Healthier You
ALLIANCE IN ACCOUNTABLE CARE
Via Christi Health

Depression Care Path

Screening and Diagnosis

Diagnosis: Major Depressive Disorder is defined as depressed mood, markedly diminished interest or pleasure in almost all activities, >5% body weight changes in 1 month, insomnia/hypersomnia, fatigue, loss of energy, feelings of worthlessness, hopelessness, inability to concentrate and/or recurrent thoughts of death. These symptoms should be present most of the day, nearly every-day and cause significant distress or impairment in functioning.

In severe cases of mania or depression, patient may have psychotic symptoms.

Anxiety is often comorbid with depression.

Screening: Use of an age appropriate depression screening tool is advised. The PHQ-2 is recommended for initial screening. A positive PHQ-2 would trigger further screening using the PHQ-9. The PHQ-9 is widely accepted evidence based self-administered screening tool for depression. Treatment recommended with scores >10.

IMPORTANT: If answer to question # 9 is "YES": assess suicide risk and take emergency action

Most common differential diagnoses to consider:

- Rule out history of a "manic episode" in the patient or family history of Bipolar Disorder as giving anti-depressant medications to treat depressive episode of a Bipolar Disorder may precipitate a manic episode.
- Hypothyroidism
- Anemia
- Substance abuse or over-prescription of CNS depressant medications

Treatment

A. Psychotherapy
B. Pharmacotherapy:

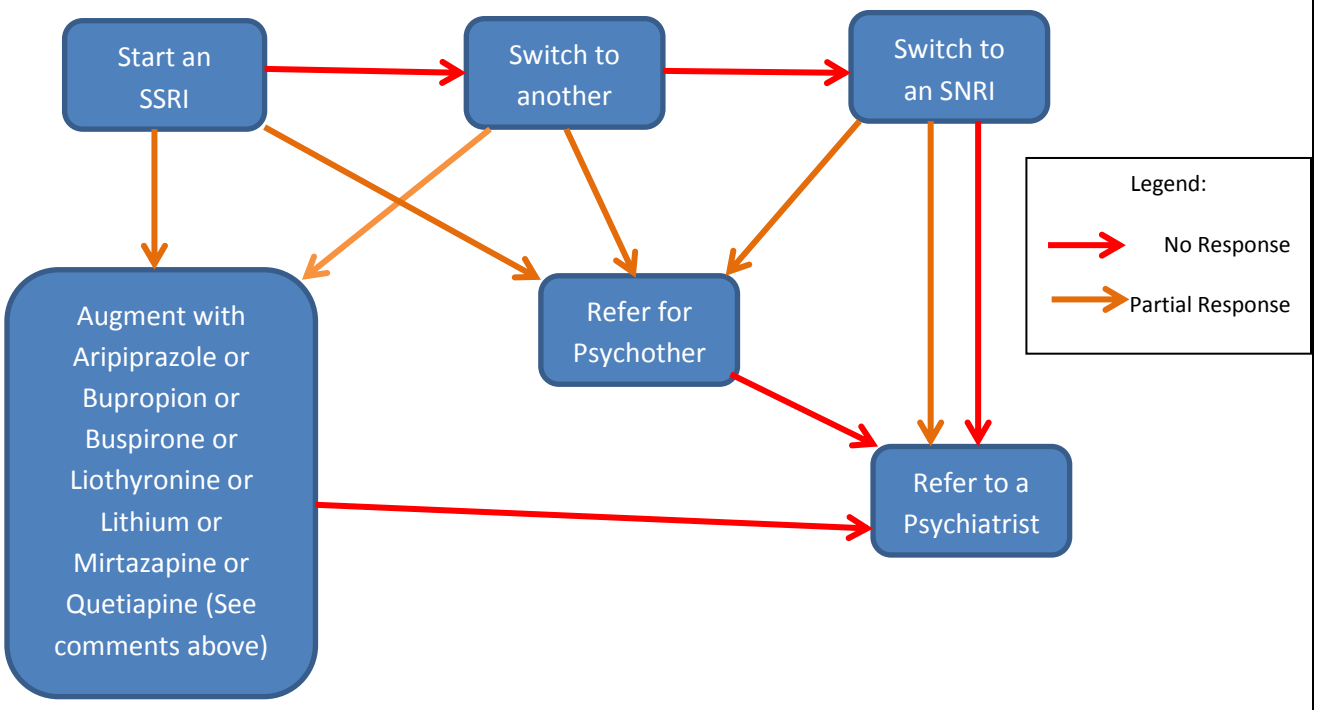
1. Goal of treatment is remission.
2. First line treatment is an SSRI medication such as fluoxetine, paroxetine, fluvoxamine, sertraline, citalopram and escitalopram. Maximum therapeutic benefit seen in 6 weeks. Maximize dose. Watch for gastrointestinal side effects, sexual side effects and restlessness. Gastrointestinal side effects and restlessness are usually transient. Consider potential drug-drug interactions that may occur with fluoxetine, paroxetine and fluvoxamine when used with other medications. Paroxetine is pregnancy category D, all other SSRIs are category C. Watch for QTc prolongation with citalopram. Max dose is 20mg if concomitant use of omeprazole. Max dose of citalopram in patients > 60 years in 20 mg.
3. If patient achieves REMISSION, continue treatment and monitor. If less than 2 episodes of major depression, may try taper and discontinue of medication after 12 months of sustained remission.
4. If PARTIAL RESPONSE, may refer patient for psychotherapy or augment SSRI with one of the following medications:
    - Aripiprazole: usually not the first choice for augmentation and would not be recommended at primary care setting. Very expensive. Watch for akathisia. Avoid in patients with obesity, Diabetes Mellitus, Dyslipidemia, age >65 (risk of stroke).
    - Buspirone: consider if co-morbid anxiety. Clinically only modest response observed.
    - Bupropion: contraindicated in patients with seizure disorder, binging & purging behavior and hx of TBI. Avoid if co-morbid anxiety or chronic heavy alcohol use. Advantage if smoking cessation is desired. Also a good augmentation strategy if sexual side effects were problematic with SSRIs.
    - Liothyronine: usually not the first choice for augmentation and would not be recommended at primary care setting. No effect on Thyroid Function Tests.
    - Lithium: usually not the first choice for augmentation and would not be recommended at primary care setting. check Renal Function Tests and Thyroid Function Tests. Avoid in females of child bearing age (risk of cardiac defects) and in patients with electrolyte abnormalities. Avoid when patients are taking NSAIDs, ACE inhibitors and thiazide diuretics. Narrow therapeutic index and requires therapeutic drug monitoring with Lithium level. Avoid if high risk of suicide.
    - Mirtazapine: consider if poor appetite & insomnia. A good choice if co-morbid gastrointestinal symptoms. Watch for agranulocytosis.
    - Quetiapine: usually not the first choice for augmentation and would not be recommended at primary care setting. Avoid in patients with obesity, Diabetes

Mellitus, Dyslipidemia, age >65 (risk of stroke). Causes sedation, may be used if also targeting insomnia. Also watch for orthostasis which is usually transient.

5. If NO RESPONSE to one trial of SSRI, switch to another SSRI and follow step 3 & 4. Do not use two pharmaceutical agents from same class.
6. If NO RESPONSE to two trials of SSRIs at maximum doses and maximum duration, switch to an SNRI such as duloxetine, venlafaxine, desvenlafaxine or levomilnacipran. Maximum therapeutic benefit seen in 6 weeks. Maximize dose. Watch for orthostasis, gastrointestinal side effects, sexual side effects and restlessness. Orthostasis, gastrointestinal side effects and restlessness are usually transient.

Other Treatment Considerations:

- Remove access to means of self-harm in severe phase of a depressive episode such as firearms. Avoid giving 90 day supply of medications.
- If patient needs emergent mental health services because of suicidal thoughts or self-care failure, send patient to nearest ED. If concerned about safety of the patient and patient is not reachable, can ask law enforcement to do a "welfare check" on the patient.



Reassessment

Use PHQ-9 to monitor treatment response (12 months out, +/- 30 days).

Therapeutic drug monitoring where applicable

Patient Engagement

Psychoeducation

Encourage compliance

Sleep hygiene education

Community engagement

Exercise

Specialist Consult

When to Refer:

- Poor treatment response, intolerable side effects.
- Co-morbid personality disorders, substance abuse or psychotic symptoms.
- Complex psychosocial environment.

References:

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3. Practice Guideline for the Treatment of Patients with Major Depressive Disorder. 3rd ed. American Psychiatric Association Work Group on Major Depressive Disorder. Gelenberg AJ et al. October 2010.
4. The STAR*D Project Results: A Comprehensive Review of Findings. Warden D et al Current Psychiatry Reports 2007, 9:449-459