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Targeting depression: Primary care tips and tools

The resources provided here can help you determine if depression is to blame for your patient's symptoms. A handy antidepressant guide can inform your Tx choices.

▶ THE CASE

As you get ready to see your next patient, 52-year-old Jim M, you see in his chart that during an annual routine nurse screening (per office protocol), he scored positive for depressed mood/anhedonia on the Patient Health Questionnaire-2 (PHQ-2) and scored a 21 out of 27 on the full version (PHQ-9), suggesting that he has severe major depressive disorder and that antidepressants should be considered.

When you enter the exam room, you notice his sad expression, poor eye contact, and stooped posture. Mr. M says his wife "made him" come to see you. He reports low energy and not wanting to leave his house, which started about a year earlier after he lost his job. When you discuss his job loss and the impact it has had on him, he sheepishly admits to sometimes thinking that things would be better if he were dead. Upon further questioning, you learn that he does not have suicidal intentions or plans.

○ HOW WOULD YOU PROCEED WITH THIS PATIENT?

Depression is the most common mental health complaint in primary care settings; in 2015, an estimated 16.1 million (6.7%) adults in the United States ages 18 or older had at least one depressive episode in the past year.¹ Depression results in significant health, work, and social life impairments,² and comorbid anxiety is highly prevalent in patients with depression.

Primary care physicians see almost twice as many mental health patients as psychiatrists³ due to barriers in behavioral health treatment (such as wait times, cost, and stigma) and the fact that primary care physicians often provide first-line access to behavioral health resources. Depression is caused by biological, psychological, and social factors, and pri-

mary care physicians are ideally positioned to develop therapeutic, healing relationships with patients that coincide with the biopsychosocial model of the disease.⁴

This review will provide some useful tips and tools to ensure that these patients get the care they need.

DEPRESSION? OR ARE OTHER FACTORS AT PLAY?

Major depressive disorder (MDD) is defined as a clinically significant change in mood that lasts at least 2 weeks.⁵ The main symptoms of MDD include depressed mood and markedly diminished interest or pleasure; additional symptoms may include reduced self-esteem,

TABLE 1

Potential organic causes of depressive symptoms⁶

Causes	Tests
Anemia, leukocytosis	Complete blood count
Metabolic/electrolyte abnormalities, poor renal function	Metabolic/chemistry panel
Hormonal abnormalities	TSH, ACTH stimulation test, dexamethasone suppression test
Substance use	Urine drug screen, blood alcohol level
Pregnancy	Urine hCG
Nutritional deficiencies	Vitamin B12, vitamin D
Sleep apnea	Polysomnogram

ACTH, adrenocorticotropic hormone; hCG, human chorionic gonadotropin; TSH, thyroid stimulating hormone.

weight/appetite changes, fatigue or reduced energy, guilt/worthlessness, decreased activity, poor concentration, and suicidal thinking.⁵ To meet the criteria for a diagnosis of MDD, patients must experience symptoms for most of the day, nearly every day. (Dysthymia or persistent depressive disorder is a type of depression that is milder and more chronic than MDD, but does not have as many symptoms as MDD.) The focus of this article will be on MDD.

Shared symptoms with other disorders

Depression often displays some of the same symptoms as bereavement disorder and adjustment disorder, as well as other conditions.

■ **Grief over loss and depressive symptoms circumscribed to a stressor** are considered bereavement disorder and adjustment disorder, respectively. These disorders are usually limited to weeks or months as the patient adapts to his/her particular situation.

■ **Organic problems** such as nutritional deficiencies and sleep apnea can cause, exacerbate, or mimic depression (TABLE 1⁶). Pain and depression are often associated, in that chronic pain can precipitate or perpetuate depression.⁷

■ **Bipolar disorder** consists of both depressive and manic episodes; patients may be misdiagnosed and treated for depression alone.

■ **Substance intoxication** or withdrawal can precipitate or perpetuate depression. A period of abstinence of at least one month may

be necessary to see if depressive symptoms persist or resolve.

■ **Premenstrual dysphoric disorder** is defined as a period of depressed mood that is limited to the final week before the onset of menses and resolves in the week post-menses.

HOW TO MAKE THE DIAGNOSIS

Inquiring about prolonged feelings of sadness and/or lack of enjoyment in activities is an effective way to begin the screening process for depression.⁸ Screening tools such as the PHQ-9 (TABLE 2⁹), Beck Depression Inventory, Hamilton Rating Scale for Depression, and Geriatric Depression Scale are useful when combined with a clinical interview. Another useful tool is the Mood Disorder Questionnaire, which can help one determine if a patient is suffering from depression or bipolar disorder. It's available at: <http://www.dbsalliance.org/pdfs/MDQ.pdf>. (Asking about a history of consecutive days of elevated, expansive, or irritable mood accompanied by increased activity or energy can also provide valuable insight.)

For its part, the US Preventive Services Task Force recommends screening adults for depression when adequate systems are in place (eg, referrals to settings that can provide necessary care) so as "to assure accurate diagnosis, effective treatment, and follow-up."¹⁰⁻¹²

■ **Assessing severity.** Asking about functional impairments at work and at home and



About two-thirds of all patients with depression contemplate suicide and 10% to 15% will attempt suicide.

TABLE 2
Patient Health Questionnaire (PHQ-9)⁹

Question	Response							
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 may have noticed, or 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 <input type="checkbox"/>	Somewhat difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Extremely difficult <input type="checkbox"/>				
Score interpretation								
1 to 4: No depression.								
5 to 9: Mild depression; watchful waiting; consider repeating PHQ-9 at follow-up visit.								
10 to 14: Moderate depression; consider counseling and/or pharmacotherapy.								
15 to 19: Moderately severe depression; start pharmacotherapy and/or counseling.								
20 to 27: Severe depression; start pharmacotherapy; hospitalize if actively suicidal; refer to behavioral health specialist if patient has severe impairment or poor response to treatment.								

with academics and relationships will help determine severity, as will inquiring about a patient's past or current suicidal thoughts. About two-thirds of all patients with depression contemplate suicide and 10% to 15% will attempt suicide.¹³

There is no evidence that inquiring about thoughts of death or suicide exacerbates suicidal risk.^{14,15} Confirming a diagnosis of MDD

may require multiple visits, but should not delay treatment.

MAKING THE MOST OF THE TOOLS AT YOUR DISPOSAL

As a family physician (FP), you are especially well positioned to help patients suffering from MDD by offering education, counseling, and

support; prescribing antidepressants; and coordinating care. Collaboration with behavioral health teams may be beneficial, especially in complex and treatment-resistant cases.

■ **Counseling**, alone or combined with pharmacotherapy, may improve patient outcomes.^{16,17} A first step may be recommending behavior modifications (such as adequate sleep, exercise, and a healthy diet). FPs can learn to utilize several counseling techniques, such as motivational interviewing, solution-focused therapy, and supportive therapy, for a variety of clinical situations in which behavioral change would be helpful.¹⁸ Establishing a therapeutic alliance through empathy and creating treatment expectations are key to helping patients overcome depression.^{19,20} Referral to a therapist can help identify and manage psychosocial factors that are often inherent in depression. Explaining to the patient that depression is best improved with a combination of medication and therapy is often helpful in motivating the patient to see a therapist.

■ **Selecting an antidepressant.** There is insufficient evidence to show differences in remission rates or times to remission among antidepressants,²¹ so medication choice involves balancing factors such as cost, previous treatments, adverse effects, and comorbid conditions (TABLE 3²²). A recent systematic review and meta-analysis involving 66 studies and more than 15,000 patients found tricyclic/tetracyclic antidepressants and selective serotonin reuptake inhibitors (SSRIs) to have the best evidence for treatment of depression in the primary care setting.²³ Ask the patient about previous antidepressant prescriptions they were given, if any, and weigh the benefits and adverse effects with the patient.

Patients may notice a partial response as early as one to 2 weeks after starting treatment with antidepressants, but it's important to tell them that a full response can take up to 4 to 6 weeks. The goal of treatment is remission of depressive symptoms, which is defined as scoring below the cutoff point on a validated depression scale, such as less than 5 on the PHQ-9.²⁴ It's advisable to increase the antidepressant dose if the patient has a partial response and switch to a new class if the patient has no response or severe adverse effects.

Antidepressants should be maintained for at least 6 months or the length of a previous episode, whichever is greater.²⁴ Prophylactic treatment should be considered for patients who have had severe episodes in the past (eg, a history of suicidal ideations and/or past hospitalizations). If an antidepressant is discontinued, it should be tapered over one to 2 weeks to minimize the risk of discontinuation syndrome (flu-like symptoms, nausea, insomnia, and hyperarousal). There is a lack of consistent evidence for the use of St. John's wort, and as such, it is not recommended.²⁴

■ **Adjunct medications** can also be used when remission does not occur after 8 to 12 weeks of maximum antidepressant doses. Insomnia, which is a common complaint in patients with MDD, can be treated with trazodone (an off-label indication), diphenhydramine, or melatonin. (See "Insomnia: Getting to the cause, facilitating relief" on page 216.) Benzodiazepines and other hypnotics (eg, zolpidem) can be used initially until antidepressants have had time to become effective. Antipsychotics such as aripiprazole, risperidone, quetiapine, and ziprasidone can be used to treat psychotic symptoms of depression or boost antidepressant effectiveness.²⁵ Lithium and thyroxine are effective for treatment-resistant depression.²⁶ Nutraceuticals such as S-Adenosyl-L-methionine, methylfolate, omega-3, and vitamin D can reduce depressive symptoms when combined with an antidepressant.²⁷

There is some evidence to support combining 2 antidepressants from different classes (eg, an SSRI plus a serotonin-norepinephrine reuptake inhibitor [SNRI] or norepinephrine-dopamine reuptake inhibitor, or an SNRI plus a noradrenergic and specific serotonergic antidepressant) when adjunct therapy has proven ineffective.²⁸

Inpatient psychiatric admission is warranted in severe cases, such as when a patient has active suicidal intentions/plans or poor self-care.

Your critical role, even when depression is co-managed

Collaborative care for depression (patient contact with both primary and behavioral health care providers in the same clinic) signif-



If an antidepressant is discontinued, it should be tapered over one to 2 weeks to minimize the risk of discontinuation syndrome.

TABLE 3

Commonly used antidepressants²²

Class	Types (usual daily dosing)	Unique properties	Common adverse effects
TCA's	Amitriptyline (100-300 mg) Nortriptyline (40-200 mg) Imipramine (50-150 mg)	Effective in patients with chronic pain, diabetic neuropathy, migraines, and fibromyalgia.	Anticholinergic effects include sedation, constipation, and urinary retention. Can cause orthostatic hypotension. Risk of fatal arrhythmia in overdose.
SSRIs	Citalopram (20-60 mg) Escitalopram (10-20 mg) Sertraline (50-200 mg) Fluoxetine (10-40 mg) Paroxetine (20-50 mg)	Generally safe to use in pregnancy. Citalopram can cause QTc prolongation. Good for comorbid anxiety.	Adverse effects include decreased sexual libido; gastrointestinal problems (diarrhea, nausea, vomiting); emotional blunting; and bruising (inhibition of platelet function). When taking other serotonergic medications (eg, tramadol, ondansetron, triptans), serotonin syndrome (diarrhea, restlessness, autonomic instability, rigidity, myoclonus) is also a concern.
SNRIs	Duloxetine (30-60 mg) Venlafaxine (150-375 mg)	Good for patients who are also suffering from neuropathic pain. Venlafaxine is good for comorbid anxiety and comes in regular- and extended-release formulations.	In addition to SSRI adverse effects listed above, SNRIs can cause elevated blood pressure.
NDRI's	Bupropion (200-400 mg)	Good for ADHD-like symptoms and tobacco users; no sexual adverse effects.	Headaches, insomnia, tremors, lowers seizure threshold, worsens anxiety.
NaSSA's	Mirtazapine (15-30 mg)	Good for insomnia and poor appetite; no sexual adverse effects.	Somnolence, weight gain.

ADHD, attention-deficit/hyperactivity disorder; NaSSA's, noradrenergic and specific serotonergic antidepressants; NDRI's, norepinephrine-dopamine reuptake inhibitors; SNRIs, serotonin-norepinephrine reuptake inhibitors; SSRIs, selective serotonin reuptake inhibitors; TCAs, tricyclic antidepressants.

icantly improves clinical outcomes at 6 months compared to primary care treatment alone.²⁹ Patients who have failed 2 therapeutic trials (at least 6-8 weeks of separate antidepressant treatments without response) are considered treatment-resistant.³⁰ Referral to a psychiatrist is appropriate in this setting to determine alternative treatment options.

> CASE

Based on further conversation with Mr. M, you learn that he actually began exhibiting symptoms of depression (anhedonia, poor concentration, insomnia) years before he lost his job, but that he had considered the symptoms "normal" for his age. He reports that he didn't want to socialize with others anymore

and harbors feelings of worthlessness. You tell him that you believe he is suffering from MDD and talk to him about some options for treatment. You decide together to begin a trial of escitalopram 10 mg/d, as it was covered by his insurance, has minimal adverse effects, and was a good match for his symptoms. You also educate and instruct Mr. M on self-management goals such as limiting alcohol intake, eating at least 2 meals a day, walking with his wife each evening, and following a regular sleep schedule. You discuss a safety plan with Mr. M, should his depressive symptoms worsen. Specifically, you tell him that if he begins to have suicidal intentions or plans, he should call 911 or go to the nearest emergency department.

Mr. M returns 4 weeks later and reports that his mood has slightly improved, as evidenced by a brighter affect and increased energy, so you increase the dose of escitalopram to 20 mg/d. At his third visit 4 weeks later, Mr. M discloses a remote history of trauma and current intermittent heavy drinking. After offering support and education and discussing his options, you refer Mr. M to a counselor in your clinic through a “warm handoff” (the counselor is brought briefly into the current session with the patient to meet and set up an appointment). During this time, he is given information about an outpatient substance abuse treatment group.

Mr. M’s PHQ-9 improves by 8 points by his fourth visit 4 weeks later. He reports that he is still taking the escitalopram and you recommend he continue to take it. Mr. M tells you he’s been seeing the counselor at your clinic every other week and that he has begun attending meetings with the substance abuse group. He also says that he and his wife go out for walks now and then. Mr. M says he feels as though he is a failure, prompting you to recommend that he explore the cognitive distortions (ie, inaccurate thoughts that reinforce negative feelings) with his therapist.

You schedule another appointment with Mr. M in 3 months to keep track of his progress. Fortunately, Mr. M’s therapist works in the same clinic as you, so you can contact her to discuss his progress with therapy. **JFP**

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