenance dose 150-225mg	Sleep disturbance, headache, dry mouth, constipation, nausea, sweating	As dose increases-monitor BP and HR (can increase). Serious discontinuation syndrome - electric shock like impulses can occur. SNRI's helpful with co-morbid chronic pain disorders and anxiety disorders.
Mirtazapine (NaSSA -Noradrenergic and Specific Serotonergic Antidepressants)	7.5mg once daily **(45mg/day)**	Dizzy, sedation, dry mouth, constipation, edema, arthralgias, sexual dysfunction.	Increase appetite and weight gain. Rare- Neutropenia
Moclobemide (RIMA- Reversible Monoamine Oxidase Inhibitor)	100 mg bid **(900 mg/day)**	CNS effects, dizziness, tremor, restlessness, headache, anticholinergic effects, dry mouth, can alter BP/HR, nausea, less sexual dysfunction	Never combine MAOI with SSRI due to risk of serotonin syndrome. Tyramine in diet can cause hypertensive crisis.

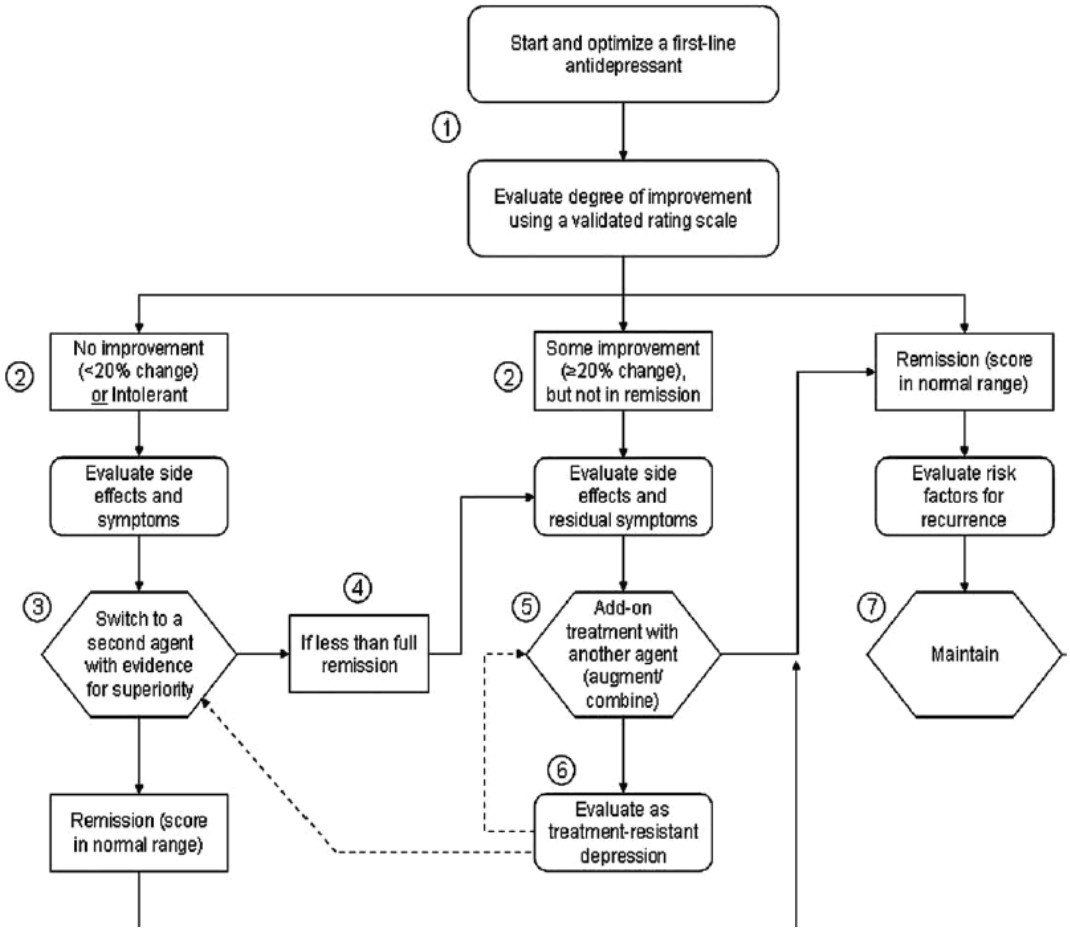
Dr. Michael Evans developed the One-Pager concept to provide clinicians with useful clinical information on primary care topics

Bupropion (Norepinephrine Dopamine Reuptake Inhibitor)	100 to 150 mg sustained release (SR) once daily, can titrate up to bid a week later **(450mg/day)**. SR dose over 150mg must be given in 2 divided doses. Or 150mg extended release (XL) qam (300mg/day)	Agitation, insomnia, tremor, sweating, dry mouth, decreased appetite, GI intolerance Rare: psychosis, can decrease seizure threshold, increasing risk of seizure by 0.4% ~ 400mg/d.	Indicated for concomitant smoking use or ADHD. Can potentiate sexual side effects of SSRIs.
2nd line agents (one example from each class)			
Amitriptyline (Tricyclic Antidepressant)	25 mg qhs **(300 mg/day)**	CNS effects, drowsiness, blurry vision, dry mouth, constipation, urinary retention, GI intolerance, weight gain, fatal in overdose > 2g.	Indicated in neuropathic pain conditions.
Quetiapine (Atypical Antipsychotic)	25mg – 50mg once daily **(800 mg/day)**	Somnolesence, dizzy, drowsy, constipation, dry mouth, hypotension, weight gain, dyslipidemia, dysglycemia	Require annual slit lamp exam for lens changes. Rare: QT prolongation
Trazadone (SARI - Selective Seratonin Reuptake Inhibitor)	50 mg qhs or bid **(600 mg/day)**	Drowsiness, dizzy, hypotension, headache, nausea Rare: priapism 1/6000	Indicated for comorbid sleep disorders.
3rd line agent			
Phenelzine (MAOI - Non Selective and Irreversible Monoamine Oxidase Inhibitor)	15 mg po tid; **(90mg/day)** Indicated for atypical or refractory depression	Orthostatic hypotension, dizziness, headache, tremor, paresthesias, sweating, anticholinergic side effects, weight gain, sexual dysfunction	Never combine MAOI with SSRI due to risk of serotonin syndrome. * Many drug-drug interactions. Avoid tyramine in diet - risk of hypertensive crisis.

* For elderly or medically compromised patients consider starting at half the usual dose

Strategies for Incomplete Responders[8,10,12,13,16]

At each visit patient should fill out a validated rating scale (see below) to assess baseline mood and track treatment progression.
Examples: PHQ-9, Beck Depression Inventory, Zung self rated Depression scale (can be accessed via www.canmat.org)[1,2]
If no response within 1-3 weeks: the antidepressant should be switched, rather than optimized or augmented (switch using a tapering schedule and use caution with crossover when switching to new antidepressant by allowing sufficient wash-out periods)
If there is partial response in 3-4 weeks, optimize the dose
If after optimizing dose there is a poor clinical effect, re-evaluate diagnosis, and consider augmenting pharmacotherapy by adding a second agent.



Pharmacotherapy Counselling Points[1,2,4,7,10-12]

When prescribing an antidepressant to a patient, be sure to include the following eight counselling points:
1) Take your medication everyday. The physical symptoms of depression (appetite, sleep, energy) should improve within 1-3 weeks.
2) The cognitive and emotional symptoms of depression (anhedonia, guilt, hopelessness). These non-physical symptoms take approximately 6-8 weeks to impr
3) Although you may feel better after 6-8 weeks, it is likely that you will need to continue for 6-12 months (first episode) and at least 2 years (third episode of depression).
4) Do not stop antidepressant treatment abruptly.
5) Unfortunately, not all antidepressants work for all people, so make sure to follow up with your doctor in 1-3 weeks.
6) Side effects are common, but usually temporary (see above table for class specific side effects)
7) Tell all health care professionals who look after you that you take this medication.
8) If you experience new or more intense feeling of suicide, go directly to the emergency room of your closest hospital.

Psychotherapy[2-4,7,9,11]

The primary care physician should advocate psychotherapy alone when depression is mild or when a patient has a preference for psychotherapy. For moderate to severe depression combination treatment (psychotherapy + pharmacotherapy) has been shown to be more effective then pharmacotherapy alone. Below is a table of first line psychotherapeutic options.

Psychotherapy	General Principles	Length of Therapy
Cognitive Behavioral Therapy (CBT)	• Identify automatic, maladaptive thoughts and distorted beliefs that lead to depressive moods. • Learn strategies to modify these beliefs and practice adaptive thinking patterns. • Use a systematic approach to reinforce positive coping behaviours.	8 to 12 sessions
Interpersonal Therapy (IPT)	• Identify significant interpersonal/relationship issues that led to, or arose from, depression (unresolved grief, role disputes, role transitions, social isolation). • Focus on 1 or 2 of these issues, using problem-solving, dispute resolution, and social skills training.	12 to 16 sessions
Problem-Solving Therapy (PST)	• Use a structured approach to identify and actively solve problems that contribute to depression.	6 to 8 sessions

Table adapted from www.canmat.org

Patient Resources

Canadian Network of Mood and Anxiety treatment: www.canmat.org
Canadian Mental Health Association: www.cmha.ca
Centre for addiction and Mental Health: www.camh.net
National institute of Mental health: www.minh.nih.gov
Canada Suicide and Crisis Hotlines: http://suicidehotlines.com/canada.html
Centre for Suicide Prevention: www.suicideinfo.ca
Antidepressant skills at work (CBT based booklet): www.comh.ca/antidepressant-skills/work
Free CBT online: www.livinglifetothefull.com; www.moodgym.anu.edu.au

References can be found online at http://www.dfcm.utoronto.ca/programs/postgraduateprograme/One_Pager_Project_References.htm