

Treating Depression in the Primary Care Setting

MHNet has adopted this guideline from the American Psychiatric Association's (APA) Practice Guideline for the Treatment of Major Depression. This synopsis is provided as a service to primary care practitioners. This guideline summary is not designed to stand on its own and should be used in conjunction with the full text of the Practice Guideline which is available at the APA's web site, www.psych.org. If you do not have access to this web site and would like a hard copy of the complete practice guideline, please contact MHNet's Corporate Quality Improvement Department at (512) 347-7900.

Major depression is a common illness affecting roughly 15 percent of the population at sometime during their life. Most people with major depression do seek professional help. For those who do, primary care physicians remain the point of entry into the behavioral health system, even when managed behavioral health care organizations such as MHNet are in place.

Depression presents myriad challenges to PCP's. Successful treatment of major depression requires a proactive and systematic approach to detection and management through a combination of psychotherapy and, often, medication. The therapy does not have to be sophisticated. Brief supportive therapy is sufficient for many individuals.

Primary care physicians have several functions with regards to major depression: they need to identify patients with the condition, prescribe medications, provide supportive therapy, adjust medications as necessary, continue maintenance medications if appropriate, refer specific patients for psychiatric evaluation and counseling, and monitor treatment compliance.

EVALUATING PATIENTS

It is recommended that all PCP's have some mechanism for routinely screening patients for major depression. This can be formalized by using a screening questionnaire (e.g. PrimeMD), or by routinely including questions about depression in the review of systems. The PCP should be knowledgeable about the cardinal symptoms of depression:

- Depressed mood most of the time;
- Loss of interest and pleasure;
- Weight loss (or gain);
- Insomnia (or hypersomnia);
- Psychomotor agitation or retardation;
- Fatigue;
- Hopelessness and worthlessness;
- Poor concentration; and
- Thoughts of death

Since many patients do not spontaneously report these symptoms, it is important that the PCP ask direct questions of any patient who presents with a new onset of vague symptoms that are not clearly diagnostic of a specific medical condition.

If the PCP identifies new onset major depression (or a recurrence of major depression in a patient with a prior history), he or she should either refer for psychiatric evaluation or initiate supportive counseling along with an antidepressant medication

INITIATING ANTIDEPRESSANTS

The first step is to get a thorough history of medication use and response. In general, if a patient has shown a clear response to a specific agent in the past, the same drug should be restarted. The only exception would be a patient whose prior treatment was in the remote past before the discovery of newer generation antidepressants. For these individuals, one may elect to try a newer drug with fewer side effects than an older tricyclic or monoamine oxidase inhibitor (MAOI) antidepressant.

If there is no prior history of antidepressant responsiveness, most physicians initiate therapy with a selective serotonin reuptake inhibitor (SSRI). There are currently four FDA approved SSRIs available for the treatment of major depression (Celexa, Paxil, Prozac and Zoloft). Of these, only Prozac currently has a generic substitute. It is recommended that PCP's become familiar with one or two of these medications and use them as their first line drugs.

SSRI's can be started at the full therapeutic dose (20mg/day for Celexa, Paxil or Prozac, 50mg/day for Zoloft). However, many physicians start at ½ dose for several days to minimize initial side effects. After several weeks, if there has been no response, an upward dosage adjustment of 50-100% of the starting dose can be made. If there has been no significant response within six weeks, an alternative drug should be tried or a referral made to a psychiatrist.

SUPPORTIVE THERAPY

If the PCP does not refer the patient for counseling, then he or she should provide the patient with supportive therapy. This should include brief visits (15 to 30 minutes) once a week or every other week for the first two months until the patient reports significant improvement.

CONTINUATION MEDICATION

Once patients report significant benefit from medication therapy, they should continue the antidepressant medication for at least nine months. Patients should be counseled that premature discontinuation of their medication can result in a prompt relapse. Follow up visits should be based upon the need for continued supportive counseling and the need to insure medication compliance. Most psychiatrists will see patients once a month for several months after they report significant improvement to encourage continued compliance with treatment. After nine months, patients can be weaned of the SSRI (typically by taking ½ the dose for a month then stopping). Some patients may experience physical withdrawal (particularly with the shorter acting Paxil) that may necessitate more gradual withdrawal.

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MAINTENANCE MEDICATION

Patients who have had more than 3 episodes of major depression (or two episodes if the depression was severe) should be considered for maintenance antidepressant therapy. In weighing this decision, the physician should balance the relatively small risk of long-term drug therapy against the significant risk of recurrent depression. Depression is usually quite incapacitating and is associated with significant mortality due to suicide. Although some clinicians use lower dose for maintenance therapy, as long as the patient reports no significant side effects from their medication, lowering the dose is not warranted.

CHOOSING A DIFFERENT AGENT

Outcome studies suggest that all antidepressants are effective in about 60% of patients with major depression. Therefore, it is common that a patient will not respond to the first agent prescribed. It is recommended that PCP's become familiar with one or more non-SSRI medications to use as a second line drug. Possible agents include Wellbutrin, Remeron, or Serzone. Wellbutrin should be initiated at a dose of 100mg/day and titrated up to 150mg twice a day. Remeron should start at 15mg hs. As needed, one can adjust the dose up to 45mg hs. Serzone is usually started at a low dose (100mg/day) and gradually increased to 300-450mg/day in divided doses or all at bedtime.

CONCOMMITMENT MEDICATIONS

Antidepressants take several weeks before there is significant benefit. Therefore, it is frequently beneficial to give patients some immediate symptomatic relief with anxiolytics during the day (Ativan, Xanax or Serax) and hypnotics at night for sleep (Ambien, Sonata, Restoril). These should be for short-term use only (2-4 weeks). Since most of these drugs are short acting, patients should be advised about rebound anxiety when they wear off. In particular, the short acting hypnotics (Ambien and Sonata) may not provide prolonged sleep for the severely depressed.

ELDERLY PATIENTS

Special consideration needs to be given to elderly patients. This includes increased sensitivity to antidepressant side effects especially sedation, agitation, unsteadiness, and confusion. Possible interactions with other medications should be considered before initiating therapy. Starting doses should be adjusted downward. One typically starts with ½ the usual starting dose of an antidepressant, ¼ the usual starting dose of an anxiolytic. The possibility of a medical condition causing or exacerbating the depression is increased in the elderly population. Therefore, one must be sure to exclude any underlying treatable physical condition.

WHEN TO REFER

Patients should be referred for counseling if they have multiple or severe life stressors in addition to their depressive illness. They should be referred if the depression is profound, overwhelming, and brief supportive contact is insufficient. If the depression is negatively impacting the family, counseling may be helpful in addressing their concerns.

Patients should be referred for psychiatric assessment if they are suicidal, psychotic, or possibly in need of hospitalization. They should be referred if they have a secondary psychiatric condition such as active substance abuse, panic disorder, dysthymia or personality disorder. They should be referred if there has been no significant improvement in two months with a single antidepressant (3 months if two agents are tried).

INTENT

This practice guideline is not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The practitioner, in light of the clinical data presented by the patient and the diagnostic and treatment options available, must make the ultimate judgment regarding a particular clinical procedure or treatment plan.

REFERENCES

These guidelines were adapted from the American Psychiatric Association's practice guidelines [American Psychiatric Association: Practice Guidelines for the Treatment of Patients with Major Depressive Disorder. *Am J Psychiatry* 2000; 157 (April suppl)]. The reader is referred to the original article for detailed references as well as the work group that prepared the APA guidelines.

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