Canadian Family Medicine Clinical Card

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# Depression

## Diagnosis: DSM-V Criteria

**≥5** of the following symptoms nearly every day for **>2 wks**, causing sig.distress or impairment in social, occupational, or other area(s) of functioning

| | |
|---|---|
| ≥ 1 of | depressed mood, anhedonia |
| other sx | psychomotor slowing, ↓ concentration, feeling worthless/guilty, insomnia/hypersomnia, ↓ energy, recurrent thoughts of death or suicide, weight/appetite change |

## PHQ-9 to aid with Diagnosis and Monitoring

| For each item below, answer "Over the last 2 weeks, how often have you been bothered by <the item>" with 'Not at all' = 0, 'Several days' = 1, 'More than half of days' = 2, and 'Nearly every day' = 3 points. |
|---|
| 1. Little interest or pleasure in doing things |
| 2. Feeling down, depressed, or hopeless |
| 3. Trouble falling or staying asleep, or sleeping too much |
| 4. Feeling tired or having little energy |
| 5. Poor appetite or overeating |
| 6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way |

**Scoring**

5-9: supportive care, help patient develop resilience
10-14: mod. dep.; treatment plan, counseling, follow-up, possib. meds
15-19: mod/severe: active tx with pharmacotherapy and/or psychotx
20-27: severe: immed meds, likely psychotx; consider inpt. care

## Management Plan:

- Investigations: consider TSH and possibly CBC, ferritin, B12, folate
- Lifestyle: daily exercise/activity, balanced diet, sleep hygiene
  - Moderate to intense resistance and aerobic exercise has best effect.
- Psychotherapy cognitive behavioural or interpersonal therapy
- Positive Action/Crisis Management Plan: for suicidal risk and intimate partner violence (IPV); if IPV present, then must assess children's safety, follow up, and notify authorities as required
- Antidepressant Medications: if required, consult table to the right; in general, start low, ↑ over first few wks; usual 5-6 (at most 8) wks to full effect; 40% may respond to 1st med; most get ≥ 1 side-effect

## Secondary Depression

| |
|---|
| Personal/Social: alcohol use, intimate partner violence (IPV), stressful life events, social isolation, cocaine/amphetamine use |
| Medical Conditions: hypothyroidism, adrenal insufficiency, MI, stroke, diabetes, Parkinsons, MS, schizophrenia, chronic pain or disease/conditions |
| Medication Induced: glucocorticoids, interferons, anti-neoplastics, OTC sympathomimetics, older anti-HTN rs, cimetidine, hormonal therapies |

## Context-Based Medication Guidance

| | Context | Guidance |
|---|---|---|
| Prominent Symptoms | not sleeping enough | mirtazapine or duloxetine; avoid bupropion, sertraline |
| | sleeping too much | bupropion, venlafaxine or vortioxetine; avoid mirtazapine or duloxetine |
| | ↑ appetite, ↑ weight | bupropion, venlafaxine, sertraline, fluoxetine |
| | ↓ appetite, ↓ weight | mirtazapine or paroxetine |
| | sexual dysfunction | bupropion or mirtazapine; avoid SSRIs |
| | nausea / GI symptoms | mirtazapine; avoid sertraline, duloxetine, venlafaxine |
| | psychotic features | quetiapine, or co-treatment with antidepressant and antipsychotic |
| | prominent cog. sx. | vortioxetine; avoid paroxetine |
| | suicidal / self-harm | Avoid TCAs |
| Co-Morbid Conditions | depression in bipolar disorder | lithium, quetiapine, lurasidone; avoid TCAs, venlafaxine and antidepressant monotherapy |
| | features of OCD | fluvoxamine |
| | gen. anxiety or panic | venlafaxine, paroxetine, citalopram |
| | pain syndrome | duloxetine, possibly venlafaxinr; avoid paroxetine and fluoxetine (strong 2D6 inhib.) |
| | compromized liver function | desvenlafaxine or venlafaxine; avoid paroxetine or fluoxetine |
| | requires warfarin | venlafaxine or desvenlafaxine; avoid citalopram and escitalopram |
| Stage of Life | adolescent | CBT alone or in combination with fluoxetine |
| | pregnancy | CBT or Interpersonal Psychotherapy or citalopram/escitalopram |
| | mild post-partum depression (PPD) | CBT or Interpersonal Psychotherapy |
| | severe PPD | citalopram, escitalopram, sertraline |
| | peri-menopause | desvenlafaxine or venlafaxine |
| | late-life depression | mirtazapine or duloxetine |

## Related Depressive Syndromes & Specific Scenarios

- Postpartum Depression: must look for it; requires a comprehensive approach
- Anxiety: often comorbid with depression; may be difficult to sort out
- Dysthymia: less severe, longer duration, more treatment-resistant
- Bipolar: prior periods of ↑ mood, ↑ energy, ↓ need/desire to sleep, grandiosity
- Adjustment Disorder: linked to event, may evolve to major depressive episode

**Key References**: Depression: Management of depression in primary and secondary care – NICE guidance <guidance.nice.org.uk> 2009 *Journal of Psychopharmacology*. 23(4):346-388. 2009. *DSM V*, 5th Edition, American Psychiatric Association 2013; *AHRQ: Choosing Antidepressants for Adults: Clinician's Guide*, August 2007; Canadian Psychiatric Association Clinical Practice Guidelines for the Treatment of Depressive Disorders, *Can J Psych* 2001:46 Suppl 1. Kroenke K, Spitzer RL, Williams JB. The PHQ-9: Validity of a brief depression severity measure. J Gen Intern Med. 2001;16(9):606-613.