Depression Management Adult, Ambulatory Clinical Practice Guideline Brief

DEPRESSION MANAGEMENT GUIDELINE USE

Full Dartmouth-Hitchcock Depression Management Adult, Ambulatory Clinical Practice Guideline:
http://one.hitchcock.org/intranet/docs/default-source/d-h-knowledge-map-documents/depression_cpg_final.pdf

Depression Management Adult, Ambulatory Clinical Practice Pocket Guide:
http://one.hitchcock.org/intranet/docs/default-source/d-h-knowledge-map-documents/dep_pocketguide_final.pdf

SUMMARY RECOMMENDATIONS

1. Identify Patients

- Physical complaints are extremely common in depression and are often the primary manifestation of the illness. It is important to recognize somatic manifestations of depression, as well as biological, psychological and environmental risk factors.
- Screening for depression is recommended by the US Preventive Services Task Force. Initial screening should be completed using the PHQ-2 at new patient visits, annual preventive visits, and at any visit if not done in previous 90 days (D-H Expert Opinion). A PHQ-2 score of ≥3 triggers a full PHQ-9.
- A PHQ-9 score of 10 points or greater indicates the need for clinical evaluation and documentation of a follow-up plan.

2. Establish Diagnosis

- Determine that DSM-5 criteria have been met, other psychiatric or medical conditions have been identified, and that patient functioning has been assessed.
- Differential diagnosis of depression includes certain medical conditions, medication side effects, and other psychiatric conditions or co-morbidities.

3. Initiate Treatment

- The use of psychotherapy, pharmacotherapy, or both should be based on depression severity, comorbid conditions, insurance coverage and patient preferences.
- Selection of a particular medication is based on coexisting conditions (appendix 5), side effect profile (appendix 6), concurrent medications and cost issues.
- All patients with depression in primary care should be enrolled in the Collaborative Care Model (CoCM), in which a care manager (supervised by a psychiatrist) proactively tracks patient symptoms and promotes adherence to the treatment plan.

4. Follow-up Care and Treat to Target

- The goal of treatment is to resolve all signs and symptoms of depression (as assessed by the PHQ-9) and to restore psychological and occupational functioning. Contact (telephone or in-person, by clinician and/or care manager) should occur 1 week after diagnosis and initiation of treatment, and then every 2-4 weeks until there is remission (PHQ<5) or response (defined as a 50% or greater reduction in symptoms as measured by the PHQ-9).

- Side effects can often be managed by a gradual titration up to the full dose. Sedation or restlessness and sexual side effects can persist, and may require dose or medication adjustment. Bupropion can help lethargy, low motivation or trouble concentrating, while mirtazapine can help insomnia or lack of appetite- and neither has the sexual side effects common with SSRIs/SNRIs.
- If the patient does not demonstrate a response to pharmacotherapy (alone or in combination with psychotherapy) within 6 weeks of initiation (4 weeks in severely ill), or responds only partially by 12 weeks, other treatment options should be considered using a stepped care approach.
- Continue pharmacotherapy for 4-9 months following remission of symptoms. Continue maintenance medication indefinitely after a third episode of depression, or after a second episode in the setting of severe or persistent symptoms, strong family history, or significant ongoing stressors. Prior to discontinuation and tapering of treatment, patients should be informed of the potential for relapse and a plan should be established to seek treatment if symptoms reoccur.

5. Referrals

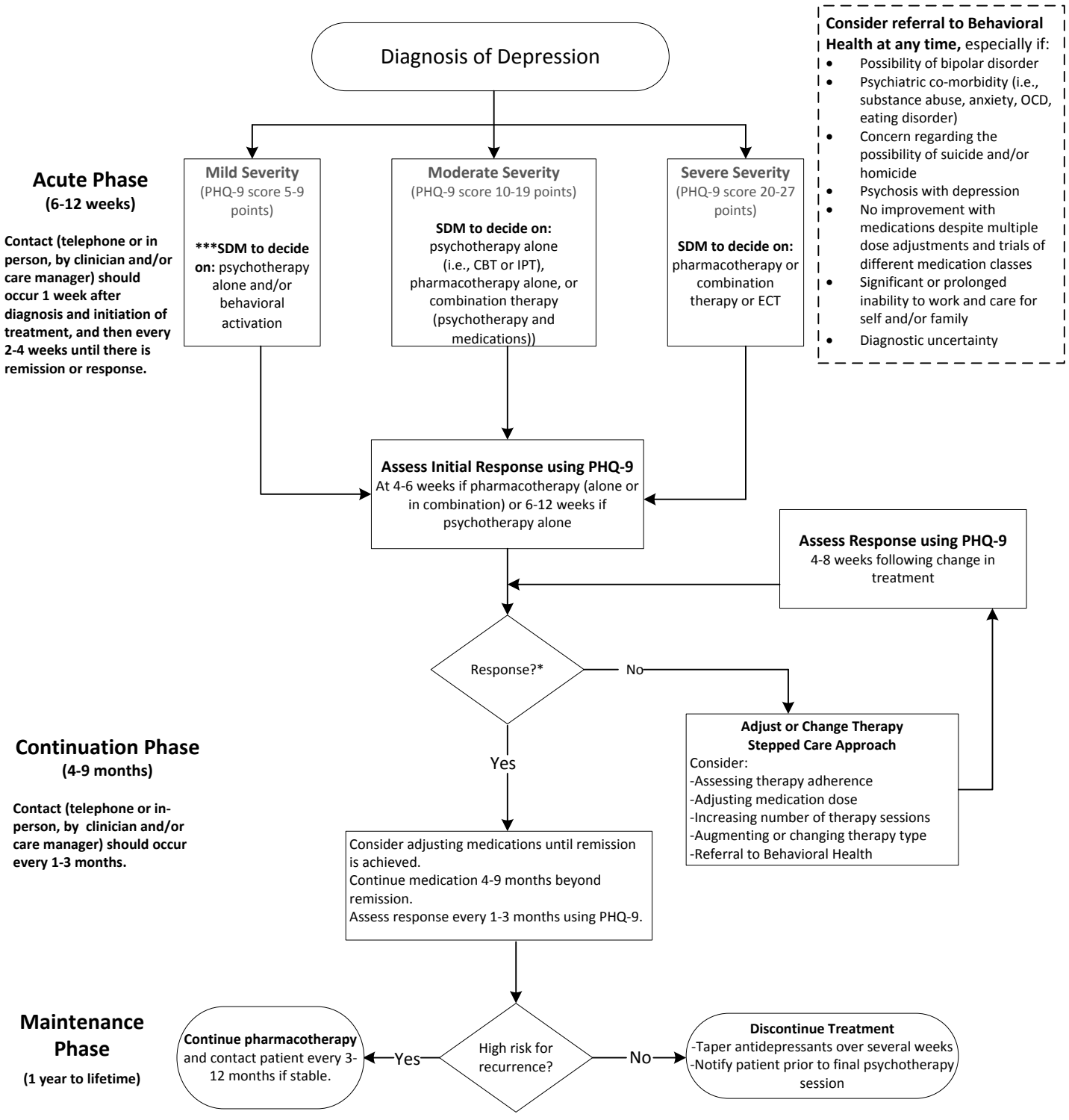
- All patients with significant symptoms should be followed by a CoCM case manager.
- Psychiatric consultation is recommended for diagnostic uncertainty, significant psychiatric co-morbidity, or lack of improvement after initial trials of therapy.
  patients should be informed of the potential for relapse and a plan should be established to seek treatment if symptoms reoccur.

Patient Resources

- A D-H internet web-page will be built that summarizes information, self-help strategies, self-help groups, counseling resources, etc. for depression (below).
- Healthwise resources on D-H internet site: dozens of topics available
- Other web resources
  - Information
    - www.nimh.nih.gov/health/topics/depression/index.shtml
    - www.psychiatry.org/patients-families/depression
    - www.suicidepreventionlifeline.org
  - Finding a therapist
    - https://therapists.psychologytoday.com
  - CBT based self-management
    - http://www.moodjuice.scot.nhs.uk
    - https://moodgym.anu.edu.au/welcome
    - http://www.beatingtheblues.co.uk/patients/
- Apps
  - Pacifica- anxiety, stress and depression relief
  - MoodKit- CBT for depression, anxiety, anger management
- Books
  - The Cognitive Behavioral Workbook for Depression- William Knauss, EdD

Pathways & Guidelines: Clinical Practice Guideline and pathways are designed to assist clinicians by providing a framework for the evaluation and treatment of patients. This Clinical Practice Guideline outlines the preferred approach for most patients. It is not intended to replace a clinician's judgment or to establish a protocol for all patients. It is understood that some patients will not fit the clinical condition contemplated by a guideline and that a guideline will rarely establish the only appropriate approach to a problem.

APPENDIX 2: Depression Treatment in Adults Algorithm



Risk factors for recurrence:
3 or more major depressive episodes OR 2 prior episodes and any of the following factors:
-Chronic major depressive disorder
-Presence or residual symptoms
-Ongoing psychological stressors
-Early age at onset
-Family history of mood disorders

***Response:** a 50% or greater reduction in symptoms (as measure by the PHQ-9).
****Remission:** the absence of depressive symptoms, or the presence of minimal depressive symptoms (PHQ-9 score < 5 points)
*****SDM:** Shared decision making

APPENDIX 5: Consideration of Concurrent Conditions

Depression With	First-Line Therapeutic Options*	May be Problematic
No Additional Comorbid Conditions	Fluoxetine, Citalopram, Escitalopram, Paroxetine, Sertraline, Trazodone, Mirtazapine, Venlafaxine, Desvenlafaxine, Bupropion	TCA-side effect profile less desirable Nefazodone-hepatotoxicity
Pregnancy	Sertraline, Citalopram, Fluoxetine, TCA	Paroxetine, Venlafaxine, Duloxetine
Elderly patients		Fluoxetine, Paroxetine
Alcohol Use		Duloxetine=Liver injury, as manifested by ALT and total Bilirubin elevations, with evidence of obstruction have occurred with coadministration of alcohol and Duloxetine.
Anxiety or Panic Disorder	Paroxetine, Fluoxetine, Mirtazapine, Sertraline, Citalopram, Escitalopram Venlafaxine, Desvenlafaxine	Bupropion-may increase anxiety
Cardiac Condition	Sertraline	TCA Venlafaxine Desvenlafaxine, Bupropion (increases blood pressure). Mirtazapine (increases cholesterol), Citalopram
Chronic Pain	TCA, SNRI such as Duloxetine	
Decreased Appetite	TCA, Mirtazapine	Venlafaxine Desvenlafaxine SSRI
Dementia	Bupropion, Mirtazapine, Citalopram	
Dementia, Head Injury, Post-Stroke Patients	Citalopram, Escitalopram, Sertraline	TCAs, Paroxetine, Mirtazapine, Bupropion
Diabetes	Fluoxetine, Citalopram, Escitalopram, Paroxetine, Sertraline	TCAs, Mirtazapine (may increase carbohydrate cravings), Duloxetine (causes slowed gastric emptying), Paroxetine
Eating Disorders (anorexia, bulimia)	Fluoxetine, Paroxetine, Sertraline	Bupropion, Mirtazapine
Fibromyalgia	Duloxetine, Venlafaxine	
Glaucoma	Fluoxetine, Citalopram, Escitalopram, Sertraline, Bupropion	TCA, Paroxetine, Duloxetine, Venlafaxine, Desvenlafaxine
Lactation	Sertraline, Paroxetine	Fluoxetine
Liver Disease	Sertraline, Venlafaxine (use at low dose) , Desvenlafaxine (use at low dose)	TCAs, Fluoxetine, Paroxetine, Citalopram, Escitalopram, Trazodone, Mirtazapine, Nefazodone, Duloxetine
Obsessive Compulsive Disorder	Fluoxetine, Citalopram, Escitalopram, Sertraline, Paroxetine	
Parkinson's Disease	Bupropion, Trazodone, Desipramine, Amoxapine, Nortriptyline, Protryptyline	SSRIs, Venlafaxine, Desvenlafaxine, Nefazodone, Mirtazapine
Pheochromocytoma		Selegiline patch
Renal Disease	Fluoxetine, Citalopram, Escitalopram, Sertraline	Mirtazapine, Paroxetine, Venlafaxine, Desvenlafaxine, TCA-levels not predictive
Seizures/Seizure Disorder	Fluoxetine, Citalopram, Escitalopram, Sertraline, Paroxetine	Bupropion, Maprotiline, TCA (in overdose), Duloxetine, Venlafaxine Desvenlafaxine
Symptoms of: insomnia, weight loss, or overstimulation	Mirtazapine, Trazodone, TCAs, Paroxetine	Venlafaxine, Desvenlafaxine, SSRI, Bupropion
Symptoms of: oversedation, weight gain, or lethargy	Bupropion, Venlafaxine, Desvenlafaxine	Mirtazapine, TCA, Trazodone, Fluoxetine, Sertraline, Citalopram, Escitalopram, Paroxetine
***Prior to selecting an individual agent for therapy, prescribers should screen for other medications and supplements that may cause problematic effects for the patient.**		

APPENDIX 6: Depression Side Effect Profiles

Side effects may be observed early in pharmacotherapy treatment and improve over time. If side effects persist, alternatives may be considered.[8]

Presenting Symptom	First Line Therapeutic Options	May Be Problematic
Agitation/Insomnia	Mirtazapine, TCA	Selegiline Patch, Fluoxetine, Sertraline, Paroxetine, Citalopram, Escitalopram, Bupropion, Venlafaxine, Desvenlafaxine
Anticholinergic Side Effects (dry mouth, blurred vision, constipation, urinary retention)	Citalopram, Escitalopram, Fluoxetine, Sertraline, Venlafaxine, Desvenlafaxine, Bupropion	TCA, Mirtazapine, Paroxetine, Duloxetine, Selegiline Patch
GI Sensitivity	Bupropion, TCA, Mirtazapine	Fluoxetine, Sertraline, Paroxetine, Citalopram, Escitalopram, Nefazodone, Venlafaxine, Desvenlafaxine, Duloxetine (20% pts nausea)
Headache	TCA, Mirtazapine	Fluoxetine, Sertraline, Paroxetine, Citalopram, Escitalopram, Nefazodone, Venlafaxine, Desvenlafaxine, Bupropion, Selegiline Patch
Orthostatic Hypotension	Fluoxetine, Sertraline, Paroxetine Citalopram, Escitalopram, Venlafaxine, Desvenlafaxine, Bupropion	TCA, Mirtazapine, Trazodone, Selegiline Patch
Sedation	Fluoxetine, Sertraline, Paroxetine, Citalopram, Escitalopram, Venlafax-ine, Desvenlafaxine, Bupropion	TCA, Nefazodone, Trazodone, Mirtazapine, Selegiline Patch, Paroxetine
Sexual Dysfunction	Bupropion, Mirtazapine	Fluoxetine, Sertraline, Paroxetine, Citalopram, Escitalopram, Venlafaxine, Desvenlafaxine, Bupropion, Trazodone
Weight Gain	Fluoxetine, Sertraline, Citalopram, Escitalopram, Venlafaxine, Desvenlafaxine, Bupropion	TCA, Paroxetine, Mirtazapine, Trazodone
Special Considerations for Older Adults (age 65 years or older) [5,56,58]		
Poor sleep/Insomnia	Mirtazapine	Benzodiazepines, Paroxetine
Weight loss	Mirtazapine	
Anxiety	SSRIs, SNRIs	
Hypersomnia and low energy	Bupropion	