

DEPRESSION IN THE PRIMARY CARE SETTING

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INTRODUCTION

Depression is common and treatable. It does not mean weakness and laziness; however it does mean the person have a medical disorder that needs to be treated. The lifetime risk of major depressive disorder (MDD) in community samples varies from 10% to 25% for women and from 5% to 12% for men (DSM-IV) (American Psychiatric Association, 1994). Possible reasons for gender differences: hormonal, genetic, interpersonal and social factors.

Diagnosis

The diagnostic criteria for major depressive disorder (based on a consensus of experts included in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition [DSM-IV]) state that 5 or more of the following symptoms must be present for at least 2 weeks:

1. Depressed mood
2. Anhedonia (loss of interest or pleasure in activities)
3. Changes in weight or appetite
4. Insomnia or hypersomnia
5. Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Feelings of worthlessness or excessive guilt
8. Decrease concentration and/or indecisiveness
9. Recurrent suicidal ideation or suicide attempt.

The symptoms described are:

1. Not due to substance abuse or a general medical condition
2. Significant enough to cause impairment in social, occupational or other important functioning
3. Not consistent with the criteria for a mixed affective episode.

Course

Mortality: 15% of persons with major depression end their lives with suicide.

Recurrence: 50% chance of second episode, after 3 episodes > 90% likelihood of a forth episode.

Clinical: untreated episodes often last 6 months with return to premorbid state or a chronic course of partial or no recovery in the minority.

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Treatment

1. Psychotherapy
2. Pharmacotherapy
 - a. 50%-70% of patients with major depression benefit from treatment
 - b. Major classes: MAO-I, TCA, SSRI, Atypicals
 - c. Points to consider:
 - i. Best predictor: previous good response of patient or family
 - ii. Side effects
 - iii. Drug-drug interactions
 - iv. Adequate trial: 4-8 weeks at a therapeutic dose, may consider change after three weeks with absolutely no response
 - d. Phases of treatment
 - i. Acute phase: Initiate treatment, obtain response, achieve full remission
 - ii. Continuation phase: once remission is obtained, continue for at least four months
 - iii. Maintenance phase: continued antidepressant to prevent recurrence
3. Electroconvulsive therapy (ECT)
4. Social interventions (e.g., job placement, financial assistance, sorting out accommodation problems).

Psychotherapy

Conveying an attitude of caring and acceptance of the patient as a person in need of professional services is therapeutic, as depressed individuals usually have negative feelings about themselves that can interfere with treatment. It is also important to listen and explore beliefs about illness or methods of treating it that could interfere with recovery.

For the busy Primary care Physician, The BATHE technique allows the Family Physician to reinforce effective coping strategies and also provide general support and ideas for the patient to use.

1. B = Background. Ask open-ended question to encourage open dialogue about issues that may be troubling the patient
2. A = Affect. Question such as "how do you feel about that?" or "what is your mood like lately?" make it possible for the patient to talk about the state of his or her feelings
3. T = Trouble. Asking, "what about the situation troubles you most?" helps the Family Physicians elicit the meaning of a specific situation

4. H = Handling. Asking, “how are you handling that?” help the Family Physician assess the patient’s coping skills and level of function.
5. E = Empathy. Comments such as “that must be very difficult for you” or “I understand that is a difficult situation” legitimize the patient’s reaction to a situation.

Cognitive Behavioral Therapy and other depression specific forms of psychotherapy, such as interpersonal therapy and problem solving therapy, have shown improved outcomes in major depression and this can also be delivered by trained Family Physician.

Cognitive Behavioral Therapy is a way to change negative thinking patterns and habits, so the patient does not always think the worst of the situation. It is based on the belief that one’s surroundings have an impact on thinking and behavior, and that the awareness of what is happening is necessary for one to more carefully choose the behavior and thought patterns.

Pharmacotherapy

Medication is an effective means for the treatment of depression. Antidepressants are the drug of choice for treatment of depression and for patients with concurrent anxiety. The aim of medication is to achieve symptom remission in the acute phase of treatment, to prevent relapse in the continuation phase of treatment and to prevent recurrence after the recovery during the long-term maintenance phase. This is important as recurrence and relapse increases the patient morbidity, suicide and reduces functional capacity.

How to choose an agent?

In 1999 the Agency for Health Care Policy and Research release a report that all drugs have similar efficacy when compare to TCAs. Therefore when selecting a antidepressant the following factors should be considered:

1. Patient’s past history of response to an antidepressant
2. History of antidepressant response in a first degree relative
3. Medical status
4. Target symptoms of depression
5. Side-effect profile of agent
6. Safety of an agent following an overdose (especially with TCAs)
7. Simplicity of use
8. Cost
9. Familiarity and comfort of the family physician with the pharmacology of the agent
10. Drug-drug interactions
11. Food-drugs interactions
12. Drugs-disease interactions.

Commonly used antidepressants in Singapore

Name	Starting Dose mg/day	Usual dose mg/day
Tricyclics		
Amitriptyline	25-50	100-300
Clomipramine	25	100-250
Dothiepin	25-50	100-300
Imipramine	25-50	100-300
Nortriptyline	25	50-200
SSRIs		
Citalopram	20	20-60
Fluvoxamine	50	50-300
Fluoxetine	20	20-60
Paroxetine	20	20-60
Sertraline	50	50-200
Escitalopram	10	10-20
Dopamine-norepinephrine reuptake inhibitors		
Bupropion	150	300
Serotonin-norepinephrine reuptake inhibitors		
Venlafaxine	37.5	75-225
Serotonin reuptake enhancer		
Tianeptine	25	25-75
Norepinephrine-serotonin modulator		
Mirtazapine	15	15-45
MAOIs		
Reversible MAOI-A		
Moclobemide	150	300-600

TCAs

Avoid TCAs if possible in the following conditions

1. Cannot tolerate daytime sedation
2. Urinary retention, constipation, glaucoma
3. Suicidal tendency (high dose TCAs can be fatal)
4. Cardiac disease, arrhythmias.

The following conditions would require consideration for treatment with TCAs

1. Chronic pain syndromes
2. Migraine
3. Depression, where sedation or hypnotic effects are required
4. Diabetes (some SSRIs cause hypoglycemia).

SSRIs

Compared to TCAs, SSRIs are relatively free from side effects. It is safe even in overdose and can easily be titrated to therapeutic dose because of simple dose regime. It has no adverse effect on cognitive skills and psychomotor ability. In the selection of a

SSRI consideration should be given to symptoms of the patient, properties of the SSRI and its side effect. One should also be aware that SSRI might be associated with undesirable behavioral changes such as irritability, restlessness, increased level of energy, euphoria and disinhibition. However, its effect on ejaculation is put to good use in patients with premature ejaculation.

PEARLS

Choice of drug in depression with agitation/insomnia

1. Paroxetine and fluvoxamine give some sedation
2. Mirtazepine is useful
3. Most tricyclics antidepressants are sedating.

Choice of drugs in depression with retardation/excess tiredness/withdrawal

1. Most SSRIs are advantageous in this group of patients
2. Fluoxetine, especially if weight gain is a problem
3. Citalopram, Setraline and Paroxetine are good agents
4. May require a higher dose.

Choice of drugs in depression with associated anxiety

1. Citalopram
2. Paroxetine
3. Fluvoxamine
4. Tricyclics.

ECTs

ECT is indicated in patients with very severe or refractory depression, bipolar disorder, psychotic depression, geriatric depression, and suicidal patients.

REFERENCES

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