

Identification and Treatment of Depression in Primary Care For Adults Ages 18 and Older

PRACTICE PRINCIPLE

Practice Guidelines and Principles: Guidelines and principles are intended to be flexible. They serve as reference points or recommendations, not rigid criteria. Guidelines and principles should be followed in most cases, but there is an understanding that, depending on the patient, the setting, the circumstances, or other factors, care can and should be tailored to fit individual needs.

Key Points:

- Depression is treatable.
- Untreated depression may interfere with recovery from co-morbid conditions.
- Screening in Primary Care along with coordinated treatment and follow-up of depressed adults decreases clinical morbidity.
- Medical conditions can lead to depression. For example, CAD, diabetes, chronic pain, dementia, cancer, HIV/AIDS, trauma, obesity, pregnancy/ postpartum, chronic medical/psychiatric conditions.
- Research has demonstrated that a person is more likely to develop depression based on the presence of the number of risk factors. Such as, age, gender, family history, stress (i.e., marital problems, divorce, death of loved one, unemployment) and emotional trauma.
- Mild to moderate depression may be treated by medication and/or psychotherapy, more severe depression requires medication or other somatic treatments.
- Adequate dosing of antidepressant medication, patient compliance with medication and/or psychotherapy is the key to favorable outcomes.

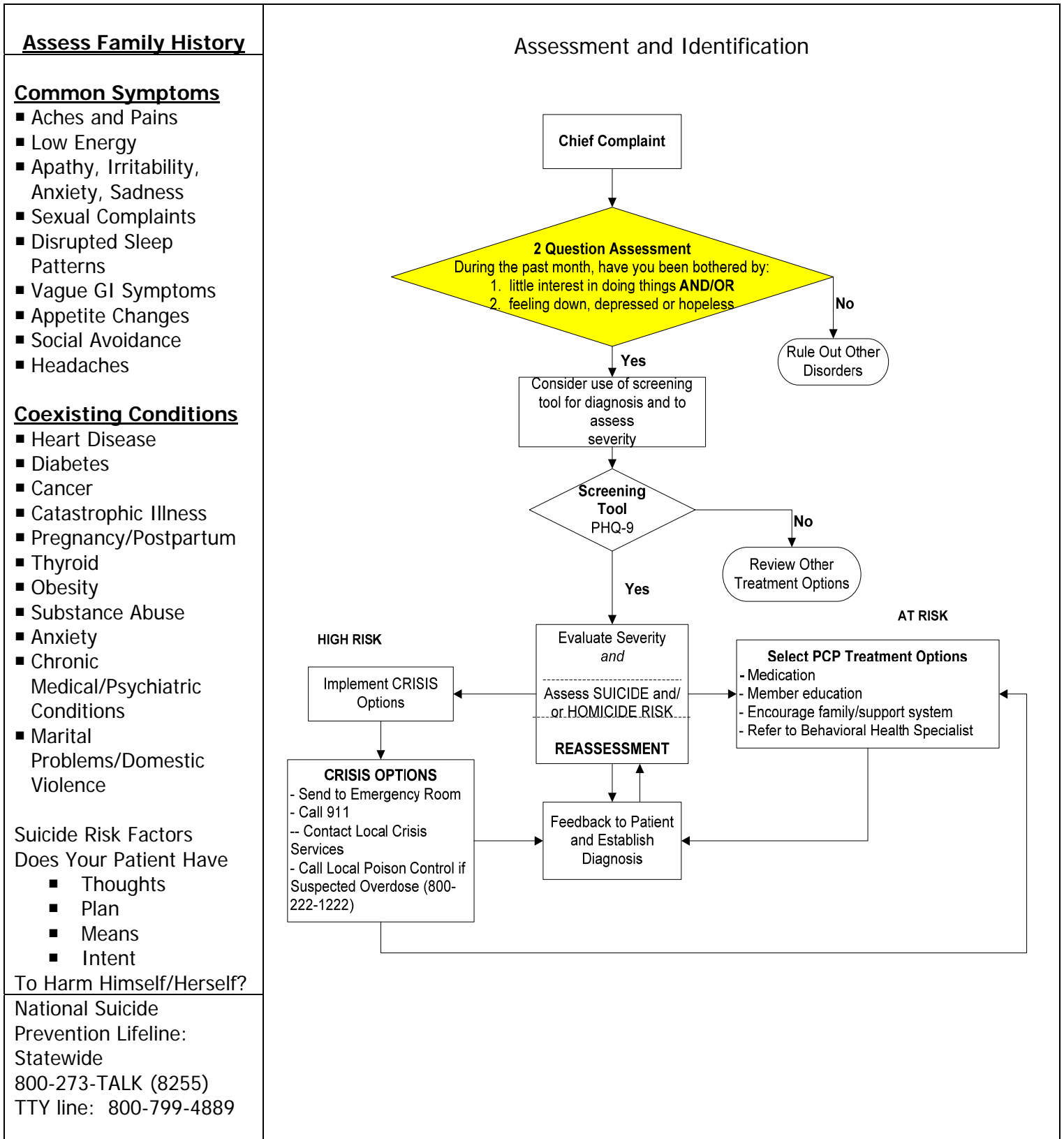
High Risk Populations/Disparities:

- Depression affects twice as many women as men, regardless of racial and ethnic background or income.
- Suicide is the second leading cause of death for men 18-24. Men over 55 are also at significant risk.
- Depression is one of the most common conditions associated with suicide in older adults, but it is not always recognized and is often under treated.
- African Americans are treated for depression less often than Caucasians; however they are 40% more likely to experience depression than Caucasians or Hispanics.
- African Americans may mistrust conventional treatment and are more likely to discuss care with their pastor.
- Poverty and low socioeconomic status contribute to depression.

Purpose: To improve the identification and treatment of patients with Major Depressive Disorder (MDD or Major Depression) in the primary care setting. Depressive symptoms which are not considered to reflect Major Depressive Disorder, and are related to other diagnoses e.g., Dysthymia, Seasonal Affective Disorder, Bipolar Disorder (Manic Depressive Illness), are not considered to be the focus of this guideline.

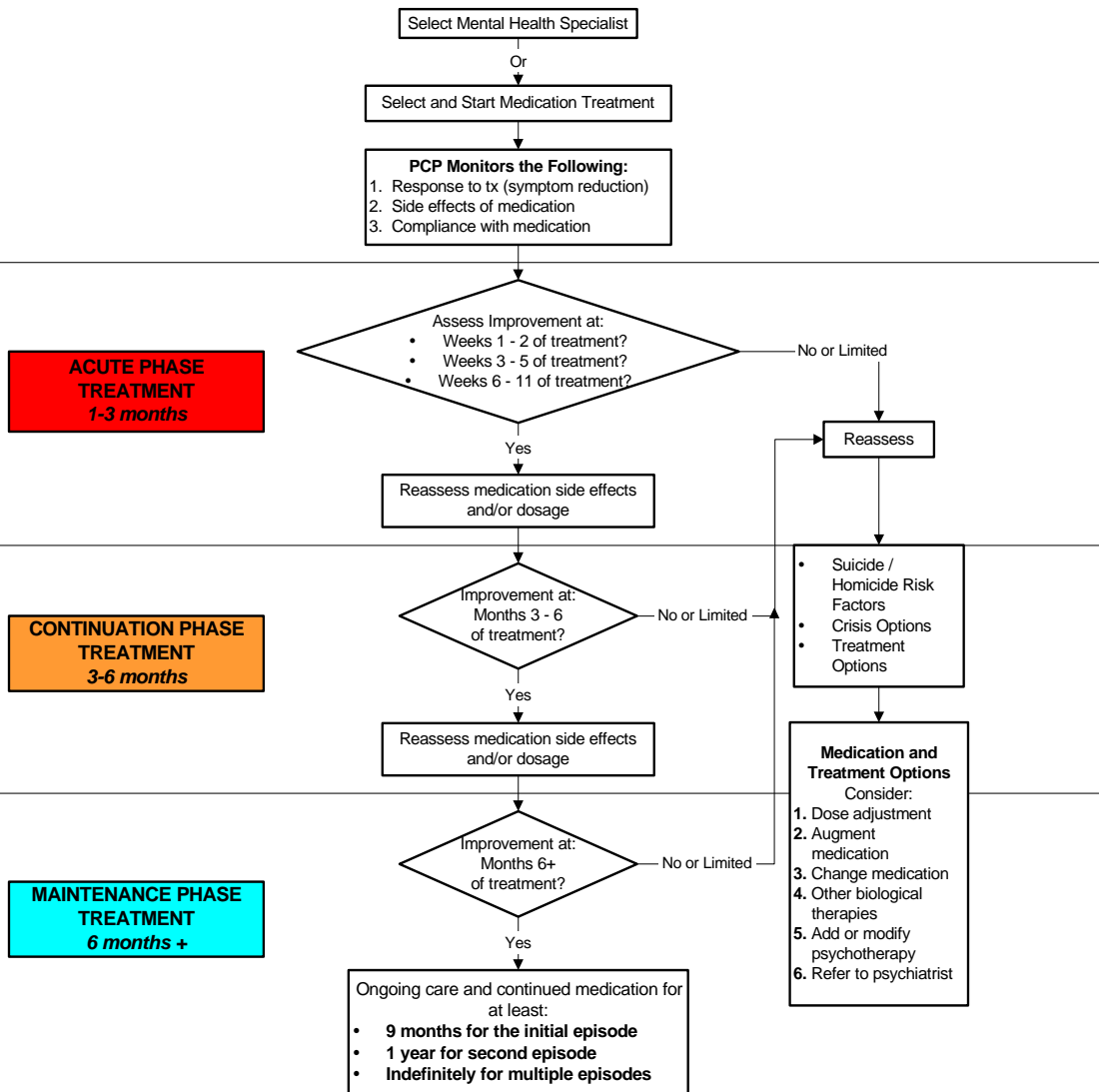
Distributed to: Primary care physicians including internists, family practitioners, general practice physicians, and pediatricians; specialists/sub-specialists including obstetricians/gynecologists, and psychiatrists; and psychologists, psychiatric nurse practitioners and licensed clinical social workers.

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Treatment of Depression



When to Refer to a Mental Health Specialist

- Active Suicide Potential
- Psychotic Symptoms
- Lack of Response to Treatment
- Need for Psychotherapy/ Counseling
- Substance Abuse
- Poor Adherence/ Compliance
- Diagnostic Consultation (Treatment/ Medication Management)
- Need for Hospitalization or Electroconvulsive Therapy (ECT)
- Recurrent or Chronic Depression
- Patient or Family Request
- Cultural Considerations

Resource Materials:

1. American Psychiatric Association Clinical Resources, April 2000, Practice Guideline for the Treatment of Patients with Major Depression, 2nd Edition, Washington, D.C.
2. American Psychiatric Association, Clinical Resources, September 2005, Guideline Watch: Practice Guideline for the Treatment of Patients with Major Depressive Disorder, 2nd Edition.
3. Texas Implementation of Medication Algorithms (TIMA) Guidelines for Treatment Major Depressive Disorder, TIMA Physician Procedural Manual, revised 9/2000, last edited 12/2000.
4. The MacArthur Initiative on Depression in Primary Care at Dartmouth & Duke, Depression Management Tool Kit, © 2009 Trustees of Dartmouth College, Created by and for The John D. & Catherine T. MacArthur Foundation's Initiative on Depression & Primary Care.
5. Institute for Clinical Systems Improvement (ICSI), Depression, Major, In Adults in Primay Care. Bloomington (MN) Thirteenth Edition, May 2010

For questions or assistance with depression care call:

Behavioral Health
Department

1-800-277-2138

Antidepressant Fact Sheet

All antidepressants may be started at a lower dose to decrease side effects

Generic Name	Brand Name	Dosage Forms ++ <i>liquid</i>	Usual Daily Dose
SSRI's			
citalopram	Celexa*	10,20,40mg ++	20-60 mg
paroxetine	Paxil*	10,20,30,40mg ++	20-50 mg
	Paxil CR*	12.5,25,37.5 mg	12.5-37.5 mg
sertraline	Zoloft*	25,50,100mg ++	50-200mg
fluoxetine	Prozac*	10,20,40mg ++	20-60mg ¹
	Prozac Time Release Capsule*	90mg weekly	90mg weekly
escitalopram	Lexapro	5,10,20mg ++	10-20mg ¹
DNRI			
bupropion hydrochloride	Wellbutrin* Wellbutrin SR* Wellbutrin XL*	75,100mg 100,150,200mg 150,300mg	200-450mg 150-400mg 300-450mg
bupropion hydrobromide	Aplenzin	174,348,522mg	174-522mg
SNRIs			
venlafaxine	Effexor* Effexor XR	25,37.5,50,75,100mg 37.5, 75,150mg	75-375mg 75-225mg
	Venlafaxine ER tablet	37.5,75,150,225 mg	75-225mg
desvenlafaxine	Pristiq	50,100mg	50-400mg
mirtazapine	Remeron*	7.5,15,30,45mg	15-45mg
	Remeron SoluTab*	15,30,45mg	15-45mg
duloxetine	Cymbalta	20,30,60mg	60mg
Tricyclics			
amitriptyline	Elavil*	10,25,50,75,100,150mg	25-300mg
desipramine	Norpramin*	10,25,50,75,100,150mg	50-300mg
doxepin	Sinequan*	10,25,50,75,100,150mg ++	50-300mg ¹
imipramine	Tofranil*	10,25,50mg	75-300mg
nortriptyline	Pamelor*	10,25,50,75mg ++	25-150mg
Atypical Antipsychotics (increased safety risks- recommend using only as 3rd line therapy for depression; try other treatment options first)			
aripiprazole	Abilify	2,5,10,15,20,30mg ++	2-15mg as adjunctive treatment of depression
	Abilify Discmelt	10,15mg	
quetiapine	Seroquel XR	150,200,300,400, 500mg	150-300mg as adjunctive therapy in the treatment of depression

*Available in Generic.

¹ FDA approved in the treatment of depression for children. Please refer to package inserts for specific ages, as some are indicated for children 8 years and older and others are for children 12 years and older.

For a full range of drug interactions and side effects, see the Physician's Desk Reference (PDR). Some medications may cause excessive weight gain and sexual problems, which may be substantial.

MAC approval August 19, 2010. Next scheduled update August 2012

Contraindications to therapy:

- All SSRIs, TCAs, DNRI, and SNRIs listed above are contraindicated with the concurrent use of MAOI therapy.
- Bupropion is contraindicated in patients with history of seizures or eating disorders, and should be used with caution with agents that lower seizure threshold.
- Cymbalta is contraindicated in individuals with uncontrolled closed-angle glaucoma.
- Elavil, Norpramin, Tofranil, and Pamelor are contraindicated in individuals with acute myocardial infarction.
- Sinequan is contraindicated in patients with glaucoma and urinary retention.

Do not use Sarafem with Prozac, as both are Fluoxetine.

Do not use Zyban with Wellbutrin or Aplenzin, as both are bupropion.

**FDA Issues Public Health Advisory on Antidepressant Use: March 22, 2004 the FDA asked manufacturers to add a warning statement indicating the possibility of worsening depression or emergence of suicidal tendencies in adults and pediatric patients on the labels of the following drugs: ²

Celexa® (Citalopram)	Effexor® (venlafaxine)	Lexapro® (escitalopram)
Paxil® (paroxetine)	Prozac® (fluoxetine)	Remeron® (mirtazapine)
Wellbutrin® (bupropion)	Zoloft® (sertraline)	Luvox® (fluvoxamine)
Serzone® (nefazodone)	Cymbalta® (duloxetine)	

Prescribers should carefully monitor patients on the above medications especially at the beginning of treatment or when doses are adjusted. ² **Now applies to ALL SSRIs**

*****On May 2nd 2007 the FDA stated that all antidepressants should carry new warnings about an increased risk of suicidal thoughts and behavior in young adults ages 18-24 during the first few months of treatment.**

Samples: Caution should be used in assuming that free samples reduce patients' out of pocket prescription costs. Patients who receive free samples end up paying for that prescription after the initial samples. The medications that are given as free samples are often the newest and the most expensive. Studies show that adherence to a drug regimen increases for patient who fill generic medications compared to non-preferred brand name drugs.

References:

1. www.fda.gov/cder/drug/antidepressants
2. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.
<<http://clinicalpharmacologyip.com/Forms/drugoptions.aspx?cpnum=690&n=Celexa>>
Updated October 17, 2009.