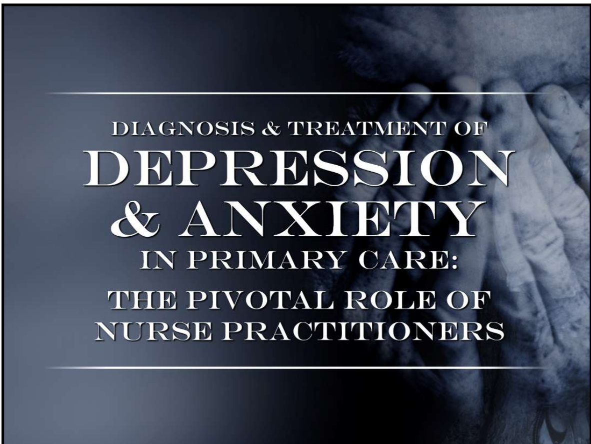

Objectives

- Upon completion, the participant will be able to:
  - Discuss signs and symptoms of the patient with depression and anxiety
  - Discuss various pharmacologic treatments for the patient with depression and anxiety
  - Compare and contrast various pharmacologic agents currently available

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Disclosures

- Speaker Bureau:
  - Sanofi-Pasteur, Takeda, Merck
- Consultant:
  - Merck, Arbor, Pfizer

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Case Study – Mary

- 42-year–old woman
- Complaining of fatigue, insomnia, inability to concentrate
- Feeling overwhelmed, racing heart
- Feeling agitated and frustrated
- Difficulty functioning

What is Mary's differential diagnosis and problem?
Could her depression and anxiety be related?

Epidemiology of Depression

- Most common mental disorder in the US
- 17.1% of US population reported a major depressive episode in their lifetime
- Average age of onset: late 20s
  - More than half of patients have first episode by 40 years of age
- Duration: 6 months to 2 years if left untreated
- Estimated economic burden of depressive disorders in 2000: $83.1 billion

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Prevalence of Depression

- Adolescence (9–17 years)
  - Depressive symptoms occur in 10%–15% of adolescents
  - Major depression diagnosed in 5% of adolescents
- Women
  - Depression is twice as common in women
  - Depressive episodes are most prevalent during childbearing years
    - Mean age of onset: mid to late 20s
- Late-Life
  - Depression occurs in 8%-20% of older adults (>65 years)
  - 46% of nursing home residents have some degree of depression

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Prevalence of Depression in Patients With Other Medical Disorders

Medical Disorder	Prevalence of Depression
Alzheimer's	30-50%
Cancer	22-29%
Cerebrovascular disease	14-19%
Diabetes	9-26%
Parkinson's disease	4-75%
Obesity	20-30%

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Impact of Anxiety as a Comorbidity

- Up to 85% of major depressive disorder (MDD) patients also have an anxiety disorder
- Coexisting anxiety in depressed patients is associated with:
  - Increased severity of depression
  - More chronic course
  - Poorer outcome
  - Impaired psychosocial functioning
  - Increased risk of suicide

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U.S. Suicide Statistics
Breakdown by Gender/Ethnicity/Age Group
Source- www.cdc.gov/violenceprevention/pdf/Suicide-DataSheet-a.pdf

All Ages Combined			Elderly (65+ yrs)		Youth (15-24 yrs)	
Group	**Number of Suicides**	**Rate of Suicide per 100,000**	**Elderly Suicides**	**Elderly Suicide Rate per 100,000**	**Youth Suicide**	**Youth Suicide Rate per 100,000**
Nation	32,439	11.1	5,198	14.3	4,316	10.4
Men	25,566	**17.7**	4,397	**29.0**	3,596	**16.8**
Women	6,873	**4.6**	801	**3.8**	720	**3.6**
Whites	29,251	12.3	4,924	15.4	3,610	11.0
Nonwhites	3,188	5.8	274	6.2	706	7.9
Blacks	2,019	5.2	148	4.8	465	7.2
White Men	23,081	19.6	4,180	31.1	3,016	17.9
White Women	6,170	5.1	744	4.0	594	3.8
Nonwhite Men	2,485	9.3	217	12.4	580	12.8
Nonwhite Women	703	2.4	57	2.2	126	2.8
Black Men	1,655	9.0	134	11.3	396	12.2
Black Women	364	1.8	14*	0.7	69	2.2

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Importance of Early Diagnosis

- Failure to diagnose early can lead to:
  - More chronic course
  - Changes in the brain
- Primary care clinicians fail to diagnose depression and/or anxiety in up to 50% of patients
- Once diagnosis is made, clinicians provide adequate treatment only 50% of the time
- Often too low dosage, too short duration

Causes of Depression

- Biochemical dysfunction
  - Neurotransmitters
    - Serotonin
    - Norepinephrine
    - Dopamine
  - Limbic system
  - Endocrine system
- Familial predisposition
- Environment
- Medical conditions/medications

Common Medications That May Cause Depression

- Reserpine
- Propranolol
- Thiazide diuretics
- Digitalis
- Oral contraceptives
- Steroids
- Cimetidine
- Ranitidine
- Benzodiazepines
- Neuroleptics
- NSAIDs
- Amphetamines
- Disulfiram
- Cocaine
- Interferon

History, Physical Examination and Laboratory Evaluations

- Complete history and physical examination should be conducted
  - Chemical abuse
  - Losses (relationships, death, job)
  - Hormonal changes
- Laboratory tests (based on presenting symptoms)
  - CBC with differential (anemia)
  - CMP (glucose, kidney, liver tests, lytes)
  - TSH (thyroid disorder)
  - Vitamin D
  - Lyme
- Office tests
  - 12-lead ECG (prior to prescribing tricyclic antidepressants)

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Tools Available for the Primary Care Provider

- **Beck Depression Inventory, Primary Care** (BDI-PC) http://harcourtassessment.com/haiweb/cultures/en-us/productdetail.htm?pid=015-8018-370
- **Beck Anxiety Inventory** (BAI) http://harcourtassessment.com/haiweb/cultures/en-us/productdetail.htm?pid=015-8018-400
- **Zung Depression Scale*** http://www.neurotransmitter.net/depressionscales.html
- **Hamilton Rating Scale for Depression*** (HAM-D) http://www.neurotransmitter.net/depressionscales.html
- **Hamilton Rating Scale for Anxiety*** (HAM-A) http://www.anxietyhelp.org/information/hama.html

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DSM IV-TR Diagnostic Criteria for MDD

- 5 or more symptoms in the same 2-week period on most days (see next slide)
- 1 of these symptoms must include:
  - Depressed mood, lack of interest or pleasure in most activities (anhedonia)

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Pneumonic SIG E CAPS for the Diagnosis of MDD

- **S**leep (or **S**ex)
- **I**nterest
- **G**uilt
- **E**nergy
- **C**oncentration
- **A**ppetite
- **P**sychomotor
- **S**uicidal thoughts

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DSM-IV

DSM-IV Criteria for Major Depressive Disorder (MDD)

- Depressed mood or a loss of interest or pleasure in daily activities for more than two weeks.
- Mood represents a change from the person's baseline.
- Impaired function: social, occupational, educational.
- Specific symptoms, at least 5 of these 9, present nearly every day:
  1. **Depressed mood or irritable** most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).
  2. **Decreased interest or pleasure** in most activities, most of each day
  3. **Significant weight change (5%) or change in appetite**
  4. **Change in sleep**: Insomnia or hypersomnia
  5. **Change in activity**: Psychomotor agitation or retardation
  6. **Fatigue or loss of energy**
  7. **Guilt/worthlessness:** Feelings of worthlessness or excessive or inappropriate guilt
  8. **Concentration**: diminished ability to think or concentrate, or more indecisiveness
  9. **Suicidality:** Thoughts of death or suicide, or has suicide plan

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http://www.psnpaloalto.com/wp/wp-content/uploads/2010/12/Depression-Diagnostic-Criteria-and-Severity-Rating.pdf
Accessed 12-27-2013

DSM V

- **Major Depressive Disorder**
  - Neither the core criterion symptoms applied to the diagnosis of major depressive episode nor the requisite duration of at least 2 weeks has changed from DSM-IV.

http://www.dsm5.org/Documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf
Accessed 12-27-2013

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DSM IV-TR Diagnostic Criteria for Generalized Anxiety Disorder (GAD)

- 3 or more symptoms occurring on most days for 6 months or longer
  - Physical:
    - Restlessness or feeling keyed-up
    - Fatigue
    - Muscle tension
  - Psychological:
    - Excessive anxiety or worry*
    - Difficulty controlling worry*
    - Irritability
    - Difficulty concentrating or mind going blank
    - Sleep disturbance

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*Both must be present

Assessment of Suicidal Risk

- 1/2 to 2/3 of people who commit suicide have seen a health provider within the month
- Assessment focus
  - Ideation
  - Plan
  - History of previous attempt
  - History of family or friend's suicide
  - Support system
  - History of social embarrassment
  - Use of Beck Suicide Intent Scale

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Differential Diagnoses to Consider

- Substance-induced mood disorder
- Bipolar disorder (often missed)
- Seasonal affective disorder (SAD)
- Premenstrual dysphoric disorder (PMDD)
- Dysthymia
- Panic disorder
- Schizophrenia
- Grief reaction
- Post-traumatic stress disorder
- Medical disorders

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American Psychiatric Association Guidelines for Treating Depression

- Acute Phase
  - 1-8 weeks of treatment
  - Goal: Quick remission
  - Treatments: therapy, antidepressants
  - Light therapy, exercise, alternative therapies
- Continuation Phase
  - 8-20 weeks
  - Goal: Sustaining remission
  - Maintain same dose of medication as with the acute phase
  - Psychotherapy must be continued (enhances recovery); discontinued at end of phase
  - Note: suicide rates increase here

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American Psychiatric Association Guidelines for Treating Depression (cont)

- Maintenance Phase
  - Goal: Prevent relapse
  - This is often when the medications get discontinued (must taper off)
- Discontinuation of Active Treatment
  - Consider discontinuing medication if this is first episode
  - Decision to discontinue medication must be carefully considered and discussed with patient

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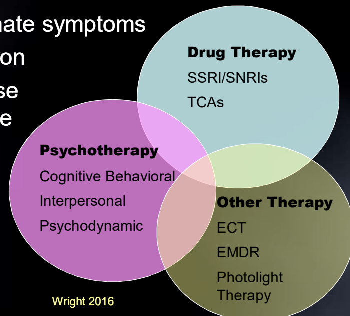
Treatment of Depression

Goals of Treatment:

- Reduce/eliminate symptoms
- Restore function
- Prevent relapse and recurrence



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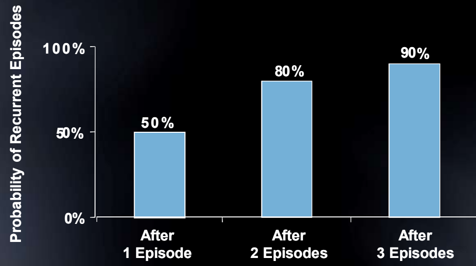

Nonpharmacologic Options

- Psychotherapy—use a familiar therapist
- EMDR (eye movement desensitization reprocessing)
- ECT (electroconvulsive therapy)
  - Reduces cortisol levels
- Biofeedback/relaxation response
  - Reduces cortisol levels
- Massage therapy
  - Reduces cortisol levels
- Nutritional therapy
- Exercise
- Light box
- Community groups/support

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Psychotherapy

- Cognitive/behavioral—focus is on behaviors, thoughts, and emotions
- Psychodynamic/psychoanalytic—time limited, premise is that psychological events are not produced randomly but by causal forces operating in the individual
- Family therapy—family oriented, directed at the group system

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Pharmacologic Treatment Options

- SSRIs/SNRIs
- DNRI
- Atypical antidepressants
- Tricyclic antidepressants (TCAs)
- Norepinephrine/serotonin modulators
- Combination therapy

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Choosing a Medication

- Use familiar medications
- Base medication choice on symptoms
- Check history of previous use
- Check history of family success w/Rx
- Consider financial/insurance coverage
- Consider adherence
- Use evidence-based guidelines
- Beware of drug-drug interactions

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Returning to Mary

- Early diagnosis and treatment is imperative
- The first few weeks of therapy are the most crucial
  - The educated patient is more likely to stay on a recommended treatment plan
  - Recognize the patient's cognitive level when discussing possible side effects
  - Be candid, yet give assurance that most of the side effects will begin to lessen or abate over the first week of therapy
  - Advise patient that mood changes will be subtle
  - Monitor daily (family) for signs of irritability, agitation, unusual behaviors, suicidality
- How would you treat Mary?

SSRIs

- Considered first-line treatment for major depressive and anxiety disorder
  - Applies to all age groups
  - All antidepressants have black-box warning regarding use in children and adolescents
  - Fluoxetine/escitalopram – pediatric/adolescent depression
- Easy to use
- Well tolerated
  - As effective as TCAs
- Inhibit the reuptake of serotonin and/or enhance serotonergic neurotransmission
  - Possible weak effects on dopamine

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SSRIs Dosing and Time to Effect

	Citalopram (Celexa)	Escitalopram (Lexapro)	Fluoxetine (Prozac)	Paroxetine (Paxil)	Sertraline (Zoloft)
Start dose*	20 mg	10 mg	10-20 mg	20 mg	25-50 mg
Max dose	40 mg	20 mg	80 mg	50 mg	200 mg
Time to effect	4-6 wks	1-2 wks	4-6 wks	4-6 wks	4-6 wks
Titration Incre-ment	1 week	1 week	3-4 weeks	1 week	1 week

*In clinical practice, based on patient symptoms, starting doses are sometimes lower than that recommended by the drug manufacturer

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CYP450 Isozyme Inhibition by Various SSRIs

CYP Isozymes

	1A2	2C9/19	2D6	3A4
Citalopram	0	0	0	0
Escitalopram	0	0	0	0
Fluoxetine	+	++	+++	++
Paroxetine	0	0	++++	0
Sertraline	0	+++	++	+

0 = minimal or weak inhibition; +, ++, +++ = mild, moderate, or strong inhibition

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Vilazodone hydrochloride

- Vilazodone (Viibryd)
- Indications
  - MDD in adults
- Class: SSRI and 5HT1A partial agonist
- Dosage:
  - 10 mg once daily to start
  - Maximum: 40 mg once daily
  - Dosed with food (without food – decreased levels of medication)

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•VIIBRYD™ (vilazodone hydrochloride) Prescribing Information. Trovis Pharmaceuticals LLC 2011 New Haven, Connecticut. http://www.frx.com/pi/viibryd_pi.pdf

SSRI Side Effects

	Citalopram (Celexa)	Escitalopram (Lexapro)	Fluoxetine (Prozac)	Paroxetine (Paxil/CR)		Sertraline (Zoloft)
Headache			+++	++	++++	++++
Insomnia	++	++	+++	++++	++	++++
Somnolence	+++	+++	++	++++	+++	++
Nervousness			+++	++++		++
Anxiety	+++	+++	++++	+++		+++
↓ Libido	+	+	++	+++	+++	++++
Fatigue	+++	+++				++++
Constipation			++	++++	++++	+++
↓ Appetite				++++	+++	

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Mary: 2 months later

- **Scenario #1:** Mary had been given SSRI
  - Titrated to maximum dose
  - Presents at 2-month visit without symptoms in remission
- What is the next step?
- **Scenario #2:** Mary had been given SSRI
  - Titrated to maximum dose
  - Presents at 2-month visit with complaints of persistent symptoms
    - insomnia
    - sad mood
    - inability to concentrate
    - anhedonia
- What is the next step?

Nonresponders: Next Steps

1) Optimize current therapy (use maximum dose)
2) Switch to a different SSRI
3) Augment with non antidepressant medication
4) Change class of medication
5) Use a combination of therapies
6) Optimize nonpharmacologic therapies

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Fine-Tuning Treatment

- Second-line therapy for depression
  - Bupropion (Wellbutrin/SR/XL)
  - Venlafaxine (Effexor/XR)
  - Duloxetine (Cymbalta)
  - Desvenlafaxine (Pristiq)
  - Newer options:
    - Levomilnacipran (Fetzima)
    - Vortioxetine (Brintellix)

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Fine-Tuning Treatment

- Third-line therapy for depression
  - Mirtazapine (Remeron)
  - TCAs
  - Nefazodone (Serzone)
- Augmenting for persistent insomnia
  - Trazodone (Desyrel)
  - Zolpidem (Ambien/CR)
  - Zaleplon (Sonata)
  - Lorazepam (Ativan)
  - Ramelteon (Rozerem)
  - Eszopiclone (Lunesta)

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Dopamine-Norepinephrine Reuptake Inhibitors

- Bupropion SR (Wellbutrin SR or XL)
  - Weak inhibitor of norepinephrine and dopamine; does not inhibit re-uptake of serotonin
  - 150 mg once daily in am as starting dose
  - Typical dosage: 300 mg/day; maximum: 400 mg-450 mg/day
  - Side effects
    - Seizures
    - Headaches
    - Agitation
    - Anxiety
    - Insomnia
    - Weight change
  - Contraindicated in patients with a history of seizures, significant head trauma, bulimia

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Serotonin-Norepinephrine Reuptake Inhibitors

- Venlafaxine (Effexor/Effexor XR)
  - Potent inhibitor of neuronal serotonin and norepinephrine reuptake and weak inhibitor of dopamine reuptake
  - Usual dosage: 150 mg/day
    - Start at 37.5 mg – 75 mg/d
    - Titrate as high as 225 mg/d in 75 mg increments every 4 d
  - Side effects
    - Nausea
    - Dizziness
    - Nervousness
    - Hypertension
    - Sexual dysfunction

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Serotonin-Norepinephrine Reuptake Inhibitors

- Desvenlafaxine (Pristiq)
  - Potent inhibitor of neuronal serotonin and norepinephrine reuptake and weak inhibitor of dopamine reuptake
  - Usual dosage: 50 mg once daily
    - Start at 50 mg
    - Titrate as high as 100 mg once daily
  - Side effects
    - Nausea
    - Dizziness
    - Nervousness
    - Hypertension
    - Sexual dysfunction

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Serotonin-Norepinephrine Reuptake Inhibitors

- Duloxetine hydrochloride (Cymbalta)
  - Inhibitor of neuronal serotonin and norepinephrine reuptake; less potent inhibitor of dopamine reuptake
  - Dose range: 60 mg/day; may push to 120 mg for patients with chronic pain
  - Side effects
    - Nausea
    - Dry mouth
    - Constipation
    - Insomnia
    - Sexual dysfunction
  - It is recommended that duloxetine not be administered to patients with any hepatic insufficiency

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Levomilnacipran

- Brand name: Fetzima
- Class: Extended release selective norepinephrine and serotonin reuptake inhibitor (SNRI)
- Indication: Major Depressive Disorder
- Dosage:
  - 40 mg to 120 mg once daily with or without food
  - Initiate dose at 20 mg once daily for 2 days
  - May increase by 20 – 40 mg every 2 days
  - The maximum recommended dose is 120 mg once daily
  - The capsules should be swallowed whole

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http://www.frx.com/pi/Fetzima_pi.pdf#page=1 accessed 12-28-2013

Levomilnacipran

- Efficacy:
  - 2673 patients involved in clinical trials
  - Statistically superior to placebo
  - Studies ranged from 8 weeks – 1 year of exposure
- Contraindications:
  - Hypersensitivity to any components
  - Concomitant MAOI use
  - Uncontrolled narrow angle glaucoma
- Drug/Drug Interactions:
  - Strong 3A4 inhibitors – increase exposure to levomilnacipran
    - i.e. ketoconazole, clarithromycin, ritonavir
    - Do NOT exceed doses > 80 mg

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http://www.frx.com/pi/Fetzima_pi.pdf#page=1 accessed 12-28-2013

Levomilnacipran

- Pregnancy Category:
  - C
  - May cause fetal harm and therefore, caution recommended
- Lactation:
  - Not known if excreted in human breast milk
  - However, was present in milk of lactating rats

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http://www.frx.com/pi/Fetzima_pi.pdf#page=1 accessed 12-28-2013

Levomilnacipran

- Precautions:
  - Suicidal ideations
  - Serotonin syndrome
  - Increased blood pressure and heart rate
  - Bleeding
  - Narrow angle glaucoma
  - Urinary retention/hesitancy
  - Activation of mania
  - Caution in individuals with seizure disorders

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http://www.frx.com/pi/Fetzima_pi.pdf#page=1 accessed 12-28-2013

Levomilnacipran

- Additional important information
  - Reduce dosage in setting of renal impairment:
    - CrCl 30-59: dosage $\leq$ 80 mg
    - CrCl 15-29: dosage $\leq$ 40 mg
  - Taper slowly for individuals discontinuing medication
- Side effects levomilnacipran vs. placebo:
  - Nausea: 17% vs 6%
  - Constipation: 9% vs. 3%
  - Vomiting: 5% vs. 1%

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http://www.frx.com/pi/Fetzima_pi.pdf#page=1 accessed 12-28-2013

Levomilnacipran

- Side effects levomilnacipran vs. placebo:
  - Tachycardia: 6% vs. 2%
  - Palpitations: 5% vs. 1%
  - Erectile dysfunction: 6% vs. 2%
  - Hyperhidrosis: 9% vs. 2%
- Advantages:
  - Another SNRI
  - Have experience with this medication since 2009
  - Enantiomer of the racemic drug milnacipran

http://www.frx.com/pi/Fetzima_pi.pdf#page=1 accessed 12-28-2013

Vortioxetine

- Brand name: Trintellix (formerly, Brintellix)
- Class: Serotonin modulator and stimulator
  - Novel class of medication
  - Enhances serotonergic activity by:
    - Inhibiting reuptake of 5HT, 5HT1A receptor agonist and antagonist of 5-HT3, 5HT1D and 5HT7
- Indication: Major Depressive Disorder
- Dosage:
  - 10 mg once daily; with or without food
  - Maximum dosage: 20 mg once daily
  - May use 5 mg for the individual experiencing side effects
  - 10 mg/day for individuals known to be 2D6 poor metabolizers

https://www.brintellixhcp.com/ accessed 12-27-2013

Vortioxetine

- Efficacy:
  - 6 studies performed; 18 years – 75 years
  - Placebo and active arms (venlafaxine, duloxetine)
  - Statistically superior to placebo
  - Efficacy within 2 weeks and maximum effect at 4 weeks
- Contraindications:
  - MAO's within 21 days
  - Hypersensitivity to any components

https://www.brintellixhcp.com/ accessed 12-27-2013

Vortioxetine

- Drug/drug interactions:
  - Reduce dose by ½ for those on strong 2 D6 inhibitors such as:
    - Bupropion
    - Fluoxetine
    - Paroxetine
    - Quinidine
  - Strong CYP inhibitors
    - Increase dose if on any of the following:
    - Rifampin, carbamazepine, phenytoin

ttps://www.brintellixhcp.com/ accessed 12-27-2013

Vortioxetine

- Pregnancy category: C
- Lactation:
  - Found in breast milk of lactating rats
- Additional information:
  - No weight gain seen when compared with placebo at month 6
  - Taper off medication, if needing to d/c
- Precautions:
  - Serotonin syndrome
  - Bleeding
  - Mania
  - Hyponatremia

ttps://www.brintellixhcp.com/ accessed 12-27-2013

Vortioxetine

- Side effects: (vortioxetine vs. placebo)
  - Nausea: 21-32% vs. 9%
  - Constipation: 7-10% vs. 6%
  - Dizziness: 6-9% vs. 6%
  - Remainder: similar to placebo

ttps://www.brintellixhcp.com/ accessed 12-27-2013

Norepinephrine-Serotonin Modulator

- Mirtazapine (Remeron)
  - Enhances central noradrenergic and serotonergic activity
  - Potent H_1 receptor blocker
  - Dose range: 15-45 mg/hs
  - Side effects (the lower the dosage, the higher the side effects):
    - Sedation
    - Increased appetite
    - Weight gain
    - Dizziness
    - Anticholinergic effects

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Serotonin Modulators

- Nefazodone (generic)
  - 300 mg-600 mg/d
  - Starting dose: 200 mg/d (100 mg BID), titration in increments of 100-200 mg/d (BID schedule) at intervals of at least 1 week
- Trazodone (Desyrel)
  - Dosage: Maximum 400 mg/d for outpatients
  - Initial dose: 150 mg/d increased by 50 mg every 4 d

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Tricyclic Antidepressants

	Amitriptyline (Elavil)	Desipramine (Norpramin)	Imipramine (Tofranil)	Nortriptyline (Pamelor)
Start Dose	50 mg hs	25-50 mg	75 mg	10-25 mg
Max Dose	150 mg hs	100-200 mg	150 mg	100 mg

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Benzodiazepines

	Alprazolam (Xanax/XR)	Clonazepam (Klonopin)	Diazepam (Valium)	Lorazepam (Ativan)
Start Dose	0.25-0.5 3x/d	0.25 mg	2 mg 2-4x/d	1.0 mg
Max Dose	4 mg divided	1 mg	10 mg 2-4x/d	10 mg
Half life	~11 hrs	30-40 hrs	20-100 hrs	12-18 hrs
Onset	Intermediate-fast	Intermediate	Fast	Intermediate
Indication	GAD	Panic disorder	Anxiety or anxiety disorder	Anxiety disorders/anxiety with depressive symptoms

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Other Antianxiety Medications

- Buspirone (BuSpar)*
- Hydroxyzine (Vistaril) †
- Gabapentin (Neurontin)†
- Beta-Blockers†

*Indicated for anxiety disorder
†Off-label use

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Additional Medications

- Lamotrigine (Lamictal)
  - MDD, Seizure disorder, Bipolar (25 mg starting dose; 200 mg maintenance)
- Aripiprazole (Abilify)
  - MDD, Bipolar, Schizophrenia (2 – 5 mg once daily starting; 15mg/day maximum)
- Lithium
  - Bipolar (300 mg once – twice daily; maximum 2400 mg/day)
- Ziprasidone (Geodon)
  - Bipolar, Schizophrenia
- Quetiapine fumarate (Seroquel)
  - MDD, Bipolar, Schizophrenia

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Patient Education: Medications

- Side effects
- Warnings found in the package inserts including suicidal thoughts, worsening depression, and allergic reactions.
- Use of other drugs including alcohol
- Improvement of symptoms: expect 3-4 weeks
- Duration of treatment
- Frequent follow-up
- Discontinuation: Do not stop abruptly to avoid serotonin withdrawal symptoms
- Teach patient symptoms of serotonin syndrome and discontinuation syndrome

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Mary: 9 Months Later

- Has been in clinical remission for 6 months
- Recommended lengths of therapy:
  - 1st episode: 6-9 months after remission achieved
  - 2nd episode: 9-12 months after remission achieved or indefinitely
  - 3rd episode: indefinitely

Words of Wisdom

- Avoid using SSRIs and TCAs together
  - Increases the risk of serotonin syndrome
- In the elderly, start low, go slow
- Taper off medication slowly to avoid withdrawal symptoms
- Address weight gain and sexual dysfunction
- Be attentive to follow-up schedule
  - Weekly x 2-4 weeks (may be coordinated or augmented with therapist visits)
  - Every 2 weeks x 2-4 weeks

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When to Consult/Refer

- Patient is seen and therapies fail
  - 1 or 2 adequate trials of antidepressants
- Any suicidal/homicidal ideations
- Children with depression/anxiety
- Comorbidities
  - Psychotic depression
  - Bipolar disorder
  - Obsessive-compulsive disorder
  - Concomitant thought disorder (eg, schizophrenia)
  - Severe depression

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Techniques to Improve Adherence

Be as forthright as possible with what to expect from the medication

- Efficacy/time to improvement
  - Some improvement within 2 weeks
  - Significant improvement in 6 weeks
  - If no improvement in 6 weeks, the med is unlikely to work at all
- Side effects
  - Outline the common side effects for whichever medication is prescribed
  - "Start low and go slow" to minimize side effects

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Common Reasons Why Patients Discontinue Medication Therapy

- Sexual dysfunction
- Weight gain

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Documentation for Depression and Anxiety Visits

Documentation should include:

- Appearance and behavior
- Attitude (to examiner)
- Psychomotor activity: normal, slow, agitated
- Affect and mood
- Speech and thinking
- Perceptual disturbances
- Orientation
- Quotation of suicidal ideation denial
- Attention
  - Recall of three objects, serial sevens
- Comprehensive physical exam
- Time spent with patient

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Reimbursement

- You may bill for the amount of time spent provided that the visit is predominantly counseling (>50%)
- If the nurse practitioner elects to choose the level of service based on counseling:
  - The total length of time of the encounter should be documented
  - The record should describe the amount of time spent in counseling

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Summary and Questions

- For further information, contact:
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