Oxford Health Plans®

2002 Clinical Practice Guidelines

DETECTION, DIAGNOSIS AND TREATMENT OF MAJOR DEPRESSION IN PRIMARY CARE

OVERVIEW

Major depressive disorder (MDD) is a syndrome consisting of a group of signs and symptoms that are not normal reactions to life's stress. MDD is a serious, potentially disabling medical condition with significant personal and public health consequences.

- MDD causes intense anguish and substantial disability in the sufferer; disrupts family, job, and social functioning; worsens the prognosis of other general medical illnesses, and may lead to suicide.
- About 7-12% of men and 20-25% of women will suffer from MDD at some time in their life; fewer than one in three will be accurately diagnosed and treated.
- Because of the widely held layman's view of depression as a character defect or lack of will power, the patient with MDD frequently suffers guilt, and blames his or her condition on personal weakness or fault.
- MDD can frequently go unrecognized and untreated by primary care practitioners. Practitioners should be sensitive to the occurrence of MDD in their patient population, institute screening methods o identify MDD, and implement parameters for treatment and referral.

WHEN TO REFER TO A MENTAL HEALTH SPECIALIST

Primary care physicians should refer a depressed patient to a psychiatrist or experienced mental health specialist under the following circumstances:

First and foremost, IF THE PATIENT PRESENTS A SUICIDE RISK*

- **The patient presents persistent reduced capacity to function.**
- **The patient fails to respond to an adequate trial of antidepressants.**
- **There is no evidence of social supports.**
- **The patient requires inpatient care.**
- **The patient has a previous history of depression and or suspicion of bipolar disorder.**
- **The patient is pregnant or plans to become pregnant.**
- **The depression is resistant to treatment.**
- **The patient has a complex medication regimen.**
- **The patient has certain co-morbid conditions (i.e. substance abuse, panic disorder, obsessive-compulsive disorder, dementia).**

SUICIDE RISK*

- All depressed patients should be assessed for the risk of suicide by subtle questioning about suicidal thinking, impulses, and personal history of suicide attempts.
- Patients are generally reassured by questions about suicidal thoughts and by education that suicidal thinking is a common symptom of the depression itself, and not a sign that the patient is "crazy."

Derived from The Agency for Health Care Policy and Research Clinical Practice Guideline "Depression in Primary Care" 1993 under the review and supervision of the Behavioral Health Committee of Oxford Health Plans. Updated and reviewed by Regional Quality Management, April, 2000, June 2001

Oxford Health Plans®

2002 Clinical Practice Guidelines

DETECTION, DIAGNOSIS AND TREATMENT OF MAJOR DEPRESSION IN PRIMARY CARE

DIAGNOSING MAJOR DEPRESSIVE DISORDER

1. USE THE CLINICAL INTERVIEW TO IDENTIFY DEPRESSIVE SYMPTOMS:

It may be useful to employ a **self-report questionnaire**, which provides the patient with a written list of depressive symptoms and asks the patient to indicate any symptoms experienced. *(see attachment)*

2. BE ATTENTIVE TO THESE COMMON PATIENT COMPLAINTS, WHICH MAY INDICATE MDD ALTHOUGH MEDICAL WORK-UPS ARE PERSISTENTLY NEGATIVE:

- **Pain** — including headaches, abdominal pain, and other body aches.
- **Low energy** — excessive tiredness, lack of energy, or a reduced capacity for pleasure or enjoyment.
- **Mood disturbance** — apathy, irritability, or even anxiety, alone, or in addition to overt sadness.
- **Sexual complaints** — problems with sexual functioning or desire.

3. SEEK OTHER CLINICAL CLUES IN THE PATIENT HISTORY WHICH PREDISPOSE FOR MDD:

- Prior episodes of depression
- Family history of major depressive or bipolar disorder
- Family history of eating disorders, substance abuse, obsessive compulsive disorder, or panic disorder
- Personal or family history of suicide attempt(s)
- Use of St. John's Wort
- Female gender
- Age of onset under age 40
- Recent stressful life events or postpartum period
- Concurrent general medical illnesses
- Concurrent substance abuse
- Lack of social supports

4. THOROUGHLY EVALUATE THE PATIENT'S INITIAL COMPLAINTS WITH A MEDICAL REVIEW OF SYSTEMS AND A PHYSICAL EXAMINATION

5. CONSIDER GENERAL MEDICAL CONDITIONS RELATED TO MDD:

- Stroke
- MI
- Diabetes
- Hypothyroidism
- Pseudodementia
- Dementia
- Alzheimer's
- Parkinson's
- Cancer
- Fibromyalgia
- Coronary artery disease medications
- Side-effects of medications
- Drug Interactions

6. IDENTIFY AND TREAT POTENTIAL KNOWN CAUSES, IF PRESENT, OF MDD:

- Alcohol and drug abuse
- General medical disorder
- Causal non-mood psychiatric disorder
- Grief reaction

7. SCREEN FOR MEDICATIONS WHICH CAN CAUSE DEPRESSIVE SYMPTOMS (DS*)* or PRECIPITATE MAJOR DEPRESSION (MDD):

Cardiovascular Drugs

-Alpha-methyldopa (MDD) *-Guanethidine (DS)* *-Reserpine (MDD)*
-Propranolol (DS) *-Clonidine (DS)* *-Digitalis (DS)* *-Thiazide diuretics (DS)*

Anti-Inflammatory / Anti-Infective Agents

-Nonsteroidal anti-inflammatory agents (MDD) *-Sulfonamides (DS)* *-Ethambutol (DS)*
-Baclofen (DS) *-Disulfiram (MDD)* *-Metoclopramide (DS)*

Hormones

-Oral contraceptives (MDD) *-ACTH/glucocorticoids (MDD)* *-Anabolic steroids (DS)*

Psychotropics

-Benzodiazepines (MDD) *-Neuroleptics (DS)*

Others

-Cimetidine (DS) *-Ranitidine (DS)* *-L-dopa (MDD)*
-Amphetamines (withdrawal) (DS) *-Cocaine (withdrawal) (DS)* *-Cycloserine (MDD)*
- Chemotherapy drugs

Derived from The Agency for Health Care Policy and Research Clinical Practice Guideline "Depression in Primary Care" 1993 under the review and supervision of the Behavioral Health Committee of Oxford Health Plans. Updated and reviewed by Regional Quality Management, April, 2000, June 2001

Oxford Health Plans®

2002 Clinical Practice Guidelines

DETECTION, DIAGNOSIS AND TREATMENT OF MAJOR DEPRESSION IN PRIMARY CARE

DIAGNOSTIC CRITERIA FOR MAJOR DEPRESSIVE DISORDER

- Depressed mood or markedly diminished interest or pleasure in almost all activities
- Duration = 2 weeks
- At least five of the following symptoms:
  - depressed mood most of the day, nearly every day.
  - loss of interest or pleasure in almost all activities (anhedonia) most of the day, nearly every day.
  - significant weight loss or gain, or decreased or increased appetite, nearly every day.
  - insomnia or hypersomnia nearly every day.
  - psychomotor agitation or retardation, nearly every day.
  - loss of energy or fatigue, nearly every day.
  - feelings of worthlessness or excessive or inappropriate guilt, nearly every day.
  - diminished ability to think or concentrate, or indecisiveness, nearly every day.
  - recurrent thoughts of death or suicidal ideation, or a suicide attempt or plan.
- Symptoms cause clinically significant distress or psychosocial impairment.
- Symptoms are not accounted for by bereavement, general medical condition, or psychotropic substance use.
- Presence of one or more prior major depressive episodes.
- No evidence or history of manic or hypomanic episode.
- The major depressive episode is not superimposed upon psychotic disorders and is not better explained by a diagnosis of schizoaffective disorder, a psychotic illness with both schizophrenic (severely disordered behavior with delusions, and deteriorating function) and affective (mood) symptoms.

DIFFERENTIAL DIAGNOSIS OF OTHER DEPRESSIVE DISORDERS

- **Bipolar illness**—characterized by the presence of major depressive symptoms with the addition of mood cycles with discrete episodes of depression and mania (hyperexcitability, euphoria, hyperactivity, rapid thought and speech, agitation, decreased need for sleep, and increased energy). It is recommended that patients identified as (or suspected of) having bipolar illness be referred to a specialist.

Patients with depressive symptoms who do not meet the criteria for MDD may have one of several mood disorders:

- **Dysthymic disorder (chronic depression)**—characterized by persistent depressed mood greater than 50% of the time, accompanied by two of the other depressive symptoms listed above, for at least two years. Supportive, regularly scheduled visits with the primary care provider, with or without a cautionary trial of pharmacotherapy, may be helpful for the management of chronic depression. Referral to a specialist should be considered for patients who do not improve after initial management efforts.
- **Minor depression**—characterized by appropriate sadness, in response to stressful life events, which continues for an inordinate amount of time, becomes excessive, or is mixed with anxiety symptoms, yet lacks the full complement of five depressive symptoms. Because most cases of minor depression are self-limiting, a period of one to two months of watchful waiting may be sufficient for patients with mild impairment. The presence of moderate or severe impairment calls for referral to a specialist.
- **Adjustment disorders and/or personality disorders**—may present with depressive symptoms and require referral to a specialist for cognitive-behaviorally oriented short-term therapy.

Derived from The Agency for Health Care Policy and Research Clinical Practice Guideline "Depression in Primary Care" 1993 under the review and supervision of the Behavioral Health Committee of Oxford Health Plans. Updated and reviewed by Regional Quality Management, April, 2000, June 2001

DETECTION, DIAGNOSIS AND TREATMENT OF MAJOR DEPRESSION IN PRIMARY CARE

PSYCHOTHERAPY AND DEPRESSIVE DISORDERS

- **Psychotherapy**—cognitive and interpersonal therapy, alone or in combination with antidepressants, has been demonstrated to be effective in research studies. Patients with minor depression, chronic depression, or mild to moderate major depression may benefit from a short course—approximately 8-12 weeks—of counseling or psychotherapy. These therapies are time-limited, focused on current problems, and aimed at symptom resolution rather than personality change. Family members may benefit from education on the issue.

OTHER TREATMENT MODALITIES

- **Electroconvulsive therapy (ECT)**—is primarily used after several adequate antidepressant trials have failed or with patients with depression marked by delusions or malignant suicidality.
- **Light therapy**—indicated for seasonal affective disorder (recurrent fall and winter depressions which resolve in spring and summer).

Both ECT and light therapy should be administered under the guidance of a mental health specialist.

MANAGING MEDICATION FOR MDD

PRIOR TO INITIATING DRUG TREATMENT:

- Primary care physicians are encouraged to consult with or refer to a psychiatrist when determining appropriate treatment of MDD.
- Before initiating a medication regime, it is essential to identify and refer any patients at risk for self-harm or medically meaningful self-neglect.
- Communicate the side effects of medication prior to start of medication regime.
- When communicating with the depressed patient:
  1. Frame the depressive disorder as a medical illness, with specific signs and symptoms.
  2. Refer to a neurochemical dysregulation in the brain.
  3. Emphasize that having depression is not indicative of a personal weakness or fault.

STEPS TO PLACING A PATIENT ON MEDICATION

Step 1: In selecting medication, consider:

- Prior positive response
- Response in family member
- Long-term side effects
- Age
- Concurrent general medical disorder
- Concurrent causal psychiatric disorder
- Interaction with concurrent nonpsychiatric medication
- Convenience
- Cost
- Patient preference

Step 2: Begin medication and be available by phone.
Step 3: Adjust dosage (every two weeks) and monitor side effects (weekly/biweekly).*****
Step 4: Reevaluate symptoms/side effects (weekly/biweekly).
Step 5: Assess symptomatic outcome at six weeks. For those with no meaningful symptom response within six weeks, referral to a specialist is recommended.

+ *Referral to a psychiatrist should be made if a previously non-suicidal patient begins to express suicidal thoughts or behavior which have surfaced as a result of undergoing treatment.*

Derived from The Agency for Health Care Policy and Research Clinical Practice Guideline "Depression in Primary Care" 1993 under the review and supervision of the Behavioral Health Committee of Oxford Health Plans. Updated and reviewed by Regional Quality Management, April, 2000, June 2001

SELECTING AMONG ANTIDEPRESSANT MEDICATIONS

Selective serotonin reuptake inhibitors (SSRIs): These medications have an excellent safety record, are relatively safet in overdose, and produce fewer side effects. Most commonly prescribed SSRIs include:

Generic Name	Brand Name	Tablets	Initial Dose	Titrate Dose to
Fluoxetine	*Prozac*	10, 20 mg	10-20mg/QD	20-40mg/QD
Sertraline	***Zoloft***	50, 100mg	50mg/QD	100-250mg/QD
Paroxetine	***Paxil***	10, 20, 30, 40mg	10-20mg/QD	20-60mg/QD
Fluvoxamine	*Luvox*	25, 50, 100mg	50-100mg/QD	100-250mg/QD

Tricyclic antidepressants (TCAs): These medications require blood work, are lethal when overdosed, and may produce anticholinergic, antihistaminic, or anti a_1-adrenergic side effects. Patients may respond with poor compliance. Most commonly prescribed TCAs include:

Generic Name	Brand Name	Tablets	Initial Dose	Titrate Dose to
Amitriptyline	*Elavil*	10, 25, 50, 75, 100, 150mg	25mg/QHS	150-300mg/QHS
Nortriptyline	*Pamelor*	10, 25, 50, 75mg	10-25mg/QHS	50-150mg/QHS
Desipramine	*Norpramin*	10, 25, 50, 75, 100, 150mg	100-200mg/QHS	200-300mg/QHS
Imipramine	*Tofranil*	10, 25, 50, 75, 100, 150mg	25mg/QHS	150-300mg/QHS or in divided doses

Atypical antidepressants: These medications are relatively safe in overdose, maintain a variable side-effect profile, and lack significant cardiac effects. Most commonly prescribed atypical antidepressants include:

Generic Name	Brand Name	Tablets	Initial Dose	Titrate Dose to
Trazadone**	*Desyrel*	50, 100, 150, 300mg	50-100mg/QHS	200-600mg/QD
**Recommended for female patients only, due to risk of priapism in males.				
Nefazodone	*Serzone*	100, 150mg	100mg/BID	150-300mg/BID
Venlafaxine	***Effexor***	25, 37.5, 50, 75, 100mg	37.5mg/QD	75-150mg/BID
Mirtazapine	*Remeron*	15, 30mg	15mg/QD	15-45mg/QD
Bupropion	***Wellbutrin***	75, 100mg	75-100mg/BID	100-150mg/TID

Monoamine oxidase inhibitors (MAOI's) have been used primarily in the treatment of certain atypical depressive subtypes or as a second line of treatment for depression, mostly in treatment-resistant patients. Due to the risk of lethal hypertensive crisis related to interactions with relatively common foods containing tyramine and with sympathomimetic drugs, their use in the primary care setting, in the absence of close psychiatric consultation, is discouraged.

CONSIDERATIONS IN TREATING DEPRESSION IN THE ELDERLY

Concurrent non-psychotropic medications may:

Cause depression; change antidepressant blood levels; increase antidepressant side effects; biochemically block antidepressant effects, and/or call for modifying the oral dosage

Concurrent medical illnesses may:

Reduce the efficacy of antidepressant medication or psychotherapy; change antidepressant drug metabolism; impair ability to participate in psychotherapy; or Increase the need for simplified medication dosing schedules (e.g., once daily)

Concurrent non-mood psychiatric conditions may:

Cause depression; call for different medications; or impair participation in psychotherapy

Other considerations:

Slower metabolism often requires lower dosages; transportation difficulties may restrict access to care; fixed income may limit availability of therapy and antidepressant medications due to cost

Derived from The Agency for Health Care Policy and Research Clinical Practice Guideline "Depression in Primary Care" 1993 under the review and supervision of the Behavioral Health Committee of Oxford Health Plans. Updated and reviewed by Regional Quality Management, April, 2000, June 2001

Oxford Health Plans®

2002 Clinical Practice Guidelines

DETECTION, DIAGNOSIS AND TREATMENT OF MAJOR DEPRESSION IN PRIMARY CARE

Medical Record Flow Sheet—Evaluation and Treatment of Depression

Patient Name_____ Age_____ ID #_____

SYMPTOM RATINGS:	**0**	**1**	**2**	**3**
	ABSENT	**MILD**	**MODERATE**	**SEVERE**

Symptom	Duration	Visit date	Visit date	Visit date	Visit date	Visit date
1. Depressed mood						
2. Anhedonia (diminished interest or pleasure in activities)						
3. Sleep disorder						
4. Weight loss or change						
5. Fatigue or loss of energy						
6. Psychomotor agitation or retardation						
7. Feelings of worthlessness or guilt						
8. Poor concentration						
9. Suicidal ideation						
SUM of nine symptoms above						
Medication(s)	Dosage(s)					
Comments:						

Derived from The Agency for Health Care Policy and Research Clinical Practice Guideline "Depression in Primary Care" 1993 under the review and supervision of the Behavioral Health Committee of Oxford Health Plans. Updated and reviewed by Regional Quality Management, April, 2000, June 2001

Oxford Health Plans®

2002 Clinical Practice Guidelines

DETECTION, DIAGNOSIS AND TREATMENT OF MAJOR DEPRESSION IN PRIMARY CARE

Date_____ Name_____ ID #_____Age_____

Please place a mark in the appropriate box. Answer all questions to the best of your ability:

1. During the last four weeks, how much have you been bothered by the following?	Not at all bothered	Bothered a little	Bothered a lot	Not applicable
A. Stomach pain?				
B. Back pain?				
C. Muscle or joint pain in your arms and legs?				
D. Menstrual cramps or problems with your period?				
E. Pain or problems during sexual intercourse?				
F. Headaches?				
G. Chest pain?				
H. Dizziness?				
I. Fainting spells?				
J. Heart palpitations (pounding or racing heart)?				
K. Shortness of breath?				
L. Constipation, loose bowels, or diarrhea?				
M. Nausea, gas or indigestion?				
2. Over the last two weeks, how <u>often</u> have you been bothered by any of the following problems?	Not at all bothered	Several days	More than half the time	Nearly every day
A. Little interest or pleasure in doing things?				
B. Feeling down, depressed and hopeless?				
C. Trouble falling or staying asleep, or sleeping too much?				
D. Feeling tired or having little energy?				
E. Poor appetite or overeating?				
F. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down?				
G. Trouble concentrating on things, such as reading the newspaper or watching TV?				
H. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?				
I. Thoughts that you would be better off dead or of hurting yourself in some way?				
J. Had an anxiety attack, suddenly feeling fear or panic?				
K. Felt that you can't control what, or how much you eat?				
L. Missed work because you were drinking or hung over?				
M. Had problems getting along with people while you're drinking?				
If you checked off any problems of this questionnaire, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not at all difficult	Somewhat difficult	Very difficult	Extremely difficult
TOTALS				

Derived from The Agency for Health Care Policy and Research Clinical Practice Guideline "Depression in Primary Care" 1993 under the review and supervision of the Behavioral Health Committee of Oxford Health Plans. Updated and reviewed by Regional Quality Management, April, 2000, June 2001

Oxford Health Plans®

2002 Clinical Practice Guidelines

DETECTION, DIAGNOSIS AND TREATMENT OF MAJOR DEPRESSION IN PRIMARY CARE

Quick Guide to Patient Problem Questionnaire

Purpose: The Patient Problem Questionnaire (PPQ) is designed to facilitate the recognition of the most common mental disorders in primary care patients.

Who Should Take the PPQ: Ideally, the PPQ should be used with all new patients, all patients who have not completed the questionnaire in the last year, and all the patients suspected of having a mental disorder.

Making a Diagnosis: Since the questionnaire relies on patient self-report, definitive diagnoses must be verified by the clinician, taking into account how well the patient understood the questions in the questionnaire, as well as other relevant information from the patient, his or her family, and other sources.

Interpreting the PPQ: To facilitate interpretation of patient responses, all clinically significant responses are found in the column farthest to the right. The only exception is for suicidal ideation when diagnosing a depressive syndrome.

Directions for Scoring

Somatoform disorder If at least three of Question #1, A-M bother the patient "a lot" and lack an adequate biological explanation.

Major depressive disorder If answer to Question #2 A or B is "nearly every day," and five or more of Question #2 A-I are “nearly every day" (count Question #2 I if present at all); **Other depressive disorder** the same but only two, three, or four of the answers to Question #2 A-I are “nearly every day".

Note: The diagnoses of major depressive disorder and other depressive disorder require ruling out normal bereavement (mild symptoms, duration less than 2 months), a history of manic episode (bipolar disorder) and a physical disorder, or medication or other drug as the biological cause of the depressive symptoms.

Additional Clinical Considerations: After making a provisional diagnosis with the PPQ, there are additional clinical considerations that may affect decisions about management and treatment.

Have current symptoms been triggered by psychosocial *stressor(s*)?

What is the *duration* of the current disturbance and has the patient received any *treatment* for it?

To what extent are the patient's symptoms *impairing* his or her usual work and activities?

Is there a *history* of similar episodes and were they *treated*?

Is there a *family history* of similar conditions?

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues. For more information, contact Dr. Spitzer at 722 W. 18th Street, Unit 74, New York, NY 10032.

Derived from The Agency for Health Care Policy and Research Clinical Practice Guideline “Depression in Primary Care” 1993 under the review and supervision of the Behavioral Health Committee of Oxford Health Plans. Updated and reviewed by Regional Quality Management, April, 2000, June 2001

2002 Clinical Practice Guidelines

DETECTION, DIAGNOSIS AND TREATMENT OF MAJOR DEPRESSION IN PRIMARY CARE

MS-02-072 5260

Derived from The Agency for Health Care Policy and Research Clinical Practice Guideline “Depression in Primary Care” 1993 under the review and supervision of the Behavioral Health Committee of Oxford Health Plans. Updated and reviewed by Regional Quality Management, April, 2000, June 2001