Primary Care Guide to Managing Depression

Establish the Diagnosis of Depression

A challenge for the primary care practitioner is how to efficiently and accurately determine whether a patient is suffering from major depression. There are no confirmatory or screening laboratory tests that are sufficiently sensitive or specific to be clinically useful. Thus, the diagnosis must be based on clinical grounds:

- Medical history
- Physical examination
- Laboratory tests (to rule out other medical conditions or drugs that can cause a depressive episode)

In the primary care setting the presenting picture generally falls into one of four categories:

- Mood or emotional complaints:
  - Low self-esteem or feelings of inadequacy
  - Anxiety
  - Irritability
  - Apathy
  - Loss of interest
- Somatic complaints:
  - Insomnia
  - Fatigue
  - Headache
  - Weight change (loss or gain)
- "Memory" problems
- Life complaints:
  - Inability to cope with marital or job stresses
  - Social withdrawal or isolation
  - Financial problems

Be **cautious** not to conclude that the depressive symptoms are understandable results of the patient's life situation and/or recent stressors. Having a "reason" for major depression does not alter its course, reduce its severity and consequences, nor change its responsiveness to treatment. Major depression may be the cause of the life problems rather than being the result of them. After all, this illness can adversely affect work performance, motivation, and social skills.

The fundamental point in diagnosing and understanding major depression is that it is a syndrome. It is not just low mood, but rather a cluster of signs and symptoms termed a depressive episode and consisting of:

- Change in mood:
  - Usually "depressed," "blue" or "sad"
  - Sometimes irritable or anxious

  (Of note, while the syndrome takes it name from the mood symptom, the two are not synonymous. Not everyone who is "blue" has major depression, nor is "depressed mood" necessarily the most prominent symptom for every patient with major depression.)
- Change in sleep patterns
- Change in appetite
- Change in weight
- Change in activity levels

- A sense of fatigue
- Decreased motivation
- Decreased interest
- Decreased sex drive
- Decreased concentration and attention.

A patient suffering from a major depressive episode may have five or more of these signs and symptoms every day for weeks to months, and even years, if not effectively treated.

Refer:

Certainly, some patients are not suitable for management in the outpatient primary care setting and should be referred to a psychiatrist or other emergency care. Such patients included:

- Patients who are a significant risk of harm by suicidal thoughts, threats against others, or inability to care for themselves. Such patients are likely to require hospitalization.
- Patients with a history of slow response to previous treatment or with a complicated course to recovery.
- Patients with a history of manic episodes.
- Patients with psychotic symptoms.
- Patients who have had significant side effects from antidepressant medications.
- Patients with significant and active substance abuse.
- Patients who fail to respond to 2 or more trials of antidepressant medications.

Education:

The patient with a first-time episode of clinical depression has a 50:50 chance of having another episode some time in the future. The likelihood increases if the patient has a strong positive family history for recurrent depressive illness. The patient should be educated about the early warning signs of a recurrent episode to reduce the time between when the patient experiences the onset of an episode and when he or she seeks help. That, in turn, hopefully will reduce the severity and the duration of the episode.

Therefore, it is useful to explain to the patient with a single depressive episode that there is a good chance he or she will not have another one. In the event another episode occurs, there may be years between the episodes. It should also be emphasized that should future episodes occur, they should be just as responsive to medication as the first one was. There is no reason why the patient should not have a full, productive, and happy life. The goal is to provide a realistic recognition that there is a chance of a recurrence without over-emphasizing the risk.

Treatment:

If the severity of the syndrome is mild and/or not convincingly present, the clinician may decide to defer initiating antidepressant pharmacotherapy and schedule the patient for a follow-up within one week. This approach permits an assessment of the temporal stability of the patient's complaints. Conversely, if the illness is sufficiently severe to be causing distress and/or dysfunction, the prescriber may elect to start a trial of medication, and schedule a followup visit in one week.

Treatment begins with the selection of an antidepressant for the patient. Current prescribing data indicates that the serotonin selective reuptake inhibitors (SSRIs) as a class are the antidepressants of first choice for most practitioners, with over 50 percent of all antidepressant prescriptions being for one of the SSRIs. These medications are a reasonable

and safe choice for the busy primary care practitioner particularly considering as little as seven minutes are may be allocated for a patient visit.

SSRIs include: Celexa, Lexapro, Paxil, Prozac, and Zoloft.

The appropriate interval between the initial visit and the first follow-up visit will typically be either one or two weeks depending on how well the patient will likely tolerate the medication. Obviously, the more severe the episode, the closer the follow-up should be. The patient should be instructed to either call the clinic or decrease the dose if he or she is having any adverse effects that are more than a nuisance. At the return visit, the practitioner can assess the adequacy of the dosing schedule and determine how well the medication is working.

At the end of a four- to six-week trial of the medication, the patient's response can be assessed. The response can be divided into three categories:

- Full remission
- Partial response
- No response

For patients who experience only a partial or no response consider dose increases or switching to a second trial of an alternative SSRI.

If this is a first episode, the patient should remain on the antidepressant for at least four months after remission. This interval is a vulnerable period during which the probability of a relapse is high if the patient does not remain on medication. During this phase, the patient should be seen generally every one to two months for follow-up medication checks. During these visits, the practitioner will determine whether the medication continues to be effective in terms of maintaining remission and whether it continues to be well-tolerated and safe. In addition, education about the illness continues by clarifying any questions that the patient may have.

At the last few visits prior to the termination of continuation therapy, education should shift to the likelihood of a recurrent episode. This training can help the patient be more sensitive to the recurrence of symptoms after the antidepressant medication has been stopped.

Antidepressant medication can be used to prevent future episodes as well as to treat current ones. If the patient has had two previous episodes, there is almost a 90 percent chance of having future episodes after medication is discontinued. Even so, the next episode may be years into the future (e.g. every 10 years). Indefinite therapy for all such patients seems excessive. Instead, each episode may be treated separately. There are some patients for whom the benefits of indefinite antidepressant treatment outweigh the downside. Ideally, the patient should make this decision based on balancing the following factors: the frequency, severity, duration, and recurrent depressive episodes versus problems or inconveniences associated with maintenance antidepressant therapy. Follow-up visits during active prophylactic treatment may be a number of months apart, depending on how long the patient has been on the antidepressant and the nature of his or her depressive illness.

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1. *Diagnostic and Statistical Manual of Mental Disorders;* Fourth Edition. Washington, DC, American Psychiatric Association, 1994, pp. 317-391.

Treatment.2

2. Amir Qaseem, MD, PhD, MHA, et al; and for the Clinical Efficacy Assessment Subcommittee of the American College of Physicians, ***Using Second-Generation Antidepressants to Treat Depressive Disorders: A Clinical Practice Guideline***

from the American College of *Physicians;* Annals of Internal Medicine, November 18, 2008 vol. 149 no. 10 725-733.

Refer, Education, and Treatment.3

1. *Practice Guideline for the Treatment of Patients With Major Depression,* Second Edition. Washington, DC, American Psychiatric Association, 2000.