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Depression in Adults: Information for Primary Care

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Summary: Depression is a common mental health condition seen in primary care. Family physicians can play a key role in ruling out medical conditions, helping patients develop healthier attachments as well as referral to specialized mental health services if required.

Epidemiology

- Prevalence of depression
  - 2%-4% of persons in the community (Katon, 1992)
  - 5%-10% of primary care patients (Katon, 1992)
  - 10%-14% of medical inpatients (Katon, 1992)
- More than 90% of patients diagnosed with depression receive care exclusively from their family physician (Bilsker, 2007).
- Complications:
  - 2% of people with depression commit suicide, and of these, 50% will have had contact with their family physician in the month prior to suicide (Luoma, 2002)

Screening

There are two main approaches:

1. Screen all patients: The US Preventative Task Force recommends depression screening in all adult patients (Annals of Internal Medicine, May 2002)

2. Screen those at increased risk of having depression such as with

   - Recent losses (including grief/bereavement, as well as relationship breakups)
   - Medical stresses such as cancer, cardiovascular problems
   - Somatic symptoms that do not appear to have any obvious medical cause
   - Family history of mental health issues
   - History of relationship and interpersonal issues
   - Recent postpartum status, i.e. new mother who is sleep deprived

Screening Questions

Two screening questions:

1. Clinician: “In the past month, have you lost interest or pleasure in things you usually like to do?”
2. Clinician: “In the past month, have you felt sad, low, down, depressed or hopeless?”

Yes to either 1) or 2) indicates need for further assessment…

Diagnosis (Dx)

- Major Depression
    - Problems with mood with significant neurovegetative symptoms

- Persistent depressive disorder (includes dysthymic disorder in DSM-IV)
    - Depressed mood for at least 2-years (in adults) (or at least 1-year in children/youth) but not to the severity (nor with significant neurovegetative symptoms) to meet for major depression

DSM-5 Criteria Summary

DSM-5 Major depression

At least five of the following symptoms have been present for the same 2-week period, and at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure:

- Depressed mood (or irritable mood in children/adolescents)
- Loss of interests or pleasure
- Loss of weight or appetite (or failure to make expected weight gain in children/adolescents)
- Insomnia or hypersomnia
- Fatigue or loss of energy
- Feelings of worthlessness, excessive or inappropriate guilt
- Concentration problems
- Psychomotor agitation or retardation
- Suicidal ideation or recurrent thoughts of death

DSM-5 Persistent depressive disorder (includes dysthymia)

1. Depressed Mood for at least 2-years (or at least 1-year in children/youth)
2. At least two or more of:

    - Appetite problems (loss of appetite or over-eating)
    - Sleep problems (insomnia or hypersomnia)
    - Energy problems (low energy or fatigue)
    - Low self-esteem
    - Poor concentration
    - Feelings of hopelessness

Differential Diagnosis (DDx)

Depression due to medical illnesses such as

- Cancer
- Vitamin deficiencies such as B12 / folate
- Thyroid
    - Hypothyroidism
    - Hyperthyroidism

- Adrenal
    - Cushing’s, Addison’s
- Toxic
    - Wilson’s disease
    - Heavy metal poisoning
- Neurologic causes
    - Alzheimer’s
    - Stroke
    - Parkinson’s
    - Multiple sclerosis (MS)
    - Seizures
    - Dementia
- Infections
    - Infectious mononucleosis
    - Lyme disease
    - Autoimmune disorders
    - Celic disease
    - Lupus
    - Rheumatoid arthritis
- HIV testing (if HIV is suspected)

Medication-induced such as

- Beta blockers and other anti-hypertensives
- Corticosteroids
- Sedatives and anti-anxiety medications
- Oral contraceptives
- Substance use or alcohol use
    - Alcohol or drug use can also cause fatigue, memory problems, insomnia and anxiety

Psychiatric diagnoses such as

- Bipolar depression
    - Individuals with bipolar disorder have mood swings classically with high energy, euphoric phases, but also can have depressed moods as well
- Anxiety disorders
    - Similar symptoms include fatigue, poor concentration, restlessness
    - Individuals with anxiety are at a higher risk of developing depression
- Eating disorders such as anorexia, bulimia
- Psychotic disorders such as schizophrenia, delusional disorder
- Attention deficit hyperactivity disorder (ADHD)

Investigations

- Depression is a clinical diagnosis based on history and physical findings
- There are no diagnostic laboratory tests for the diagnosis of depression
- Typical investigations to rule out medical conditions include:
    - Complete blood count (CBC)
    - Thyroid indices (e.g. TSH, free T4)
        - Elevated TSH may suggest hypothyroidism, with mental slowing, lethargy, weight gain, sleep problems
        - Decreased TSH may indicate hyperthyroidism, with weight loss, fatigue, irritability

    - Vitamin B12
    - Folate
    - Electrolytes including sodium (Na+), potassium (K+), as well as calcium (Ca), phosphate (P) and magnesium (Mg)
- Additional investigations that might be ordered if indicated
    - Kidney function tests, e.g. BUN and Creatinine (Cr)
    - Liver function tests
    - Testing for common substances of abuse such as:
        - Urine for cannabinoids
        - Blood alcohol level
    - Cortisol test for Cushing's disease, linked to obesity, back pain, mental changes
    - Sleep testing if sleep disorders such as sleep apnea suggested

Physical Exam (Px)

- Depression is a clinical diagnosis based on history and physical findings
- There are no specific physical findings for the diagnosis of depression

Treatment / Management

- Education about Depression
- Psychotherapy/Counselling
    - Office-based psychotherapy/counseling by family physicians with sufficient training and time
    - Refer to psychologist or other mental health professional in private practice
- Self-Management strategies include
    - Getting enough sleep
    - Getting enough exercise
    - Having a healthy diet
    - Spending quality time with people
    - Getting out into nature
- Support groups such as the local chapter of the Mood Disorders Society of Canada

Medications

Specific serotonin reuptake inhibitor (SSRI)

- Citalopram (Celexa or generic)
    - Start at 20 mg daily, increase up to 20-60 mg daily
- Escitalopram (Cipralex or generic)
    - Start at 10 mg daily, increase up to 10-20 mg daily
- Fluoxetine (Prozac or generic)
    - Start at 10-20 mg daily, increase up to 20-60 mg daily
- Paroxetine (Paxil or generic)
    - Start at 20 mg daily, increase up to 20-50 mg daily
- Sertraline (Zoloft or generic)
    - Start at 50 mg daily; increase up to 50-200 mg daily

Serotonin-noradrenaline reuptake inhibitor (SNRI)

- Duloxetine
    - Start 20 mg daily; increase up to 40-60 mg daily

- Venlafaxine XR
    - Start at 37.5 mg daily; increase up to 75-225 mg daily

Noradrenaline dopamine reuptake inhibitors (NDRI)

- Bupropion SR
- Start at 150 mg daily, increase up to 300-450 mg daily

Noradrenaline-serotonin modulator

- Mirtazapine
    - Start at 15 mg QHS; increase up to 15-45 mg QHS

Duration of initial trial

- If patient does not respond to at least 4-8 weeks of antidepressant therapy at an adequate dosage
    - Confirm that the diagnosis of depression is corret
    - Confirm that patient was taking the medication
    - Rule out medical causes of depression
- Options
    - Switch to another antidepressant
    - If there was a partial response to the first antidepressant, then consider augmenting, i.e. adding a second antidepressant
    - Augment with
        - Psychotherapy, such as cognitive behavioural therapy (CBT)
        - Bupropion (Wellbutrin)

Duration of maintenance therapy

- If patient responds to treatment, then continue antidepressants for at least 6-12 months in order to reduce risk of relapse

When and Where to Refer

Consider referral to a psychiatrist for:

- Bipolar disorder, psychotic symptoms and/or a substance use disorder;
- Risk of suicide or harm to others;
- Severe co-morbid psychiatric or medical illness;
- History of treatment resistance;
- Lack of response to standard treatments
- Unclear diagnosis

Clinical Algorithms

- Khan A, Green D: Depression Algorithm for Primary Care, 2005.

Clinical Practice Guidelines

- Kennedy S et al.: CANMAT 2016 Clinical Guidelines for the Management of Adults with Major Depressive Disorder: Section 3. Pharmacologic Treatments, Can J. Psychiatry, 2016, 61(9): 540-560.
  HTML http://journals.sagepub.com/doi/abs/10.1177/0706743716659417
  PDF http://journals.sagepub.com/doi/pdf/10.1177/0706743716659417
- Major depressive disorder in adults: Diagnosis and management, Dec 2013
  http://www.bcguidelines.ca/guideline_mdd.html

- Depression: the treatment and management of depression in adults, NICE clinical guideline (CG90), Oct 2009
  http://guidance.nice.org.uk/CG90
- Patton SB, Kennedy SH, Lam RW et al. Canadian Network for Mood and Anxiety Treatments (CANMAT): Clinical Guidelines for the management of major depressive disorder in adults, J. Affective Disorders 2009; 117(Suppl 1): S5-S14.
  http://www.canmat.org/resources/CANMAT%20Depression%20Guidelines%202009.pdf
- Practice guideline for the treatment of patients with major depressive disorder, American Psychiatric Association, Oct 2010s
  http://psychiatryonline.org/data/Books/prac/PG_Depression3rdEd.pdf

References

- Bilsker D, Goldner EM, Jones W. Health service patterns indicate potential benefit of supported self-management for depression in primary care. Can J Psychiatry 2007;52(2):86-95.
- Katon W, Schulberg H: Epidemiology of depression in primary care. Gen Hosp Psychiatry. 1992 Jul; 14(4): 237-47.
- Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. Am J Psychiatry. 2002;159(6):909-16.
- Puyat et al.: Estimating the prevalence of depression from EMRs, Canadian Family Physician April 2013 vol. 59 no. 4 445.
- Wong ST, Manca D, Barber D et al.: The diagnosis of depression and its treatment in Canadian primary care practices: an epidemiological study. CMAJ Open 2014; 2:E337-E342.

About this Document

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