eSantéMentale.ca

Depression in Adults: Information for Primary Care

Image credit: Adobe Stock

Sommaire : Depression is a common mental health condition seen in primary care. Family physicians can play a key role in ruling out medical conditions, helping patients develop healthier attachments as well as referral to specialized mental health services if required.

Epidemiology

- Prevalence of depression
  - 2%-4% of persons in the community (Katon, 1992)
  - 5%-10% of primary care patients (Katon, 1992)
  - 10%-14% of medical inpatients (Katon, 1992)
- More than 90% of patients diagnosed with depression receive care exclusively from their family physician (Bilsker, 2007).
- Complications:
  - 2% of people with depression commit suicide, and of these, 50% will have had contact with their family physician in the month prior to suicide (Luoma, 2002)

Screening

There are two main approaches:

1. Screen all patients: The US Preventative Task Force recommends depression screening in all adult patients (Annals of Internal Medicine, May 2002)

2. Screen those at increased risk of having depression such as with

   - Recent losses (including grief/bereavement, as well as relationship breakups)
   - Medical stresses such as cancer, cardiovascular problems
   - Somatic symptoms that do not appear to have any obvious medical cause
   - Family history of mental health issues
   - History of relationship and interpersonal issues
   - Recent postpartum status, i.e. new mother who is sleep deprived

Screening Questions

Two screening questions:

1. Clinician: “In the past month, have you lost interest or pleasure in things you usually like to do?”
2. Clinician: “In the past month, have you felt sad, low, down, depressed or hopeless?”

Yes to either 1) or 2) indicates need for further assessment…

Diagnosis (Dx)

- Major Depression
    - Problems with mood with significant neurovegetative symptoms
- Persistent depressive disorder (includes dysthymic disorder in DSM-IV)
    - Depressed mood for at least 2-years (in adults) (or at least 1-year in children/youth) but not to the severity (nor with significant neurovegetative symptoms) to meet for major depression

DSM-5 Criteria Summary

DSM-5 Major depression

At least five of the following symptoms have been present for the same 2-week period, and at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure:

- Depressed mood (or irritable mood in children/adolescents)
- Loss of interests or pleasure
- Loss of weight or appetite (or failure to make expected weight gain in children/adolescents)
- Insomnia or hypersomnia
- Fatigue or loss of energy
- Feelings of worthlessness, excessive or inappropriate guilt
- Concentration problems
- Psychomotor agitation or retardation
- Suicidal ideation or recurrent thoughts of death

DSM-5 Persistent depressive disorder (includes dysthymia)

1. Depressed Mood for at least 2-years (or at least 1-year in children/youth)
2. At least two or more of:
    - Appetite problems (loss of appetite or over-eating)
    - Sleep problems (insomnia or hypersomnia)
    - Energy problems (low energy or fatigue)
    - Low self-esteem
    - Poor concentration
    - Feelings of hopelessness

Differential Diagnosis (DDx)

Depression due to medical illnesses such as

- Cancer
- Vitamin deficiencies such as B12 / folate
- Thyroid
    - Hypothyroidism
    - Hyperthyroidism

- Adrenal
    - Cushing’s, Addison’s
- Toxic
    - Wilson’s disease
    - Heavy metal poisoning
- Neurologic causes
    - Alzheimer’s
    - Stroke
    - Parkinson’s
    - Multiple sclerosis (MS)
    - Seizures
    - Dementia
- Infections
    - Infectious mononucleosis
    - Lyme disease
    - Autoimmune disorders
    - Celic disease
    - Lupus
    - Rheumatoid arthritis
- HIV testing (if HIV is suspected)

Medication-induced such as

- Beta blockers and other anti-hypertensives
- Corticosteroids
- Sedatives and anti-anxiety medications
- Oral contraceptives
- Substance use or alcohol use
    - Alcohol or drug use can also cause fatigue, memory problems, insomnia and anxiety

Psychiatric diagnoses such as

- Bipolar depression
    - Individuals with bipolar disorder have mood swings classically with high energy, euphoric phases, but also can have depressed moods as well
- Anxiety disorders
    - Similar symptoms include fatigue, poor concentration, restlessness
    - Individuals with anxiety are at a higher risk of developing depression
- Eating disorders such as anorexia, bulimia
- Psychotic disorders such as schizophrenia, delusional disorder
- Attention deficit hyperactivity disorder (ADHD)

Investigations

- Depression is a clinical diagnosis based on history and physical findings
- There are no diagnostic laboratory tests for the diagnosis of depression
- Typical investigations to rule out medical conditions include:
    - Complete blood count (CBC)
    - Thyroid indices (e.g. TSH, free T4)
        - Elevated TSH may suggest hypothyroidism, with mental slowing, lethargy, weight gain, sleep problems
        - Decreased TSH may indicate hyperthyroidism, with weight loss, fatigue, irritability

    - Vitamin B12
    - Folate
    - Electrolytes including sodium (Na+), potassium (K+), as well as calcium (Ca), phosphate (P) and magnesium (Mg)
- Additional investigations that might be ordered if indicated
    - Kidney function tests, e.g. BUN and Creatinine (Cr)
    - Liver function tests
    - Testing for common substances of abuse such as:
        - Urine for cannabinoids
        - Blood alcohol level
    - Cortisol test for Cushing's disease, linked to obesity, back pain, mental changes
    - Sleep testing if sleep disorders such as sleep apnea suggested

Physical Exam (Px)

- Depression is a clinical diagnosis based on history and physical findings
- There are no specific physical findings for the diagnosis of depression

Treatment / Management

- Education about Depression
- Psychotherapy/Counselling
    - Office-based psychotherapy/counseling by family physicians with sufficient training and time
    - Refer to psychologist or other mental health professional in private practice
- Self-Management strategies include
    - Getting enough sleep
    - Getting enough exercise
    - Having a healthy diet
    - Spending quality time with people
    - Getting out into nature
- Support groups such as the local chapter of the Mood Disorders Society of Canada

Medications

Specific serotonin reuptake inhibitor (SSRI)

- Citalopram (Celexa or generic)
    - Start at 20 mg daily, increase up to 20-60 mg daily
- Escitalopram (Cipralex or generic)
    - Start at 10 mg daily, increase up to 10-20 mg daily
- Fluoxetine (Prozac or generic)
    - Start at 10-20 mg daily, increase up to 20-60 mg daily
- Paroxetine (Paxil or generic)
    - Start at 20 mg daily, increase up to 20-50 mg daily
- Sertraline (Zoloft or generic)
    - Start at 50 mg daily; increase up to 50-200 mg daily

Serotonin-noradrenaline reuptake inhibitor (SNRI)

- Duloxetine
    - Start 20 mg daily; increase up to 40-60 mg daily

- Venlafaxine XR
    - Start at 37.5 mg daily; increase up to 75-225 mg daily

Noradrenaline dopamine reuptake inhibitors (NDRI)

- Bupropion SR
- Start at 150 mg daily, increase up to 300-450 mg daily

Noradrenaline-serotonin modulator

- Mirtazapine
    - Start at 15 mg QHS; increase up to 15-45 mg QHS

Duration of initial trial

- If patient does not respond to at least 4-8 weeks of antidepressant therapy at an adequate dosage
    - Confirm that the diagnosis of depression is corret
    - Confirm that patient was taking the medication
    - Rule out medical causes of depression
- Options
    - Switch to another antidepressant
    - If there was a partial response to the first antidepressant, then consider augmenting, i.e. adding a second antidepressant
    - Augment with
        - Psychotherapy, such as cognitive behavioural therapy (CBT)
        - Bupropion (Wellbutrin)

Duration of maintenance therapy

- If patient responds to treatment, then continue antidepressants for at least 6-12 months in order to reduce risk of relapse

When and Where to Refer

Consider referral to a psychiatrist for:

- Bipolar disorder, psychotic symptoms and/or a substance use disorder;
- Risk of suicide or harm to others;
- Severe co-morbid psychiatric or medical illness;
- History of treatment resistance;
- Lack of response to standard treatments
- Unclear diagnosis

Clinical Algorithms

- Khan A, Green D: Depression Algorithm for Primary Care, 2005.

Clinical Practice Guidelines

- Kennedy S et al.: CANMAT 2016 Clinical Guidelines for the Management of Adults with Major Depressive Disorder: Section 3. Pharmacologic Treatments, Can J. Psychiatry, 2016, 61(9): 540-560.
HTML http://journals.sagepub.com/doi/abs/10.1177/0706743716659417
PDF http://journals.sagepub.com/doi/pdf/10.1177/0706743716659417
- Major depressive disorder in adults: Diagnosis and management, Dec 2013
http://www.bcguidelines.ca/guideline_mdd.html

- Depression: the treatment and management of depression in adults, NICE clinical guideline (CG90), Oct 2009
  http://guidance.nice.org.uk/CG90
- Patton SB, Kennedy SH, Lam RW et al. Canadian Network for Mood and Anxiety Treatments (CANMAT): Clinical Guidelines for the management of major depressive disorder in adults, J. Affective Disorders 2009; 117(Suppl 1): S5-S14.
  http://www.canmat.org/resources/CANMAT%20Depression%20Guidelines%202009.pdf
- Practice guideline for the treatment of patients with major depressive disorder, American Psychiatric Association, Oct 2010s
  http://psychiatryonline.org/data/Books/prac/PG_Depression3rdEd.pdf

References

- Bilsker D, Goldner EM, Jones W. Health service patterns indicate potential benefit of supported self-management for depression in primary care. Can J Psychiatry 2007;52(2):86-95.
- Katon W, Schulberg H: Epidemiology of depression in primary care. Gen Hosp Psychiatry. 1992 Jul; 14(4): 237-47.
- Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. Am J Psychiatry. 2002;159(6):909-16.
- Puyat et al.: Estimating the prevalence of depression from EMRs, Canadian Family Physician April 2013 vol. 59 no. 4 445.
- Wong ST, Manca D, Barber D et al.: The diagnosis of depression and its treatment in Canadian primary care practices: an epidemiological study. CMAJ Open 2014; 2:E337-E342.

About this Document

Written by members of the eMentalHealth.ca/PrimaryCare team which includes members of the Department of Psychiatry and Family Medicine at the University of Ottawa. Reviewed by members of the Family Medicine Program at the University of Ottawa, including Dr's Farad Motamedi; Mireille St-Jean; Eric Wooltorton.

Disclaimer

Information in this pamphlet is offered ‘as is' and is meant only to provide general information that supplements, but does not replace the information from a health professional. Always contact a qualified health professional for further information in your specific situation or circumstance.

Creative Commons License