DEPRESSION

- APPROACH TO DEPRESSION
- CONFIRMATION OF MAJOR DEPRESSION
- SUICIDE RISK ASSESSMENT
- MANAGEMENT OF DEPRESSION

Contributors
Dr Benjamin Cheah
Dr Lee Mun Tuck
Dr Lee Hon Yee

Advisor
Dr Kwek Seow Khee Daniel
APPROACH TO DEPRESSION (AN OVERVIEW)

HIGH INDEX OF SUSPICION IN
- Female
- Elderly
- Patients with general medical illness, complications, new diagnosis
- Life stressors ie job loss, divorce

Confirm major depression
Exclude organic conditions
Exclude drugs that cause depression

Exclude bipolar

Assess for high risk patient
(i.e. suicide / homicide / substance abuse / pregnancy)

YES
- Refer to Psychiatrist

NO
- Manage in the primary care clinic

Pharmacological treatment
- Non Pharmacological Treatment (Psychotherapy)
CONFIRMATION OF MAJOR DEPRESSION BY DSM IV

In Singapore prevalence of depression was 8.6% in adults and 5.7% in elderly.

Five or more of the following must be present during the same two week period; at least one symptom must be 1 or 2 below:

1. **Depressed mood**
   OR

2. **Loss of interest or pleasure in most activities**
   And 4 more below

3. Significant weight loss or gain (>5% body weight in one month)
4. Insomnia or hypersomnia nearly every day
5. Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Feelings of worthlessness or excessive guilt
8. Indecisiveness, inability to think or concentrate
9. Recurrent thoughts of death or suicidal ideation

Other important questions to ask are:

- Effect on job, family and social life
- Psychotic features – Delusions or hallucinations (Seeing things, hearing voices, paranoid)
  To exclude depression with psychosis or psychosis with secondary depression
- Life events and stressors

Note: Consider treatment even if DSM IV criteria are not fulfilled if symptoms are severe and significantly affect functioning.

Assess Medical Conditions

- Exclude drugs that may cause depression
  - Cardiac and antihypertensive: hydralazine, methyldopa, propranolol
  - Steroid: oral contraceptive pill and prednisolone
  - Neurological: bromocriptine, levodopa
  - Drug abuse

- Exclude bipolar disorder that may cause depression
  - Bipolar disorder is depression alternating with mania
  - It is important to exclude this as anti-depressant can precipitate mania in such patients

- Medical conditions associated with depression
  - Hypothyroidism
  - Malignancy
  - Neurological conditions – Parkinson, Stroke
  - Endocrinopathies – Cushing’s syndrome, adrenal insufficiency, hyperparathyroidism
  - Chronic illness – Diabetes, congestive heart failure, SLE
  - Sleep disorder

Assess Medical Conditions
SUICIDE RISK ASSESSMENT

1. Assessment of Suicide Risk Is Critical.
   High Suicide risk is a psychiatric emergency that warrants immediate admission.
   Presence of the following features indicates a risk of suicide:
   • Demographic factors – the classic profile for a successful attempt is an elderly single male
   • Other demographic factors include divorce, widowed, unemployed with no religion
   • Poor or no social support
   • Presence of a psychiatric condition: especially depression and schizophrenia
   • Comorbid substance abuse and dependence
   • Personality traits: impulsive, poor coping with stress, borderline and anti-social personality disorders
   • Presence of a painful debilitating condition
   • Previous suicide attempts
   • Family history of suicide
   • Premeditation – e.g. timing and location of the attempt; collection of necessary materials; rehearsal of the act
   • Last acts – e.g. writing goodbye letters; distributing personal belongings
   • Effort to avoid detection – e.g. attempting suicide while alone in a locked room; choosing a time when the family is away or asleep
   • Choosing a method that they perceive as lethal
   • Regret that they are still alive
   • Absence of specific plans and goals for the future; having nothing to live for

2. How to Inquire About Suicidal Ideation
   Asking for suicidal ideations will not result in this happening.
   In fact, it is more likely to be missed if not enquired.
   Here is a suggested flow for this line of questioning which is less challenging to ask:
   1. “Do you sometimes have a feeling that life isn’t worth living, or do you think about death much?”
   2. “Do you sometimes think that if you died tomorrow from an accident or illness, that it just wouldn’t matter?” (Passive ideation)
   3. “Have you had thoughts of killing yourself?” (Active ideation)

3. Cases for Specialist Referral
   Referral is recommended when there is:
   • Suicide risk
   • Need for hospitalization
   • Failure of treatment
     - failed treatment after 6 weeks on optimum therapeutic dose
     - relapse depression within 2 months after stopping medicine
   • Complicated medical or psychiatric morbidity including antepartum or postpartum depression, history of recurrent depression
   • When other psychiatric disorders are present ie schizophrenia, bipolar disorder
   • Substance abuse
   • Need for combined medication & psychotherapy
   • Evaluation for pharmacotherapy
   • Need for ECT
MANAGEMENT OF DEPRESSION

Non-Pharmacological Treatment

1. A brief counseling technique (BATHE) for doctors
   i. **BACKGROUND**: Encourage open dialogue about issues troubling the patient. Ask open-ended questions “What is going on in your life?”
   ii. **AFFECT**: To encourage patient to talk about his feelings, “How do you feel about that?”, “How is your mood?”
   iii. **TROUBLE**: Enable the physician to elicit the meaning of a specific situation, “What about the situation troubles you most?”
   iv. **HANDLING**: To assess the patient’s coping skill and level of functioning “How are you handling that?”
   v. **EMPATHY**: Legitimise a patient’s reaction to a situation, “It sounds like a difficult situation”

2. Other areas of help within NHGP
   i. Medical social worker can offer social emotional help
   ii. Psychologist can offer psychotherapy
   iii. Financial counselor for financial aid

Pharmacological Treatment

1. Choice of antidepressant
   - Both TCAs and SSRIs are first line drugs for depression.
   - SSRIs are more often used especially in the elderly and in those who are suicidal due to the better side effect profile.
   - Most drugs have comparable efficacy. Choice is dependant on side effects, safety, tolerability and cost.

2. Contraindications

   **To TCA**

<table>
<thead>
<tr>
<th>Absolute</th>
<th>Relative</th>
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</thead>
<tbody>
<tr>
<td>i. Recent myocardia infarct</td>
<td>i. Epilepsy</td>
</tr>
<tr>
<td>ii. Arrhythmias especially heart</td>
<td>ii. Pregnancy and breast feeding</td>
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<tr>
<td>blocks</td>
<td>iii. Thyrotoxicosis</td>
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<tr>
<td>iii. Severe liver impairment</td>
<td>iv. Pheochromocytoma</td>
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<td></td>
<td>v. Bipolar</td>
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<td></td>
<td>vi. Angle closure glaucoma</td>
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<td></td>
<td>vii. Benign Prostatic hypertrophy</td>
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<td></td>
<td>viii. Elderly &gt; 65 years old</td>
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</tbody>
</table>

   **To SSRI**

   - To be used with caution in patients with hepatic or renal impairment; and pregnant patients
   - Therefore patients on Warfarin may have increased and unstable INR. Patients on Warfarin who are depressed should be referred to the psychiatrist.
## DEPRESSION

<table>
<thead>
<tr>
<th>CLASS OF DRUG</th>
<th>NAME OF DRUG</th>
<th>INITIATION DOSE</th>
<th>MAINTENANCE DOSE</th>
<th>AVAILABILITY IN POLYCLINIC</th>
<th>SIDE EFFECTS: COMMON</th>
<th>SIDE EFFECTS: LESS COMMON</th>
</tr>
</thead>
<tbody>
<tr>
<td>TCA (TRICYCLIC ANTI-DEPRESSANT)</td>
<td>A) AMITRYPTYLINE</td>
<td>25 mg (10mg)*</td>
<td>50-75mg</td>
<td>LIST 1</td>
<td>a) Dry mouth</td>
<td>a) Glaucoma</td>
</tr>
<tr>
<td></td>
<td>B) DOTIEPIN HYDROCHLORIDE (PROTHI-ADEN)</td>
<td>25 mg</td>
<td>50-75mg</td>
<td>LIST 1</td>
<td>b) Weight gain</td>
<td>b) Urinary retention</td>
</tr>
<tr>
<td>SSRI (Selective Serotonin Reuptake Inhibitor)</td>
<td>A) FLUOXETINE HYDROCHLORIDE (PROZAC)</td>
<td>10-20 mg</td>
<td>20-40mg</td>
<td>LIST 2</td>
<td>c) constipation</td>
<td>c) Postural hypotension</td>
</tr>
<tr>
<td></td>
<td>B) FLUOXAMINE MALEATE (FAVERIN)</td>
<td>25-50mg</td>
<td>50-100mg</td>
<td>LIST 2</td>
<td>d) Sedation</td>
<td>d) Cardiac conduction impairment (More cardiotoxic during overdose)</td>
</tr>
</tbody>
</table>

For the elderly, start low and go slow
* indicates suggested starting dose for elderly

TCA are less well tolerated in elderly

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TCA are less well tolerated in elderly


Subsequent Follow-Up

1. Follow-up
   Recommended: initial 2 weekly follow up and if well 2 to 3 monthly
   Evaluate
   - Side effects
   - Dosages: Start at initiation dose
   - Effectiveness of medicine: Appetite and sleep to improve first before interest in activity and mood. Will take at least 2 weeks
   - Suicide risk
   Expect symptoms to resolve in 4 - 12 weeks.

2. Maintenance and Stopping Therapy
   After symptomatic recovery, continue treatment for at least 6-9 months. Patient must be well before stopping medicine. Taper gradually over 4 weeks to avoid withdrawal symptoms or rebound.
   Withdrawal symptoms include sleep disturbances, GI upset, irritability, mild anxiety, tremor of fingers and fatigue.
   Follow up on the patient over next few months to monitor for recurrence. If recurrence occurs, the patient is likely to respond to the same anti-depressant at the same dosage that was effectively previously, which should then be continued for 6 months.
   Maintenance treatment is considered in those patients with presence of co-morbid conditions, residual symptoms between episodes, severe depressive episodes (with suicidality, psychotic features and severe functional impairment) and previous multiple depressive episodes.

References
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