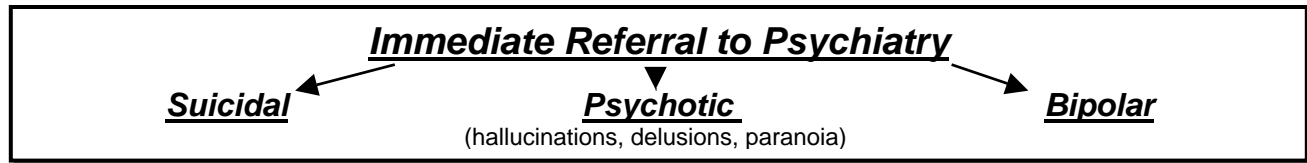


Quick Reference Guide

Recommended Treatment Guidelines for Primary Care Practitioners Treating Adult Patients with Depression



Use Two Question Assessment
(See Depression Screening Tools)

Consider use of PHQ-9 or other validated screening tool for diagnosis and to assess severity

Diagnosis of Depression (DSM-IV Criteria)
Must have 5 symptoms for at least 2 weeks. One of the symptoms must be **Depressed mood** or **Loss of interest**. Medical/ pharmacological causes of depression should be ruled out.

Use the SIG E CAPS mnemonic:

S leep disturbance (insomnia/hypersomnia)	Lack of E nergy/Fatigue	P sycho motor-lethargy or restlessness
L oss of I nterest/ anhedonia	Lack of C oncentration	R ecurrent thoughts of S uicide/death
G uilt /worthlessness/hopelessness	C hange of A ppetite/weight	<i>(see Suicide Screening Questions)</i>

Select and initiate treatment with an adequate trial of an SSRI antidepressant
Discuss the need for counseling and refer if indicated
Discuss medication side effects and delayed onset of effect of antidepressants
Encourage the patient to call immediately if experiencing unacceptable side effects, significant worsening of symptoms, OR suicidality

At 2 weeks, office visit to assess response to medication, side effects, and adherence; reassess for suicidal ideation

At 4 weeks, office visit to assess response to medication, side effects, and adherence; reassess for suicidal ideation. *If the response is:*

Partial Resolution of Symptoms:
Continue current medication or adjust the dose. See the patient again in 4 weeks to reassess response. If the patient does not achieve a significant resolution of symptoms, switch to a different SSRI or another type of antidepressant.

If the patient does not respond after two antidepressant trials, consult with, or refer to, a psychiatrist

Complete Resolution of Symptoms:
Successful Response

Reassess every 2-3 months for continued response to medication, side effects, and adherence. Discuss with the patient the recommended length of treatment for this episode (see guidelines for continuation period).

No Response:
Try another antidepressant using the above protocol. It is reasonable to try a different SSRI or another type of antidepressant

If the patient does not respond after two antidepressant trials, consult with, or refer to, a psychiatrist

- Other Reasons to Refer to Behavioral Health for Counseling or Medication Management**
1. Coexisting substance abuse disorder
 2. Patient younger than 18 years old
 3. Patient wants or needs psychotherapy
 4. Inadequate response to trials of 2 antidepressants
 5. Family history of bipolar disorder

- Guidelines for Continuation Period**
1. For an initial episode, treatment should last for at least 6 months from the time of response. Most experts recommend continuing the medication for 9-12 months
 2. For the second episode, continue the medication for at least 12 months
 3. Maintenance treatment is strongly recommended if the following are present:
 - There is a history of three or more episodes of depression
 - There is a history of two episodes, plus one of the following:
 - Family history of depression
 - History of recurrence within 12 months of last treatment
 - Both episodes were severe or life threatening in past 3 years

Note: These guidelines are not intended to replace the physician's judgment regarding an individual patient. Primary Reference Source: APA Guideline for Major Depression in Adults, 2nd Edition 2000. Clinical practice guidelines are reviewed at least once every two years. Web sites of nationally recognized sources from which guidelines have been adopted are checked monthly for changes/updates. Original: July 2004. Rev. May 2006.

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Depression Screening

- The U.S. Preventive Services Task Force (www.ahrq.gov/clinic/) recommends screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up.
- Screening improves identification, and treatment decreases clinical morbidity.
- These two simple screening questions may be as effective as longer instruments:
 1. During the past month have you often been bothered by feeling down, depressed, or hopeless?
 2. During the past month, have you often been bothered by little interest or pleasure in doing things?
- A “no” response to both questions makes the presence of depression highly unlikely.
- A “yes” response to either question should be followed by a screening tool and/or a diagnostic interview.

Suicide Screening Questions

When a diagnosis of depression is made, an assessment of suicide risk is required. All depressed patients should be asked the following questions:

- Have these symptoms or feelings we’ve been talking about led you to think you might be better off dead?
- Recently, have you had any thoughts that life is not worth living or that you’d be better off dead?
- What about thoughts about hurting or killing yourself? IF YES: What have you thought about? Do you have a plan to hurt yourself? Have you actually done anything to hurt yourself?

Assessment of Suicide Risk

Risk	Description	Action
Low Risk	No current thoughts	Continue follow-up visits and monitoring of depression and suicidal ideation.
Intermediate Risk	Current thoughts, but no plan	Assess suicide risk carefully at each visit and contract with patient to call you if suicide thoughts become more prominent; consult with an expert as needed.
High Risk	Current thoughts with plans	Emergency management by qualified expert.

Screening for Alcohol Abuse or Dependence

CAGE QUESTIONNAIRE

1. Have you ever felt you ought to **C**ut down on your drinking?
2. Have people **A**nnoyed you by criticizing your drinking?
3. Have you ever felt bad or **G**uilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (**E**ye-opener)?

Two or more “Yes” responses constitute a positive screen for alcohol abuse and should be followed by more in depth questioning.

Patient Education Talking Points

Discussing these 5 important educational messages with your patients at each visit can help improve compliance with antidepressant treatment:

1. It may take 4 to 6 weeks for your medication to work, so make sure you keep taking it even if you don’t feel better right away.
2. Take your medication every day as prescribed.
3. If your depression goes away, do not stop taking the medication. Most people need to be on the medication for at least 6 months to avoid a relapse.
4. Do not stop taking your medication without talking to your provider. If you are having side effects, your provider can help by suggesting changes in the dose or dosage schedule. If you think your medication is not working, your provider might want to change you to a new medication.
5. Call your provider if you have any questions or concerns about your medication. If your question can wait until your next appointment, write it down so you won’t forget it.

Screening for Mania or Bipolar Disorder

Ask the following questions to help you determine if your patient has a history of bipolar disorder: “Has there ever been a period of at least 1 week when you were so happy or excited that you got into trouble, or your family or friends worried about it, or a health care provider said you were manic?”

A “Yes” response indicates potential bipolar disorder and you should assess further for manic symptoms. Diagnostic criteria for mania include the presence of at least four of the following symptoms, one of which must be the first symptom listed (**bolded**):

1. **A distinct period of abnormal, persistently elevated, expansive, or irritable mood.**
2. Decreased need for sleep.
3. Inflated self-esteem or grandiosity.
4. More talkative than usual (pressured speech).
5. Racing thoughts.
6. Significant distractibility.
7. Increased goal-directed activity or psychomotor agitation.
8. Excessive involvement in pleasurable activities without regard for negative consequences (e.g., buying sprees, sexual indiscretions, foolish ventures).

Antidepressant Comparison Chart

	Generic/ Brand	Initial & Max Dose	Usual Adult Dose Range	Side Effects	Pearls and Additional Uses	Receptor Affinity	Pregnancy & Lactation
SSRIs	citalopram Celexa	10-20 mg am 60mg/day	20-40mg po qd	General SSRI side effects: nausea, anxiety, insomnia, agitation, anorexia, tremor, somnolence, sweating, dry mouth, headache, dizziness, diarrhea, constipation, sexual dysfunction, SIADH, EPS D/C Syndrome=flu-like symptoms ("FINISH" flu, insomnia, nausea, imbalance, sensory disturbance, hyperesthesia)	Few interactions: for qty limit, tablet splitting is required. Write for higher strength and include a sig of 1/2 tablet po qd	5HT selective (SSRIs)	Preg Cat C avoid in breastfeeding
	escitalopram Lexapro	10 mg qd 20 mg/day	10-20mg po qd		Few interactions; for qty limit, tablet splitting is required. Write for higher strength and include a sig of 1/2 tablet po qd		
	fluoxetine Prozac	10-20mg qd 80mg/day	20-40mg po qd		Most anorexic and stimulating; long half-life		
	fluvoxamine Luvox	25-50mg hs 300mg/day	100-150mg hs		Most nauseating, constipating, & sedating SSRI; many drug interactions		
	paroxetine Paxil	10-20mg am 60mg/day	10-20mg am 60mg/day		Most anticholinergic SSRI: for qty limit, tablet splitting for 10 and 20 mg is required. Write for higher strength and include a sig of 1/2 tablet po qd		
	sertraline Zoloft	25-50mg am 200mg/day	100 mg/day		Few drug interactions; Most diarrhea & male sexual dysfunction; for qty limit, tablet splitting is required. Write for higher strength and include a sig of 1/2 tablet po qd		
Phenyl- piperazine	nefazodone Serzone	50-100 mg bid 600 mg/day	100-150mg po bid	Hypotension, nausea, dizziness, constipation, dry mouth, off market in many countries due to hepatotoxicity	Least stimulating serotonergic, least weight gain, less sexual dysfunction and interactions; useful in anxiety and insomnia	SARI 5HT Selective SSRI+ 5HT2 rec. antagonism	Preg Cat C dosages in the infant are <1% of the mother's mg/g dosage
Triazolo- pyridine	trazodone Desyrel	50 mg bid 600 mg/day	50 mg po hs 100-200 mg po bid pc	Hypotension, dizziness, headache, nausea; alpha blockage, priapism	Fewer cardiac effects than TCAs		
Tricyclic Antidepressants	amitriptyline Elavil	10-25 mg hs 300 mg/day	50-200 mg po hs	General TCA side effects: increased HR, decreased BP, weight gain, sexual dysfunction, sweating, rash, tremors, ECG abnormalities, seizures Fatal in overdose (>2 grams) due to cardiac and neurologic toxicity Secondary amines usually better tolerated than tertiary amines (less ACh effects)	10-30 mg hs for sleep and chronic pain; use for migraine prophylaxis	5HT & NE effects tertiary amines	Preg Cat C up to 150 mg/day have not caused observable effects in infants (HNCOEII)
	clomipramine Anafranil	10-25 mg hs 300 mg/day	50-200 mg po hs		Especially effective for OCD; most serotonergic TCA; higher risk of seizures		
	doxepin Sinequan	10-25 mg hs 300 mg/day	50-200 mg po hs		Most histamine block		
	imipramine Tofranil	10-25 mg hs 300 mg/day	50-200 mg po hs		Childhood enuresis (age 6+)		
	desipramine Norpramin	10-25 mg hs 300 mg/day	50-200 mg po hs		Most NE activity, least ACh effects; use in ADHD		
	nortriptyline Aventyl	10 mg hs 150 mg/day	25-100 mg po hs		Least hypotensive TCA; use for migraine prophylaxis		
Amino- ketone	bupropion SR Wellbutrin SR	100 mg qd am 450 mg/day	100-150 mg po bid	Risk of seizure, less sexual dysfunction, low weight gain		NE & DA reuptake inhibitor	Preg Cat B undetectable in one 14 month old infant whose mother was taking 300 mg/day and nursing bid
	bupropion XL Wellbutrin XL	150 mg qd am 450 mg/day	300 mg po qam		Smoking cessation use		
Phenethyl- amine	venlafaxine Effexor and XR	18.75-37.5 mg bid 375 mg/day	37.5-75 mg po bid OR 75-150 mg XR po qd	Increase in BP, agitation, tremor, sweating, nausea, headache, sleep disturbances; withdrawal effects	Initial nausea, "clean TCA," side effects similar to SSRIs, low weight gain, few drug intx, adjust dose for renal impairment	5HT & NE reuptake inhibitor (some dopamine)	Preg Cat C Doses of up to 9.2% of the mother's mg/kg dosage detectable in infant's serum
Tetra- cyclic	mirtazapine Remeron	15 mg/day hs 45 mg/day	30 mg po hs	Dry mouth, sedation and drug interaction with clonidine	Increases appetite and weight, low sexual dysfunction, sedating, may be good for seniors where wt gain and somnolence would benefit	5HT and NE reuptake inhibition	Preg Cat C safety unknown in lactation
SNRI	duloxetine Cymbalta	20 mg bid 60 mg/day	40-60 mg/day div qd-bid	Dry mouth, sedation, nausea, constipation	Caution if CrCl<30, avoid abrupt withdrawal, also indicated for diabetic peripheral neuropathy		Preg Cat C infants receive 0.14% of maternal dose