Depression in Primary Care

Nazhat Taj-Schaal, MD, FAAP, FACP
Assistant Professor of Internal Medicine
Division of General Internal Medicine
The Ohio State University Wexner Medical Center

Objectives

- Define the prevalence and impact of depression on patients in primary care
- Review screening, monitoring, and treatment guidelines
- Review CPC + requirements
- Review common medications used in treatment
- Review gene testing to assist medication selection

Disclosures

- None

CASE PRESENTATION
Case W.C.

- 32 yo male with poorly controlled HTN and DM reports worsening diabetic control over past 3 months. Not checking his sugars because “it doesn't matter, it's always high.”
- Reports good compliance with insulin (glargine 60 BID, and humalog sliding scale—takes at least two shots per day), sitagliptin.
- BP 158/100, BMI 33
- A1c this visit up to 11.9, was 10.7 last time.

What will you advise next?

Why are his chronic diseases uncontrolled?

- Medication adherence
  - Cost of meds
  - Perceived efficacy
  - Side effects
- Diet (his choices or his finances)
- Other contributing conditions (COPD with recent prednisone?)
- Mood disorder

Depression isn’t just being a bit sad. It's feeling nothing.

--JK Rowling
DSM 5 Criteria Major Depression

- Depressed mood and/or loss of interest or pleasure AND
- Significant weight loss/gain
- Insomnia/hypersomnia
- Psychomotor agitation/retardation
- Fatigue/loss of energy
- Feelings of worthlessness, excessive guilt
- Diminished concentration or ability to think
- Recurrent thoughts of death or suicidal ideation

“There is no point treating a depressed person as though she were just feeling sad, saying, ‘There now, hang on, you’ll get over it.’ Sadness is more or less like a head cold—with patience, it passes. Depression is like cancer.”

--Barbara Kingsolver, The Bean Trees

Practice Guidelines

- US Preventive Services Task Force

- American College of Physicians
  Nonpharmacologic Versus Pharmacologic Treatment of Adult Patients With Major Depressive Disorder: A Clinical Practice Guideline From the American College of Physicians

Link to Mood Disorders in Chronic Illness
Impact of Depression

What percent of the US population suffers from depression?

“The statistics on sanity are that one out of every four people is suffering from a mental illness. Look at you 3 best friends. If they’re ok then it’s you.”

- Rita Mae Brown

Impact of Depression

- Up to 8% of US residents suffer from depression resulting in 8 million visits per year
  - 4 million of these visits to primary care
- Cost of depression yearly $83 billion including $26 billion in health care costs and rest related to losses such as work absenteeism
- Comorbid depression increases risk of death from heart disease, respiratory disorders and stroke

Source: Agency for Healthcare Research and Quality Web
Morbidity and Mortality

- Increased functional impairment, decreased work productivity
- Decreases quality of life more than COPD, cancer, hypertension
- Barrier to positive productive relationships with providers and patients
  - PCP tend to rate depressed patients more difficult to treat
  - Depressed patients less satisfied with their PCP


Morbidity and Mortality

- Significant association with hyperglycemia
  - Significant association with complications of diabetes (retinopathy, nephropathy, neuropathy, macrovascular complications) and severity of those complications
- Modest association with all cause mortality
  - Stronger association with mortality resulting from cardiovascular disease


Screening Guidelines

- **USPSTF (1/26/16, JAMA)**
  - The USPSTF concludes with at least moderate certainty that there is a moderate net benefit to screening for depression in adults, including older adults, who receive care in clinical practices that have adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up after screening (grade B)

Comprehensive Primary Care Plus

- Encourages practices to integrate behavioral health into practice or have priority access for its patients
- Co management—share records, treatment plans
- System capability
  - Standard screening tool, preferably integrated into EHR
  - Registries to track care of patients with behavioral health conditions
  - Monitor and assess treatment response, behavioral health outcomes
  - Share records between behavioral health and primary care


*Screening Guidelines

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**SCREENING**

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### Tools
- PHQ 9
- Hospital Anxiety and Depression Scales
- Geriatric Depression Scale
- Postpartum
  - Use Edinburgh Postnatal Depression Scale (EPDS)
- Bipolar
  - Use Mood Disorder Questionnaire (MDQ)

### Symptoms in Primary Care
- >5/year medical visits
- Multiple unexplained symptoms
- Work/relationship dysfunction
- Dampened affect
- Poor behavioral follow through with treatment recommendations
- Weight gain or loss
- Sleep disturbance
- Fatigue
- Memory/cognitive complaints
- IBS
- “stress”
- POORLY CONTROLLED CHRONIC ILLNESS

### Special Population
- Adolescents
  - Poor school performance
  - Poor attendance
  - Somatic complaints (fatigue, headaches, abdominal pain)
- LGBTQ
  - Particularly high rates of depression
  - High rate of suicide
    - leading cause of death

### Selected Medications Associated with Depressive Symptoms
- Clonidine
- Contraceptives (progesterone)
- Beta blockers
- Interferons
- Isotretinoin
- Reserpine
- Corticosteroids
- Benzodiazepines, sedative hypnotics
- Barbituates
- Varenicline
- Topiramate
- Levetiracetam
- Tamoxifen

VA/DOD Guidelines 2016
Monitoring Guidelines

- Proactive Followup Contact
  - First followup within 30 days
  - Several visits in first 6 months of therapy
- Monitor and management tool (PHQ 9)
  - Full Remission is PHQ 9 <5
  - Response is defined as 50% reduction in symptoms
- Collaboration with mental health

Depression in Primary Care

Kelli Barnes, PharmD, BCACP
Assistant Professor of Clinical Pharmacy
The Ohio State University College of Pharmacy
The Ohio State University Wexner Medical Center

TREATMENT
### Acute Phase Treatment Modalities

<table>
<thead>
<tr>
<th>Modality</th>
<th>Severity of Illness</th>
<th>Pharmacotherapy</th>
<th>Depression-Focused Psychotherapy</th>
<th>Pharmacotherapy in Combination With Depression-Focused Psychotherapy</th>
<th>Electroconvulsive Therapy</th>
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</thead>
<tbody>
<tr>
<td>Mid to Moderate</td>
<td>Yes</td>
<td>Yes</td>
<td>May be useful for patients with psychosocial or interpersonal problems, intrapsychic conflict, or co-occurring Axis II disorder</td>
<td>Yes, for certain patients</td>
<td>Yes</td>
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<tr>
<td>Severe Without Psychotic Features</td>
<td>Yes, No</td>
<td>Yes</td>
<td>Yes, provide both antidepressant and antipsychotic medication</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Recommended Modalities for Acute Phase Treatment of Major Depressive Disorder

Source: APA Major Depressive Guidelines 2010

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### Psychotherapy and Alternative Treatment

**Psychotherapy**

- Cognitive behavioral therapy
- Interpersonal psychotherapy
- Psychodynamic therapy
- Problem-solving therapy
- Other types
- Little data on optimal duration and frequency
  - Most clinical trials consisted of 12-16 weekly sessions
- Integrative medicine

**Other treatment modalities**

- Physical Activity
- Integrative medicine (insufficient evidence to recommend)
  - Acupuncture while pregnant
  - Yoga
  - St Johns Wort, SAM-E (insufficient evidence, medication interactions)
  - Saffron (ongoing research)
  - Link between depression and deficiencies (magnesium, zinc, omega 3 fatty acids)
  - Cannabis (insufficient evidence)
  - Light therapy 10,000 lux for 30 minutes each am
### Pharmacotherapy for Depression

**Antidepressants in 2010 APA Guidelines**
- Selective serotonin reuptake inhibitors (SSRI)
- Selective norepinephrine reuptake inhibitors (SNRI)
- Tricyclic antidepressants (TCA)
- Bupropion
- Mirtazapine
- Trazodone/Nefazodone
- Monoamine oxidase inhibitors (MAO-I)

#### SSRI
- Citalopram
- Escitalopram
- Fluoxetine
- Fluvoxamine
- Paroxetine
- Sertraline

#### SNRI
- Duloxetine
- Desvenlafaxine
- Venlafaxine

#### TCA
- Amitriptyline
- Clomipramine
- Desimpramine
- Doxepin
- Imipramine
- Nortriptyline

#### Other Antidepressants
- Bupropion
- Mirtazapine
- Nefazodone
- Trazodone
- MAO-I
- Isoxcarboxazid
- Phenelzine
- Selegiline
- Tranylcypromine
- Moclombemide
### Antidepressant Adverse Effects

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<tr>
<th></th>
<th>SSRI</th>
<th>SNRI</th>
<th>TCA</th>
<th>MAOI</th>
<th>Buproprion</th>
<th>Mirtazapine</th>
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<tbody>
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<td>X</td>
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<tr>
<td>Weight Gain</td>
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<td></td>
<td>X</td>
<td></td>
<td>Paroxetine</td>
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<tr>
<td>Increased HR and BP</td>
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<td>X</td>
<td>With</td>
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<tr>
<td>Headache</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Seizures</td>
<td></td>
<td></td>
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![APA Major Depressive Guidelines 2010](image)

### New Antidepressants

**Vilazodone (Viibryd®)**

- Combined SSRI and 5-HT₁₃ partial agonist
  - Serotonin partial agonist-reuptake inhibitor (SPARI)
- Dosing: 20-40 mg once daily with food
- Adverse Effects
  - Most common ADE: diarrhea, nausea, headache
  - No impact on QTc interval, LFTs, or BP
- Contraindications/Precautions
  - Use with monoamine oxidase inhibitor
  - Seizure disorder?

Mc Cormack PL. Drugs. 2015; 75: 1915-23.

**Vilazodone (Viibryd®)**

- Four phase 3/4 placebo-controlled RCTs
  - 8-10 weeks in duration
  - Significant improvement in MADRS score
    - As soon as 1 week in 1 trial
- One open-label, non-comparative 52 week study

Vilazodone’s Potential Benefits

- Potential benefits of 5-HT_{1A} activation
  - Greater efficacy than traditional antidepressants
  - Not proven in clinical trials
- More rapid onset of action
  - Not proven in clinical trials
  - May be limited due to necessary dose titration
- Mitigation of sexual ADE
  - Sexual dysfunction high at baseline in trials
  - Sexual function improved with vilazodone and placebo
  - Unclear how vilazodone compares to other antidepressants

McCormack PL. Drugs. 2015; 75: 1919-23.

Vortioxetine (Trintellix™)

- SSRI/multimodal serotonin modulator
  - 5-HT_{1A}, 5-HT_{1B}, 5-HT_{3}, 5-HT_{7}, SERT
- Dosing 10 – 20 mg once daily
- Long half-life
  - Low risk for discontinuation symptoms – taper still recommended
- Adverse Effects
  - Nausea, vomiting, constipation
  - No significant change in vitals, weight, QTc, or labs
- Contraindications/Precautions
  - Use with monoamine oxidase inhibitor

Levomilnacipran SR (Fetzima®)

- Serotonin norepinephrine reuptake inhibitor
- More potent inhibition of NE vs. 5-HT
- Dosing: 40 – 120 mg daily

Adverse effects

- Nausea, vomiting, constipation
- Sexual dysfunction (dose-related)
- Cardiovascular effects
  - Mean +3.9 mmHg SBP, 3.1 mmHg DBP
  - Mean +7 bpm HR
- LFT elevations
- Contraindications/Precautions
  - Use with monoamine oxidase inhibitor
  - Seizures?
  - Chronic liver disease


Levomilnacipran SR (Fetzima®)

- Five RCTs, 8-10 weeks duration
  - Four trials – decrease in MADRS score vs. placebo
  - One trial – no statistically significant decrease in MADRS score
- One open-label trial, 48-week duration
  - Lower MADRS score at week 48 vs. week 0
  - No placebo comparison
- One continuation RCT, 24 week duration
  - Lower relapse rates vs. placebo (not statistically significant)


Choosing Pharmacotherapy

- Response in prior major depressive episodes
- Family history of response
- Anticipated side effects/comorbidities
  - Safety and tolerability
- Pharmacological properties
  - Half-life
  - Drug interactions
  - Disease state interactions
- Cost
- Patient preference
- Pharmacogenomics

APA Major Depressive Guidelines 2010
**STAR*D Trial**

**Level 1**
- Citalopram x 12-14 weeks (mean dose > 40 mg/day)
- Remission rate: 27-33%

**Level 2**
- Switch to sertraline, bupropion SR, venlafaxine XR, or CBT
- Remission rate: 20-25% (medications), 31% (CBT)
- Add on bupropion SR, buspirone, or CBT
- Remission rate: 30-39% (medications), 31% (CBT)

**Level 3**
- Switch to mirtazapine, nortriptyline
- Remission rate: 9-20%
- Add on lithium or triiodothyronine
- Remission rate: 16-25%

**Level 4**
- Start monoamine oxidase inhibitor
- Remission rate: 7-14%
- Start venlafaxine + mirtazapine
- Remission rate: 14-16%


**STAR*D Take Home Points**

- Rate of remission after 2 medication trials decreases substantially
- Cumulative remission rate after 4 levels of treatment ~ 67%
- No clear 2nd line treatment choice
- Augmentation and switching therapy appropriate

**Partial or Nonresponse to Pharmacotherapy**

- ENSURE ADEQUATE TREATMENT DURATION
  - 4-8 weeks duration
- Confirm correct diagnosis
- Determine presence of clinical barriers
  - Medical conditions, drug interactions, substance abuse
- Confirm adherence to medication
  - Including treatment emergent side effects

APA Major Depressive Guidelines 2010

**Partial or Nonresponse to Pharmacotherapy**

- Change to different antidepressant
- Increase dose of antidepressant
- Augment with psychotherapy
- Augment with antidepressant
  - SSRI/SNRI + bupropion
  - SSRI/SNRI + mirtazapine
- Augment with non-antidepressant medication

APA Major Depressive Guidelines 2010
Pharmacogenomics and Antidepressant Use

- CYP2D6 involved in metabolism of 25% of medications
- CYP2C19 also involved in metabolism of some antidepressants
- Functional variations in gene coding
  - Poor metabolizer
  - Intermediate metabolizer
  - Extensive metabolizer (60-85% of Caucasians)
  - Ultra-rapid metabolizer
- Limited data on impact of genetic testing on patient outcomes and cost of care
- Some third party payers are covering cost of testing
- Combinatorial pharmacogenomics decision support available


Duration of Pharmacotherapy

- Continuation phase: 4-9 months
- Maintenance phase: > 1 year
  - ≥3 major depressive episodes
  - Residual symptoms
  - Ongoing psychosocial stressors
  - Early age at onset
  - Family history of mood disorders
  - Other considerations
    - Patient preference
    - Presence of side effects
    - Probability of recurrence
    - Frequency and severity of prior episodes
      - Suicide/psychosis

APA Major Depressive Guidelines 2010

Summary

- Antidepressant therapy is a recommended first line treatment in depression
- Antidepressants typically considered equally effective
- In partial/non-response situations switching to another agent or augmenting treatment is recommended
- Pharmacogenetic testing available to guide drug therapy decisions
- Antidepressant discontinuation is based on risk for relapse; medications should typically be tapered

Depression in Primary Care

Nazhat Taj-Schaal, MD, FAAP, FACP
Assistant Professor of Internal Medicine
Division of General Internal Medicine
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Potential Changes in Practice

- Screen for depression in chronic illness
- Measure severity with standardized tool
- Followup frequently and escalate therapy if not working (use standardized tool to measure)
- Integration of Behavioral health providers into the primary care office (CPC+)
- Cognitive Behavioral Therapy

References
