Depression : Clinical Practice Guidelines

Screening

WHOM TO SCREEN

- Adolescents 12-18 y
- Adults older that 18 years
- Pregnant women at least once during perinatal period
- Postpartum Women
- Geriatric population
- Patients with Chronic Medical Conditions

WHEN TO SCREEN

- New patient visits
- Annual preventive visits
- Any visit if not done in the previous 90 days

SCREESING TOOLS Box1

PHQ 2, If score is >3, it is a + screen

PHQ 9, A score ≥ 10 points requires further clinical evaluation

Diagnosis

Diagnosis of Major Depression
Requires ≥5 of the following Symptoms for >2 weeks: SIG ME CAPS

S: Sleep changes
I: Loss of interest (anhedonia)
G: Feelings of guilt
M: Depressed mood
E: Poor Energy
C: Poor concentration
A: Appetite or weight change
P: Psychomotor changes
S: Suicidality, Thoughts of death
NOTE: M and Or **I** must be present.
Don't include symptoms that are clearly due to GMC.
Symptoms do not meet criteria for Mixed episode

BOX1: SCREENING TOOLS

- PHQ2 & PHQ9
- Edinburgh Postnatal Depression scale : postpartum females
- The Geriatric Depression Scale 5, 15 or 30 item questionnaire: elderly
- The Cornell scale: patients with dementia

Management of Depression

MILD Depression

- PHQ-9 Score 5-9 points
- Psychotherapy alone and/or behavioural activation

MODERATE Depression

- PHQ-9 score 10-19 points
- Psychotherapy alone, or pharmacotherapy alone or combination therapy

SEVERE Depression

- PHQ-9 score 20-27
- Pharmacotherapy or combination therapy or ECT

ACUTE PHASE (6-12 WEEKS)
Follow up should be 1 wk. after diagnosis and initiation of therapy and then every 2-4 weeks until there is remission or response

ASSESS INITIAL RESPONSE, USE PHQ-9

At 4-6 weeks if on Pharmacotherapy (alone or in combination) or 6-12 weeks if psychotherapy alone

RESPONSE

YES

Adjust Medications until **remission** is achieved

Continue medication **4-9 months** once remission is achieved

Assess response every 1-2 months using PHQ-9

NO

STEPPED CARE APPROACH

- Assess compliance/ adherence
- Adjust medication dose
- Increase number of therapy sessions
- Augment or change therapy type
- Referral to Behavioural health

Asses in 4-6 wks. using PHQ9 score

CONTINUTION PHASE
- (4-9 MONTHS)
- Follow up every 1-3 months

HIGH RISK FOR RECURRENCE

NO

- **Discontinue Treatment**
- **Taper antidepressants over several weeks**

YES

- **Continue Pharmacotherapy**
- **Follow should be every 3-12 months if stable**

MAINTENANCE PHASE
1 year to Lifetime

RISK FACTORS FOR RECURRENCE

3 or more major depressive episodes or 2 prior episodes and any of the following factors:

- Chronic major depressive disorder
- Ongoing Psychological Presence or residual symptoms
- Early age at onset
- Family history of Mood disorders

Pharmacotherapy

•SSRIs are the most widely prescribed class of antidepressants, Choice depend on :adverse effect profile/ Safety, Patient preference, History of prior response to specific medication, Response of first degree relative to specific medication, Cost, Specific depressive symptoms, Co-morbid illnesses, Concurrent medications and potential drug-drug interaction

SWITCHING BETWEEN DRUGS AND CLASSESS

•Switching between SSRI : substitute new SSRI at equivalent dose of former SSRI

• Switching from SSRI to SNRI :Cross taper or switch to equivalent dose: Venlafaxine 75mg, Duloxetine 60mg

(Dose of current antidepressant in reduced over several weeks, while dose of new antidepressant is increased)

CONSIDER REFERRAL TO BEHAVIOURAL HEALTH AT ANYTIME IF:

•Depression that endangers life of the patient or others, Suicidality and/or Homicidally
•Depression that occurs in the context of Bipolar disorder, Schizoaffective disorder or Schizophrenia
•Psychiatric co-morbidity (i.e. substance abuse, OCD, anxiety, eating disorders)
•No improvement with medications despite multiple dose adjustments and trials of different medication classes
•Significant or prolonged inability to work and care for self and/ or family
•Diagnostic uncertainty
•Severe Psychotic and Catatonic depression

SSRI(selective serotonin reuptake inhibitors (Citalopram, Escitalopram, Fluoxetine, paroxetine, sertraline

Indications : Depression , GAD, Obsessive-compulsive disorder
Contraindications: poorly controlled epilepsy, mania. Escitalopram (prolonged QT-interval)
Cautions: cardiac disease, DM, history of GI bleeding, history of mania, susceptibility to angle –closure glucose. Risk of significant hyponatremia in elderly **Side effects: COMMON:** anxiety, appetite abnormal, arrhythmias, arthralgia, impaired concentration, confusion, constipation/diarrhea, dry mouth, drowsiness, fever, GI discomfort, headache, hyperhidrosis, memory loss, menstrual cycle irregularities, sexual dysfunction, sleep disorders, tinnitus, tremor, weight change ,yawning, Sinusitis (Escitalopram). Fluoxetine(postmenopausal bleeding) Sertraline(increased risk of infection, neuromuscular dysfunction) **UNCOMMON& RARE:** alopecia, mania, movement disorder, postural hypotension, suicidal tendency, syncope, photosensitivity, seizure, galactohrea, hepatitis, serotonin syndrome, SIADH, Fluoxetine (dyspnea, muscle twitching, dysphagia, vasculitis, bone fracture). Sertraline(conversion disorder, diabetes, hypothyroidism, drug dependence, genital discharge, hiccups, myocardial infarction, peripheral ischemia)
Pregnancy & Breast feeding: Use with caution . **Liver impairment:** reduce dose. **Renal impairment :** caution if eGFR≤30
Treatment cessation : withdrawal effects may occur within 5 days of stopping treatment, usually mild and self limiting. The risk is increased if stopped suddenly after regular administration for 8 weeks. Advice to reduce dose gradually over 4-6 weeks or longer. **Withdrawal effect:** headache , GI disturbances, dizziness, sleep disorders , fatigue, flu like symptoms, palpitations
Dose: Escitalopram : 10mg daily increase up to 20 mg , half dose in elderly . **Fluoxetine**: 20 mg daily increase every 4 weeks up to 60 mg daily. . **Paroxetine:** 20mg in the morning , no evidence of greater efficacy at higher doses
Sertraline: 50mg daily, increase weekly up to maximum of 200 mg daily

SNRI(serotonin- norepinephrine reuptake inhibitors (Venlafaxine, Duloxetine)

Indications : depression , GAD, menopausal symptoms mainly hot flushes in women with breast cancer, Duloxetine (diabetic neuropathy , stress incontinence in females). **Cautions:** similar to SSRI **Contraindications: Venlafaxine** (uncontrolled hypertension) **Side effects:** Similar to SSRI. **Pregnancy & Breast feeding:** use with caution **Liver impairment:** avoid duloxetine , ½ dose venlafaxine **Renal impairment :** avoid duloxetine if eGFR≤30, use ½ dose venlafaxine **Treatment cessation :** withdrawal effects may occur. Advice to reduce dose gradually over 1-2 weeks or longer **Dose: Venlafaxine**: 37.5mg daily increase after a week to 75 mg, if needed increase every 2 weeks up to 225mg daily **Duloxetine**: 60 mg daily. For diabetic neuropathy stop in 2 months if no response. 20-40mg twice daily for stress incontinence , review response in 4 weeks

Trazodone (Serotonin modulators)

Indications : depression , anxiety **Cautions:** similar to SSRI, risk of suicide, prostate hypertrophy. Contraindications: mania, immediate recovery period after MI. **Side effects:** aggression, agranulocytosis, anemia, aphasia, abnormal apatite, arrhythmias, arthralgia, chest pain, confusion, delusions, dyspnea, dry mouth , fever, headache, hyponatremia, flue like symptoms, jaundice , hypertension, hyper salivation, memory loss, edema, paralytic ileus, tremor, weight loss **Pregnancy :** avoid during 1st trimester. **. Breast feeding:** can be used. **Liver impairment:** caution **Renal impairment use with caution. Treatment cessation :** withdrawal effects may occur. Advice to reduce dose gradually over 4weeks . **Dose**: 150 mg daily in divided doses after food or 150 mg once at bedtime. Can be increased up to 300mg daily. Start with 100 mg in elderly.

Mirtazapine (Atypical agents)

Indications : depression **Cautions:** similar to SSRI **Side effects:** anxiety, weight gain , arthralgia, back pain, confusion, constipation, diarrhea , dry mouth , fatigue, sleep disorders **Pregnancy :** avoid **Breast feeding:** Avoid **Liver impairment:** avoid **Renal impairment :** reduce dose **Treatment cessation :** withdrawal effects may occur. Advice to reduce dose gradually over several weeks. **Dose:** 15-30mg daily for 2-4 weeks at bedtime up to 45 mg

Tricyclic antidepressants (amitriyline, clomipramine, imipramine, Dosulepin). Monoamine oxidase inhibitors (phenelzine, Selegiline): are typically not used as initial treatment as concerns about safety (particularly in overdose) & adverse effects.

References:
American Academy of Family Physicians
American Psychiatry Association
www.uptodate.com