Free Webcasts!

Treating Depression in Primary Care

Presented by:
Ryan Shackelford, MD

Nov 18, 2010

12:30 pm – 1:30 pm

Treating Anxiety in Primary Care

Presented by:
Nicole Lanouette, MD

Dec 16, 2010

12:30 pm – 1:30 pm

No need to travel – you can access the webcasts from your personal computer.

Both webcasts will be recorded for on-demand access for those that can't attend the live sessions.

Council of Community Clinics

Please RSVP to Marty
madelman@ccc-sd.org

Psychiatry for Primary Care: Depression

Ryan Shackelford

Family Medicine/Psychiatry Combined Program

November 18th, 2010

DEPRESSIVE DISORDERS

Pathophysiology
Video Case
Studies: STAR D Trial, Lancet, Impact, JAMA AD
Treatment Algorithim
Rating Scales
Treatment Scenarios

PRIMARY CARE DOCS ARE THE MOST IMPORTANT PIECE!

- **Depressive illness – 2nd leading cause of disability worldwide by 2020[4]**
- **<5% of clinical instruction for 20-33% of primary care practice[3]**
- **In 2008, >50% antidepressant Rx's from PCP's, 20% by Psychiatrists[6]**

MOOD STATES

- **Depressive Episode**
- **Dysthymia**
- Hypomanic Episode
- Manic Episode
- Mixed Episode

MDD PREVALENCE

Leading cause of disability in the United States for ages 15-44[1]

Affects approximately 14.8 million American adults or 6.7% of the U.S. adult population in a given year[2]

PATHOPHYSIOLOGY OF DEPRESSION

Deficiency in active neurotransmitters:

- **Serotonin (Raphe Nucleus)**
- **Dopamine (Nucleus Accumbens/Ventral Tegmentum)**
- **Norepinephrine (Locus Ceruleus)**

*****Meds increase concentration of these substances but also receptor upregulation**

MAJOR DEPRESSION (MDD)
SIG-E-CAPS

- **5 of 9 symptoms lasting at least 2 weeks:**
  - **Sleep: Insomnia/Hypersomnia**
  - **Interest: Diminished Interest or Pleasure**
  - **Guilt: Feelings of Worthlessness or Excessive Guilt**
  - **Energy: Fatigue/Loss of Energy**
  - **Concentration: Diminished/Indecisiveness**
  - **Appetite: Weight Loss or Change in Appetite**
  - **Psychomotor Agitation or Retardation**
  - **Suicide: Recurrent Thoughts of Death/SI/SA**
  - **Sadness: Depressed Mood (irritability in child/teen)**

DYSTHYMIA

- **Low mood state for most of the time over at least a 2year period**
- **2 or more of the following while depressed:**
  - **Appetite change (poor or overeating)**
  - **Insomnia or Hypersomnia**
  - **Fatigue or low energy**
  - **Low Self-esteem**
  - **Poor concentration or difficulty with decisions**
  - **Feelings of hopelessness**

AMY

20yo female w/ depressive symptoms for several months comes into your office for help.

http://picasaweb.google.com/ZisCalendar/Video#

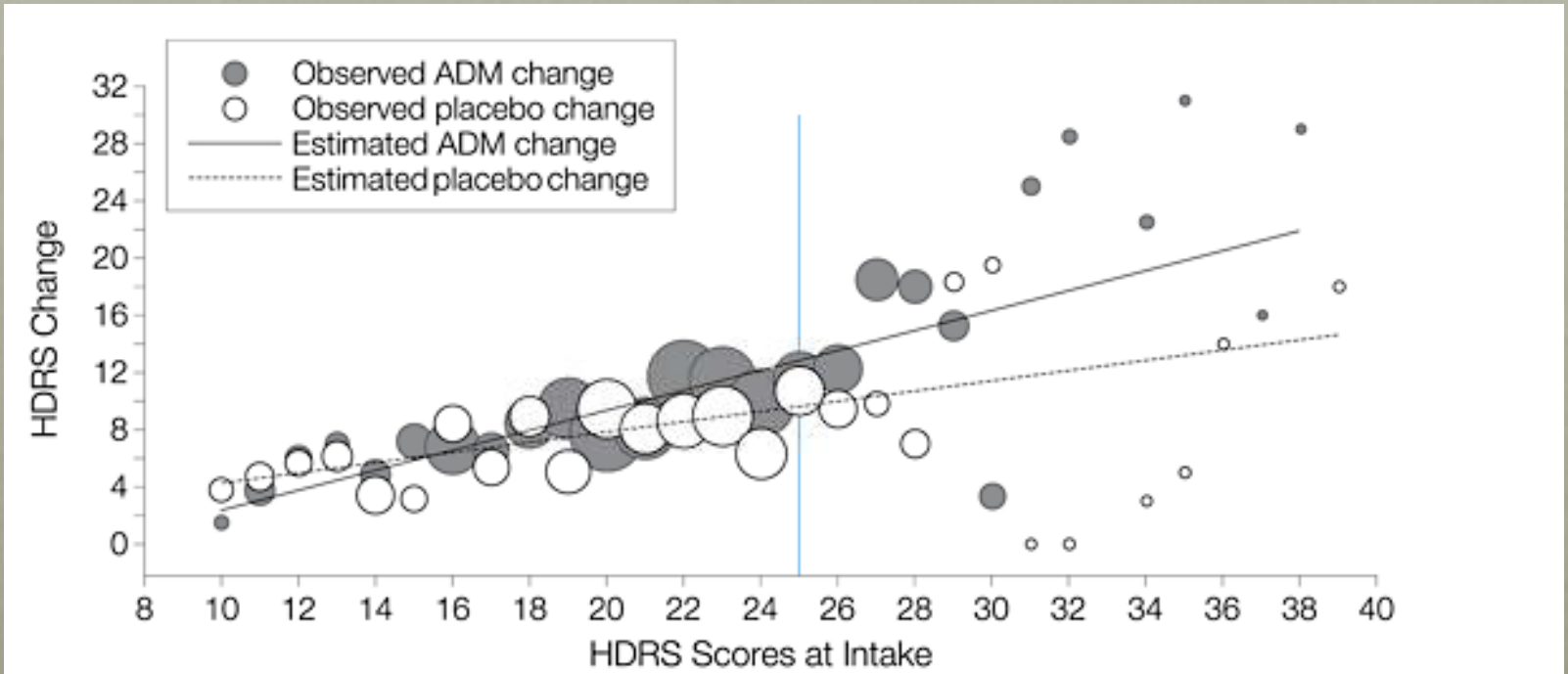
WHAT ELSE DO YOU NEED TO KNOW?

- Severity of the depressive episode.
- Suicidal thoughts?
- Mania/hypomania
- Psychotic features.

WHAT IS YOUR PRIMARY TREATMENT?

1. Anti-depressant
2. Therapy
3. Lifestyle Modification
4. Hospitalization

AD EFFECTIVENESS BY SEVERITY



Observed and Estimated Change in HDRS Scores Following Treatment With ADM and Placebo

JAMA Jan 6, 2010. Vol 303 No. 1

WHAT MED DO YOU START WITH?

1. Effexor (Venlafaxine)
2. Zoloft (Sertraline)
3. Prozac (Fluoxetine)
4. Wellbutrin (Buproprion)
5. Lexapro (Escitalopram)

TREATMENT

- **Anti-Depressant Medications**
  - **General Considerations:**
    - **Increased risk of suicide attempt**
    - **GI s.e. (nausea, diarrhea), acclimation period**
    - **Sexual s.e. (delayed ejaculation, *low libido*, anorgasmia)**
      - **Exception Wellbutrin**
    - **Serotonin Syndrome (any serotonergic meds in combination e.g. demerol, SSRI, TCA, MAOI, Tramadol)**
    - **Induction of Hypomania**

TREATMENT

- **Selective Serotonin Reuptake Inhibitors (SSRI)**
  - **Fluoxetine (Prozac):**
    - **longest half-life (t1/2 5-7days), activating, many drug-drug interactions**
  - **Paroxetine (Paxil):**
    - **weight gain and sedation common, w/d effects, many ddi**
  - **Sertraline (Zoloft):**
    - **data supports best efficacy to se ratio, some dopamine RI**

TREATMENT

- **Selective Serotonin Reuptake Inhibitors (SSRI)**
  - **Citalopram (Celexa):**
    - **anecdotally best tolerated**
    - **low ddi**
    - **safe choice but often need high doses (failure = 60mg)**
  - **Escitalopram (Lexapro AKA Celexa):**
    - **active enantiomer of Citalopram**

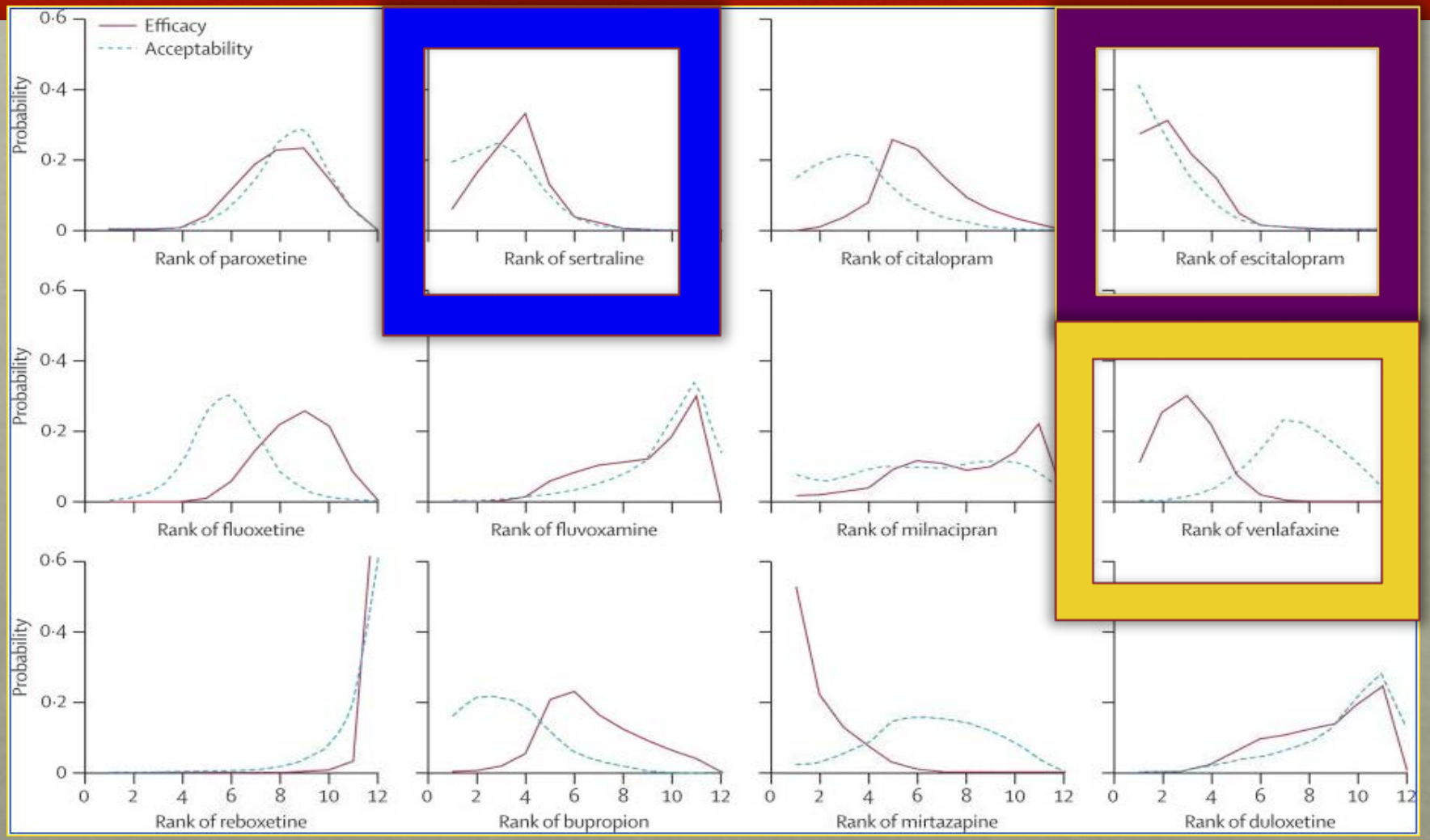
TREATMENT

- **Serotonin Norepinephrine Reuptake Inhibitor**
  - **Venlafaxine (Effexor, Effexor XR):**
    - **potent SRI at all doses/225-375mg SNRI**
    - **taper to avoid "shocking" w/d symptoms**
    - **can severely elevate BP at doses >150mg**
    - **contraindicated in heart dz**
  - **Duloxetine (Cymbalta):**
    - **"weak" antidepressant**
    - **equal SNRI at therapeutic doses**
    - **stress incontinence/fibromyalgia/neuropathy**
  - **Desvenlafaxine (Pristiq, AKA Effexor):**

TREATMENT

- **Dopamine Norepinephrine Reuptake Inhibitor**
  - **Bupropion (Wellbutrin IR/SR/XL, Zyban):**
    - **reverse SSRI sexual dysfunction/apathy, nicotine dep, se include anxiety/agitation/seizures (IR)**
- **Alpha 2-Antagonist**
  - **Mirtazapine (Remeron):**
    - **boosts SNRI's through alpha 2 antagonism, H1 histamine antagonism, se sedation (low dose=more) and weight gain**

AD EFFECTIVENESS



Lancet 2009 Vol 373, issue 9665, pg 746-58.

WHAT MED DO YOU START WITH?

A) **Zoloft (Sertraline)**

B) Effexor (Venlafaxine)

C) Prozac (Fluoxetine)

D) Wellbutrin (Buproprion)

E) **Lexapro (Escitalopram)**

AMY

No Better. No SE.

Increase Dose?

Switch Meds?

Augment?

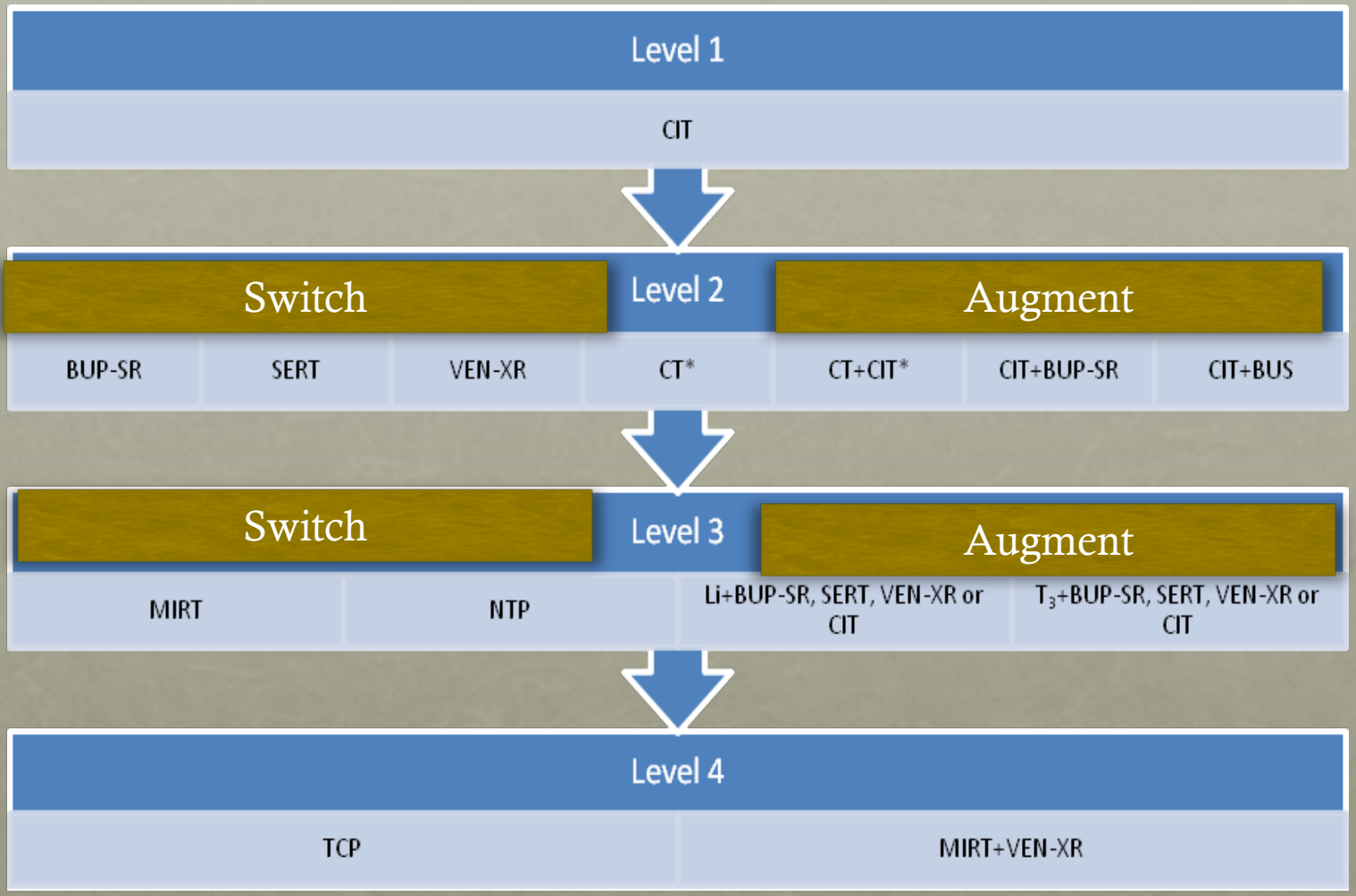
STAR*D TRIAL

- Sequenced Treatment Alternatives to Relieve Depression.

- **Goal**: Assess the effectiveness of depression treatments for MDD.

- **Participants**: 4,041, ages 18-75, 41 clinical sites in U.S. Broad range of SES and ethnic groups.

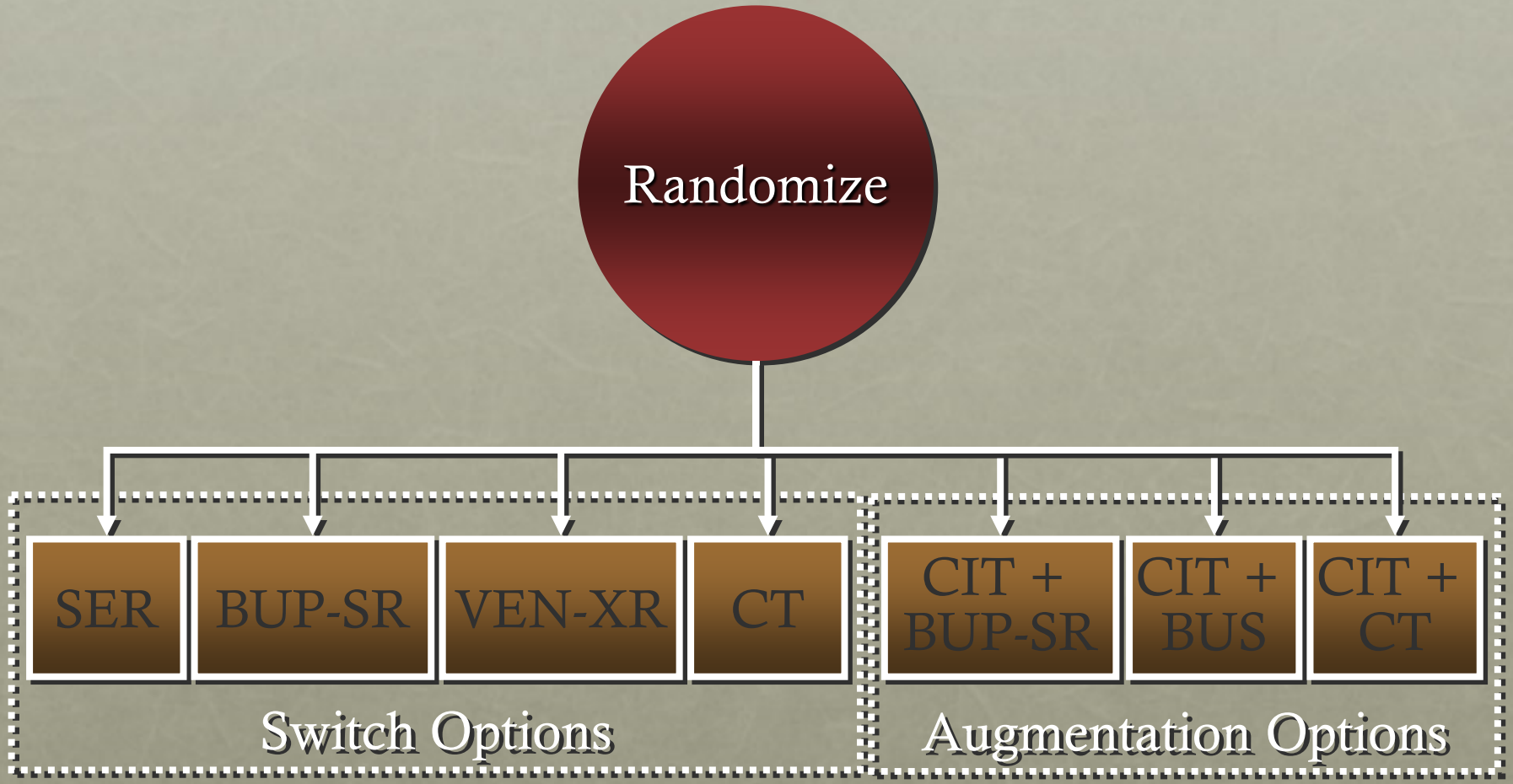
TREATMENT LEVELS IN STAR*D



CONCLUSIONS FROM LEVEL 1

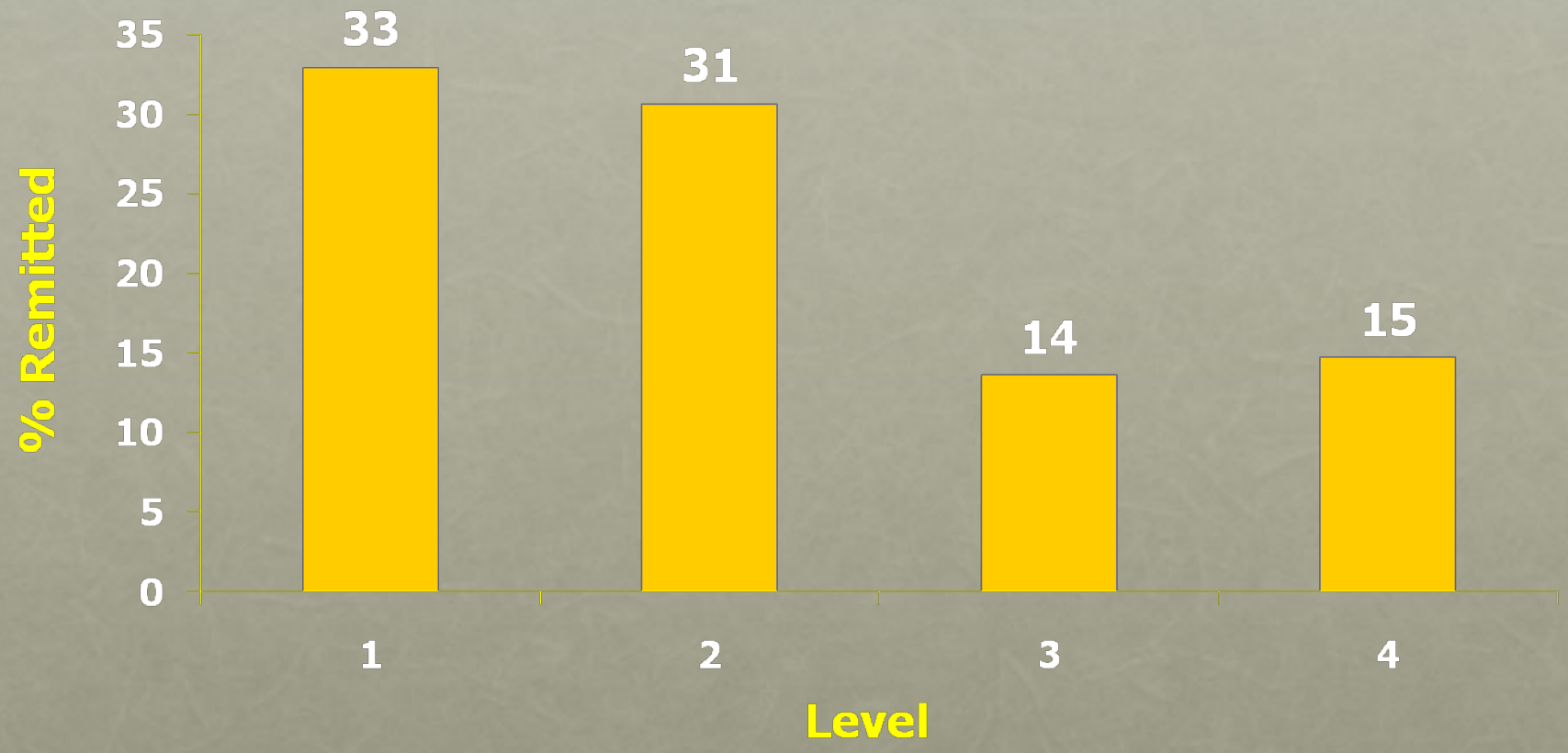
- About 1/3 will remit
- Of those who remit, remission occurs in almost 1/2 AFTER 6 weeks
- Effective treatment reduces suicide risk
- 40% will relapse within 1 year

LEVEL 2 FINDINGS



Rush AJ, et al. *Am J Psychiatry* 2003;160:237.

REMISSION RATES BY TREATMENT LEVEL (QIDS-SR_{16})



LEVEL 1-2 CONCLUSIONS

- Cumulative remission rate is over 50% with first 2 steps
  - Relapse rate and drop out rates also high
- Patient preference plays a big role in strategy selection
- Pharmacological distinctions do not translate into large clinical differences
  - Therefore, other factors (eg, expected side effects and patient preferences) should help guide treatment decisions
- Switching or augmenting with CT about as effective as switching to medications

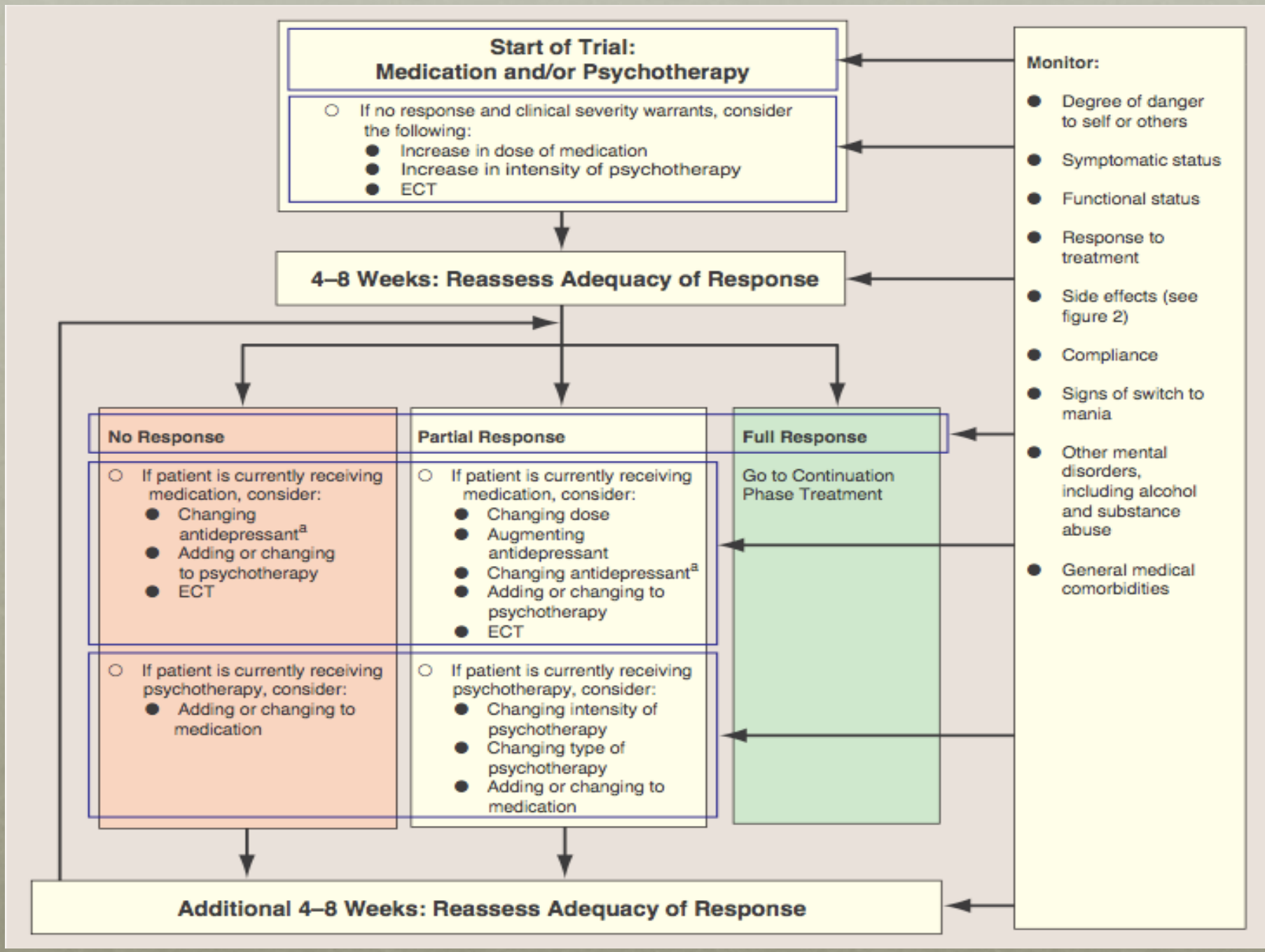
MANAGING MDD IN THE CLINIC

- IMPACT: Collaborative Stepped Care Project
- RCT in pts 60yrs+ w/ MDD or dysthymia
- Randomly assigned to IMPACT intervention (n=906) or to usual care (n=895)
- Intervention group had a depression care manager supervised by psychiatrist and PCP
  - Gave education, care management and support of AD management by PCP or a brief psychotherapy
- Assessed at 3, 6, 12mos for depression, satisfaction w/ care, functional impairment and QOL

MANAGING MDD IN THE CLINIC

- **Results IMPACT Study:**
  - **At 12mos 45% of pts had a 50% or greater reduction in depressive symptoms from baseline compared with 19% of usual care patients p<.001**
  - **Also had greater rates of depression treatment, satisfaction w/ care, lower depression severity, less functional impairment and greater QOL than usual care patients**
  - **Cost Effectiveness – Average cost IMPACT program was $580/pt, <1$pmpm. $3,300 less overall medical cost on average for 4yr period**

JAMA. 2002; 288:2836-2845



APA Practice Guidelines, 2010

DOSING STRATEGIES

Initiate Pharmacotherapy:

- **Re-eval in 4-6wks (2nd visit)**
  - **If no or mild improvement and tolerating, increase dose**
- **Re-eval in 4-6wks (3rd visit)**
  - **If no improvement, switch medications**
  - **If mild/mod improvement, increase dose again or augment (different classes)**
  - **If at or near remission, maintenance mode**
    - **- continue medication for 4-6months**
    - **- consider indefinite treatment for tx resistant or multiple relapses.**

RATING SCALES

- Hamilton Depression Inventory (HAM-D)
- BECK Depression Inventory (BDI)
- Quick Inventory of Depression (QIDS)
- Patient Health Questionnaire (PHQ-2, PHQ-9)

TAKE HOME

- Depression is very common, disabling and treatable.
- Therapy is first line for mild depression.
- Meds and therapy for severe depression.
- Give the medication time to work.
- Remember to screen for (hypo)mania/psychosis/SI.
- You can trust the patient self-rating scales to guide tx.
- Collaborative care approach is the ideal to strive for.

TREATMENT SCENARIO

- **42yo male w/ MDD currently in mild depression. On Zoloft 200mg. Prominent anhedonia, anergia, low libido. No drugs/etoh, +tobacco**
  - **Questions?**
    - **(Situational? Relationship Prob?)**
  - **Medical r/o's?**
    - **Fatigue w/u - TSH/Test/CBC/CMP/RPR**
  - **Medication vs. Therapy vs. Lifestyle?**
  - **Med Choices?**
    - **Increase Zoloft, Augment w/ Wellbutrin, Switch Meds**

TREATMENT SCENARIO

- **24yo female college student, THC abuse, with 2nd MDE, one prior hosp and SA. Predominent irritability, h/o episodes were she is super productive and "sped up".**
  - **Questions?**
    - **r/o BAD**
  - **Medical r/o's?**
    - **RPR/UPT/utox**
  - **Medication vs. Therapy?**
  - **Med Choices Initially?**
    - **Weary of BAD especially if mania worsens or made "worse" by anti-depressant.**

TREATMENT SCENARIO

- **80yo female w/ advanced ovarian CA, depressed w/ cachexia and insomnia.**
  - **Questions?**
  - **Medical r/o's?**
  - **Medication vs. Therapy?**
  - **Med Choices?**

On-line Survey

Please complete the very short 4 question survey regarding this training at:
http://www.surveymonkey.com/s/QYGR578

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