TREATING DEPRESSION IN THE ADULT PRIMARY CARE SETTING

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NO DISCLOSURES

LEARNING OBJECTIVES

- Participants will be able to use evidence-based screening tools and reproduce vital history questions to aid in a proper diagnosis of depression.
- Participants will be able determine the most appropriate first line pharmacologic treatment for depression in the adult primary care patient.
- Participants will be able to specify when to refer individuals to other professionals or higher levels of care.

DEPRESSION BY THE NUMBERS

In 2021, the CDC estimated that 4.8% of people in the U.S. are having regular symptoms of depression.

The National Institute of Mental Health (NIMH) estimates that 19.4 million adults in 2019.

There are about 45,000 psychiatrists in the United States.
Or, 1 psychiatrist for every 431 patients with depression.

~45% of patients with a suicide attempt have seen their PCP within 30 days.

DIAGNOSING DEPRESSION

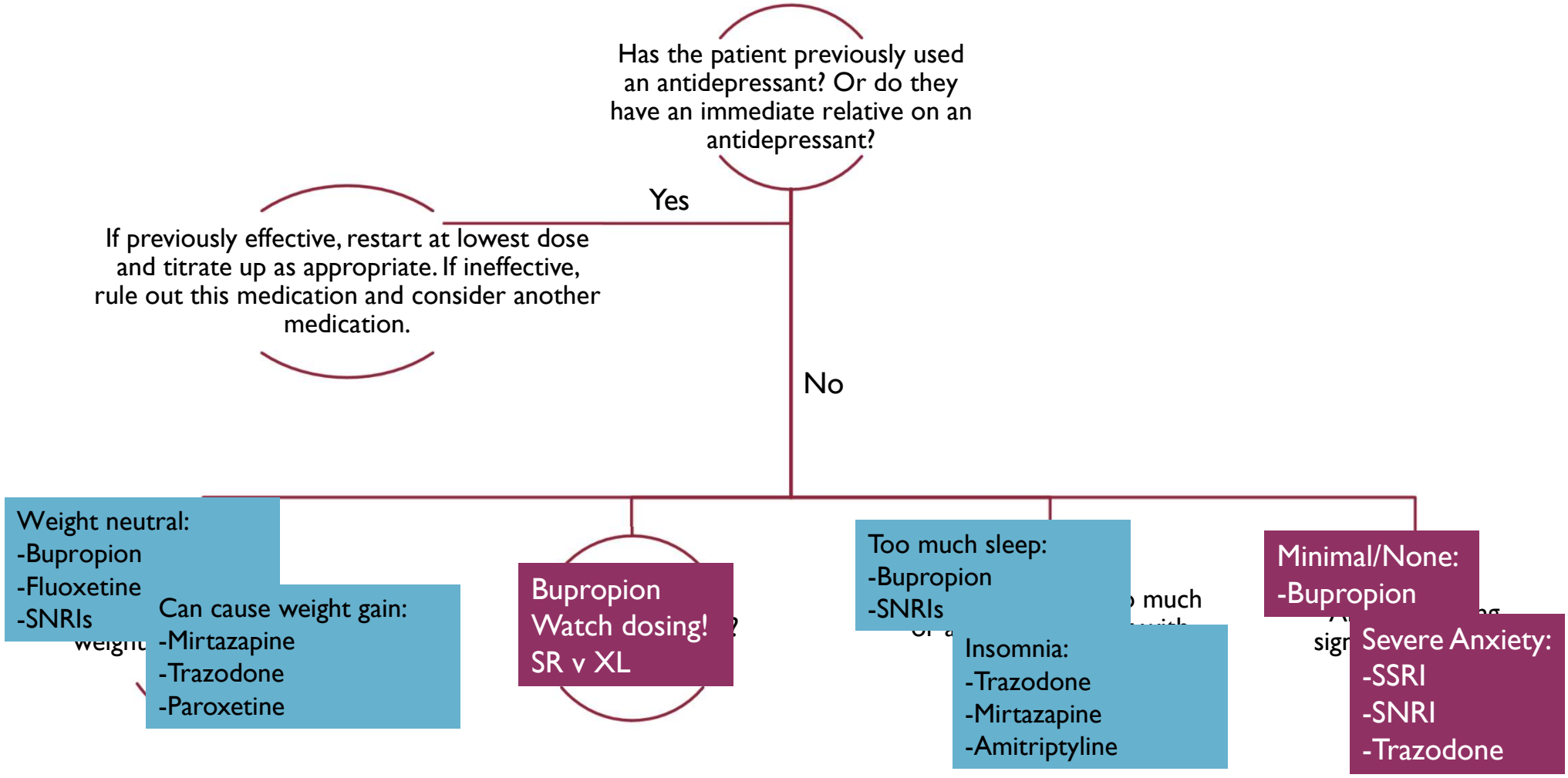
- Before treating depression, make sure you have a proper diagnosis! The first step is screening.
  - PHQ-9
  - Beck Depression Inventory
  - Geriatric Depression Scale

THOROUGH HISTORY

- What should this include?
  - Current medications
  - Lab testing: thyroid, testosterone
  - Chronic, uncontrolled diagnoses
  - Family history
  - Personal history
  - Manic episodes
    - Family/personal diagnosis, sleep patterns, energy levels, impulsivity

CHOOSING AN APPROPRIATE MEDICATION

- Selective Serotonin Reuptake Inhibitor (SSRI)
  - Fluoxetine
  - Sertraline
  - Paroxetine
  - Citalopram
  - Escitalopram
- Tricyclics
  - Amitriptyline
  - Imipramine
- Serotonin and Norepinephrine Reuptake Inhibitors
  - Venlafaxine
  - Desvenlafaxine
  - Duloxetine
- Atypical Antidepressants
  - Trazodone
  - Mirtazapine
  - Bupropion


Has the patient previously used an antidepressant? Or do they have an immediate relative on an antidepressant?
Yes
If previously effective, restart at lowest dose and titrate up as appropriate. If ineffective, rule out this medication and consider another medication.
No
Weight neutral:
-Bupropion
-Fluoxetine
-SNRIs
Can cause weight gain:
-Mirtazapine
-Trazodone
-Paroxetine
Bupropion
Watch dosing!
SR v XL
Too much sleep:
-Bupropion
-SNRIs
Insomnia:
-Trazodone
-Mirtazapine
-Amitriptyline
Minimal/None:
-Bupropion
Severe Anxiety:
-SSRI
-SNRI
-Trazodone

TREATMENT MONITORING

- When do you have the patient return?
  - Generally 4-6 weeks, possibly sooner if severe
- How do you know it is working?
  - Subjective: Does the patient feel better? Are they having any intolerable side effects?
  - Objective: Can use the screening tools as a way to evaluate objectively if the patient is improving
- Partial response?
  - Increase the dose or add therapy as an adjunct

WHEN TO REFER

- Acute Suicidality. Policy varies from state-to-state, but essentially, this is a medical emergency and patient should be sent to nearest ED for psychiatric hospitalization.
- Treatment resistant depression
- Multiple psychiatric comorbidities
- Counseling or psychologist services—can be helpful as an adjunct

SUMMARY SLIDE

- Diagnosing
  - A combination of screening tools and a thorough history is best.
- Treatment
  - Generally an SSRI, but there are times you may prefer another class based on the patient's history.
- Referrals
  - Be aware of your limitations and know the resources in your area for patients.

REMEMBER…THE BEST MEDICINE IS THE ONE THE PATIENT WILL TAKE!

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