Treating Depression Collaboratively

A Carlat Webinar

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Conflicts and Disclosures

None

Learning Objectives

After the webinar, clinicians should:

1. Summarize the role of primary care in the treatment of depression
2. Understand how to initiate depression treatment in the primary care setting
3. Recognize when augmentation and combination therapies are appropriate
4. Explain how to select antidepressant medications based on efficacy and side effect profiles

Why is depression such a problem?

- Estimated 21 million adults in the U.S. had an episode of major depressive disorder (MDD) in 2020
- Prevalence was higher among females (10.5%) compared to males (6.2%) and highest in people aged 18-25 (17%)
- The economic burden of adults with MDD in 2020 was $326.2 billion

Statistics provided by National Institute of Mental Health (NIMH). https://www.nimh.nih.gov/health/statistics/major-depression

The role of primary care in depression

- The first encounter with mental health treatment is usually in the primary care setting
- As few as 20% of those started on antidepressants in this setting will show significant clinical improvement
- When psychiatry referrals are made patients face long waits and most do not follow up

APA Collaborative Care Model: Fact Sheet. https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn

Case: “Lori” is a 42-year-old female who presented to her primary care provider with the following:

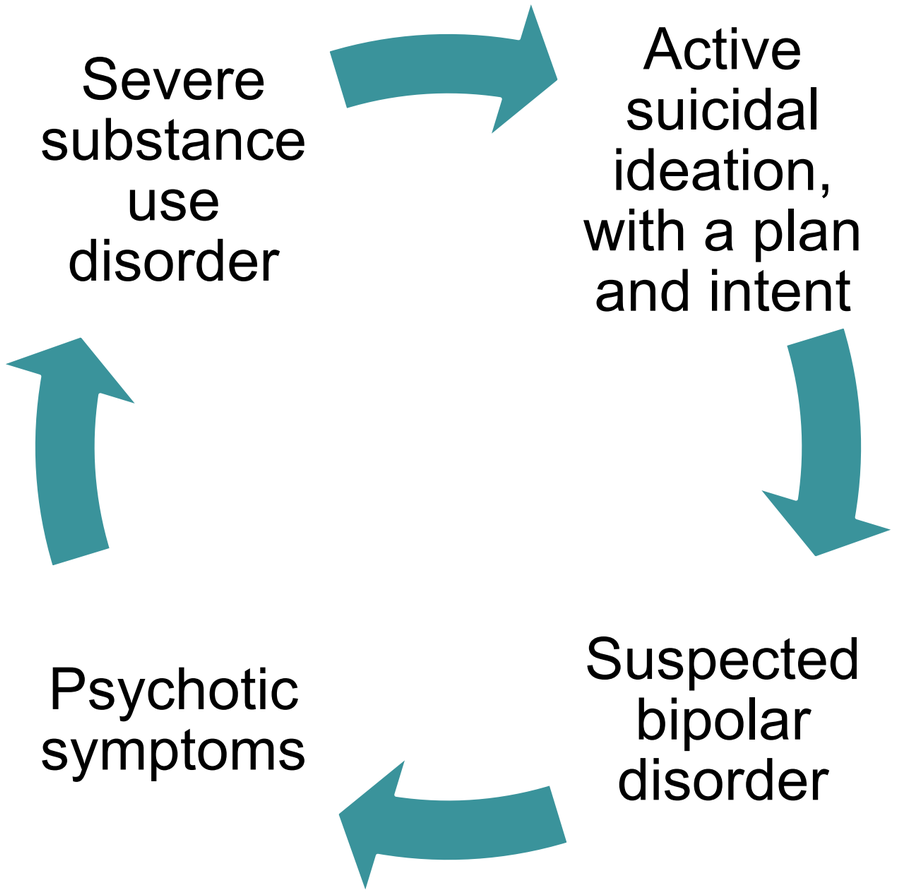
- She reports feeling stressed out due to childcare and work. She has had trouble sleeping and a loss of interest in socializing with friends
- She has a history of being on an antidepressant at age 18 but cannot remember which one she used
- What should our next steps be?

Next steps: Proper screening and evaluation

Screen for bipolar disorder	Screen for psychosis	Screen for substance use disorder

DSM-5 Criteria for Major Depressive Disorder (PHQ-9), Suicide Screening

Special considerations: Which patients need immediate referral to a psychiatrist or hospital?



You have established a diagnosis of MDD for Lori of moderate severity. How would you begin treatment?

ESTABLISH A THERAPEUTIC ALLIANCE AND EDUCATE THE PATIENT ABOUT MDD

THERAPEUTIC ALLIANCE IS MAJOR FACTOR IN TREATMENT OUTCOMES

USE EMPATHIC STATEMENTS

EDUCATE ABOUT THE DIAGNOSIS, PROGNOSIS, AND TREATMENT OPTIONS

Lifestyle interventions to improve depression

- Aerobic and anerobic exercise
- Mediterranean diet
- Sleep hygiene
- Mindfulness practice

Nutraceutical use in depression

- Patients who are resistant to medication or want to use “natural products”
- Evidence for SAMe
- Evidence for St. John’s wort
- Possible risks and side effects for each

When should psychotherapy be the first-line option?

- Brief supportive psychotherapy can be provided
- NICE Guidelines in the UK recommend CBT first line
- Medication and therapy can be Combined

Depression in adults: treatment and management (NG2022) https://www.ncbi.nlm.nih.gov/books/NBK583074/

Back to the case: Our 42-year-old female patient who presented with excessive stress and sleep disturbance

- Completed a PHQ-9 and scored 16
- Answered “no” to questions regarding suicidal thoughts
- Screened negative for bipolar disorder
- Screened negative for substance use disorders

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What are the next steps?

Things to consider before prescribing medication

- Rule out any medical causes of depression
- More advanced testing for autoimmune disease; brain imaging depending on clinical picture
- Consider obtaining labs and referring for psychotherapy
- Close follow-up in two weeks

Pharmacological treatments for major depression

- TCAs (eg, nortriptyline)
- MAOIs (eg, phenelzine)
- SSRIs/SNRIs (eg, escitalopram)
- SNRIs (eg, venlafaxine)
- Serotonin modulators and atypical antidepressants (eg, bupropion)

Efficacy of antidepressants

- All classes of antidepressants are equally effective in treating MDD
- The NIMH-sponsored STAR*D
- Remission rates at each level were 37%, 56%, 62%, and 67%

Sinyor M et al, Can J Psychiatry 2010;55(3):126-135

Back to the case

- The labs come back normal, and there is nothing elicited on physical exam that would indicate the need for further work-up
- The patient still reports symptoms of depression. Medication is now a consideration

Best practices for medication selection

- History of previous response to a medication
- Family history of positive outcome with specific medication
- Side effect profile and drug interactions
- Cost of medication

First-line options

- If the patient has not had a trial of any medication, the following three options should be considered:
  -Sertraline
  -Escitalopram
  -Bupropion
- In the next slides, we will discuss each medication in more detail

Why sertraline?

- Sertraline and escitalopram had slightly superior efficacy and tolerability compared to other SSRIs
- Sertraline has an advantage when it comes to safety
- When dosed below 150 mg/day it has minimal interaction with the CYP 450 enzymes
- Most studies indicate that efficacy plateaus at 100 mg/day

Cipriani A et al, Lancet 2018;391(10128):1357–1366; Womersley K et al, Psychiatr Danub 2017;29(Suppl 3):629–644

Why escitalopram?

- Slight advantage in efficacy and tolerability
- Minimal risk for drug interactions
- Similar efficacy to antidepressant combination treatment

Rush AJ eat al, Am J Psychiatry 2011;168(7); 689-701

Why bupropion?

- Lack of sexual dysfunction and lack of antidepressant induced weight gain
- May be effective for anxiety treatment
- Bupropion works well when combined with other antidepressants
- The risk for seizure is often cited as a reason to avoid bupropion

Using symptom profile and comorbidity to guide decisions

- Severe anxiety, consider a brief course of benzodiazepines
- For patients with tobacco use disorder consider starting bupropion
- For patients with cognitive symptoms of depression or comorbid pain disorder consider using duloxetine
- For patients with impaired sleep and poor appetite with weight loss consider mirtazapine

You started the medication. Now what?

- The medication must be dosed appropriately and continued for an appropriate length of time
- medications can be started at the lowest effective dose and titrated slowly
- Medication should be continued for 4-6 weeks at the target dose before considering a change

Our patient Lori returns after 2 weeks on escitalopram 5 mg and reports no response to the medication. What would you do next?

- Increase the dose of medication
- Have the patient come back in 2 weeks and reassess depressive symptoms
- If the patient did have a response, you would continue the medication at the previous dose and reassess after 4 weeks

Lori returns after 4 weeks of treatment at an optimal dose 20 mg with response to treatment but not remission. What's next?

- Augmentation options with minimal risk for side effects include omega-3 fatty acids dosed at 1 gram twice per day; L-methyl-folate dosed at 15 mg /day; or light therapy
- Adding bupropion to the initial SSRI or SNRI medication
- Augmenting with a second-generation dopamine blocking medication
- Thyroid hormone augmentation
- Lithium augmentation

Mohamed S et al, JAMA 2017;318(2):132-145

Why are we not recommending newer serotonin modulating antidepressants?

- These medications include vortioxetine and vilazodone
- Both medications have failed to outperform other more cost-effective options
- The one area where vortioxetine may show benefit is cognitive effects associated with depression

Treatment-resistant depression

- Defined as failing two or more adequate trials of antidepressant medication
- Reassess the diagnosis
- Refer to a psychiatrist
- Consider more advanced augmentation, ECT, or ketamine

When is ECT or ketamine recommended?

- If there is an urgent need for depression improvement
- ECT has a remission rate of 75%
- If a patient refuses ECT, ketamine infusions or intranasal esketamine may be offered
- This is likely to be beyond the scope of most primary care practices

Summary

- Primary care providers play a pivotal role in the treatment of depression
- There are many nuances associated with the treatment of depression
- Most patients are going to get better with initial treatment, switching, or augmentation
- How far you go with the treatment will depend on comfort level with the medications
- Referral to a psychiatrist is always an option