Depression:
A Darker Shade of Blue

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Today's Agenda

- Welcome and Introduction – 8:00
- Clinical & In Real Life Aspects– 8:05
- **Break – 9:15**
- Medication Review – 9:30
- Questions – 10:30
- Closing – 10:55

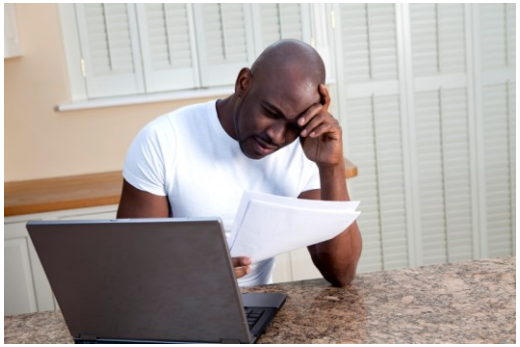
Depression by the numbers

- 19 million people in the US are affected by depression
- 41,149 annual deaths from suicide
- 8.0 million ambulatory care visits with depression as primary visit diagnosis
- Only 25% of adults with mental health symptoms believe that people are caring and sympathetic to people with mental illness

http://www.cdc.gov/nchs/fastats/depression.htm
http://www.cdc.gov/mentalhealth/data_stats/mental-illness.htm

Social Determinants of Health

- Suicide
  - 40 times more prevalent in young men unemployed >6 months
  - 6 times more prevalent in long term unemployment
- Serious psychological distress
  - 21.4% people in foreclosure vs. 1.4% homeowners with no financial strain
- Elevated depressive symptoms
  - 8.6x risk in people in foreclosure vs. homeowners with no financial strain



https://c.ymcdn.com/sites/aptr.site-ym.com/resource/resmgr/hp2020_modules/module_3_section1_slides.pdf

CCO Quality Measures

- Depression screening and follow-up plan
  - 2014 benchmark: 25%; HSO: 48.5%
  - 2015 benchmark: 25%

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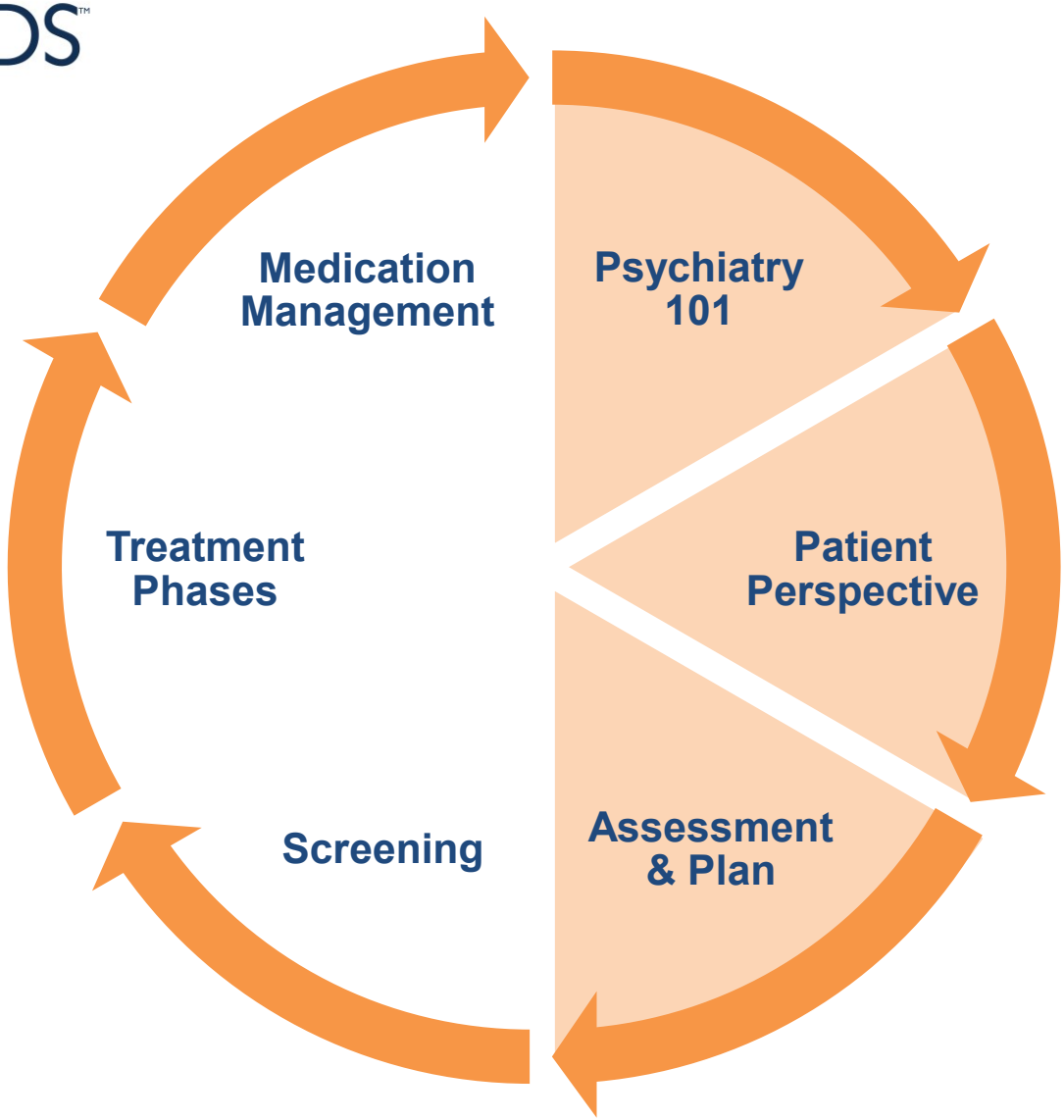
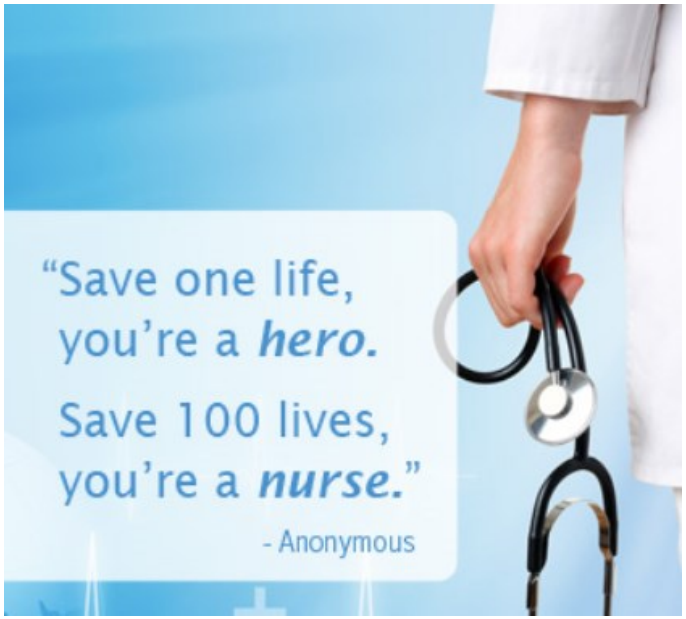


Depression
Clinical, In Real Life Aspects

John K. Bischof, MD
Psychiatric Medical Director
Old Town Recovery Center
Central City Concern

This matters to you as a nurse, because…

- Depression is COMMON,
- its presentation is VARIED
- its impact COSTLY (lives and dollars)
- YOU are in a unique position to screen, identify, refer, and change/save a life!



Psychiatry 101

Severe/Serious Mental Illness (SMI)

Formal Definition	Informal Definition
"Of sufficient duration to meet diagnostic criteria specified within the 5th edition of the Diagnostic and Statistical Manual of **Mental Disorders** (DSM-5); Resulting in **serious** functional impairment, which substantially interferes with or limits one or more major life activities"	*Most common mental health diagnoses:* Schizophrenia, Bipolar Disorder, Major Depression, Posttraumatic Stress Disorder, Generalized Anxiety Disorder, Obsessive Compulsive Disorder

http://www.nimh.nih.gov/about/director/2013/getting-serious-about-mental-illnesses.shtml

Behavioral Health Disorders and Integrated Treatment

Mental Health Disorders + **Substance Use Disorders Treatment** = **Integrated Treatment**

Common Comorbidities

Trauma /Trauma-Informed Care; Adverse Childhood Experiences (ACEs) Study*

Substance Use and Recovery Integration

Physical-Medical and Primary Care Integration

Coordination (formal) + **Collaboration (informal)** = **Goal of Integration**

Peek, CJ,. and the National Integration Academy Council. Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. Rockville, MD: Agency for Healthcare Research and Quality. Available at: http://integrationacademy.ahrq.gov/lexicon.

***http://www.acestudy.org/**

Stigma

Pervasive

- Public and personal
- Overt and internalized

Damaging

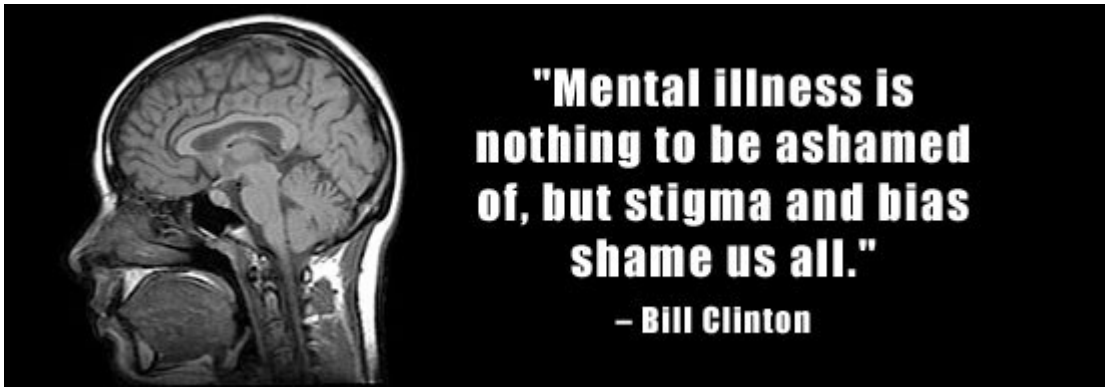
- Limited access
- Criminalization

*http://www.bhrm.org/guidelines/stigma.pdf

Stigma

Changeable: attitudes and actions

- **Protest (risk: rebound effect)**
- **Education (risk: unsustained effect)**
- **Contact = MOST effective and sustained, but MUST have a “high degree of discomfirmation of stereotype”****



**Corrigan, P. & Penn, D. L. (1999)
Lessons from social psychology on discrediting psychiatric stigma. American Psychologist

In Real Life
- David Lee Greenlee

- The Way It Was – The Spin and Chaos
- What Happened – The Change Point
- What Life is Like Now – The Maintenance Phase
- Future Plans – Bringing It Full Circle

Psychiatry 101 (continued)

DSM-5

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (May 2013)

Published by the American Psychiatric Association (APA)

- Origins: early 20th Century classification effort; DSM – I, joint effort by military and APA
- Phenomenological and epidemiological; NOT etiologic (yet)
- Controversies: validity/reliability, "overpathologizing," cultural bias
- Disorder = enduring functional impairment or clinically significant distress – NOT usual reaction to common life situations and/or cultural beliefs or customs

Psychiatric Evaluation

- aka, “Assessment”
- Initial: similar to physical-medical evaluation with a few exceptions:
  - detailed psychiatric history,
  - MSE,
  - detailed social/developmental history
- Follow-up: diagnostic “evolution”
- Continuous

Mental Status Exam (MSE)

- MSE is NOT MMSE
- Superficial to “deep” observations
  - appearance
  - behavior
  - speech
  - mood/affect
  - thought processes
  - thought content
  - cognition: A&Ox4, memory, calculation, attention/concentration, abstraction, insight, judgment

  Continuum and normal variation

Case Formulation

- NOT a restatement of assessment data
- where and how we use our clinical knowledge, skills, and experience
- synthesis => hypothesis, theory, or best guess
- a “compass guiding treatment”
- specific and person-centered (NOT “boilerplate”)
- more likely to be successful

Treatment Planning

- Engagement
- Stages of Change
- Motivational Interviewing
- Person-centered
- Specific, achievable, measurable
- Continuously updated

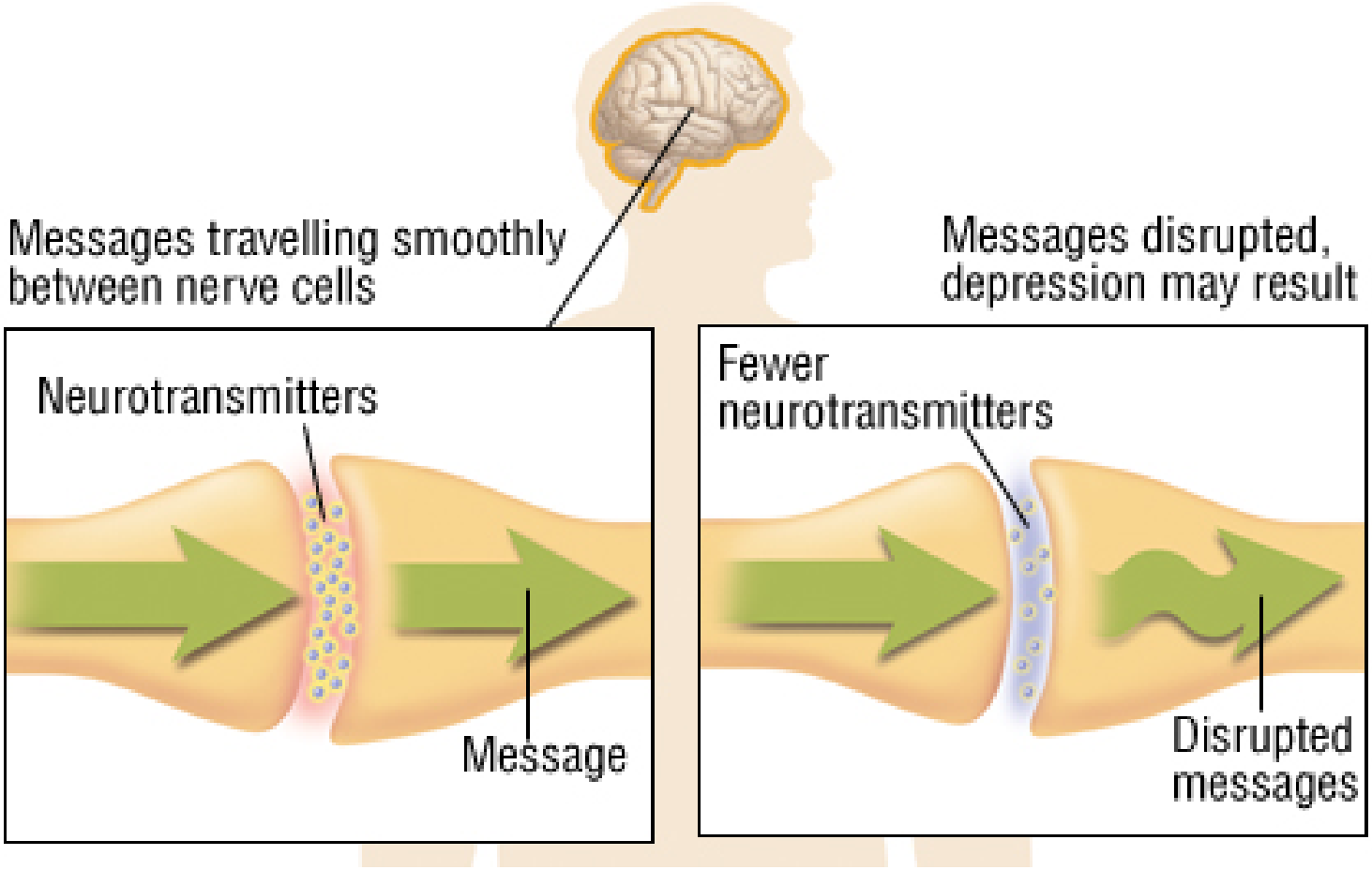
What is happening in depression?

- Disorder of the brain
- Likely not one cause
  - Genetic
    - Sibling or parent: 2-3x increased risk
  - Environmental

- Neurotransmitters decreased
  - Serotonin, dopamine, norepinephrine

Current drug therapy targets this theory

What is happening in depression?

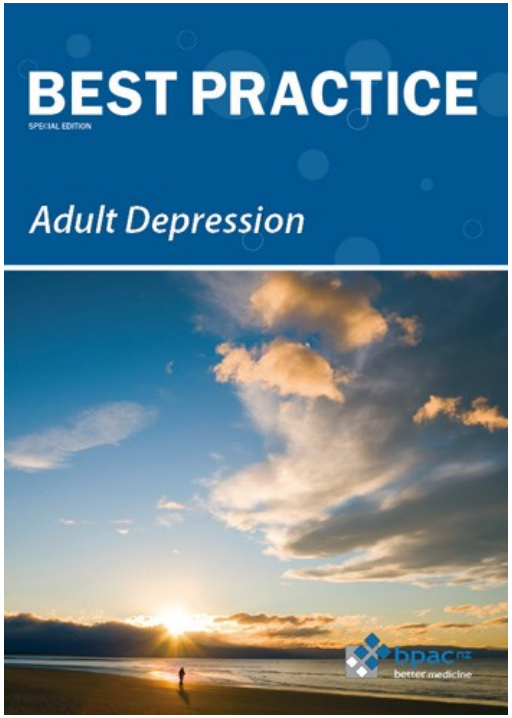


Cultural differences

- African American
- American Indian and Alaskan Native
- Latino/Hispanic
- Asian American Pacific Islander

Depression Guidelines

- Adult Depression in Primary Care
- Updated in 2013

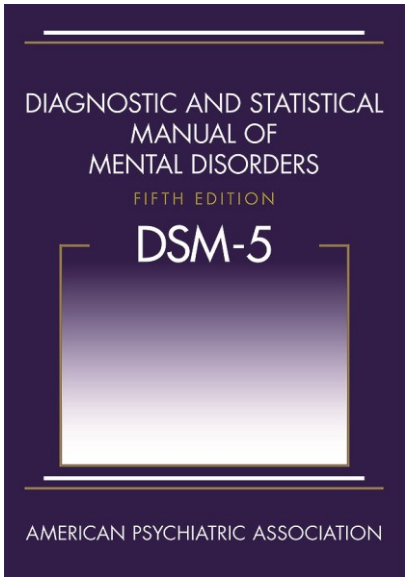


Mitchell J, Trangle M, Degnan B, Gabert T, Haight B, Kessler D, Mack N, Mallen E, Novak H, Rossmiller D, Setterlund L, Somers K, Valentino N, Vincent S. Institute for Clinical Systems Improvement. Adult Depression in Primary Care. Updated September 2013.

Diagnostic and Statistical Manual of Mental Disorders (DSM-5) Criteria

- **5 or more** of the following present during same 2 week period and change from previous functioning
- Most of the day nearly every day:
  - Depressed Mood
  - Markedly diminished interest in pleasurable activities

(Must have at least one of the above present plus….)



Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. APA, 2000.

Symptoms of Depression:

Most of the day, nearly every day

	SIGECAPS
Sleep changes:	Insomnia or hypersomnia
Interest:	Loss of interest in activities
Guilt:	…or feelings of worthlessness
Energy:	Loss of energy or fatigue
Concentration:	Diminished concentration
Appetite:	Usually decreases, may have weight loss
Psychomotor:	Agitation or slowing
Suicide:	Recurrent thoughts of death/suicidal ideation

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. APA, 2000.

Presentation

- ***Non-specific, somatic symptoms of depression:*** abdominal pain, back pain, change in weight or appetite, constipation, fatigue, headache, insomnia or hypersomnia, joint pain, neck pain, weakness
- **Risk factors for depression:** chronic physical illness, chronic pain, family history of depression, female sex, low income/job loss, low social support, prior depression, single/divorced/widowed, traumatic brain injury, younger or older age

Risk Screening

- MUST ask about suicidal or self-harm thoughts
- NOT sufficient to accept “yes” or “no”
- Consider:
  - Plan? Lethal? Access?
  - Intent? Impulsivity?
- Consider risk factors: male gender, family history of psychiatric disorder, previous attempted suicide, severe depression, hopelessness, comorbid anxiety and/or substance use disorders
- “QPR”: **Q**uestion, **P**ersuade, **R**efer; http://www.sprc.org/bpr/section-III/question-persuade-refer-qpr-nurses

Evidence-Based, Non-Pharmacological Treatments*

- Psychotherapeutic Interventions
  - Acceptance and Commitment Therapy (ACT)
  - Cognitive Behavioral Therapy (CBT)
  - Interpersonal Therapy (IPT)
- Complementary and Alternative Medicine (CAM)
  - Acupuncture
  - Meditation (e.g., mindfulness-based stress reduction)
  - Herbal Supplements
  - Yoga
- Exercise**
  - High-energy expenditure (weight-bearing, aerobic) BEST
  - Some is better than none

*http://effectivehealthcare.ahrq.gov/ehc/products/568/1923/major-depressive-disorder-protocol-141124.pdf
** http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3674785

Resources & Referrals

- Multnomah County Mental Health CRISIS Line: 24/7 triage help, 503-988-4888
- Lines for Life: 24/7 substance use and suicide prevention, 800-273-8255
- Cascadia Urgent Walk-In: direct evaluation and referral, open 7 days a week from 7 AM – 10:30 PM, 4212 SE Division, Suite 100 (corner of SE Division and 42nd Ave)
- National Alliance On Mental Illness (NAMI)
  - Depression specific: http://www.nami.org/Learn-More/Mental-Health-Conditions/Depression
  - Local: http://namimultnomah.org/

Please hold questions – thanks!

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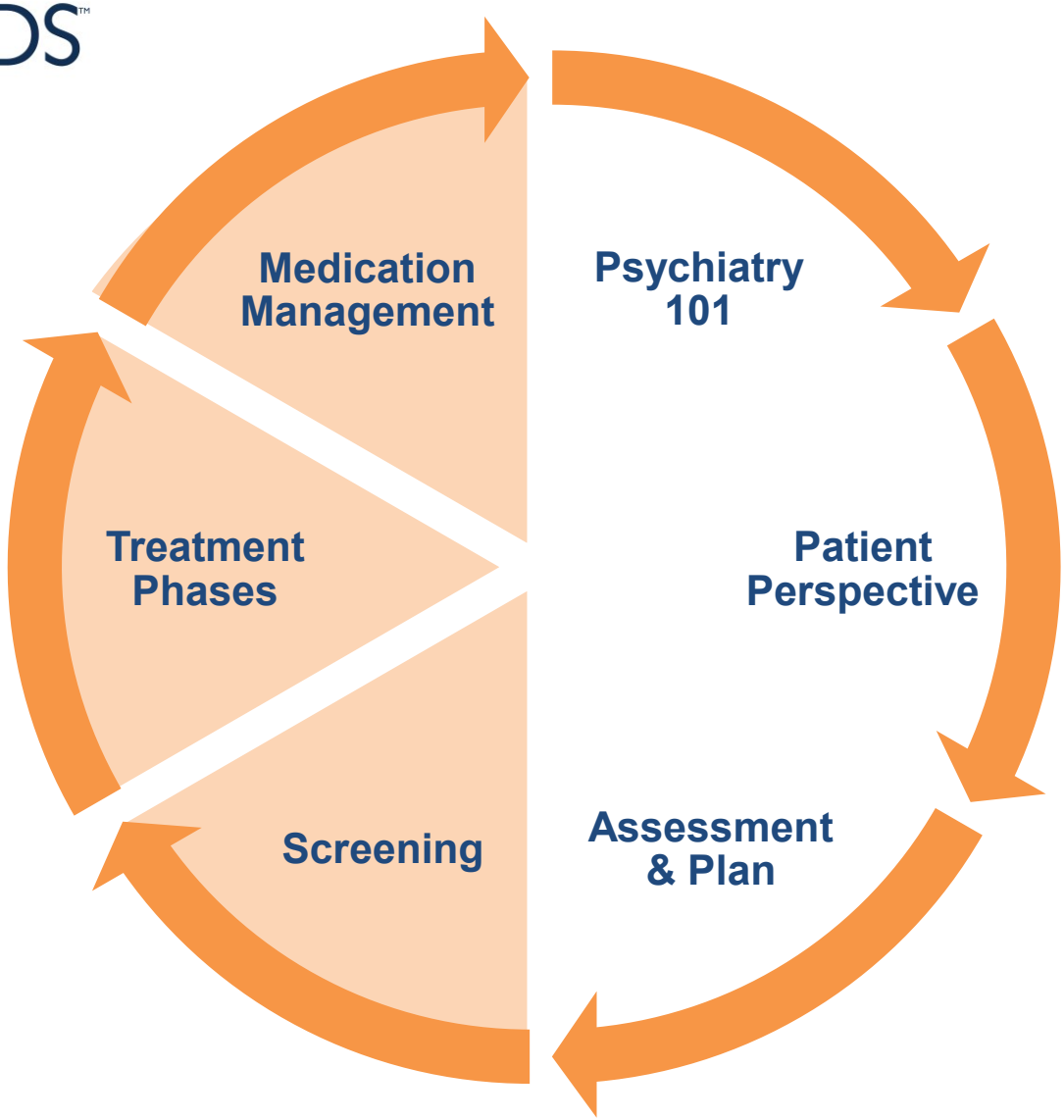


Depression
Medication Review

Bridget Bradley, PharmD, BCPP
Pacific University School of Pharmacy
Virginia Garcia Memorial Health Center

Goals of Depression management

- Improve acute symptoms
- Achieve remission within the first 6-12 weeks
- Prevent further episodes

Screening for depression: PHQ-9

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

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

PHQ-9 Severity

PHQ-9 score	Depression Severity	Proposed Treatment Actions
0 - 4	None- minimal	None
5 - 9	Mild	Watchful waiting; repeat PHQ-9 at follow up
10 - 14	Moderate	Treatment plan, considering counseling, follow-up and/or pharmacotherapy
15 - 19	Moderately Severe	Active treatment with pharmacotherapy and/or psychotherapy
20 - 27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

PHQ-9 Response

PHQ-9 change from baseline	Treatment plan
Drop of 5 or more points each month	Antidepressant &/or Psychotherapy No treatment change needed should have follow-up in 4 weeks
Drop of 2-4 points each month	Antidepressant: May warrant an increase in dose.
	Psychotherapy: Probably no treatment change needed
Drop of 1 point, no change or increase each month	Antidepressant: Increase dose or augment or switch; informal or formal psychiatric consult; add psychotherapy.
	Psychotherapy: 1. Consider adding antidepressant. 2. For patients dissatisfied in other psychotherapy, review treatment options and preferences.

Additional screening tools

QIDS-SR16

QIDS-SR16 1-3

QUICK INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY (SELF-REPORT)

THIS SECTION FOR USE BY STUDY PERSONNEL ONLY.

Questionnaire completed on visit date ☐ **or** specify date completed: _____
DD-Mon-YYYY

Only the patient (subject) should enter information onto this questionnaire.

PLEASE CHECKMARK THE ONE RESPONSE TO EACH ITEM THAT IS MOST APPROPRIATE TO HOW YOU HAVE BEEN FEELING OVER THE PAST 7 DAYS.

1. Falling asleep:
- ☐0 I never took longer than 30 minutes to fall asleep.
- ☐1 I took at least 30 minutes to fall asleep, less than half the time (3 days or less out of the past 7 days).
- ☐2 I took at least 30 minutes to fall asleep, more than half the time (4 days or more out of the past 7 days).
- ☐3 I took more than 60 minutes to fall asleep, more than half the time (4 days or more out of the past 7 days).

2. Sleep during the night:
- ☐0 I didn't wake up at night.
- ☐1 I had a restless, light sleep, briefly waking up a few times each night.
- ☐2 I woke up at least once a night, but I got back to sleep easily.
- ☐3 I woke up more than once a night and stayed awake for 20 minutes or more, more than half the time (4 days or more out of the past 7 days).

3. Waking up too early:
- ☐0 Most of the time, I woke up no more than 30 minutes before my scheduled time.
- ☐1 More than half the time (4 days or more out of the past 7 days), I woke up more than 30 minutes before my scheduled time.
- ☐2 I almost always woke up at least one hour or so before my scheduled time, but I got back to sleep eventually.
- ☐3 I woke up at least one hour before my scheduled time, and couldn't get back to sleep.

4. Sleeping too much:
- ☐0 I slept no longer than 7-8 hours/night, without napping during the day.
- ☐1 I slept no longer than 10 hours in a 24-hour period including naps.
- ☐2 I slept no longer than 12 hours in a 24-hour period including naps.
- ☐3 I slept longer than 12 hours in a 24-hour period including naps.

5. Feeling sad:
- ☐0 I didn't feel sad.
- ☐1 I felt sad less than half the time (3 days or less out of the past 7 days).
- ☐2 I felt sad more than half the time (4 days or more out of the past 7 days).
- ☐3 I felt sad nearly all of the time.

EPI0905.QIDSSR

Beck Depression Inventory

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.
- 0 I do not feel sad.
- 1 I feel sad
- 2 I am sad all the time and I can't snap out of it.
- 3 I am so sad and unhappy that I can't stand it.

2.
- 0 I am not particularly discouraged about the future.
- 1 I feel discouraged about the future.
- 2 I feel I have nothing to look forward to.
- 3 I feel the future is hopeless and that things cannot improve.

3.
- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2 As I look back on my life, all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person.

4.
- 0 I get as much satisfaction out of things as I used to.
- 1 I don't enjoy things the way I used to.
- 2 I don't get real satisfaction out of anything anymore.
- 3 I am dissatisfied or bored with everything.

5.
- 0 I don't feel particularly guilty
- 1 I feel guilty a good part of the time.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6.
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

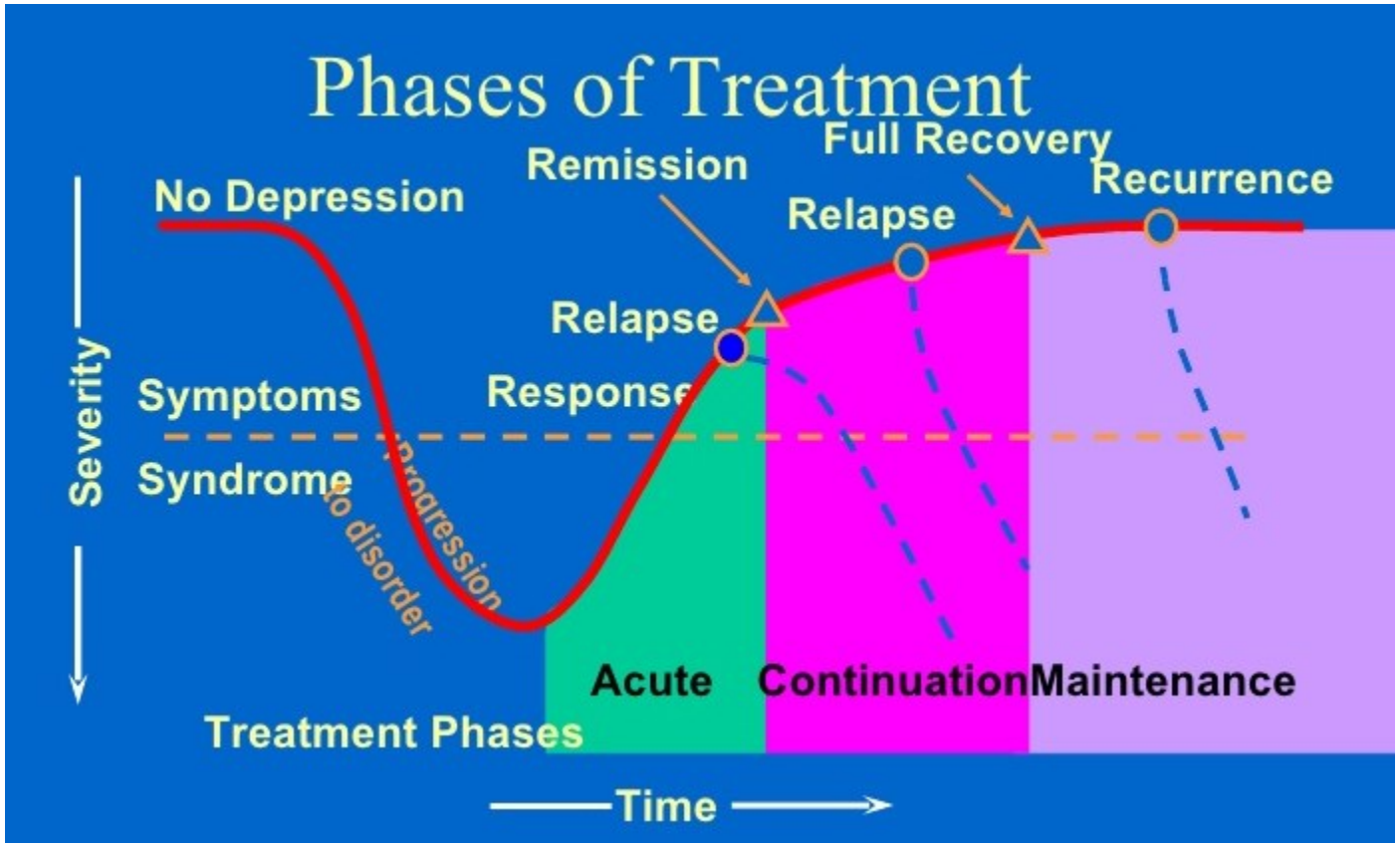
7.
- 0 I don't feel disappointed in myself.
- 1 I am disappointed in myself.
- 2 I am disgusted with myself.
- 3 I hate myself.

8.
- 0 I don't feel I am any worse than anybody else.
- 1 I am critical of myself for my weaknesses or mistakes.
- 2 I blame myself all the time for my faults.
- 3 I blame myself for everything bad that happens.

9.
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10.
- 0 I don't cry any more than usual.
- 1 I cry more now than I used to.
- 2 I cry all the time now.
- 3 I used to be able to cry, but now I can't cry even though I want to.

Treatment phases of depression



Treatment phases of depression

Acute Phase 6-12 weeks

- Assess response: Full, partial, minimal to none
  - Week 1-2: improved sleep and appetite, less anxiety/agitation
  - Week 3: improved energy level, instill hope
  - Week 4-6: improved mood
- Achieve remission
- Ensure safety
- Obtain adequate dose as soon as tolerated

Continuation Phase 4-9 months

- Prevent relapse
- Ensure optimal response
- Address adverse effects
- Ensure adherence (esp w/ symptom resolution)
- Minimize polypharmacy

Maintenance Phase > 1 year

- If necessary
- Prevent new episode (recurrence)
- Some patients are on lifelong therapy based on risk for recurrence
- >3 episodes or more

Treatment Options

Selective Serotonin Reuptake Inhibitors (SSRIs)

Generic	Brand
Fluoxetine	Prozac
Citalopram	Celexa

Other Antidepressants

Generic	Brand
Mirtazapine	Remeron
Vilazodone	Viibryd

Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)

Generic	Brand
Duloxetine	Cymbalta
Levomilnacipran	Fetzima

Tricyclic Antidepressants

Generic	Brand
Amitriptyline	Elavil

Do these even work? STAR*D results

- Level 1 (citalopram)
  - 33% of patients treated achieved remission and another 10-15% had a response to treatment
- Level 2
  - Switch group (sertraline, venlafaxine XR, bupropion SR): 25% of patients achieved remission
  - Add on group (Bupropion SR or buspirone): 33% of patients achieved remission
- Level 3
  - Switch group (mirtazapine or nortriptyline): 12-20% of patients achieved remission
  - Add on group (Lithium or T3): 20% of patients achieved remission
- Level 4- taken off all medications
  - MAOI (tranylcypromine) or Venlafaxine + mirtazapine: 7-10% of patients achieved remission

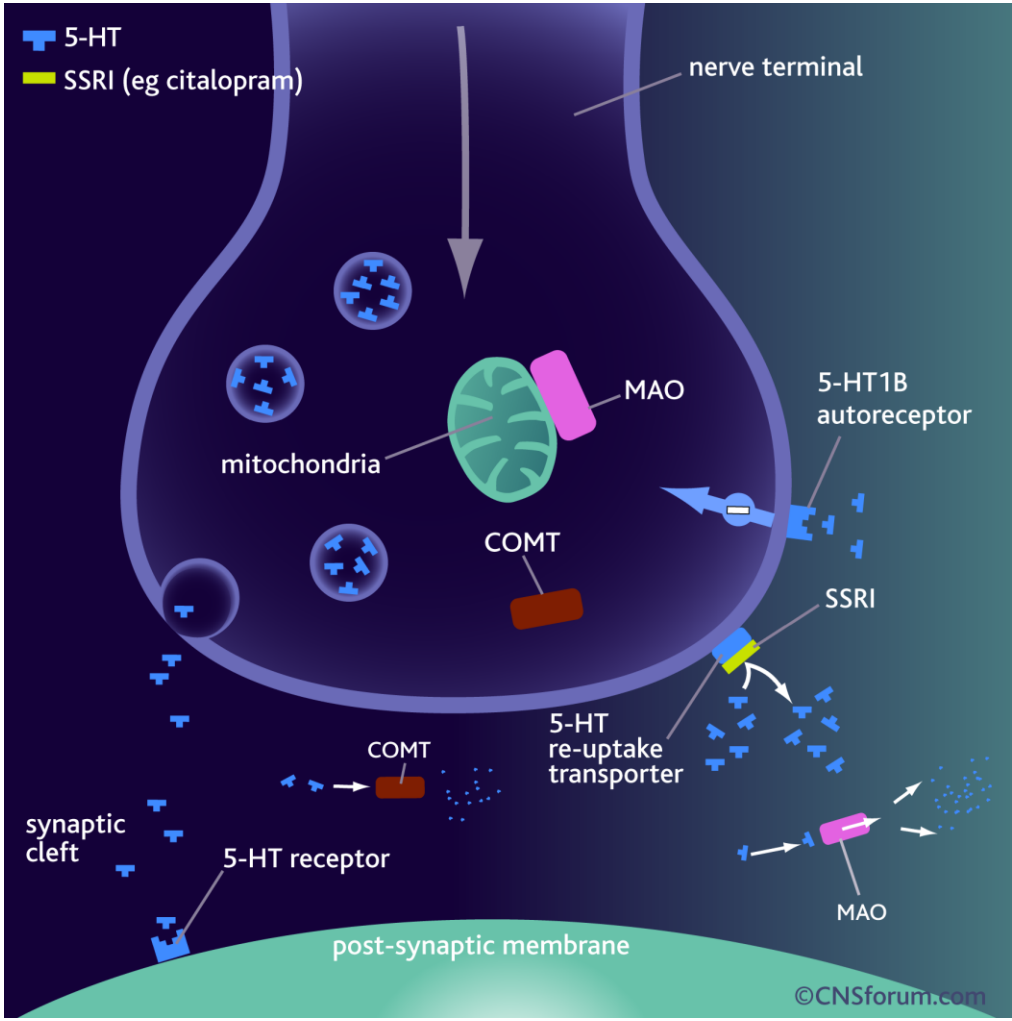
Selective Serotonin Reuptake Inhibitors (SSRIs)

How do they work?

- Inhibit reuptake of serotonin (5-HT)

Adverse effects

- GI- nausea, vomiting, diarrhea
- Sexual dysfunction
- Headache

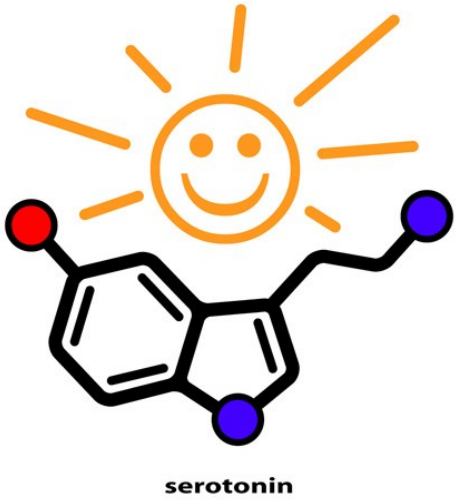


SSRI	Starting Dose	Usual Dosage	Things to consider
Paroxetine (Paxil)	20 mg	20 – 60 mg	Highest risk of withdrawal. Dose in the evening due to sedation. Pregnancy category D.
Fluoxetine (Prozac)	20 mg	20- 80 mg	Should be dosed in the am. Lowest risk of withdrawal side effects due to long half-life.
Sertraline (Zoloft)	25 – 50 mg	50 – 200 mg	Should be dosed in the am. Frequently used in pregnancy and breastfeeding
Citalopram (Celexa)	20 mg	20 – 40 mg	Previous max dose was 60 mg- FDA change due to concern with QTc prolongation. Max dose is 20 mg if > 65
Escitalopram (Lexapro)	10 mg	10 – 20 mg	Similar to citalopram- does not carry risk same risk of QTc prolongation
Class adverse effects: GI- nausea, vomiting, diarrhea, sexual dysfunction, headache			

Other Antidepressants that increase Serotonin

Generic	Brand
	Oleptro

Side effects: Sedation, nausea, dry mouth, dizziness



serotonin

Generic	Brand

Side effects: Nausea, vomiting, diarrhea, constipation

Generic	Brand

Side effects: Nausea, vomiting, constipation

Agent	Starting Dose	Usual Dosage	Things to consider	Adverse Effects
Trazodone (Desyrel, Oleptro)	150 mg	150 – 400 mg (immediate release version) 150 – 375 mg (extended release version)	Oleptro-extended release version-consider cost at brand only Insomnia dose is usually 50 – 100 mg 1 hour prior to bedtime	Sedation, nausea, dry mouth, dizziness
Vortioxetine (Brintellix)	10 mg	20 mg	Consider cost as brand only	Nausea, vomiting, diarrhea, insomnia
Vilazodone (Viibryd)	10mg	20 – 40 mg	Consider cost as brand only	Nausea, vomiting, constipation

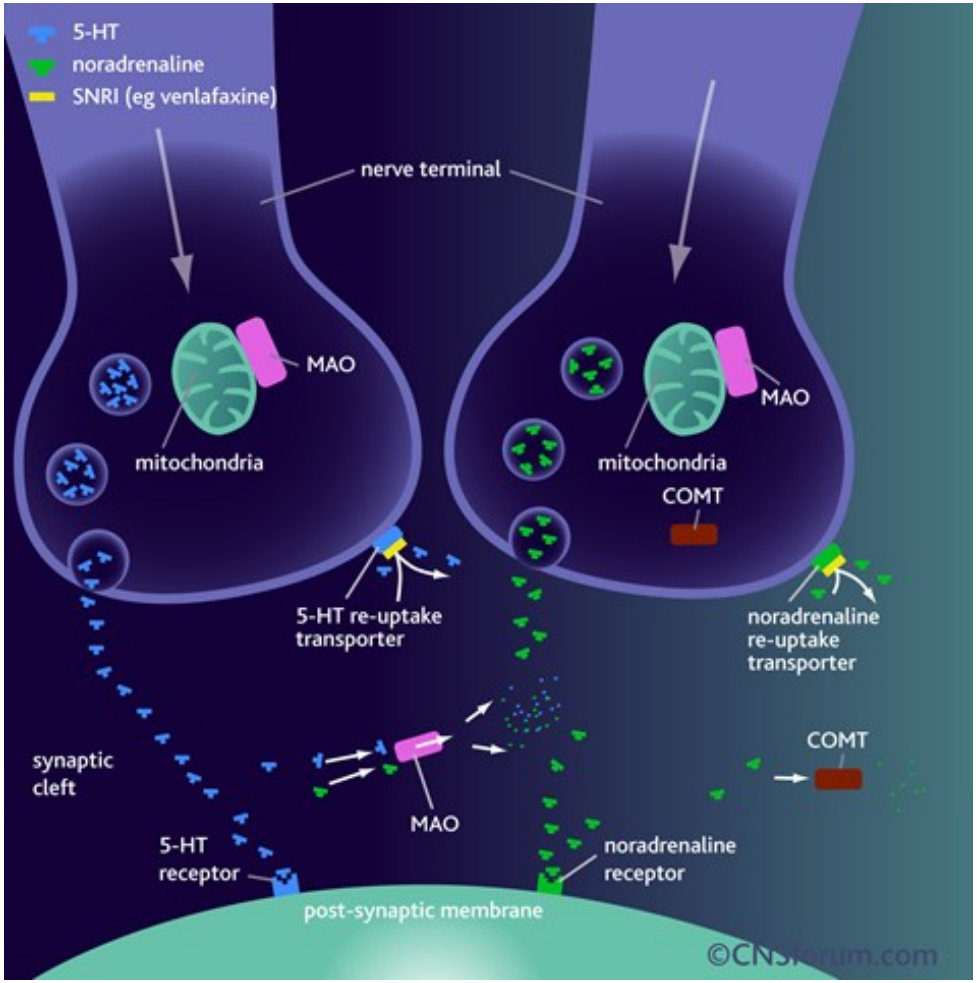
Serotonin Norepinephrine Reuptake Inhibitors

How do they work?

- Inhibits reuptake of serotonin and norepinephrine

Adverse Effects

- Nausea
- Sexual dysfunction
- Increase in diastolic blood pressure
- Sweating



SNRI	Starting Dose	Usual Dosage	Things to consider
Venlafaxine (Effexor XR)	**37.5 – 75 mg**	**225 – 375 mg**	**Mostly SSRI at doses of 150 mg or less.**
Duloxetine (Cymbalta)	**30 mg**	**30 – 90 mg**	**SNRI at all doses. Avoid in patients with chronic alcohol use due to potential to increase LFT's**
Desvenlafaxine (Pristiq)	**50 mg**	**50 – 100 mg**	**Active metabolite of venlafaxine**
Levomilnacipran (Fetzima)	**20 mg**	**40 – 120 mg**	**Active metabolite of milnacipran (savella) which is approved for fibromyalgia**
Class adverse effects: Nausea, sexual dysfunction, increase in diastolic blood pressure, sweating			

- All these need to be tapered due to withdrawal syndrome
- Also used for neuropathic pain- may consider if comorbidity

Tricyclic Antidepressants

How does it work?

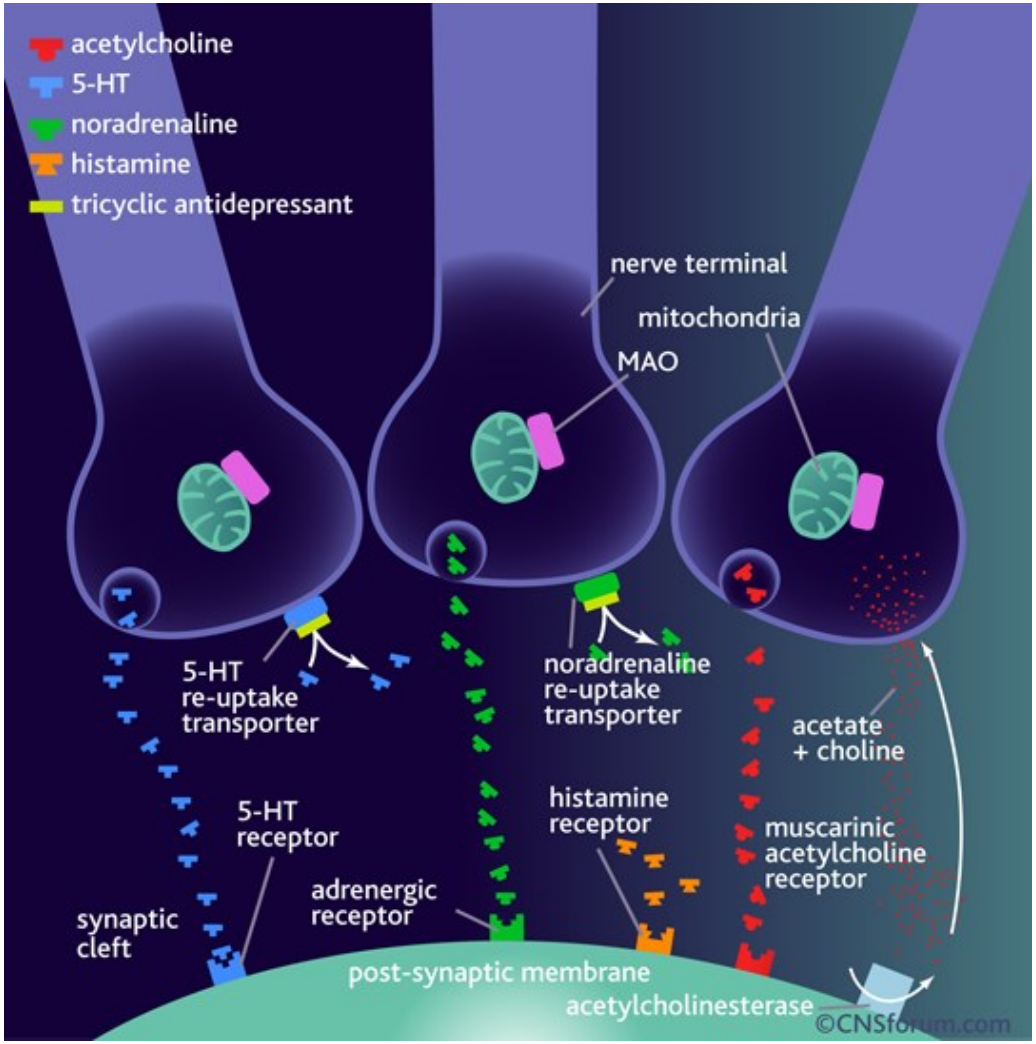
- Increases serotonin and norepinephrine
- Same as SNRI but TCA's have actions at other receptors

Side Effects

- Sedation, dry mouth, weight gain, constipation, blurred vision

Precautions

- Suicidal (lethal in overdose), arrhythmias, geriatric patients, dementia patients



TCA	Starting Dose	Usual Dosage *divided in 3-4 doses	Things to consider
Amitriptyline (Elavil)	25 mg	150 mg	Tertiary amine- inhibits reuptake of both serotonin and norepinephrine
Imipramine	25 mg	75 -150 mg (max 300 mg)	
Doxepin	25 mg	150 mg (max 300 mg)	
Nortriptyline (Pamelor)	25 mg	150 mg	Secondary amine- more selective for norepinephrine reuptake inhibition. Also tends to have less adverse effects than the tertiary amines
Desipramine	25 mg	100 – 200 mg (max 300 mg)	
Class adverse effects: Sedation, dry mouth, weight gain, constipation, blurred vision			

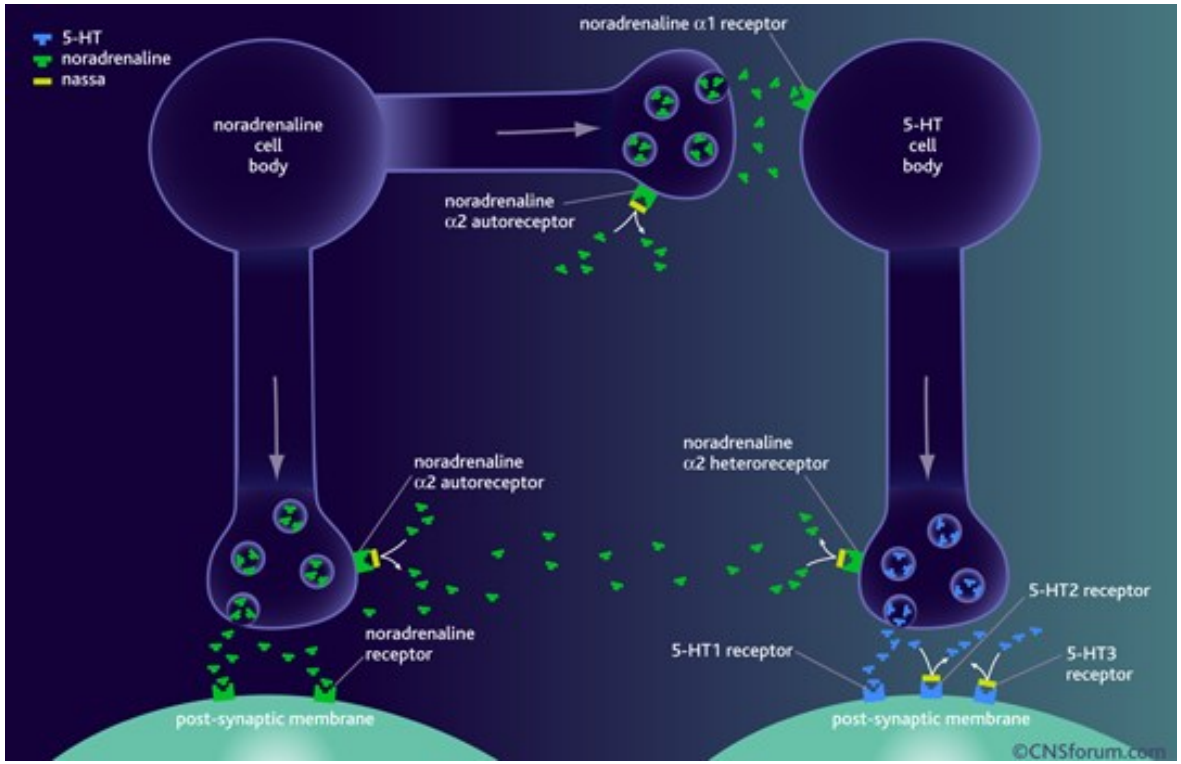
Mirtazapine (Remeron)

How does it work?

- Also increases serotonin and norepinephrine

Side Effects

- Sedation, weight gain



Bupropion (Wellbutrin SR/XL, Zyban)

How does it work?

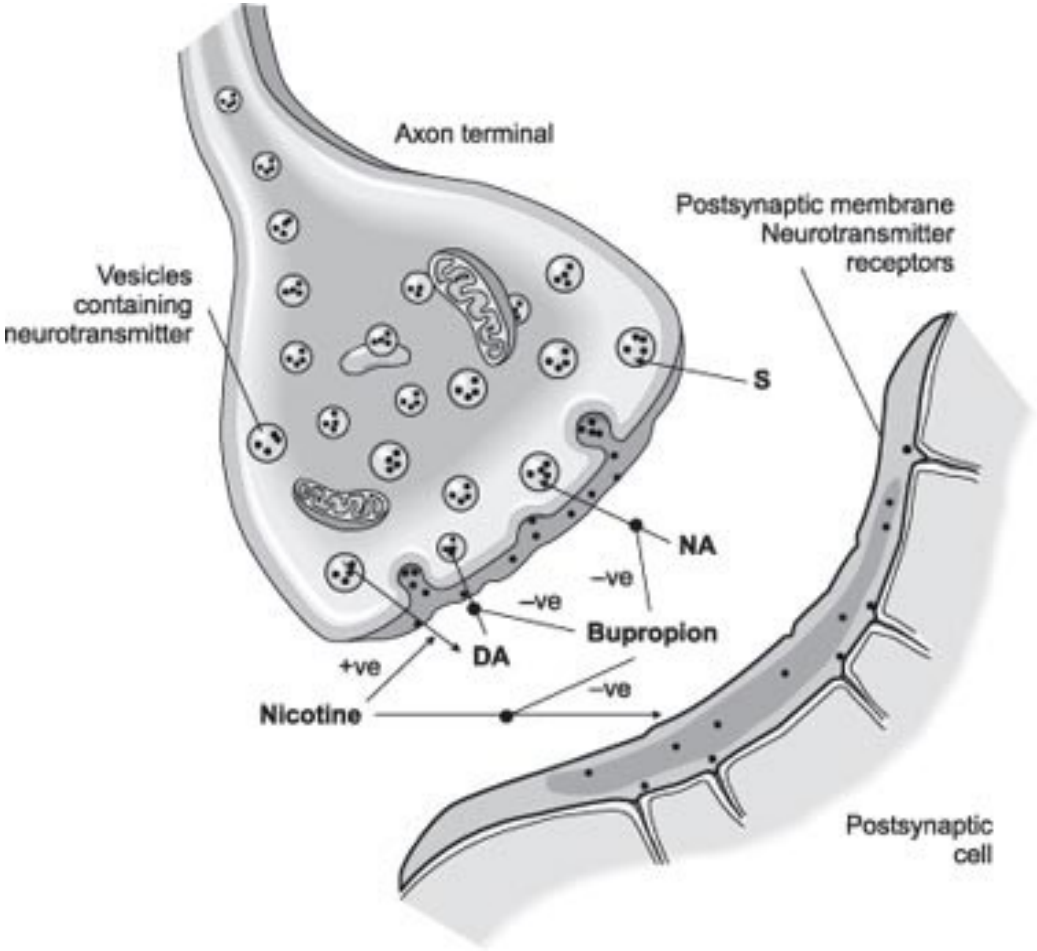
- Inhibits reuptake of Dopamine and Norepinephrine

Side Effects

- nausea, vomiting, tremor, insomnia, dry mouth, activation/agitation

Contraindications

- History of seizures, anorexia/bulimia



Agent	Starting Dose	Usual Dosage	Things to consider	Adverse effects
Mirtazapine (Remeron)	15 mg	15 – 45 mg	Should be dosed at bedtime due to sedation	Sedation, weight gain
Bupropion (Wellbutrin, Zyban)	100 mg twice daily	100 mg three times daily	Should be dose in the am due to insomnia. If giving multiple times a day last dose should be taken by 3 pm to avoid insomnia.	nausea, vomiting, tremor, insomnia, dry mouth, activation/agitation
Bupropion SR (Wellbutrin SR)	150 mg daily	150 mg twice daily		
Bupropion XL (Wellbutrin XL)	150 mg daily	300 mg daily		

Complementary Alternative Medicine

- **St. John's wort**
  - May be helpful for mild or moderate depression
  - Use with caution
    - Drug interactions: warfarin, birth control, transplant medication
    - Avoid with other antidepressants
- **SAMe**
  - Used in Europe as a prescription drug to treat depression
  - SAMe may be helpful, but more research is needed.
- **L-methylfolate (Deplin)**
  - Medical food

Recommended antidepressant combinations

SSRI/SNRI + Bupropion
Option for patients with fatigue, lower energy or sexual side effects from SSRI/SNRI therapy

SSRI/SNRI + Trazodone
Option for patients with insomnia
Consider max dose of trazodone of 100 mg if on medication that inhibits CYP2D6 (Bupropion, fluoxetine, paroxetine) or CYP3A4 (some HIV medications, clarithromycin)

SSRI/SNRI + Mirtazapine
Option for patients with insomnia, low appetite, nausea. May also help with sexual side effects from SSRI/SNRI therapy

SSRI/SNRI + TCA
Low dose of TCA (25 – 75 mg) dosed at bedtime
Option for patients with insomnia or with a comorbidity that may benefit (neuropathic pain, migraine)

Selecting the "right" antidepressant

- Previous response or lack of response
- Family history
- Side effects to your advantage
- Comorbidities and current medications
- Patient preference
- Medication cost

"It's a new anti-depressant—instead of swallowing it, you throw it at anyone who appears to be having a good time."

Adjunct treatment

Second generation antipsychotics

- FDA approved as adjunct treatment to antidepressant therapy
- Aripiprazole, olanzapine, quetiapine

Lithium

- Not FDA approved
- May decrease suicidal thoughts

Thyroid Supplementation

- Not FDA Approved

Major Depression in Children and Adolescents

Significant source of morbidity and mortality

- Increase risk of substance abuse
- Attempted and completed suicide

Epidemiology

- Prevalence of 2% (children) and 8% (adolescents)
- Mean duration of an episode: 8 months
- Relapse 70% at 5 years

Major Depression in Children and Adolescents

Fluoxetine first line treatment

- Approved for us in children > 8
- Initiate fluoxetine 10 mg daily after one week increase to >20 mg dose may be used in older children or higher body weight

Sertraline and citalopram second line treatment

- Not FDA Approved
- Sertraline is FDA approved for OCD in > 6

Escitalopram

- FDA approved for >12

Depression and Pregnancy

~13% of pregnant women will have depression

Risk Factors

- **Past history of depression**
- **Anxiety**
- **Low socioeconomic status**
- **Lack of social support**
- **Unplanned pregnancy**
- **Single**
- **Exposure to domestic violence**
- **Stressful life events**

Ment Health Clin. 2013;3(2):65. N Engl J Med 2011;365:1605-11

Untreated depression and pregnancy

Mother

- Stress
- Decreased social support
- Poor weight gain
- Use of tobacco, alcohol
- Substance abuse
- Poor prenatal care
- Risk for self-harm or suicide
- Postpartum depression

Fetus

- Premature birth
- Low birth weight
- Small for gestational age

N Engl J Med 2011;365:1605-11

General Treatment Principles

- Avoid medications in **first trimester**, if possible
- Taper medications if discontinuing
- Use monotherapy whenever possible
- Use the lowest effective dose
- Monitor therapy
  - Patient Health Questionnaire: PHQ-9
  - Edinburgh Postnatal Depression Scale: EPDS

Gen Hosp Psychiatry. 2009;31(5):403–413.

Antidepressants in pregnancy

Fluoxetine

- Most studied
- Long ½ life (neonatal withdrawal symptoms)

Citalopram/escitalopram/ sertraline

- No significant risks

Paroxetine

- Pregnancy Category D
- Swedish National Registry/U.S. database
- 1.5 – 2 fold increased risk for atrial and ventricular septal defects

Postpartum depression vs. baby blues

- **10-15%** of new mothers will satisfy the criteria for an acute episode of major depression with postpartum onset
- Low treatment rates

	"Baby Blues"	Postpartum depression
Symptom severity	**Mild-emotional lability**	**Mild to severe**
Symptom onset	**First few days immediately after delivery**	**First 1-2 weeks May occur any time during the first 12 months**
Symptom duration	**Spontaneously remit over the first 1-2 weeks**	**Persist without treatment**

Pharmacotherapy 2010;30(9(:928-41)

Antidepressants and breastfeeding

Preferred SSRIs

- Paroxetine and sertraline
- Minimal to no detectable levels in breast milk

Bupropion and duloxetine

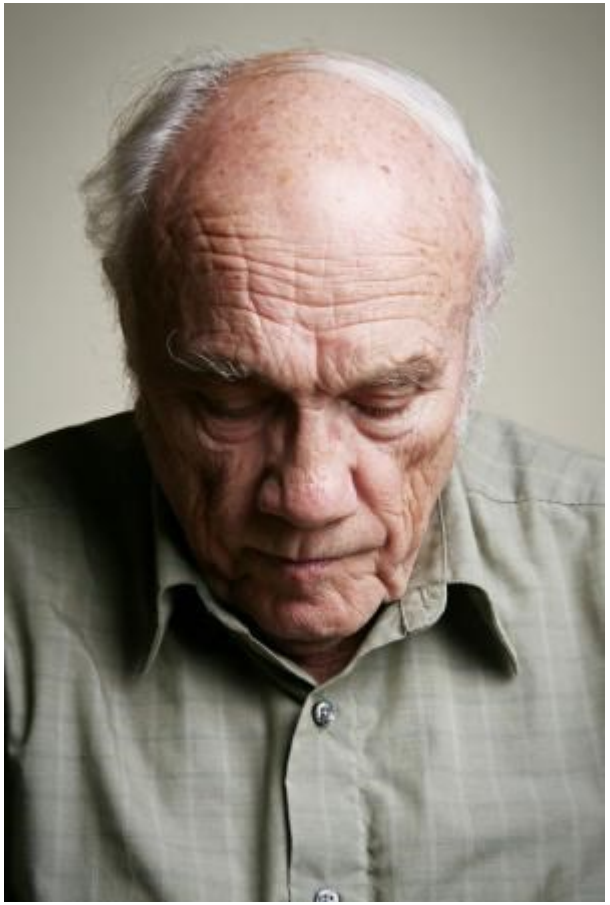
- Also minimal infant plasma levels

Fluoxetine and venlafaxine

- Highest infant plasma levels

Depression in the elderly

- May present with less depressed mood and present with loss of appetite, cognitive impairment, insomnia, and loss of interest
- Recognizing and treating depression extremely important
  - High rate of suicidality



Antidepressants in geriatrics

SSRI are usually first line

- Need to monitor Sodium- risk of hyponatremia higher in elderly patients
- Need to monitor for drug interaction that may increase risk of GI bleeds
- Initiate at lower doses

Bupropion, Venlafaxine and Mirtazapine

- Also used

Depression and comorbid disease

- In the United States, people with diabetes are twice as likely as the average person to have depression
- Depression associated with noncompliance and poor medical outcome

Side effect management when patient has good response

Wait and see
GI symptoms and headaches usually improve after a few weeks

Change medication dose or timing
If insomnia and patient taking medication at night- switch to the morning
If drowsiness and patient taking medication in morning- switch to the evening
Trial a decrease in dose slowly

What about sexual dysfunction?
Wait 6 weeks
Trial dose decrease
If good response to antidepressant may consider addition of bupropion or mirtazapine

Questions to ask in non-response

- Adequate trial length?
- Adequate dose?
- Patient adherence?
- Adverse effects?
- Drug interactions?
- Correct diagnosis?
- Psychosocial factors?
- Co-morbidity?

Stopping treatment safely

Treatment for at least 6 months – usually 9-12 months.

Consider risks of stopping treatment

Risk of depression recurrence

Risk of recurrence increase with increase number of depressive episodes	**The risk of recurrence is significant: 50% after one episode, 70% after two episodes, 90% after three episodes**	**Premature discontinuation of anti- depressant treatment has been associated with a 77% increase in the risk of relapse/recurrence of symptoms**

Is the patient a candidate for maintenance treatment?

Taper off

- Avoid withdrawal symptoms
- Monitor for symptom recurrence

When to seek that referral

- Suicidal thoughts
  - Don’t leave the person in the room
- Psychosis
  - Patients can have psychotic depression
- Failed treatment response

Questions?

Next Session

Congestive
Heart
Failure

October 29th

MEDS™

Closing

Charmian Casteel, RN

Primary Care Innovations Specialist

CareOregon

Thank you!