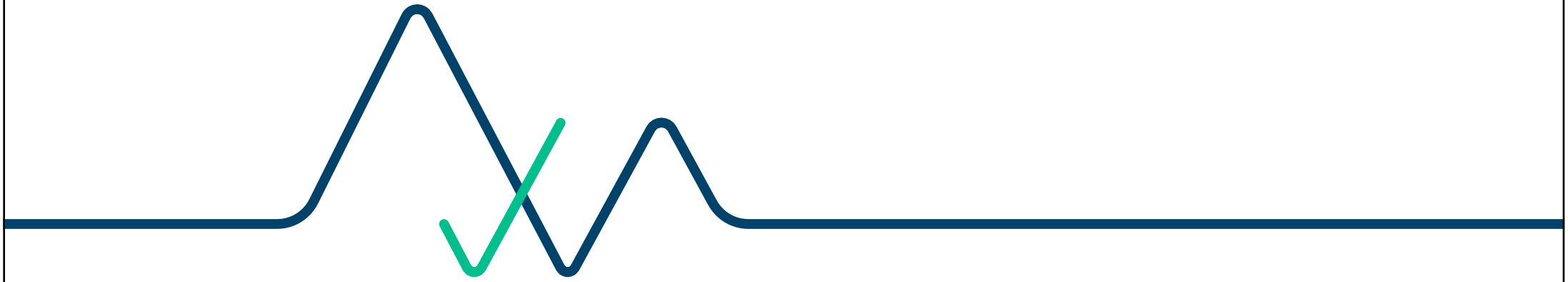
Mental Health in Primary Care

28/12/2022



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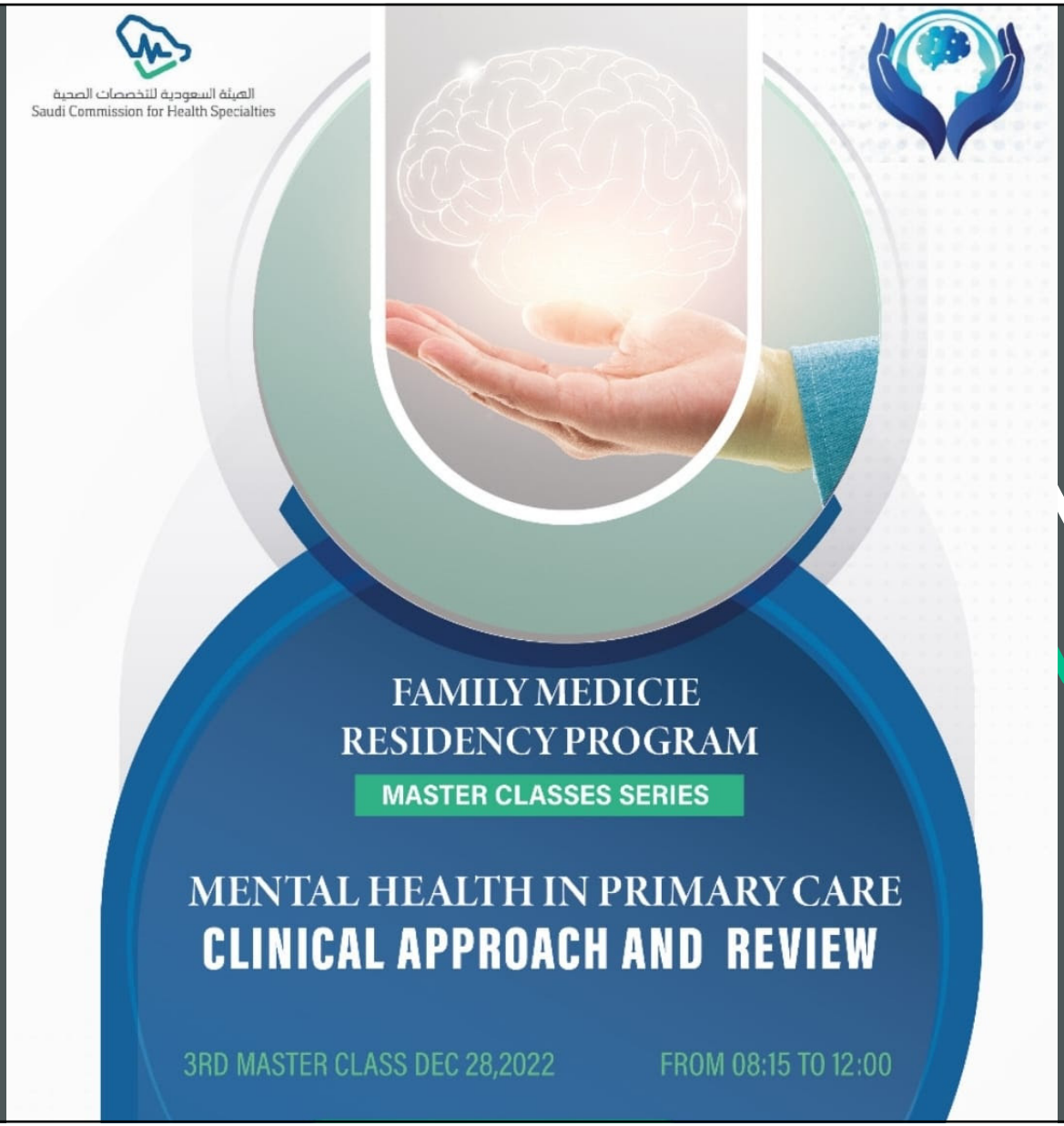
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Saudi Commission for Health Specialties
FAMILY MEDICIE
RESIDENCY PROGRAM
MASTER CLASSES SERIES
MENTAL HEALTH IN PRIMARY CARE
CLINICAL APPROACH AND REVIEW
3RD MASTER CLASS DEC 28,2022
FROM 08:15 TO 12:00

الهيئة السعودية للتخصصات الصحية
Saudi Commission for Health Specialties

MENTAL HEALTH IN PRIMARY CARE
CLINICAL APPROACH AND REVIEW

FROM 08:15 TO 12:00 3RD MASTER CLASS DEC 28,2022

FAMILY MEDICIE RESIDENCY PROGRAM

MASTER CLASSES SERIES

SPEAKERS

DR. SABAHAT KHURRAM, CCFP, FCFP,
Family Medicine Consultant

DR.MOHAMMED MAJDOU ALGHAMDI,
Consultant Family Physician

DR. WAAD ALBUSURUR
Family medicine consultant
Saudi board of family medicine.

DR.TURKI SHAREKH ALSHAREKH
Family Medicine Senior Registrar / Palliative Care Fellow.

DR.SAMIA NAYER ALMUTAIRI, R3,

DR. AFRAH SALAMAH ALHAWITI. R2

DR.HAMS AHMED ALAMRI R1,

DR. JAWAHER KAMAL ALKHAYYAL R1.

DR. NAWAL HUSSAIN BIN JALALAH, R1.

SCIENTIFIC COMMITTEE MEMBERS FOR THE FAMILY MEDICINE RESIDENCY PROGRAM MASTER CLASSES SERIES

DR MUATH ALAMMAR ,MBBS SBFM ,ABFM ,JBFM
Assistant Professor & Consultant Family medicine, Shaqra University

DR. MARIAM BAGIS, MBBS, CCFP, COE, CRA
Consultant Family Physician, and subspecialty in Care of Elderly/geriatric care. KAAUH, Princess Nourah University, Riyadh.

DR. ALJAWHARA ALSAADOUN, MBBS
R2 Family Medicine Resident at Imam Abdulrahman bin Faisal University

DR HADI SAEED ALENAZY
Member of the Family Medicine Scientific Council, SCFHS
Head of Scientific Committee, SSFCM
Advisor, HSTP, CHI, SHC

FOR REGISTRATION

Virtual

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CLINICAL APPROACH AND REVIEW

FROM 08:15 TO 12:00 3RD MASTER CLASS DEC 28,2022

FAMILY MEDICIE RESIDENCY PROGRAM

MASTER CLASSES SERIES

OBJECTIVES

1- The introduction to the Psychiatric evaluation and the tools to conduct a structured Psychiatric interview

2-To gather and present the Mental status exam

3- screening for depression

4- depression presentation and diagnosis

5- antidepressants

6-Diagnostic criteria of general anxiety disorder

8-manegment of anxiety disorder

9- Learn clinical approach to patients with Bipolar Disorder.

10- Recognize importance of screening for Substance use disorder and it's diagnosis

PRE READINGS :
www.SaudiFamilyMedicine.com

1)Go to the Book:
Section 5 (Psychiatry) and read Chapters 2, 3,4 and 5

2)Go to the Protocols section and Familiarize your self with the Depression Protcol.

3)Go the MCQ section and solve the Mental Health MCQ

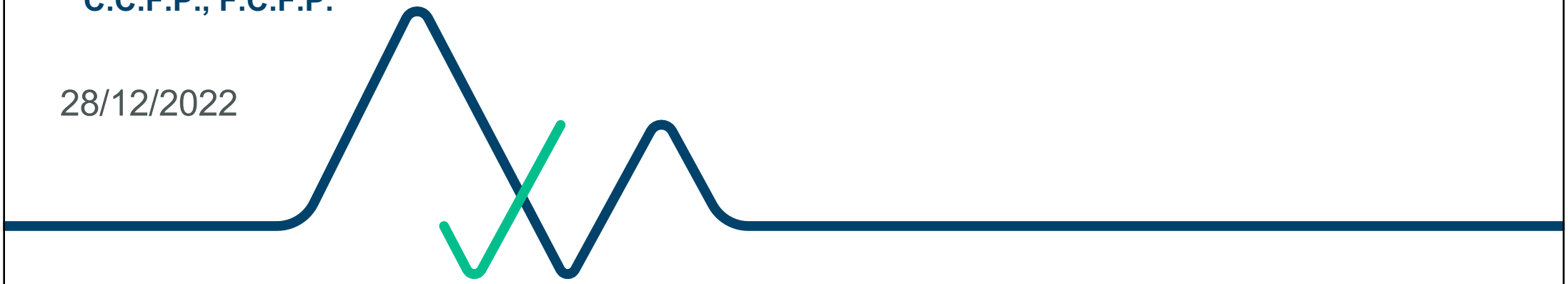
FOR REGISTRATION

Virtual

Psychiatry Master Class
Psychiatry History taking and Mental status exam

Dr. Sabahat Khurram
Family Medicine Consultant, JHAH
C.C.F.P., F.C.F.P.

28/12/2022



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Objectives

-The psychiatric interview is the core of proper psychiatric evaluation

-Aim: Discuss the tools to conduct a structured Psychiatric interview

-How to gather the Mental status exam from the interview and present it

-All information provided will be added to the FM book for reference

The Psychiatric Interview

-It is the **core** of psychiatric evaluation

-Important role in clinical assessment and therapy

-To understand

- the patient's behaviors
- emotions
- experiences
- psychological, social, and religious influences
- and motivations through verbal and nonverbal communication with the patient

The Psychiatric Interview

-The goal of a psychiatric assessment is to describe the patient's complaints, appearance and existence in an actionable psychopathological format, namely, one that results in diagnostic classification and other clinical decisions

Stages of the Psychiatric interview

- building an alliance with the patient
- psychiatric history
- diagnostic evaluation, and treatment plan formulation

The patient-provider relationship

Establishing a therapeutic relationship!

-An intact patient physician relationship increases the patient's confidence and willingness to disclose the personal or sensitive information necessary for diagnosis and facilitates patient compliance

-This will result in

- collecting, organizing and synthesizing data
- becoming the basis of a formulation, differential diagnosis and treatment plan

Some salient points

-More than the verbal communication, the psychiatric interview depends on:

- The physician being observant and being a good listener
- Non verbal communication can provide insight necessary for the patient's clinical assessment and diagnosis

-May necessitate multiple interview sessions

-May need to obtain information from addition sources such as family or friends

-Open ended Approach

Some salient points contd.

-Facilitate a mutual and open communication to help patient create a cohesive narrative of his or her past and present situation
-All interviews need to modify techniques to account for 4 elements of context:

- the setting
- the situation
- the subject
- the significance

Data Collection

Includes

- behavioural observation
- medical and psychiatric history
- a mental status exam

Concluding the interview

-Summarizing the findings and the formulation
-Seeking agreement with the patient
-Negotiating appropriate management and follow-up arrangements

Common errors

-Premature closure
-False assumptions about symptoms
-False reassurance about a patient's condition
-Defensiveness around psychiatric diagnosis and treatment
-Theoretical bias
-Inadequate explanations about psychiatric disorders and their treatments
-Undermining the severity of symptoms

The structured interview approach

Highly structured interviews have become the GOLD standard of Diagnostic interviewing in psychiatry

A structured approach is combining the psychiatric interview with the diagnostic criteria in attempt to derive a thorough psychiatric history

Approach to a psychiatric interview

-Assess the presenting complaint

-Screen for Depression, **M and I**

-If the answer is **yes**, complete the diagnostic criteria for Depression

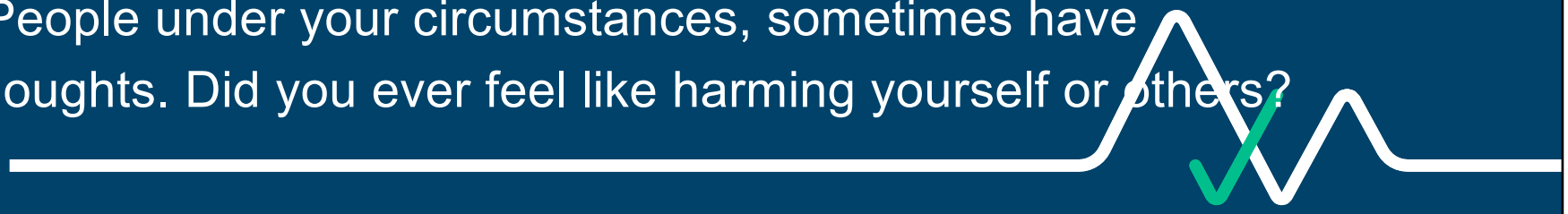
-If the answer is no, move on to screen for Anxiety and so forth for other psychiatric issues

Approach to a psychiatric interview

For all Psychiatric interviews incorporate the questions below and you will cover all!!

MOAPS

- **Mania:** Did you ever feel too high in the past, when you were working a lot without rest? Did you ever spend sleepless nights in the past? When was that? Did you seek any treatment? How long did that episode last?
- **Organic:** Thyroid, Anemia, Diabetes
- **Anxiety:** Are you a kind of person who worries a lot?
- **Psychoses:** Sometimes people who are stressed can hear or see things that others don’t. Did you ever experience it?
- **Suicide:** People under your circumstances, sometimes have negative thoughts. Did you ever feel like harming yourself or others?



Safety assessment

Suicide risk assessment

Homicide assessment

SAFETY CONTRACT!!!

-Past History
-Family history
-Social History/Support
-Functional status
-Allergies
-Females: menstrual history

SAD Hx

Smoking: How much do you smoke? Since when?
Alcohol: How much do you drink? How often? Amount?
Drugs: Are you on any medications? How about in the past? By any chance, did you ever try any recreational drugs? When was the last time?
Is there anything else that you would like to tell me about?

The Mental status exam

Mental status exam

-MSE is intended to explore all areas of mental functioning

-Denotes evidence of signs and symptoms of mental illness

-The practitioner will begin the MSE upon initiation of the interview via

- observation
- direct questioning
- the cognitive screening

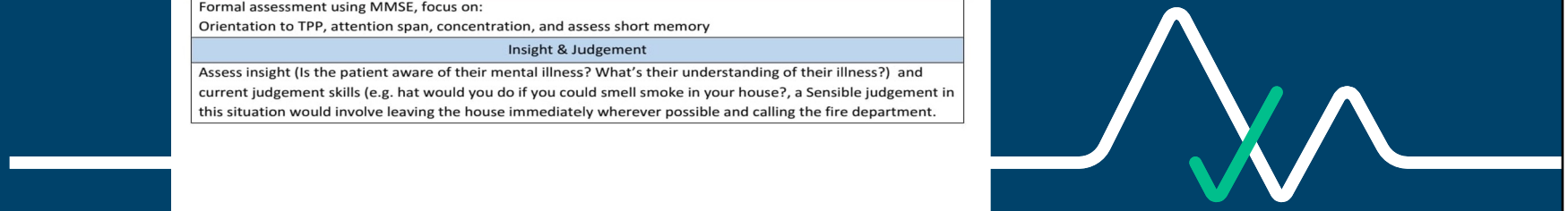
The components of screening

- appearance
- behaviour
- motor
- speech
- mood
- affect
- cognition
- abstract reasoning
- thought process

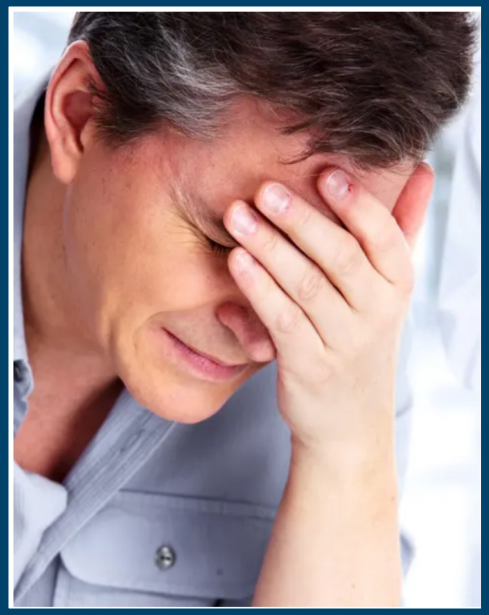
If suicidal ideations are present, assess:

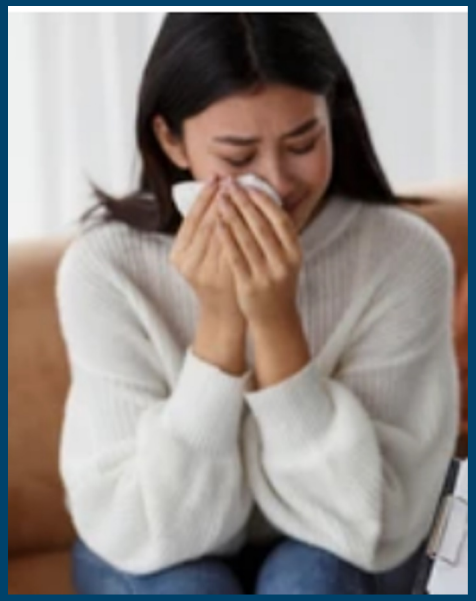
-intention
-methods
-motivation
-reason for living
-patient’s therapeutic alliance

Mental State Examination (MSE) Interactive OSCE Checklist
Opening the consultation
Wash hands, Introduce yourself (including name & role), Confirm patients name & DOB, Explain to the patient that you'd like to have a chat with him/her to see how they're currently feeling, Gain consent.
Appearance
Distinguishing features: scars (e.g. self-harm), tattoos, signs of intravenous drug use Weight: underweight or overweight. Personal hygiene: patient's current ability to care for themselves. Clothing: appropriateness for the weather/circumstances.
Behavior
Note how the patient engages and if there seems to be rapport Observe patient's level of eye contact, facial expression and body language Identify any psychomotor retardation of restlessness. Note abnormal movement or posture
Speech
Note the quantity, tone, volume rate, fluency and rhythm of the speech
Mood & affect
Explore patient's current mood by asking appropriate direct question Observe the patients affect *Note mood & affect congruency
Thoughts
Note the speed, flow, coherence of the patient's thoughts Explore any abnormal thought content Ask about thought possession (insertion/withdrawal/broadcasting) to screen for abnormalities
Perception
Explore abnormalities of perception including: Hallucinations: auditory, tactile, visual, gustatory, olfactory Illusions: misinterpretation of external stimulus (e.g. mistaking a shadow for a person) Depersonalization: patient feels they're not their true self (someone different/strange) Derealisation: a sense that the world around them is not a true reality
Cognition
Formal assessment using MMSE, focus on: Orientation to TPP, attention span, concentration, and assess short memory
Insight & Judgement
Assess insight (Is the patient aware of their mental illness? What's their understanding of their illness?) and current judgement skills (e.g. hat would you do if you could smell smoke in your house?, a Sensible judgement in this situation would involve leaving the house immediately wherever possible and calling the fire department.



The Sad patient





The flat affect

The angry patient

The Bipolar patient

The dishevelled appearance

References

The Psychiatric Interview For Differential Diagnosis [PDF] [7sjtmf6csh50]. (n.d.). Retrieved December 20, 2022, from https://vdoc.pub/documents/the-psychiatric-interview-for-differential-diagnosis-7sjtmf6csh50

The Psychiatric Interview and Diagnosis

"The Psychiatric Interview And Diagnosis". 2021, p. ., https://connect.springerpub.com/content/book/978-0-8261-6184-0/part/part01/section/sec01/chapter/ch01.

The Psychiatric Interview and Diagnosis

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"Discussion: The Psychiatric Evaluation And Evidence-Based Rating Scales - Onlinenursingpapers". *Onlinenursingpapers*, 2021, https://onlinenursingpapers.com/discussion-the-psychiatric-evaluation-and-evidence-based-rating-scales/.

ROLE PLAY

DR. NAWAL HUSSAIN BIN JALALAH, R1.
DR. AFRAH SALAMAH ALHAWITI. R2
DR. SABAHAT KHURRAM, CCFP, FCFP,
Family Medicine Consultant

Scenario

A 32-year-old female, Nourah was seen in the primary care clinic 2 weeks ago for assessment of Fatigue. A battery of laboratory tests was requested. Today she is coming for a follow-up. All laboratory tests are within normal. Please assess Nourah further for her Fatigue.

Psychiatric History taking

1- **Consent** & evaluation of the **presenting complaint**

3- Screening (**PHQ2**): Mood and Interest

4- If positive PHQ2 □ **PHQ9** (Sleep, Interest, Guilt Energy, Concentration, Appetite, Psychomotor activity, Suicidal/Homicidal Ideation)/DSM 5 criteria

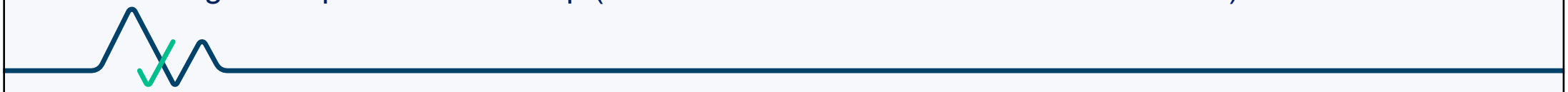
5- **Safety contract** between physician and patient

6- R/O **MOAPS** (Mania, Organic disease, Anxiety, Psychosis, Suicidality)

7- **SAD Hx** (Smoking, Alcohol, recreational drug use)

8-Past medical Hx, Family Hx, Social Hx, & support system

9-Discussing the working diagnosis and mutually agreeing on it to move forward towards a management plan and follow up (which will be discussed in the next session)

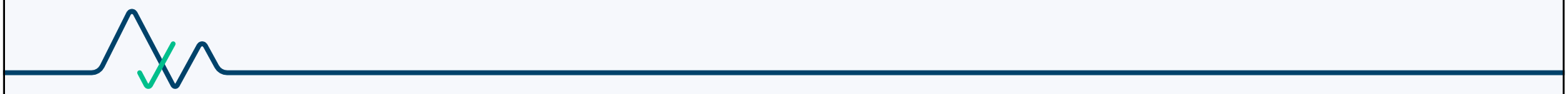


Mental State Examination Summary Example:

My patient apparently **looked sad** and had **reduced eye contact** through out the interview and she was **slowly moving**. She had **delayed answers** to my questions and her **speech** was slow and **monotonous**. No abnormal movements noted. My patient reported her **mood** to be **sad** and it was **congruent with** her **affect**. **Safety** of the patient was assessed and she had no suicidal or homicidal ideation. Her **thought** flow, coherence, content and possession all were within normal, with no reported **illusions**, **delusions**, **hallucinations**, **depersonalization** or **derealization**. In regards to **cognition**, my patient was conscious, alert and fully oriented to time, place and person. Finally, my patient had good **insight** and **judgement** to her current health problem which is depression

Summary Statement

To conclude and summarize this wonderful role play, I would like to reiterate a few points here, including **Consent** being the key!! Having a very **open ended and empathetic approach.** Moving forward in a flow, keeping in mind our **structured approach and yet being flexible.** Covering the **FIFE**, Feelings, Ideas, function and expectation, scattered between the interview. Very important would be **summarizing** mid way through and in the end to make sure patient and you are on the same page. **Assess safety of the patient and making a Safety Contract!** In the end concluding the interview with your **working diagnosis,** fully involving the patient and coming up with a **management and follow up plan.**



THANK YOU.

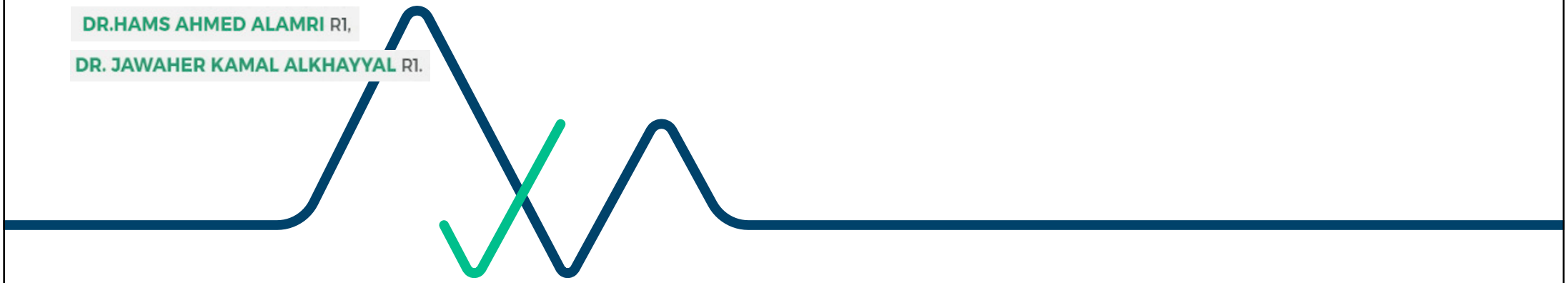
Depression, Mood Disorders.

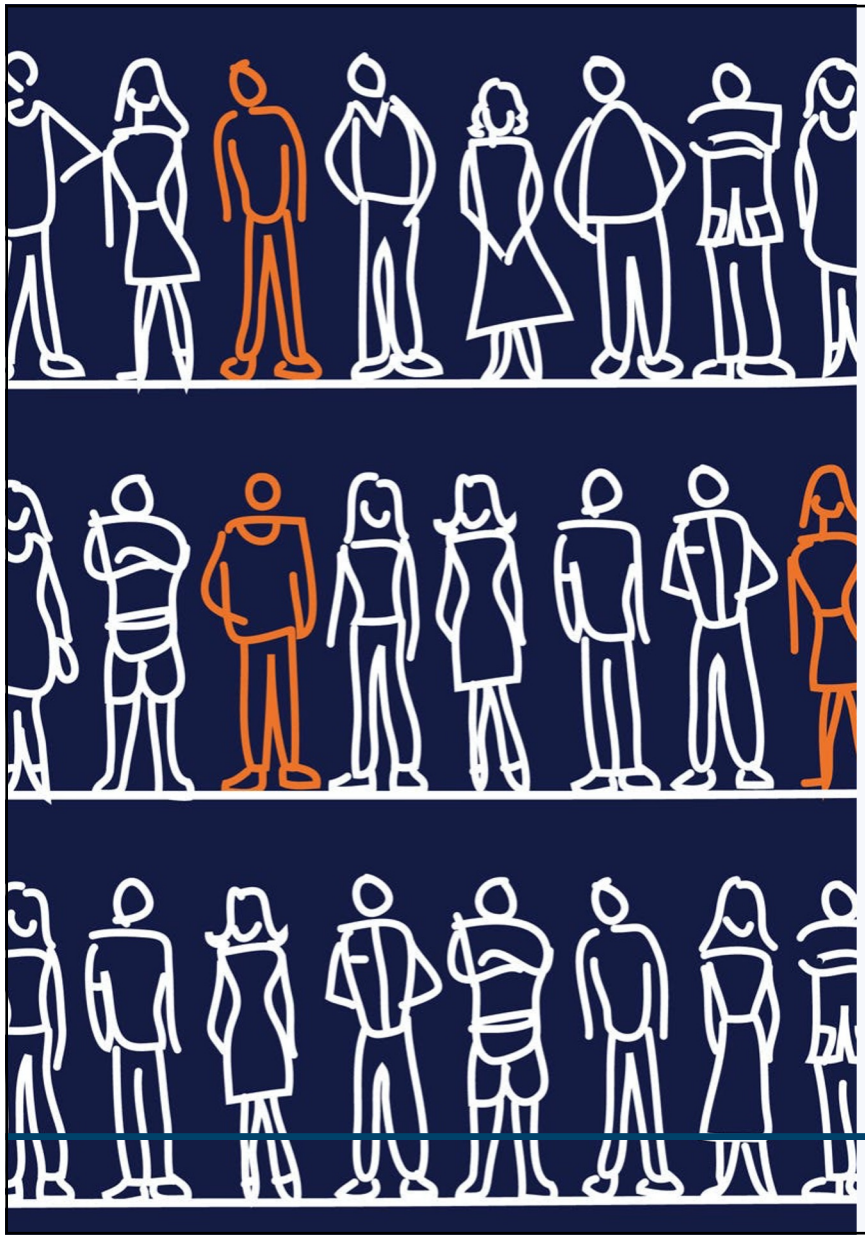
28/12/2022

DR.MOHAMMED MAJDOU ALGHAMDI,
Consultant Family Physician

DR.HAMS AHMED ALAMRI R1,

DR. JAWAHER KAMAL ALKHAYYAL R1.





Depression Objectives:

1. Definitions and epidemiology.
2. Screening.
3. Diagnostic criteria.
4. Risk factors.
5. Secondary causes.
6. Medication.
7. Role of psychotherapy.
8. Ruling out other depressive disorders
9. Indications for referrals.
10. Red flags.

Definitions

Depression:

Unipolar Major Depression is diagnosed in patient who present with at least one major depressive episodes and have no prior history of mania or hypomania

Epidemiology

Prevalence of Depression

Globally	Saudi Arabia
8 - 12%	17- 46%

- Two time greater in FEMALE
- Less common in older than younger adults
- Prevalence is higher (25%) in chronic medical illness
- Major risk factor for suicide in older men
- Suicide rates increase with age

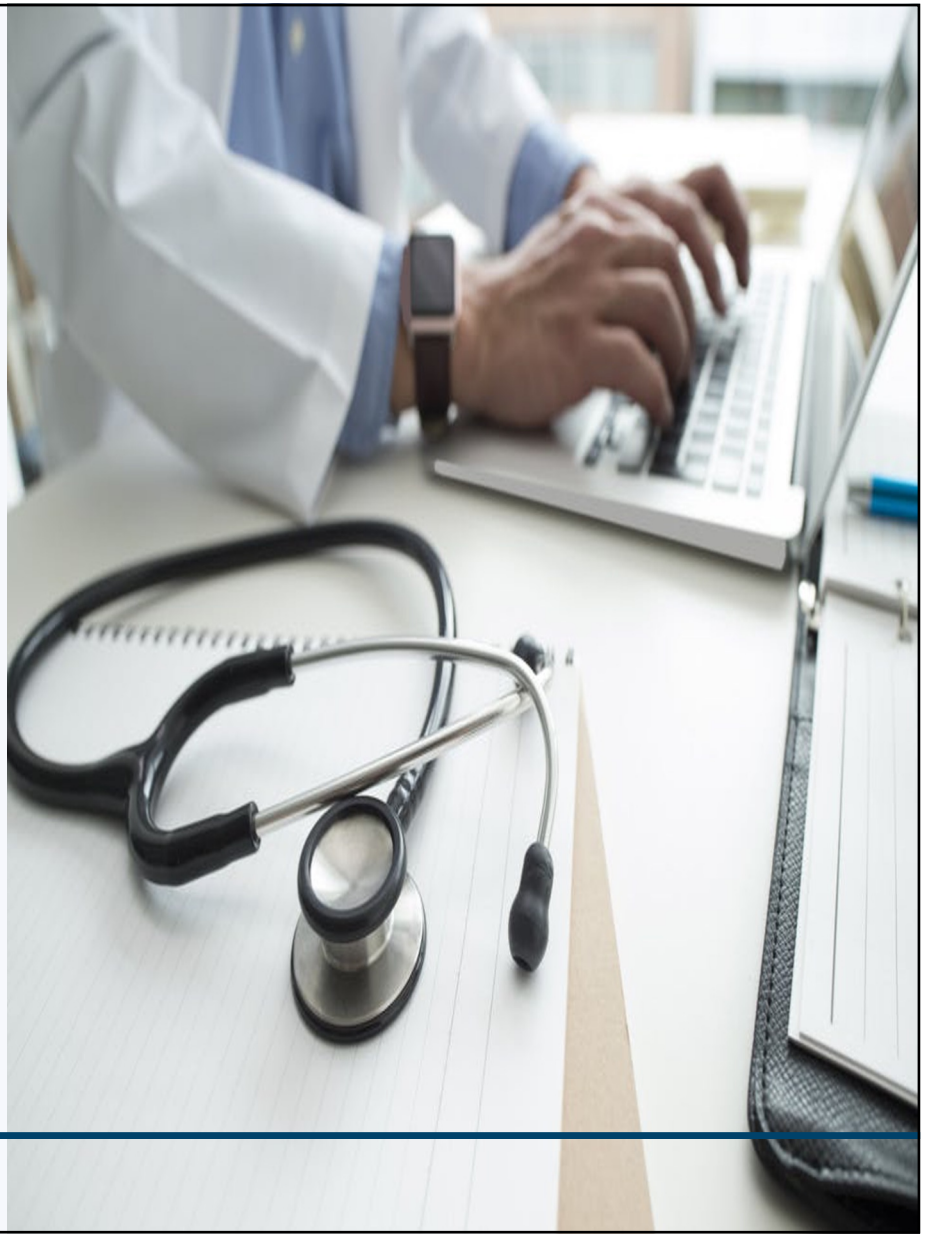
2/3 of patients with Major Depression Disorders are not aware about their depression and explain there suffer as a weakness or other disorders.

Case

1

Scenario..

- Ali is a 40 years old man known case of HTN on Atenolol came to the clinic for follow up of his HTN.
- His BP is controlled and he is adherent to HTN treatment plan with no complains in regard to HTN or the medications he is taking.
- **What else we could do to him in this visit?**



Screening for Depression

When to screen ?

- New patient visits
- Annual preventive visits
- At any visit, if not done in the previous 90 days.

What screening tools for depression?

- PHQ-2
- PHQ-9
- PHQ-A
- Hamilton
- Geriatric Depression Scale (GDS)
- Edinburgh Postnatal Depression Scale (EPDS)

استبيان حول صحة المريض-9
(PHQ-9)

كم عانيت من المشاكل التالية خلال الأسبوعين الماضيين؟ (ضع علامة "✓" للإشارة لجوابك)	أبدا	بعض الأيام	أكثر من نصف الأيام	كل يوم تقريبا
1- قلة الاهتمام أو الاستمتاع بممارسة الأشياء.	0	1	2	3
2- الشعور بالحزن أو ضيق الصدر أو اليأس.	0	1	2	3
3- الصعوبة في الركون إلى النوم أو النوم بانتظام أو النوم أكثر من العادة.	0	1	2	3
4- الشعور بالتعب أو بقلة الحيوية.	0	1	2	3
5- قلة الشهية أو كثرة الأكل.	0	1	2	3
6- الشعور بعدم الرضا عن النفس أو بالفشل أو الإحباط تجاه ذويك.	0	1	2	3
7- الصعوبة في التركيز على الأشياء، مثل قراءة الصحف أو مشاهدة التليفزيون.	0	1	2	3
8- بطء في الحركة أو الكلام بدرجة ملحوظة من الآخرين؟ أو على العكس من ذلك كثرة التململ والتحرك إلى درجة فوق العادة.	0	1	2	3
9- الشعور بتفضيل الموت عن الحياة أو بإيذاء النفس بطريقة ما.	0	1	2	3

____ + ____ + ____ + __0__ = Total Score: _____ (FOR OFFICE CODING)

إذا حددت أي مشاكل، إلى أي مدى منعتك هذه المشاكل من القيام بعملك أو الاعتناء بشؤونك المنزلية أو التعامل مع الناس؟

غير صعب بالمرة	صعب نوعا ما	صعب جدا	صعب للغاية
☐	☐	☐	☐

Depression Screening

PHQ-2 (The Patient Health Questionnaire-2)

First 2 items of PHQ-9. Ultra-brief depression screener. The PHQ-2 inquires about the frequency of depressed mood and anhedonia over the past **2 weeks**

Scoring each as 0 ("not at all") to 3 ("nearly every day"). PHQ-2 score of 3 as the optimal cutpoint for screening purposes.

Screening questions

1. **Little interest or pleasure in doing things?**
2. **Feeling down, depressed, or hopeless?**

English version

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

How to find the Screener

Table 1: PHQ-2 screening for depression

Over the past 2 weeks how often have you—	Not at all	Several days	More than half the days	Nearly every day
Had little interest or pleasure in doing things?	0	1	2	3
Felt down, depressed, or hopeless?	0	1	2	3

A score of 3 or higher is considered a positive result.

Table 2: PHQ-9 screening for depression

Over the past 2 weeks how often have you—	Not at all	Several days	More than half the days	Nearly every day
Had little interest or pleasure in doing things?	0	1	2	3
Felt down, depressed, or hopeless?	0	1	2	3
Had trouble falling asleep, staying asleep, or sleeping too much?	0	1	2	3
Feeling tired or having little energy?	0	1	2	3
Poor appetite or over feeding?	0	1	2	3
Feeling bad about yourself, or that you're a failure, or that you let people down?	0	1	2	3
Trouble concentrating on things?	0	1	2	3
Other people noticed you are moving or speaking too slowly?	0	1	2	3
Thoughts that you could be better off dead, or hurting yourself or others?	0	1	2	3
A score of 0-4: minimal; 5-9: mild; 10-14: moderate; 15-19: moderately severe; 20-27: severe				

Depression Screening

PHQ- 9 (The Patient Health Questionnaire- 9)

Screening questions

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?
9. Thoughts that you would be better off dead, or of hurting yourself in some way?

PHQ-9 interpretation

0 to 4 Points:	No depression
5 to 9 Points:	Mild depression
10 to 14 Points:	Moderate depression
15 to 19 Points:	Moderately severe depression
20 to 27 Points:	Severe depression

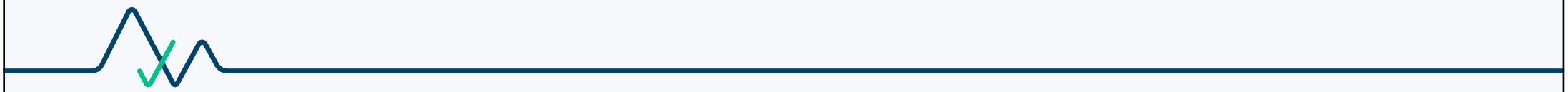
Other screening recommendations

USPSTF recommend

Screening for depression in adults (including pregnant and postpartum women) and adolescents (12-18 years old) (Grade B)

Found evidence is insufficient to recommend for or against routine screening of children (7-11 years old) for depression. (Grade I)

A “**yes**” response to the PHQ-2 questions is as effective as using longer screening tools.



Other screening recommendations

AAFP recommendations:

- **Pregnant** women should be screened for depression at least **once** during the perinatal period using a validated screening instrument such as the Edinburgh Postnatal Depression Scale or the PHQ-9. Consider screening at least once during pregnancy and again **4 to 8 weeks after delivery.** (Grade C)

- Routine use of the Edinburgh Postnatal Depression Scale improves diagnosis rates.

If screening is +ve

Interview the patient

DSM5 Diagnostic criteria

Role out comorbidities

Diagnosis of Depression

DSM5 Diagnosis of Major Depression Requires 5 or more of the following symptoms (For > 2 weeks):

Depressed mood

Sleep Change

Interest deficit (Anhedonia)

Guilt

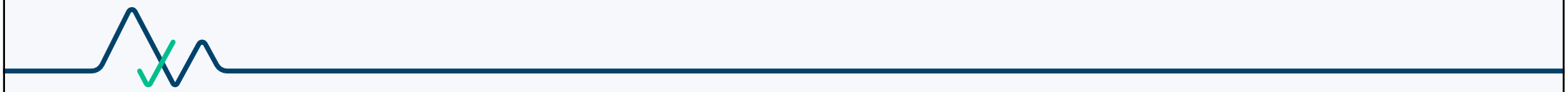
Energy

Concentration

Appetite change

Psychomotor change

Suicidality



DSM-5 Diagnostic Criteria for Major Depressive Disorder

A. 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 (1) depressed mood or (2) lack of interest or pleasure.

Note: Do not include symptoms that are clearly due to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) 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).
3. Significant weight loss when not dieting or weight gain (Note: In children, consider failure to make expected weight gain.)
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 suicide (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause significant distress or occupational, social, or other important areas of functional impairment.

C. The episode is not due to the physiological effects of a substance or to another medical condition.

Note: Criteria A–C represent a major depressive episode.
Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision

How to assess this case?

Assessment includes

History: History of present illness and current symptoms.
Address comorbidities: (Past Medical Illness)
Psychiatric: (e.g., generalized anxiety disorders and substance use disorders)

Suicide risk: All depressed patients must be asked specifically about suicidal ideation. Any positive or equivocal response should alert clinicians.

Suicide Risk Screen (SRS) 20Qs

Three Suicide Items within past month:

- **Thoughts of death**
- **Wishing you were dead**
- **Feeling suicidal**

Examination: Mental status examination. Physical examination.

Investigations: Labs. Imaging.

How else can we assess the severity?

Physiological processes

- Eating.
- Sleeping.
- Exercise.
- Sex.

Assess of functions

- Self level.
- Family level.
- Work/study level.

How about Ali ?

Ali found to had a mild to moderate severity depression with no suicidal

What risks for depression did Ali had?

Chronic Disease

Beta Blockers

Is there other risk factor for depression?

- Young age
- Female sex
- Low self esteem
- Prior depressive episodes
- Childbirth
- Childhood trauma/sexual abuse
- Stressful life event/History of Divorce
- Disturbed Family Environment
- Parental loss
- Lower income
- Substance abuse disorder
- Medications e g. Interferon

How to manage Ali’s Depression

Putting in consideration stable optimum conditions

- No problem in weight, sex, sleep, behavior.. etc

No CVD that limit our choices of pharmacology.

- E.g. we could start by any SSRI e.g. Escitalopram

Referral to psychotherapy (CBT)

Classes of Antidepressants

Drug	Usual total starting dose per day (mg).	Usual total dose per day (mg).	Extreme daily dose range (mg).
Selective serotonin reuptake inhibitors			
Citalopram	20	20 to 40	10 to 40
Escitalopram	10	10 to 20	5 to 30
Fluoxetine	20	20 to 60	10 to 80
Fluvoxamine	50	50 to 200	25 to 300
Fluvoxamine CR	100	100 to 200	100 to 300
Paroxetine	20	20 to 40	10 to 50
Paroxetine CR	25	25 to 50	12.5 to 62.5
Sertraline	50	50 to 200	25 to 300
Selective serotonin-norepinephrine reuptake inhibitors			
Desvenlafaxine	25 to 50	50 to 100	50 to 400
Duloxetine	30 to 60	60	30 to 120
Levomilnacipran	20	40 to 80	20 to 120
Milnacipran	12.5	100 to 200	50 to 300
Venlafaxine	37.5 to 75	75 to 375	75 to 375
Venlafaxine XR	37.5 to 75	75 to 225	75 to 375
Atypical agents			
Agomelatine (not available in United State)	25	25 to 50	25 to 50
Bupropion	200	300 (maximum single dose 150 mg)	100 to 450
Bupropion SR 12 hour	150	300 (maximum single dose 200 mg)	150 to 400
Bupropion XL 24 hour	150	300	150 to 450 (United State) 150 to 300 (Europe)

Serotonin modulators			
Nefazodone	200	300 to 600	50 to 600
Trazodone	100	200 to 400	100 to 600
Vilazodone	10	40	10 to 40
Vortioxetine	10	20	5 to 20
Tricyclics and tetracyclics			
Amitriptyline	25	150 to 300	10 to 300
Amoxapine	25	200 to 300	25 to 400
Clomipramine	25	100 to 250	25 to 300
Desipramine	25	150 to 300	25 to 300
Doxepin	25	100 to 300	10 to 300
Imipramine	25	150 to 300	10 to 300
Maprotiline	25	100 to 225	25 to 225
Nortriptyline	25	50 to 150	10 to 150
Protriptyline	10	15 to 60	5 to 60
Trimipramine	25	150 t0 300	25 to 300
Monoamine oxidase inhibitors			
Isocarboxazid	10	10 to 40	10 to 60
Phenelzine	15	15 to 90	7.5 to 90
Selegiline transdermal	6 mg/24 hour patch	6 to 12 mg/24 hour patch	6 to 12 mg/24 hour patch
Tranylcypromine	10	30 to 60	10 to 60

Tips in choosing antidepressants

- Why SSRI is always preferable
- Previous use
- Family history
- Coast and burden on patient
- Desirable side effects

The frequency of monitoring is to be determined based on:

- Patient's symptom severity
- Coexisting disorders
- Adherence to treatment
- The frequency and severity of side effects
- The availability of social supports

Educational tips to start SSRI

- Detailed education about side effects.
- Slow and gradual onset of action.
- Lengthy course of treatment.
- Interactions with other medications.

Treatment tips

For 1st episodes of depression, treat for 6-9 months

For recurrent depression, treat for at least 2 years.

- If patient relapses after successful treatment, > 90% will respond to the same antidepressant.

During follow up After 4 weeks

- **If partial response to SSRI, change to another SSRI**
- **If no response to SSRI, try switching to another category**

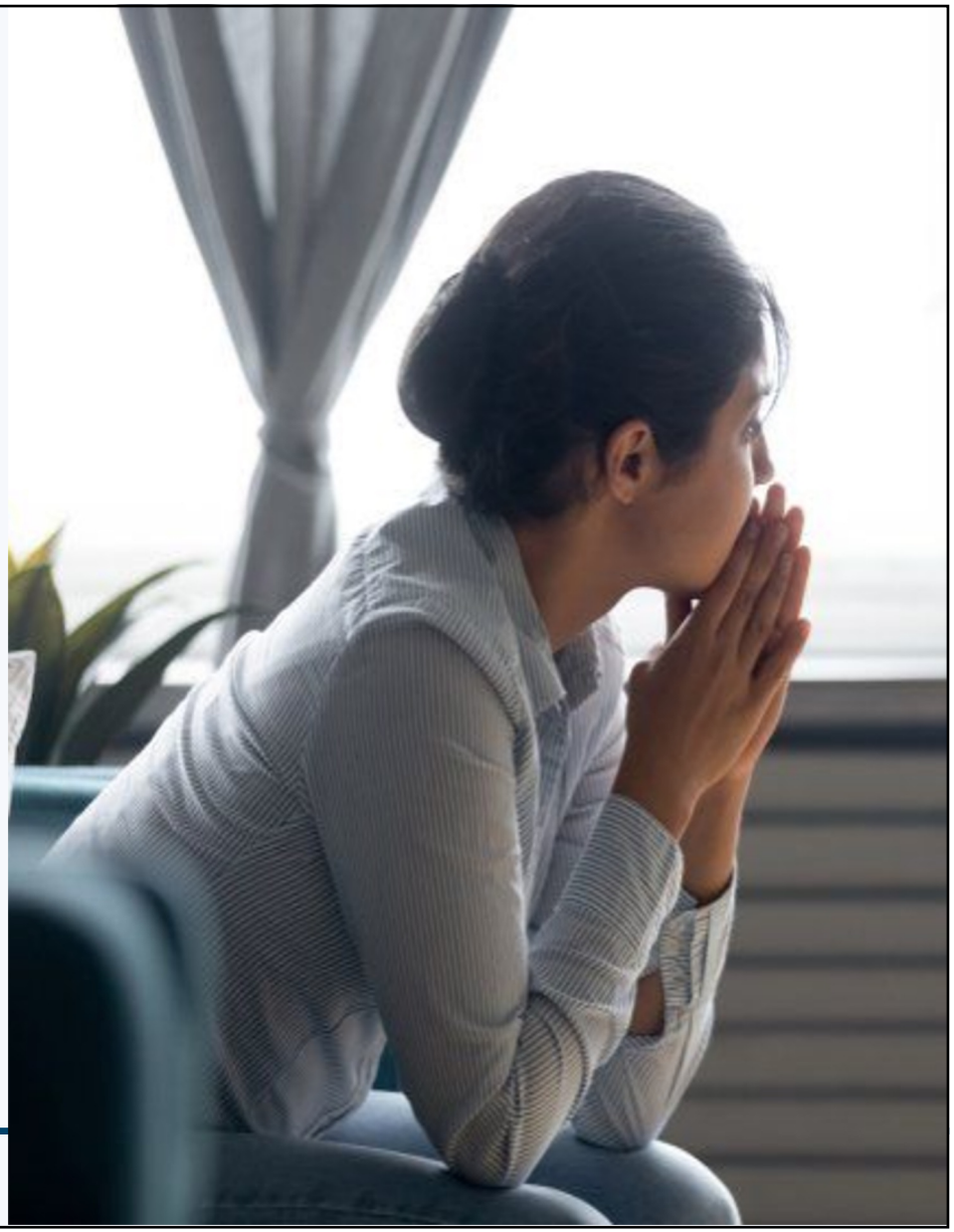
Case

2

Scenario..

- Mariam is a 27 years old female came to the clinic seeking help for being **fatigued** and **low mood** for several months.

What further history in this case?
And what diagnostic criteria we can use?



We can use DSM5 Diagnostic criteria .

- She has sad mood for **more than 3 weeks**
- She **lost interest** into things she usually enjoy doing
- Her daily activities has been decreased because of **decreased energy** and self talk of what's the point of working or making home clean or arranged.
- Life is meaningless, and **I'm worthless** and nobody cares about me.
- She feels guilty of being among successful people of whom she doesn't deserve to belong and can not return help back to them.

cont

- She has been **forgetful** recently and can’t continue a task due to trivial distractors.
- Her eating has decreased with no weight change
- Her sleep quality decreased, unrefreshing sleep with early morning awakening.
- She doesn’t have suicidal ideation but think if she were dead is better.

What further history we can ask?

Medical & Surgical & Medication history:

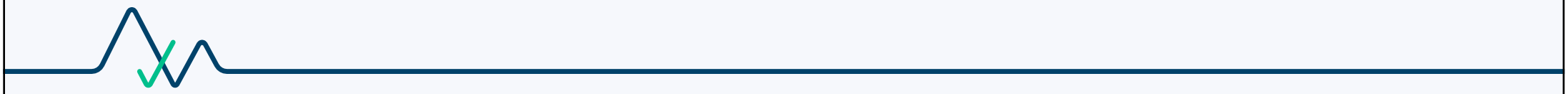
- No chronic disease
- No hospital admission or ER visits recently/surgeries or Blood transfusion
- No regular medications

Vaccination history:

- No recent vaccinations

Social History:

- Living with her family not married, Educated teacher with no major life stressors, with No Alcohol or Smoking or Drugs abuse.



What is missed important key in the history?

History of **manic attack**

History of **psychotic attack**

History of **other mental disorders**

- Anxiety
- Obsessions/compulsions
- Stressful events

Examination

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Physical Examination

- Normal vital signs
- Normal appearance and general examinations

Mental State Examination

General Appearance and Behaviour

Young female looks sad and tired with minimal care on appearance and grooming, looking down most of the interview with withdrawn behavior

Mood and Affect

Her affect is congruent with her constant sad mood

Speech

Slow with low tone and fluency

Thoughts

She has a coherent and related thoughts with no thoughts of hurting herself or others and no delusional obsessions, compulsions or preoccupation thoughts.

Perception

Intact perception of all 5 senses with no hallucinations.

Mental State Examination (cont

Cognition (MMSE)

Consciousness (Alertness)
- She is alert

Orientation (Awareness)
- She is oriented

Attention / concentration
- She is attentive, Memory x 3, ?

Language
- Normal language

Visuospatial function
- Normal

Abstract thinking
- Normal

Insight and judgment

Intact insight and judgment

What is the diagnosis for Mariam?

Major Depression Disorders (MDD)

Diagnosis confirmed as MDD by:

- Confirming symptoms with duration
- Effect on daily living and function
- Ruling out other mental disorders
- Ruling out other general medical condition
- Ruling out substance use

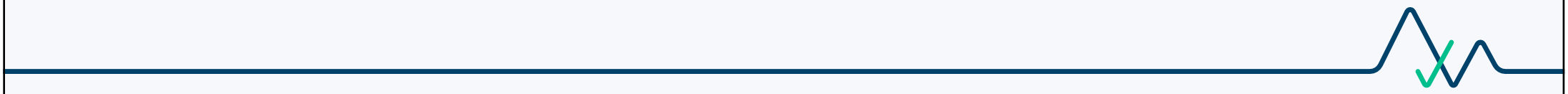
Red Flags for Depression

- Insomnia
- Fatigue
- Chronic life changes or stressors
- Fair or poor self-rated health
- Unexplained physical symptoms

What is the management for Mariam?

Management of Major Depression Disorders

- Management of MDD is approach like other disorders by **CRAPRIOP**
- Emphasis on safety and reliability is warranted in such patients



CRAPRIOP approach

Clarify / Psych Education
Reassure / realistic reassurance
Advice / non-pharmacological management
- Including TLSM

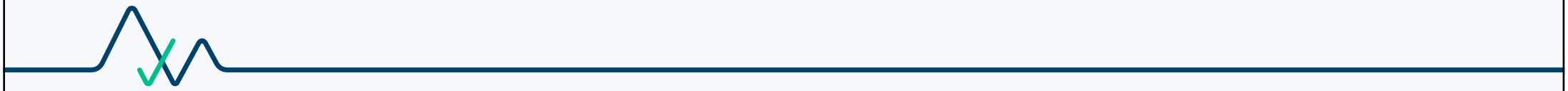
Prescribe / pharmacological management
- Including complementary and alternative medicine

Referral / search for indications
Investigation / as needed per disorder and medication related
Observation / assess risks and safety and give red flags and plan-b
Prevention and health promotion
- E.g. age specific, population specific, disorder specific

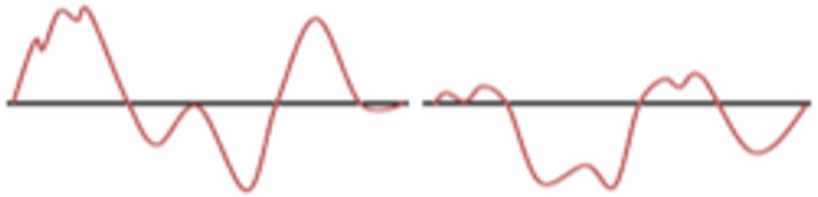
What if she has a manic attack few months ago?

Mariam has a manic attack in form of (DIG FAST)

- **D**istractibility
- **I**mpulsivity
- **G**randucity
- **F**light of ideas
- **A**ctivity increased
- **S**leep deficit
- **T**alkativeness



Bipolar Disorders



- Bipolar I
- Bipolar II

Cyclothymia

Does the management changed?

Indicated for referral

- Yes, any case diagnosed of bipolar need to be referred to psychiatric

Indicated for admission

Safety assessment

What if she is postpartum one month ago?

Rule out psychosis

Change medications to lactation suitable

- **SSRI friendly with lactation**

Severe unipolar depression

Severe Unipolar Depression

Risk assessment

For self harm and others

Reliability assessment

To follow up

To check adherence to management plan

Referral

Very severe depression

High risk of suicide

How to follow up patient with depression

Scoring system

- PHQ9

Leasurble activity and joy

Patient’s words

- Document patient’s word

Self satisfaction

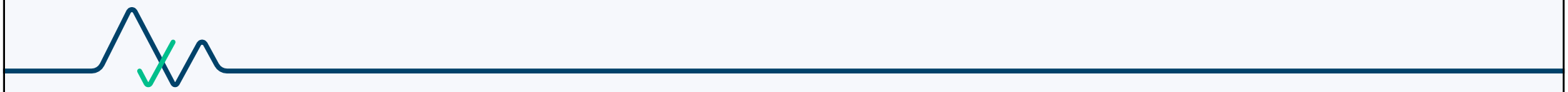
Level of activity/function

- Affect to her life activity

Self image and reflection

Special situation for choosing SSRI

- In pregnancy
- In lactating mothers
- In geriatrics
- In obese people
- In people with anorexia nervosa
- In seizure people
- In smoker

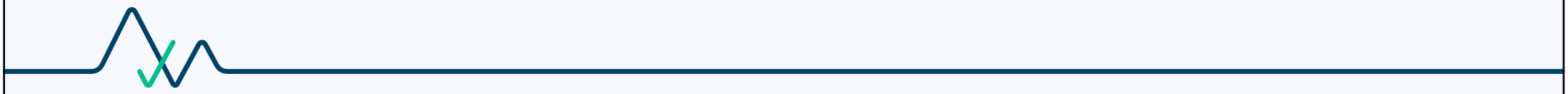


Pregnant woman with depression

All **SSRIs** are category C during pregnancy and lactation

- Except paroxetine is cat-D, Because the benefit of treating depression during pregnancy is higher than the may caused harm of SSRI exposure it's advised to treat it

Example is to use **fluoxetine**



Postpartum depression

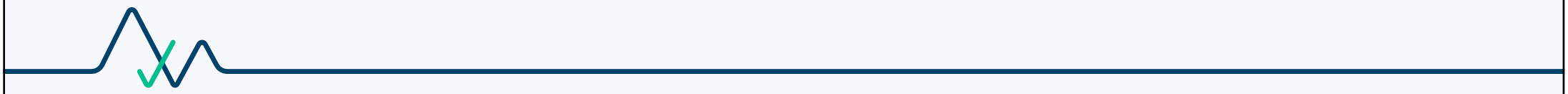
In patient who wish to breastfeed her baby

e.g.

Escitalopram

A depressed old man with insomnia and loss of appetite

e.g. Mirtazapine



A depressed young female with eating disorder

e.g. Fluoxetine

An adult patient with depression dominated by agitated behavior and irritability

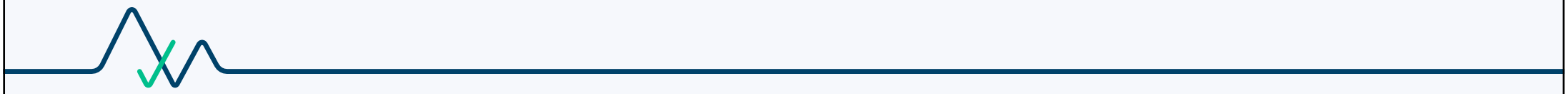
Combination of **antidepressants** with **antipsychotics** or **Benzodiazepine**
e.g. Escitalopram + Lorazipam (short-course)

An adult women with depression dominated by psychomotor retardation and concerned about her weight

e.g. Bupropion

A depressed diabetic patient with chronic peripheral neuropathic pain

e.g. Duloxetine



Treatment tips

Avoid

- **Bupropion** with seizure patient
- **Bupropion** with eating (anorexic) disorders

- **High anticholinergic antidepressants**
  E.g. **TCA** with BPH patients and dementia

- **Trazodon** with high risk patient for Priapism

Home message

- The Family medicine essentials is providing a valid material for Depression topic
- Depression Screening we use phq-2, followed by phq-9.
- Depression diagnostic criteria is DSM5
- Follow up the patient situation with PHQ-9
- To assess the severity of the depression may differ patient outcome, function, morbidity and mortality.
- To choose right antidepressant and dose for the patient.

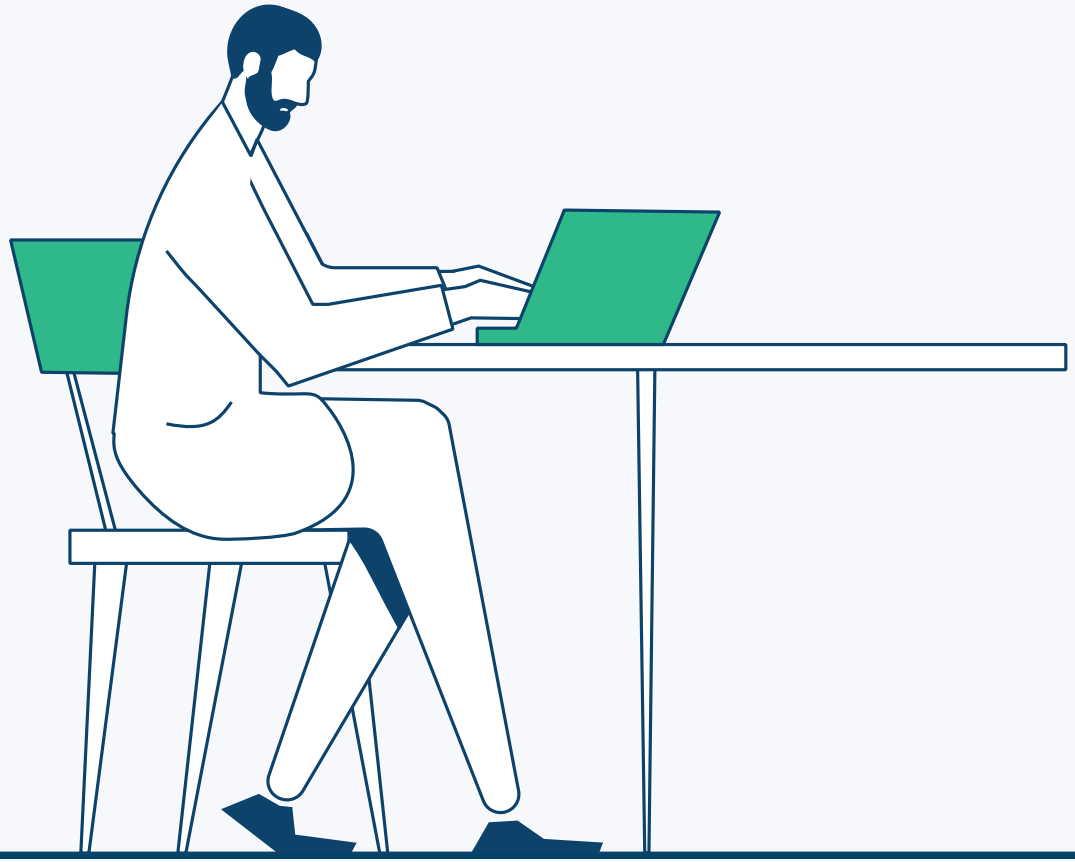
Home message

- To accurately diagnose unipolar depression vs bipolar or if it accompanies by psychotic features.
- To use right examination tools such as MME.
- paroxetine is category D in pregnancy.
- To give fluoxetine during pregnancy.
- To give escitalopram during lactation.
- To use mirtazapine in insomnia patient or lost appeatite
- To use fluoxetine in patient with eating disorder
- To use antidepressants a combined by antipsychotic or benzodiazepines in agitated and irritable patient

Home message

- **To use duloxetine with patient with peripheral neuropathy.**
- **To avoid Bupropion** with seizure patient
- To avoid **High anticholinergic antidepressants**
  E.g. **TCA** with BPH patients and dementia
- To avoid **Bupropion** with eating (anorexic) disorders

- **To avoid Trazodon** with high risk patient for Priapism



References

1. FAMILY MEDICINE ESSENTIALS
2. AAFP

Did you like this topic?

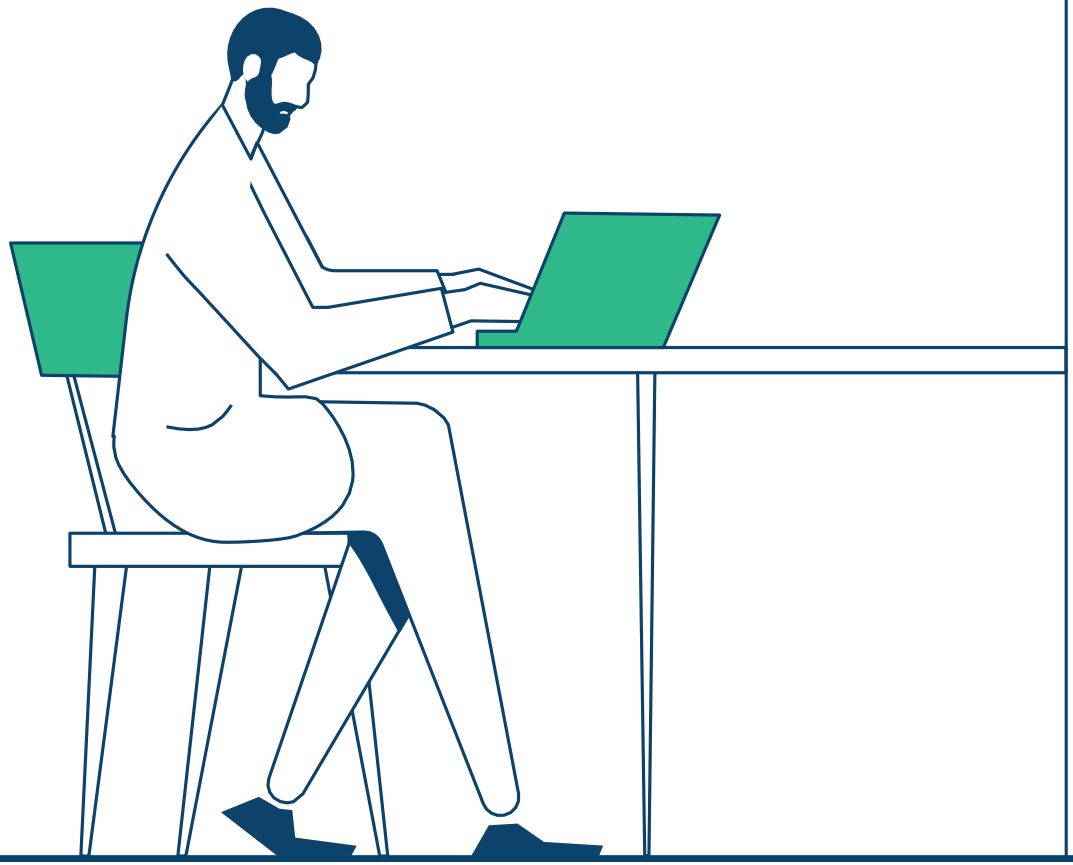
THANK YOU.

Anxiety Disorders

DR. WAAD ALBUSURUR
Family medicine consultant

DR.SAMIA NAYER ALMUTAIRI, R3,

الهيئة السعودية للتخصصات الصحية
Saudi Commission for Health Specialties



Objectives

- **By the end of this lecture Residents should know:**
  - The Definition of GAD
  - Diagnostic Criteria and how to Screen for GAD
  - How to manage GAD
  - When to refer a patient with GAD

Introduction

❖**Normal Anxiety:**
is adaptive, normal emotion experienced in threatening situations.

❖**When does anxiety become a disorder ?**

Normal Anxiety vs. Problem Anxiety

Normal

- Triggered by certain events and situations
- Intermittent
- Beneficial

Problem

- Interference with daily life
- Irrational
- Chronic

verywell

Anxiety Disorders

1. Generalized Anxiety Disorder
2. Panic Disorder
3. Agoraphobia
4. Social Phobia (social anxiety disorder)
5. Separation anxiety disorder
6. Selective mutism
7. Specific phobias

Case

Noura is 42 years women, divorced 5 years ago with 2 children, employed part time and cares for her mother who has Alzheimer's disease.

Noura has no significant past medical history.

Now Noura complains of feeling '**stressed**' all the time and constantly worries about anything and everything.

She describes herself as always having been a worrier but her anxiety has become much worse in the past **12 months** since her mother became unwell, and **she can not control these feelings.**

When worried, Noura **feels tension in her shoulders**, stomach and legs, **her heart races** and sometimes she finds it difficult to breathe.

Her sleep is poor with difficulty getting off to sleep due to worrying and **frequent awakening**. She feels tired and irritable. She does not drink any alcohol.

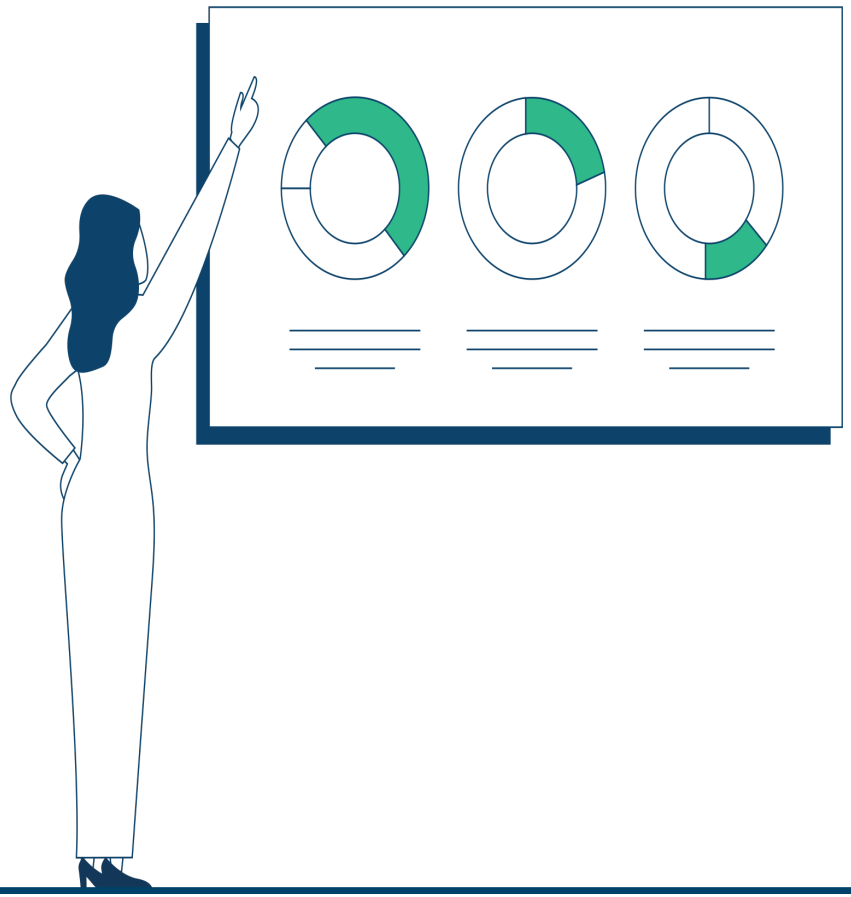
What is your Diagnosis?

A. GAD
B. Panic Disorder
C. Depression
D. Social anxiety disorder

What is Generalized Anxiety Disorder?

- GAD is a mental disorder characterized by excessive, persistent, uncontrollable worry about different events and associated with many somatic symptoms.

Epidemiology



In KSA , The prevalence of GAD estimated in a study published in 2020 is 12.3%.

The global prevalence 3.8%

Female are 2-3 times more likely experienced GAD

Case

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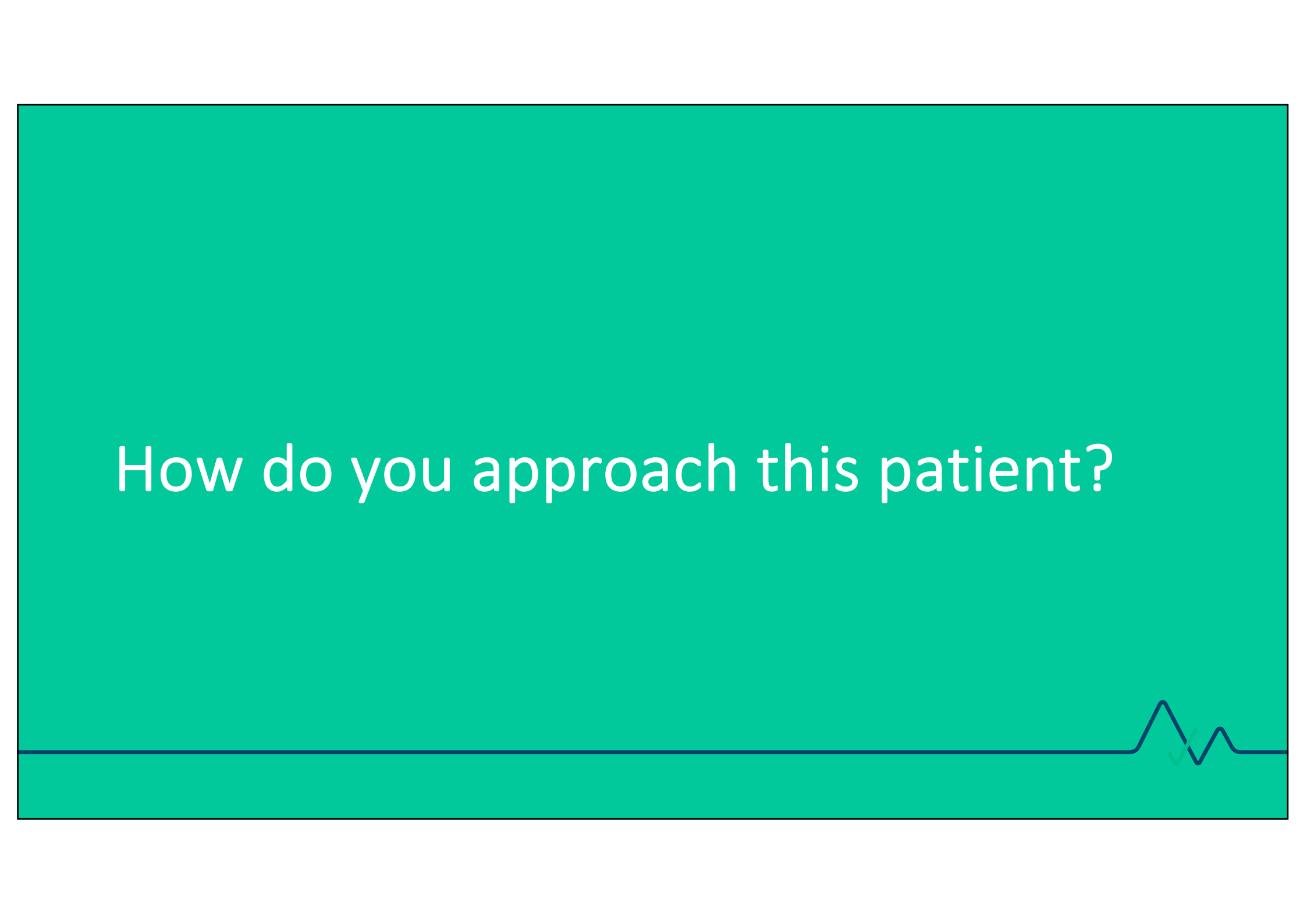
How do you approach this patient?



History Taking

- Detailed history about presenting symptoms (onset, duration, aggravating and relieving factors, previous episodes).
- Ask about any associated symptoms (palpitation, sweating , change in{ sleep , mood , concentration, and appetite}).
- Physician should inquire about any substance abuse.
- Ask about Medical history of the Patient that aims to identify the existence of contributory factors (hormonal , cardiac).
- Family medical and psychiatric record.
- Brief of life events that may be a cause such as abuse , or neglect.

Physical Examination

- During the examination , Noura looks anxious .
- Her blood pressure 118/80 mm hg, heart rate 75 beats /min, Respiratory rate 16 breath /min, BMI=20
- Cardiopulmonary examination is normal.
- Thyroid examination is unremarkable , no tenderness, no bruit.
- Abdomen is soft, no tenderness ,no organomegaly .

Would you order lab investigation for this patient ?

Investigations

To diagnose a patient with GAD other organic causes related to the symptoms must be excluded

Laboratory investigations include, without limitation to CBC, TSH, ECG especially for people older than 40 years.

Diagnostic criteria of GAD

A.Excessive anxiety and worry ,occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The individual finds it difficult to control the worry.

C.The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):

Note: Only one item is required in children.

1. Restlessness or feeling keyed up or on edge.

2. Being easily fatigued.

3. Difficulty concentrating or mind going blank.

4. Irritability.

5. Muscle tension.

6. Sleep disturbance.

D.The anxiety , worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E.The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

F. The disturbance is not better explained by another mental disorder .

MCQ

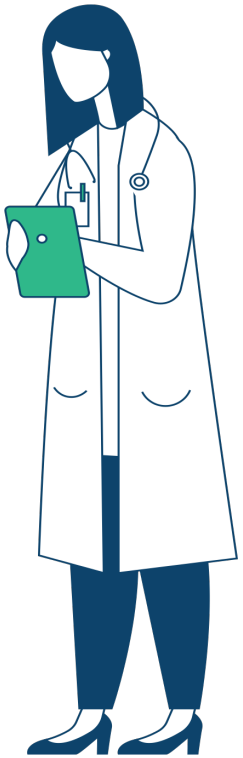
- **A 29-year-old woman presents to your office with a complaint of worsening anxiety. Which additional finding would suggest a diagnosis of generalized anxiety disorder rather than panic disorder?**

A. Anxiety occurring more days than not for at least six months
B. Changes in personality
C. Excessive concern about medically unexplained symptoms
D. Frequent periods of intense fear

Tools to screen for GAD

GAD 7 for screening

The Penn State Worry Questionnaire: a useful tool that evaluates the level of worrying(Less sensitive)



MCQ

- A 25-year-old man presents to the clinic with anxiety most days for the past six months. He reports that his worries take over his thoughts despite his attempts to suppress them. He worries about the stability of his job, his health, his appearance and social interactions. He feels tired constantly because of worrying at night, yet friends often tell him that he appears tense and restless. The patient denies appetite changes, mood changes, and weight loss or gain. His past medical history is unremarkable. He denies usage of alcohol, tobacco products, or recreational drugs. The physical examination is normal. Which of the following screening tools would help you to reach a diagnosis?

A. PHQ-9
B. GAD7 for screening
C. Penn State Worry Questionnaire

Table 2. GAD-7 Screening Tool

Over the last 2 weeks, how often have you been bothered by the following problems?	*Not at all*	*Several days*	*More than half the days*	*Nearly every day*
(Use "✓" to indicate your answer)				
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Total score _____	= ____	+ ____	+ ____	+ ____

NOTE: *Total score for the 7 items ranges from 0 to 21. Scores of 5, 10, and 15 represent cutoffs for mild, moderate, and severe anxiety, respectively. Although designed primarily as a screening and severity measure for GAD, the GAD-7 also has moderately good operating characteristics for panic disorder, social anxiety disorder, and posttraumatic stress disorder. When screening for anxiety disorders, a recommended cutoff for further evaluation is a score of 10 or greater.*

GAD = generalized anxiety disorder.

Reprinted from Spitzer RL, Williams JB, Kroenke K, et al., with an educational grant from Pfizer Inc. Patient health questionnaire (PHQ) screeners. http://www.phqscreeners.com/overview.aspx?Screener=03_GAD-7. Accessed July 22, 2014.

5-9 mild
10-14 moderate
15-21 severe

AAFP

MCQ

❖ **Which of the following is recommended as a treatment option for patients with moderate generalized anxiety disorder?**

A. **Buspirone**

B. **CBT**

C. **Sertraline**

D. **CBT + Sertraline**

Management of GAD

- The treatment plan of a patient diagnosed with GAD would be **serotonergic antidepressants** and **CBT**.
- First-line medication in case of starting the treatment using medications, SRI (SSRI or SNRI).
- The average dose of SSRI is similar to those in the case of depression.
- Initial treatment will take 4-6 weeks then reassess and readjust.
- Patients with **mild** GAD can be managed with **CBT only**
- Regarding patients with **moderate or severe** GAD , they can be managed with **both SRI+CBT**

SRI side effects

- low-dose benzodiazepine (e.g., lorazepam 1 to 2 mg/day in divided doses), can help the Patient tolerate the Agitation/insomnia from taking SRI in the first days .
- If the response of SRI was good, then the benzodiazepine dose could be reduced to be 0.5 mg per week.
- Benzodiazepine could be used for short term 2-4 weeks.

Response to SRI

Situation	Action
No response to SRI	increase the dose of the same SRI.
Maximum dose used and no response	dose shall be decreased gradually , and other medication should replace the SRI.
Partial response with some improvement	some of the second-line medications (buspirone , pregabalin) would interfere or CBT.
Relapse for the first time	the first line would be the medication that the patient used previously and showed good response.
Relapse for the second time	consider ongoing maintenance treatment.

When to refer a patient with GAD ?

Indications for referral

- Severe functional impairment.
- Risk of self-harm.
- Risk to harm others.
- No response to treatment.

Signs of a Panic Attack

Nausea

Chills or hot flashes

Sweating

Trembling or shaking

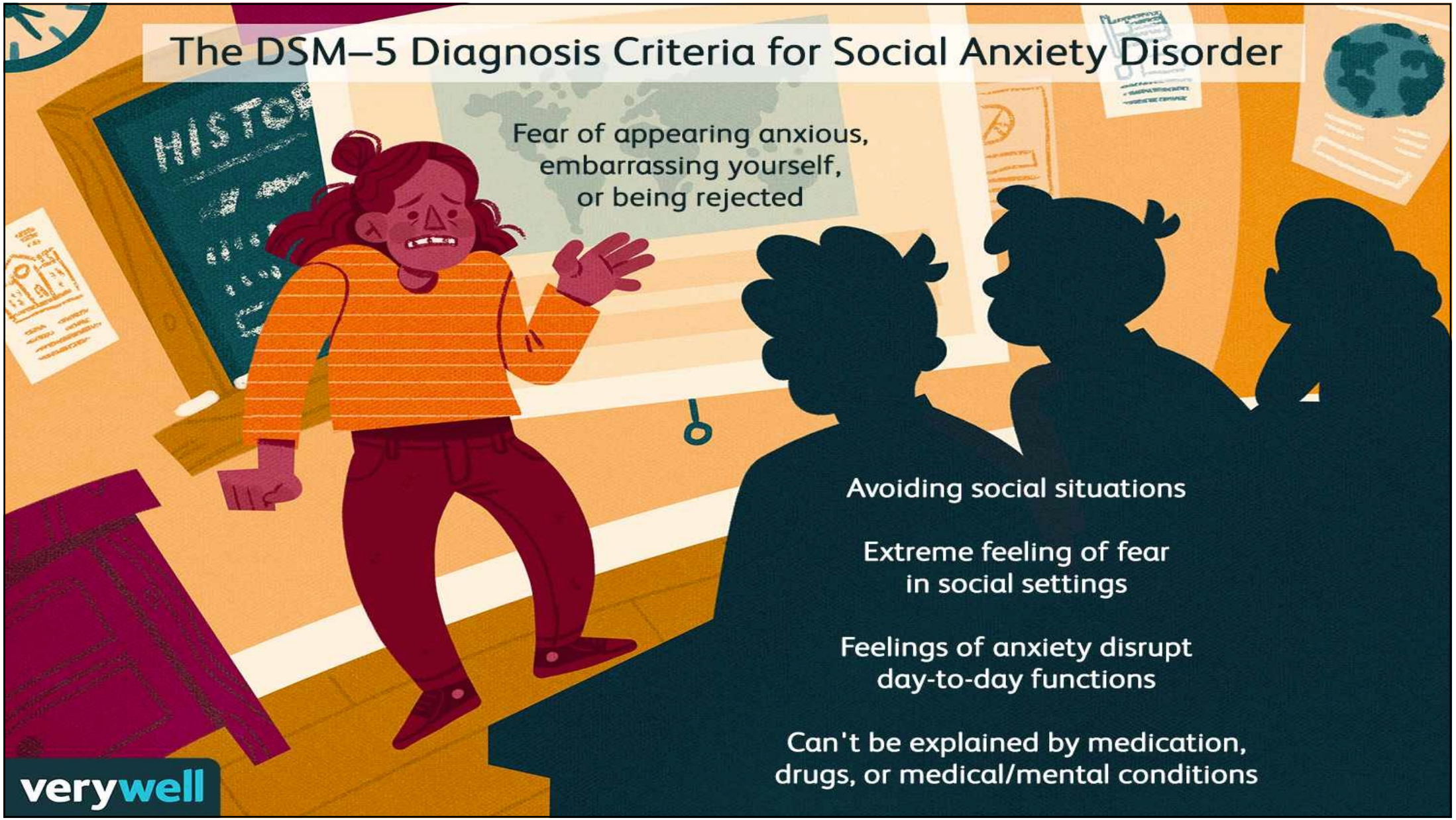
Heart palpitations

Numbness and tingling

Hyperventilation

Dizziness

verywell


The DSM–5 Diagnosis Criteria for Social Anxiety Disorder
Fear of appearing anxious, embarrassing yourself, or being rejected
Avoiding social situations
Extreme feeling of fear in social settings
Feelings of anxiety disrupt day-to-day functions
Can't be explained by medication, drugs, or medical/mental conditions
verywell


Separation Anxiety Disorder Symptoms
Separation-related distress
Reluctance to go places
Upset stomach
Excessive worry about losing attachment figure
Nightmares about separation
Fear of being alone
verywell

Selective mutism

Specific Phobias

Anxiety disorder	Clue to diagnosis	Management
GAD	Uncontrollable worry	SSRI +CBT
Panic Disorder	❖ Panic attack symptoms ❖ At least one of the attacks followed by 1m (or more) of one or both of the following: 1. Persistent concern or worry about additional panic attacks . 2. A significant maladaptive change in behavior related to the attacks	SSRI +CBT
separation anxiety	fear of separation from home or major attachment figures and harm befalling major attachment figures	CBT
social anxiety	extreme fear of situations that involve possible scrutiny by others. (concerned that embarrassment or humiliation will result)	CBT
agoraphobia	fear of open places or avoidance of many activities and circumstances	CBT
specific phobias	fear of a particular object or animal or situation that typically leads to avoidance behaviors	CBT EXPOSURE
Selective mutism	failure to speak in specific social situations in which there is an expectation for speaking. (1 month)	SSRI +CBT

UpToDate

References

- The second edition of family medicine essentials
- AAFP
- Up to date

THANK YOU.

Other psychiatric conditions

Supervised by Dr. Turki AlSharekh
Done by: Dr. Afrah AlHawiti
Dr. Nawal Bin Jalalah

الهيئة السعودية للتخصصات الصحية
Saudi Commission for Health Specialties

Case Scenario

A 31-year-old male presented to PHC Clinic with history of **low mood** that started since almost 2 year ago. He also noticed that he has become socially withdrawn and lost interest in completing his master's degree.

His symptoms were associated with insomnia, loss of appetite and weight. He is feeling guilty but has no suicidal wishes with episode lasting weeks to a month.

He is married, employed as a programmer with no children.

What is your initial impression?

Patient was initially diagnosed with MDD.

He was started on Escitalopram 10 mg with follow up after 2 months.

He came back with his wife after 6 weeks, she reports that his condition is worsening, and he started to have elevated mood, agitation and irritable all the time. Stays awake for a long periods of time. Spends hours working on his computer. Impulsively went on shopping spree. On questioning, she confirms that he had episodes like these before and currently this is 5th day in this condition.

What is your current impression?

BIPOLAR DISORDER

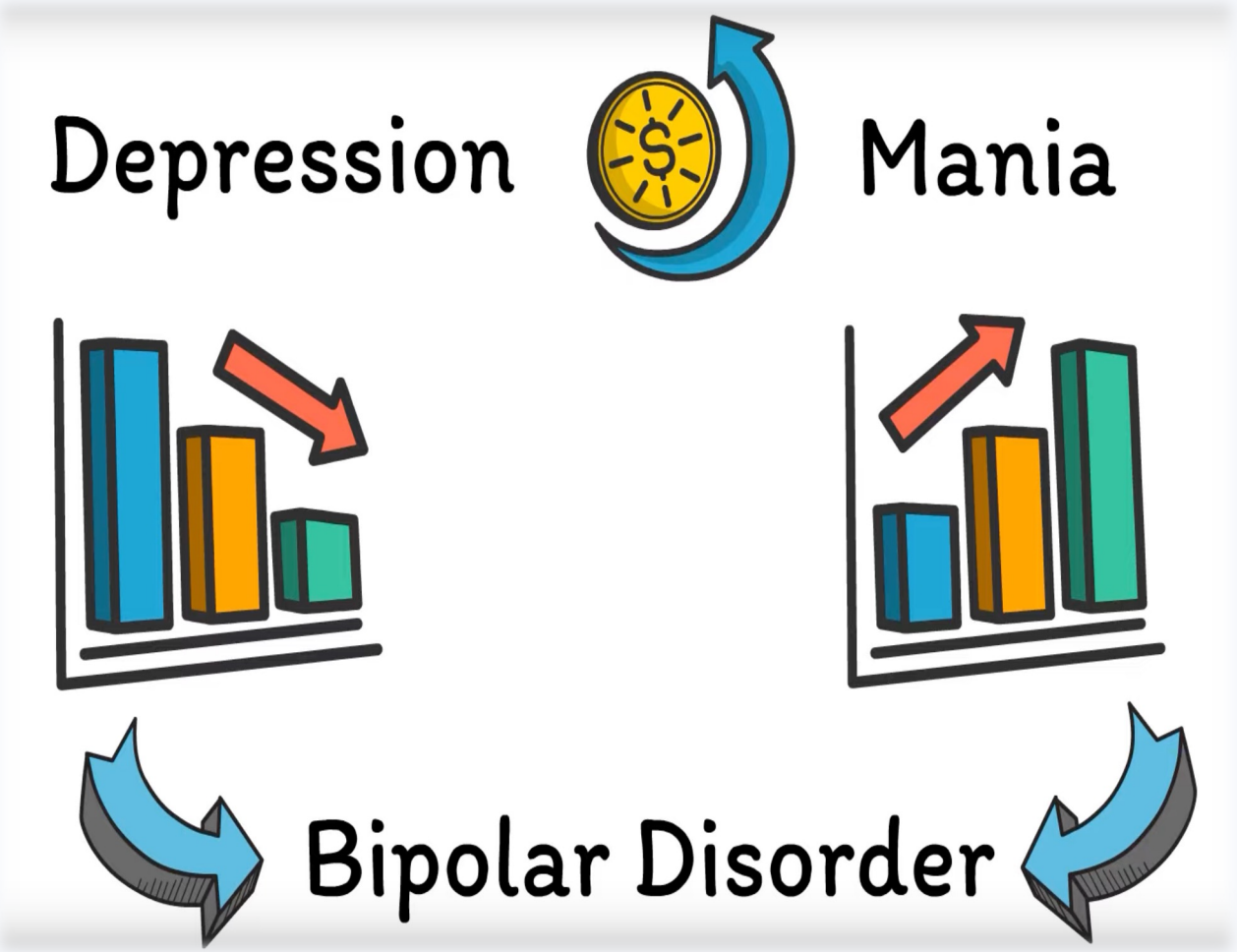
Supervised by : DR. TURKI ALSHAREKH
done by : DR. AFRAH ALHAWITI

Objectives :

- Definition of bipolar disorders
- Types
- Criteria of different episodes
- Diagnosis of bipolar disorder
- Management
- **QUIZ !!**

DEFINITION

- **Manic** or **hypomanic** episodes sometimes, but not necessarily, accompanied by **depressive** episodes.



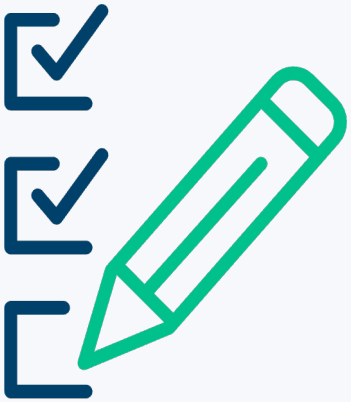
- The male to female ratio **is 1:1**
- The mean age of **onset is 19 years** of age
- Family history of a **1st degree relative** with bipolar is a **risk factor**
- High rate of **completed suicides**; 10-15%
- Often presents with **comorbid conditions**: anxiety, substance abuse, ADHD, eating disorders, PTSD, personality disorders.

https://saudifamilymedicine.com/index.php/documentation/sections/

BIPOLAR I	BIPOLAR II	CYCLOTHYMIC
At least one manic episode ± major depressive episode	At least one hypomanic episode + major depressive episode	**Doesn't meet criteria** of manic, hypomanic or depressive episode.
Episode lasting at least **1 week**	Episode lasting at **least4 consecutive days**	Symptoms on and off for at least **two years**
Manic	**Hypomanic**	**Never free** of symptoms for **more than 2** consequetive months
Social and/or occupational dysfunction	No social and/ or occupational dysfunction	Social and/ or occupational dysfunction
± Psychosis (delusions and / or hallucinations)	No psychosis	

https://saudifamilymedicine.com/index.php/documentation/sections/

•DIAGNOSIS



- **based on the DSM 5 criteria for patients presenting with major depression, mania, or hypomania.**

Bipolar major depressive episode:

- 5 of the following symptoms, presenting for at least **two weeks**, **and at least one** symptom being either **depressed mood or loss of interest:**

- Depressed mood, nearly every day
- Loss of interest
- Unintentional weight loss or weight gain (5% of body weight in 1 month) OR change in appetite.
- Insomnia / hypersomnia.
- Fatigue
- Psychomotor agitations.
- Feeling worthlessness, excessive guilt.
- Inability to concentrate.
- Suicidal ideation with or without specific plan

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Manic episode

- At least 7 days period of abnormally elevated irritable or expansive mood nearly every day
  In addition to 3 of the following symptoms (4 if the mood is irritable):

- Distractibility
- Impulsivity/poor judgment, shopping sprees, hypersexual activity.
- Grandiosity
- Flight of thoughts
- Psychomotor agitation (increased goal- directed activities)
- Decreased need for sleep
- Pressured speech

https://saudifamilymedicine.com/index.php/documentation/sections/

MNEMONIC

Bipolar Disorder

DIG FAST (Mania)

Distractibility

Impulsivity - poor judgment, spending sprees, reckless driving

Grandiosity - increased self-esteem

Flight of ideas - racing thoughts

Activities - psychomotor agitation

Sleep - decreased need

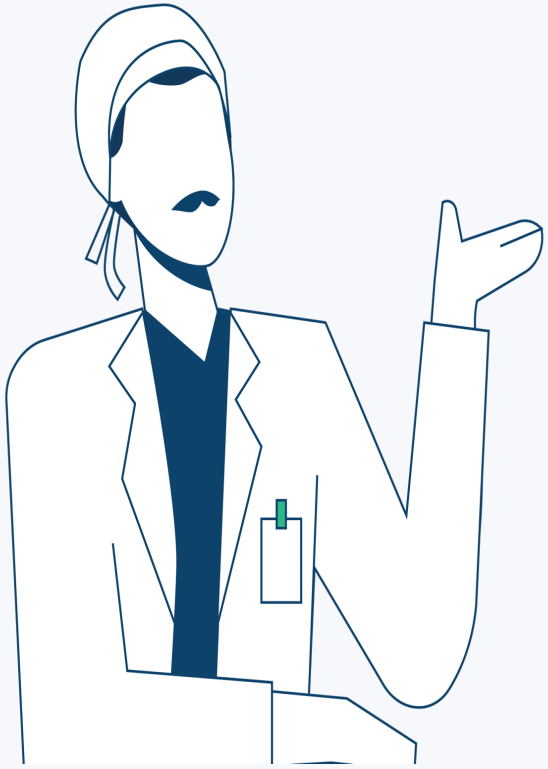
Talkativeness - pressured speech

Hypomanic episode

- At least 4-day period of abnormally elevated, irritable, or expansive mood nearly every day.
- in addition to 3 of the following symptoms (4 if the mood is irritable):

- Distractibility
- Impulsivity/ poor judgment, shopping sprees, hypersexual activity
- Grandiosity
- Flight of thoughts
- Psychomotor agitation (increased goal-directed activities)
- Decreased need for sleep
- Pressured speech

https://saudifamilymedicine.com/index.php/documentation/sections/



Differential Diagnosis

- **Unipolar depressive disorder**
- **Schizoaffective disorder**
- **Schizophrenia**
- **Attention deficit hyperactivity disorder**
- **Borderline personality disorder**

Investigations

- **No laboratory or radiological imaging** is required to diagnose bipolar disorders.

MANAGEMENT

GOALS :

- ✓ Reduction of symptoms
- ✓ Prevention and decrease of episodes
- ✓ Reducing the risk of suicide
- ✓ Decreasing psychosocial dysfunction

- **Pharmacologic:**

- **Acute** Treatment: depends on **the presenting episode.**

presenting episode

https://saudifamilymedicine.com/index.php/documentation/sections/

MANIA	INITIAL	Lithium or valproate + antipsychotic (aripiprazole, haloperidole, respiridone , olanzapine)
	Modification	Switch valproate to lithium or vice versa Change to different antipsychotic
HYPOMANIA	1st line	Risperidone olanzapine
	Alternatives	Lithium , valproate, quetiapine , aripiprazole, haloperidol.
BIPOLAR MAJOR DEPRESSION	1st line	Quetiapine / lurasidone
	2nd line	Olanzapine +Fluoxetine Valproate Lithium +valproate or lamotrigine
	3rd line	Lamotrigine / lithium / olanzapine

https://saudifamilymedicine.com/index.php/documentation/sections/

Maintenance therapy:

1st line: **same** medication used for an acute episode
2nd line: **lithium**, valproate, lamotrigine, quetiapine
3rd line: olanzapine, risperidone, aripiprazole

- **Behavioral:** cognitive behavioral therapy, psychoeducation

https://saudifamilymedicine.com/index.php/documentation/sections/

Take home messages :

1. Bipolar can misdiagnosed as depression due its presentation.
2. Always screen for suicide when evaluating depression & Bipolar.
3. Avoid using SSRIs alone in the treatment of bipolar depression.

https://saudifamilymedicine.com/index.php/documentation/sections/

Question 1

A 21-year-old woman presents to the clinic complaining of mood swings, irritability, depression, and fatigue. She reports occasionally smoking marijuana and using ecstasy. Her roommate tells you that sometimes the patient feels like she is on top of the world, but recently the patient has become more isolated and stays in bed all day. Based on this patient's presentation, which of the following is most likely the **first-line** treatment?

A. Electroconvulsive therapy
B. Fluoxetine
C. Haloperidol
D. Lithium

Correct Answer (D)

Explanation:

Mood swings, irritability, depression, and substance use strongly suggests bipolar disorder.

The mainstays of treatment are lithium, anticonvulsants, and antipsychotics used in combination (e.g., lithium plus an antipsychotic), depending upon the severity of symptoms.

Question 2

An 18-year-old man presents to the clinic for management of his bipolar disorder. Seven days ago he started taking lithium. How long after his last dose should his serum lithium level be drawn?

A. 1 hour
B. 12 hours
C. 24 hours
D. 5 hours

Correct Answer (B)

Explanation:

Lithium is absorbed through the gastrointestinal tract and depending on if the preparation is slow release or immediate release, it can take up to 12 hours for the entire dose of lithium to be absorbed. Therefore, **lithium levels should be drawn 12 hours after the last dose is taken.**

Question 3

In treatment of bipolar disease, patients treated with which of the following drugs require periodic monitoring of thyroid function tests and renal indices?

A. Divalproex
B. Lamictal
C. Lithium
D. Quetiapine

Correct Answe(C)

Explanation:

Patients on lithium therapy should be monitored with **thyroid function tests and renal indices** every two to three months in the first six months of therapy, then every six to 12 months thereafter.

The usual dosage is 900 to 1800 mg/day, usually started at 300 mg twice daily and adjusted every 2 or 3 days as tolerated; titrated to **serum level of 0.6 to 1.5 mEq/L**

Question 4

About the antipsychotics in the management of bipolar disorder, which of the following induces metabolic syndrome?

A. Lamotrigine.
B. Lithium.
C. Lorazepam.
D. Olanzepine.
E. Sodium valproate.

Correct Answer (D)

Explanation:

OLANZAPINE and RESPIRIDONE can cause **metabolic syndrome** as side effect

Question 5

Which of the following is a symptom of **lithium toxicity**?

A. Tremor
B. psoriatic rash
C. agranulocytosis
D. weight gain
E. polyuria

Correct answer (A)

Tremor is an indication of lithium toxicity.
Other signs of toxicity include diarrhea, vomiting, ataxia, and restlessness.

Weight gain, hypothyroidism, polyuria, and exacerbation of psoriasis can occur at **therapeutic levels**.

Agranulocytosis is **not** associated with lithium use.

Case Scenario

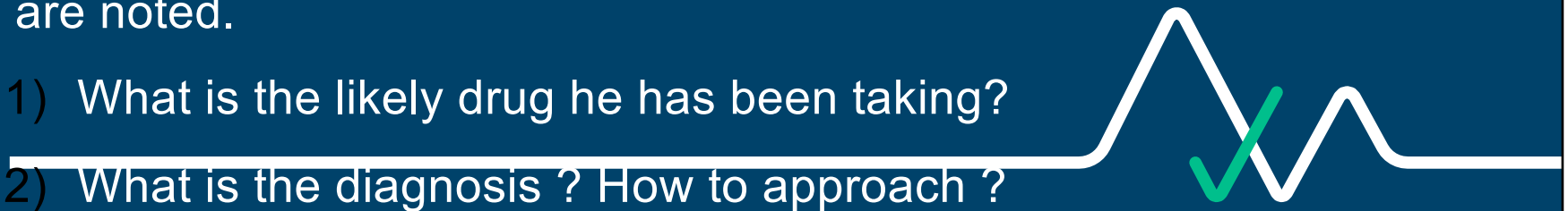
A 21 year old male presents to your clinic with history of **Palpitations** that he has been having for several months. He is describing it as episodes of where he feels his heart is racing. It's on & off with no associated symptoms.

On further questioning & exploring his concern, patient reveals that he has been taking a drug to "to help him with studying & do his part time job". It gives him energy & decrease need for sleep. Since then, he started to take it more frequently as time passed.

For the last couple of months, he admits that he is starting to be more irritable and was caught stealing from his family which led to conflicts at home. He tried to cut back but was unsuccessful. He is feeling ashamed & doesn't know what to do next.

On his mental status examination, patient is alert and oriented. He appears rather haggard, but his hygiene is good. His speech is of normal rate and tone, and he is cooperative. His mood is noted to be anxious. Otherwise, no abnormalities are noted.

1) What is the likely drug he has been taking?
2) What is the diagnosis ? How to approach ?



SUBSTANCE USE DISORDER

Supervised by: DR. TURKI ALSHAREKH
Done by . DR. NAWAL BIN JLALAH

Substance use disorders

Cluster of:

Cognitive Sx
(e.g. poor memory)

Behavioral Sx
(e.g. disinhibition)

Physiological Sx
(e.g. blurred vision)

Resulting from addiction and inability to control use of a substance despite significant disturbance to life.

What Is The Most Common Abused Substances Worldwide?

Nicotine

Alcohol

Source of information: https://www.aafp.org/pubs/afp/issues/2022/1000/practice-guidelines-substance-use-disorders.html

What Is New On This Topic?

- In 2017, e-cigarettes were the most commonly used nicotine-delivery product among high school students.
- 27% of adolescents 13 to 18 years of age who drink alcohol mix it with energy drinks. These adolescents are at increased risk for using tobacco and marijuana and for nonmedical use of prescription stimulants.

Source of information: https://www.aafp.org/pubs/afp/issues/2019/0601/p689.html

Screening for Unhealthy drug abuse

The **USPSTF** recommends screening by asking questions about unhealthy drug use in adults age 18 years or older.

Single Q

How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?

Source of information https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening

DSM-5-TR criteria for SUD:

≧ **2** symptom for **12 months** duration causing significant **distress**

Craving or a strong desire or urge to use the substance	Use of substance in larger amounts or over a longer period than was intended.	Important social, occupational, or recreational activities are given up or missed	Recurrent use in physically hazardous situations (e.g. driving)	Continued use despite persistent physical/psychologic problem due to the substance use.
Great deal of time spent in activities to obtain, use, or recover from the substance's effects.	Persistent desire or failed efforts to cut down/control use.	Recurrent use resulting in failure to fulfill obligations at work, school, or home.	Continued use despite recurrent social/interpersonal problems caused by its effects.	Withdrawal OR Tolerance

DSM5 and Level of severity

None

Mild

Moderate

Severe

1 symptom

Individual at risk

2-3 symptoms

Mild substance use disorder

4-5 symptoms

Moderate substance use disorder

≧ 6 symptoms

Severe substance use disorder

Source of information: https://www-uptodate-com.library.iau.edu.sa/contents/screening-for-unhealthy-use-of-alcohol-and-other-drugs-in-primary-care?search=Screening for unhealthy use of alcohol and other drugs in primary care&source=search_result&se

History taking in SUD:

Type, frequency, amount and route

- Perforated sinus from intranasal intake or infectious disease from injection

Mental health

- Co-occurring depression?
- Personality disorder (borderline/antisocial)?
- Any other psychiatric disorders?

Medical effects

- Serious GI problems such as pancreatitis, cirrhosis, hepatitis B&C.
- STIs such as HIV, syphilis, gonorrhea, and genital warts.

Overdose history

- More likely in individuals who have an opioid use disorder.

History taking in SUD:

Family history

If parent or primary caregiver has an SUD → higher rates of physical & sexual abuse ,trauma, poor parenting skills, and poor quality parent-child interactions, all of which are risk factors for SUDs

Social history

Substance users often have disrupted familial & social relationships, unfulfilled responsibilities at school or work, problems related to finances, the legal system, violence, and engaging in high-risk behaviors.

Source of information: https://www-uptodate-com.library.iau.edu.sa/contents/clinical-assessment-of-substance-use-disorders?search=Clinical assessment of substance use disorders&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1

Motivational Interviewing in substance misuse

Understand the patient	Listen to your patient	Empower the patient	Pros & cons analysis	Reflection & affirmation
Is there anything about your use of cocaine that you are concerned about?	We talked about possible treatment options, but I am interested in hearing what you think would work for you?	Quitting cocaine is difficult for most people, and I've been impressed by how hard you've worked to cut back.	What do you **like** about using cocaine use? What do you **not like** about cocaine use?	I understand you're feeling frustrated , but the fact you came back to talk about it tells me that you're determined. You've quitted before, I am confident you can do it again

Source of information: https://www.aafp.org/pubs/afp/issues/2013/0715/p113.html

Referral Resources			
Mutual help meetings	**Medically supervised withdrawal**	**Outpatient treatment**	**Residential treatment**
Peer-led groups supporting all stages of recovery Example: - Alcoholics Anonymous (http://www.aa.org)	A precursor to drug treatment that address the acute effect of withdrawal; inpatient treatment is appropriate if severe withdrawal.	Services include group or individual counseling & pharmacotherapy Example: - Smoking cessation clinic	24 hrs per day care and a stable living environment, longer treatment periods of weeks to months Example: - Intensive inpatient treatment in general psychiatric hospital

Source of information: https://www.aafp.org/pubs/afp/issues/2022/1000/practice-guidelines-substance-use-disorders.html

TABLE 2

Recommended Treatments for Substance Use Disorders

Substance	Pharmacotherapy		Psychosocial interventions
Alcohol	**Withdrawal** First line (moderate to severe): Benzodiazepines Acceptable (mild to moderate): Carbamazepine (Tegretol) Gabapentin (Neurontin) Valproic acid (Depakene)	**Relapse prevention (moderate to severe)** Strongly recommend: Naltrexone (Revia) Topiramate (Topamax) Weakly recommend: Acamprosate Disulfiram (Antabuse) Second line: Gabapentin	12-step facilitation Behavioral couples therapy Cognitive behavior therapy Motivation enhancement therapy
Opioids	**Withdrawal** Preferred: Buprenorphine/naloxone (Suboxone) Methadone Suggested: Clonidine Lofexidine (Lucemyra)	**Relapse prevention** First line: Buprenorphine/naloxone Methadone Second line: Extended-release intramuscular naltrexone (Vivitrol) Insufficient evidence: Oral naltrexone	None

Source of information: https://www.aafp.org/pubs/afp/issues/2022/1000/practice-guidelines-substance-use-disorders.html

TABLE 2

Recommended Treatments for Substance Use Disorders

Substance	Pharmacotherapy	Psychosocial interventions
Cannabis	None	Cognitive behavior therapy Motivation enhancement therapy Combined cognitive behavior and motivation enhancement therapy
Stimulants	None	Cocaine use disorder Cognitive behavior therapy Recovery-focused behavior therapy Contingency management with another behavioral intervention Amphetamine/methamphetamine use disorder Contingency management with another behavioral intervention
Sedative hypnotic	**Withdrawal** Tapering benzodiazepines; no definitive superior strategy (consider 25% dose reduction each week, and once the patient is at 50% of the original dose, reduce by 12.5% every 4 to 7 days)	Cognitive behavior therapy with extended tapering in structured clinical environment
All disorders	—	Group mutual help programs Peer linkage 12-step facilitation Structured telephone-based care as an adjunct to usual care

Source of information: https://www.aafp.org/pubs/afp/issues/2022/1000/practice-guidelines-substance-use-disorders.html

Follow up

- No established guidelines, it is reasonable to follow up with patient within 4-6 weeks.
- Because the severity and intensity of drug use may evolve, regular reassessment is indicated.
- In early recovery, patients are at increased risk of relapse, physicians should offer support & reinforce healthy behaviors.
- Relapse can be a source of shame and guilt for patients. Physicians can help by ensuring that their office is a safe and blame-free place for patients with drug problems, and by adopting a nonjudgmental and welcoming attitude toward patients in the event of relapse.

Source of information: https://www.aafp.org/pubs/afp/issues/2013/0715/p113.html

Take Home Messages:

- Addiction exists, don't forget to screen for substance abuse
- Family physician can play an important role in rehabilitation the right skills sets e.g. Motivational Interviewing.
- Find your local resources and know how to utilize them.

https://saudifamilymedicine.com/index.php/documentation/sections/

Resources

- AAFP: Management of Substance Use Disorders: Guidelines From the VA/DoD: https://www.aafp.org/pubs/afp/issues/2022/1000/practice-guidelines-substance-use-disorders.html
- Unhealthy Drug Use: Screening USPSTF: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening
- AAFP: Adolescent Substance Use and Misuse: Recognition and Management: https://www.aafp.org/pubs/afp/issues/2019/0601/p689.html
- UpToDate: Screening for unhealthy use of alcohol and other drugs in primary care https://www-uptodate-com.library.iau.edu.sa/contents/screening-for-unhealthy-use-of-alcohol-and-other-drugs-in-primary-care?search=Screening for unhealthy use of alcohol and other drugs in primary care&source=search_result&se
- UpToDate: Clinical assessment of substance use disorders https://www-uptodate-com.library.iau.edu.sa/contents/clinical-assessment-of-substance-use-disorders?search=Clinical assessment of substance use disorders&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1 - H4266973
- AAFP: A Primary Care Approach to Substance Misuse: https://www.aafp.org/pubs/afp/issues/2013/0715/p113.html

RESOURCES

- THE ESSENTIAL BOOK OF FAMILY MEDICINE
- ROSH Question bank
- Swanson family medicine

THANK YOU