Identification and Management of Clinical Depression in Adults 18 years or Older
Clinical Practice Guideline
MedStar Health

“These guidelines are provided to assist physicians and other clinicians in making decisions regarding the care of their patients. They are not a substitute for individual judgment brought to each clinical situation by the patient’s primary care provider-in collaboration with the patient. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but should be used with the clear understanding that continued research may result in new knowledge and recommendations.”

General Principles: The purpose of this guideline is to assist the primary care practitioner in detecting, diagnosing, and adequately treating clinical depression in patients 18 years of age and older. Depression is extremely common in primary care medicine. It is thought to be more prevalent than hypertension (6-17% compared to 5.8%). The WHO considers depression to be a major cause of disability worldwide.

Nearly three quarters of depressed patients will at some point present to their primary care practitioner, often with somatic complaints, but only 50% of these cases are diagnosed. Primary Care Providers should be skilled at evaluating and diagnosing this common disorder.

Clinical depression is a highly treatable illness. A fair to full response to therapy can be expected in 66% to 80% of patients with major depression. Unfortunately, of those diagnosed, only 10% get adequate treatment.

The “costs” of depression extend beyond absenteeism, loss of productivity and include unnecessary suffering for patients and their families, and suicide.

Disease Definition: Clinical depression encompasses four DSM-V diagnoses of unipolar affective disorders - Major Depression, Persistent Depressive Disorder (Dysthymia), Premenstrual Dysphoric Disorder, and Other Depressive Disorders.

A. Major Depression: A major depressive episode can be characterized by a period of at least 2 weeks in which five or more of the following symptoms have been present and represent a change from prior functioning. At least one of the symptoms must be either depressed mood or loss of interest or pleasure in nearly all activities (anhedonia).

• Depressed mood most of the day, nearly every day, as self-reported or observed by others
• Diminished interest or pleasure in all or almost all activities most of the day, nearly every day
• Significant weight loss when not dieting, weight gain, or decrease or increase in appetite nearly every day
• Insomnia or hypersomnia nearly every day
• Psychomotor agitation or retardation nearly every day
• Fatigue or loss of energy nearly every day
• Feelings of worthlessness or excessive or inappropriate guilt nearly every day
• Diminished ability to think or concentrate nearly every day
• Recurrent thoughts of death, recurrent suicidal ideation without a specific plan
Depression can be characterized as mild (few symptoms, minor functional impairment), moderate, or severe (many more symptoms than required for diagnosis with significant functional impairment).

Seasonal affective disorder is a subtype of major depression with seasonal onset and remission

B. **Persistent Depressive Disorder:** Depressed mood for most of the day, for more days than not for at least two consecutive years without a period of greater than two months of absence of symptoms. In addition, at least two of the following must be present:
   - Poor appetite or overeating
   - Insomnia or hypersomnia
   - Low energy or fatigue
   - Low self-esteem
   - Poor concentration or difficulty making decisions
   - Feelings of hopelessness

C. **Premenstrual Dysphoric Disorder**—Mood disorder present in most menstrual cycles in the prior year associated with significant distress and impairment of functioning. Symptoms must be present during the week prior to menses and resolve within a few days of onset of the menstrual period.

One or more of the following must be present:
   - Mood swings, sudden sadness, increased sensitivity to rejection
   - Anger or irritability
   - Hopelessness, depressed mood, self-critical thought
   - Tension, anxiety, feeling on edge

One or more of the following symptoms must also be present (to total five when combined with symptoms above)
   - Difficulty concentrating
   - Change in appetite, overeating, food craving
   - Diminished interest in usual activities
   - Low energy, fatigue
   - Feeling overwhelmed or out of control
   - Insomnia or hypersomnia
   - Breast tenderness, weight gain, bloating, joint or muscle aches

**Other Depressive Disorders:** This category encompasses depressive disorders related to substance abuse, medication side effects, medical conditions or other specified or unspecified reasons.

**Disease Detection and Screening:**

A. **Screening:** The U.S. Preventive Services Task Force (USPSTF) recommends screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and followup. Detection of depression can be enhanced by the use of a screening tool such as a questionnaire that identifies patients who are at risk of depression. The Patient Health Questionnaire- 2 and 9 (PHQ- 2, PHQ-9) are two item and nine item tools, respectively, for assisting primary care clinicians in diagnosing depression as well as selecting and monitoring treatment. Screening tools for special populations (Edinburgh Postnatal Depression Scale for pregnant and postpartum patients and Geriatric Depression Scale for elderly patients) also exist but are not clearly preferable to the PHQ-9. In general, sensitivity of the various screening tools is 80-90% and specificity is 70-85%. Patients who screen positive should be further evaluated to confirm the diagnosis, evaluate for other causes, and assess the presence of co-existing psychiatric illness. (Tools attached end of guideline)
B. High Risk Groups:
1. The primary risk factors for depression are the following:
   - Prior episodes of depression
   - Prior suicide attempts
   - Family history of depression
   - Female gender
   - Age of onset under 40
   - Postpartum period
   - Medical co-morbidity
   - Lack of social support
   - Stressful life events
   - Current alcohol or substance abuse

2. Patients with the following chronic medical illnesses are at significantly higher risk for chronic depression. It has been shown that undetected depression in these groups can worsen the course of their medical illness.
   
   a) **Stroke** - Subgroups of post-CVA patients have depression that appears to be causally related to the injury, especially if the insult is located in the left basal ganglia or left dorsal lateral frontal cortex.
   
   b) **Dementia** - Depression is often seen in patients with or antecedent to primary dementia. Thirty to forty percent of Alzheimer’s disease patients demonstrate depressive mood symptoms sometime during their illness.
   
   c) **Diabetes** - Major depressive syndrome is three times more common in this population.
   
   d) **Coronary Artery Disease** - The prevalence of various forms of depression is estimated at 40 - 65%.
   
   e) **Cancer** - Major depression occurs in approximately 25% of this population
   
   f) **Fibromyalgia**
   
   g) **HIV/AIDS**

C. Differential Diagnosis:
1. Psychiatric: Differentiation from other psychiatric and substance use disorders can be difficult. Consider:
   - Bipolar disorder – if there have been features of mania/hypomania. Note that SSRI’s may trigger manic episodes in patients with bipolar disorder.
   - Alcohol dependence/drug dependence – organic depression often accompanies substance abuse and resolves in 4-8 week of abstinence
   - Personality disorders

2. Bereavement: Distinguishing normal grief from depression can be challenging, since the response to death of a loved one varies between individuals and has a significant cultural overlay. Features favoring grief rather than major depression include the following:
   - Waves or pangs of grief or sadness rather than pervasive depressed mood
   - Preservation of self-esteem
   - Hope that the future will be better rather than a sense of hopelessness

3. Medical: A variety of medical conditions and medications can cause a depressive-like syndrome. These causes should be treated first. If the syndrome persists, a diagnosis of clinical depression can be made and treated accordingly. Medical conditions may include: hypothyroidism, Addison’s disease, vitamin B12 deficiency, parathyroid conditions, brain tumors, cocaine withdrawal, amphetamine withdrawal, etc.

D. Assessing the Patient for Suicide Potential
   **All** depressed patients should have an initial evaluation for suicide potential. Risk factors for suicide include:
   - male sex
   - family history of suicide
   - psychotic symptoms
   - hopelessness
   - general medical illnesses
• living alone with little social support
• prior suicide attempts.
• Borderline personality disorder

*Questions about plans and means should be asked.* If the evaluation reveals any degree of suicidal risk, an immediate call should be made for a psychiatric assessment.
**MEDICATIONS REPORTEDLY ASSOCIATED WITH DEPRESSION**

<table>
<thead>
<tr>
<th>Cardiovascular Drugs</th>
<th>Hormones</th>
<th>CNS Active Agents</th>
<th>Anti-cancer Agents</th>
<th>Anti-inflammatory Anti-Infectives</th>
<th>GI Drugs</th>
<th>Other Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alpha-methyldopa</td>
<td>Oral Contraceptives</td>
<td>Benzodiazepines</td>
<td>Cycloserine</td>
<td>NSAIDS</td>
<td>Ranitidine</td>
<td>Alpha &amp; Beta Interferons</td>
</tr>
<tr>
<td>Reserpine</td>
<td>Glucocorticoids</td>
<td>Neuroleptics</td>
<td>Tamoxifen</td>
<td>Ethambutol</td>
<td>Cimetidine</td>
<td>Metoclopramide</td>
</tr>
<tr>
<td>Guanethidine</td>
<td>Anabolic steroids</td>
<td>L-Dopa</td>
<td>GnRH agonists</td>
<td>Disulfiram</td>
<td>Metoclopramide</td>
<td>Varenicline</td>
</tr>
<tr>
<td>Clonidine</td>
<td></td>
<td>Baclofen</td>
<td></td>
<td>Sulfonamides</td>
<td></td>
<td>Isotretinoin</td>
</tr>
<tr>
<td>Thiazides</td>
<td>Triptans</td>
<td></td>
<td></td>
<td>INH</td>
<td></td>
<td>Efavirenz</td>
</tr>
<tr>
<td>Digitalis</td>
<td>Arpiprazole</td>
<td></td>
<td></td>
<td>Dapsone</td>
<td></td>
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<tr>
<td>Beta blockers</td>
<td>Quetiapine</td>
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</tbody>
</table>

**Clinical Management:**

**A. Goals**
1. Reduce, if not remove, all signs and symptoms of the disease.
2. Restore occupational and psychosocial functioning
3. Reduce the likelihood of relapse and recurrence.

**B. Types of Treatment:**
1. Medication - Patients with moderate to severe clinical depression are appropriate candidates to be treated with medication, whether or not formal psychotherapy is also used.
2. Psychotherapy - Patients with mild to moderate clinical depression (usually dysthymia or depressive disorder NOS) may be managed with psychotherapy alone, if the patient prefers. If symptoms do not improve within 2-3 months, then medication should be strongly considered.
3. Medication and psychotherapy - This may be advantageous for complicated, chronic depressions and for patients with only a partial response to either treatment alone.
4. Electroconvulsive therapy (ECT) - This is only for certain patients after psychiatric consultation.

**C. Medication Selection and Management (see table, page 5)**
1. **Selective Serotonin Re-uptake Inhibitors (SSRI)** should be the first choice unless the patient has a history or risk of intolerable side effects, is taking other medications that put them at risk for drug interaction, or has a personal or family history of a positive response to another class of anti-depressants.
2. **Advantages to using SSRI’s** include: ease of dosing, lack of histaminic, muscarinic and adrenergic antagonism, the potential for co-treating other psychiatric conditions (e.g. panic disorder, ADHD, bulimia, obsessive-compulsive disorder, alcoholism, self-injurious behaviors and premenstrual syndrome), and effectiveness for treating concurrent medical conditions (e.g. headaches, chronic pain, Raynaud’s and some sexual disorders). Limitations of all SSRI’s can include agitation, akathisia, nausea, diarrhea, Serotonin syndrome, Parkinson like tremor and possible sexual side effects.
3. Early signs of positive clinical response can occasionally be seen as early as one week into therapy but usually 4-6 weeks is required. Adequate treatment for 6-8 weeks is necessary before concluding a patient is not responding to a particular medication. If side effects are tolerable, then titration of the dosage upward is a first adjustment strategy to consider. Occasionally, titration of the dosage downward is a first adjustment strategy if it is concluded that the depressive symptoms are responding but side effects are interfering. If a patient is deemed unresponsive to a particular SSRI or has intolerable side effects, then a trial of a different SSRI yields positive results for about 50% of the patients. Switching from an SSRI to a tricyclic antidepressant in this situation has a 62% response rate. Thus, the data suggest that either a switch within the class or a switch to a new class is an acceptable strategy.

4. Additional medication options include combining anti-depressants or adding augmentation medications. Combining anti-depressants and adding augmentation medications is best managed by a psychiatrist.

D. **Expectations of Treatment:** Active treatment should yield a response. As noted above, a response may be evident in as little as a week or treatment may need to be continued for as long as 8 weeks before it is deemed a failure and an alternate strategy adopted. Remission, or full response to treatment, may take longer. Response and remission are not the same. No matter what the treatment modality that induced the response, it should be continued to keep the patient in remission, i.e., prevent relapse. Only after the patient has been in full remission for 4-6 months should an attempt to taper the dosage of medication be entertained. Relapse is common and close follow-up will be needed. Approximately 50% of patients will go on to have a relapse. Given a second episode of depression, the relapse rate is 70%, with a 3rd episode, it is >80% and after a 4th episode, it is >90%. For patients with a history of recurrent disease, prolonged, or even lifelong therapy, may be needed. And even long term medication is not fool proof; relapses have been reported.

If the decision is made to try to discontinue the selected medication, it should be tapered to prevent withdrawal symptoms. Patients, and their families, should be warned about early signs of recurrence of the depression.

Patients should be seen 2-4 weeks after starting therapy to assess medication tolerability, suicide risk and early response. There should be 3 contacts within the first 12 weeks. Patients on stable, long-term medication should be seen in the office every 3-6 months for re-evaluation of the treatment plan and efficacy.

E. **Continuation of Treatment:** If this is a first episode of clinical depression in a patient with a good premorbid mood history and without a significant family history of depression, then effective medication should be continued at least for 6-12 months before considering discontinuation. Some patients are candidates for indefinite medication maintenance. These patients should be re-evaluated every 3-6 months. If medicines are tapered or discontinued, patients should be warned about early signs of recurrence.

F. **Psychiatric Referral:** Referral for mental health consultation, treatment and/or psychotherapy can occur at any time at the PCP’s discretion and/or the patient’s choice.

Immediate referral is recommended for:
- significant evidence of danger to self and/or others
- presence of psychotic symptoms

Referral is strongly recommended for:
- depression with co-morbid psychiatric or substance abuse disorders
- suspicion of bipolar disorder
- treatment-resistant depression
- childhood depression
depression during pregnancy and the postpartum
depression with dementia
Patient Education:

A. Clinician counseling:
   1. Natural history of the disease: Depression isn’t just a brief blue mood or a passing sadness that lifts in a few hours or even a few days. Clinical Depression occurs when a person experiences physiological symptoms such as changes in sleep, appetite, sexual function, feeling of sadness and difficulty in the ability to function normally. These symptoms last for several weeks or more.
   2. Treatment Plan:
      • Medication - Patients with moderate to severe clinical depression are appropriate candidates for medication. Compliance with antidepressants can be a problem. Discuss with patients that usually 4-6 weeks of medication is required for a full response. Explain and discuss common side effects of medications such as sexual dysfunction, restlessness, anticholinergic effects, orthostatic hypotension, and GI symptoms. Medication guides regarding the risk of suicidal thoughts and actions with antidepressants will be provided by the pharmacy when medications are dispensed.
      • Psychotherapy - Can be successful for patients with mild to moderated clinical depression. If symptoms do not significantly improve within 2-3 months then medication should be considered.
      • Medication and Psychotherapy - This combination can be beneficial for complicated, chronic depression or with individuals who have experienced only partial response to either treatment alone.
   3. Self help strategies:
      • Identify activities that make you feel better and try to focus on them. Do things for yourself. Take up hobbies. Listen to music. Participate in activities even when you may not want to.
      • Do not withdraw from others. Join a support group and talk to your friends. Call on your support group or therapist for help when you need it. Ask for assistance at home and work if the load is too great to handle.
      • Eat nutritious, well-balance meals. Avoid drinking alcohol and coffee.
      • Exercise on a regular basis, several times a week
      • Get adequate rest and keep your sleep cycle as regular as possible.
      • Concentrate on good grooming and cleanliness.
      • Perform progressive relaxation exercises daily and diaphragmatic breathing exercises during times of high stress.
      • Perform frequent mental imaging of good life experiences. Develop and maintain an attitude that things will work out.
      • Learn new, positive problem-solving techniques.
      • Call your provider or therapist if you feel suicidal.

B. Resources:
   • National Institute Mental Health: 866-615-6464 or http://www.nimh.nih.gov/health/publications/index.shtml
   • Center for Disease Control: http://www.cdc.gov/features/Depression/index.html
   • Suicide Prevention Hotline: 1-800-273-TALK or 1-800-273-8255
   • American Psychiatric Association: http://www.psychiatry.org/mental-health
   • Mental Health America: http://www.nmha.org/mental-health-information
Selected Formulary for Medical Management of Depression

I. Selective Serotonin Reuptake Inhibitors (SSRI’s)

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Initial Dose *</th>
<th>Dosing Range *</th>
<th>Positives</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>citalopram</td>
<td>20mg daily</td>
<td>20-40mg daily</td>
<td>• Minimal drug interactions compared with other SSRIs</td>
<td>Do not use doses &gt;40 mg due to risk of QT prolongation</td>
</tr>
<tr>
<td>Celexa®</td>
<td></td>
<td>max dose 20</td>
<td>• Generic available</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>mg for age &gt;60</td>
<td>• Lower incidence of sexual dysfunction</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Escitalopran</td>
<td>10mg daily</td>
<td>10-20mg daily</td>
<td>• Minimal drug interactions compared with other SSRIs</td>
<td></td>
</tr>
<tr>
<td>Lexapro®</td>
<td></td>
<td></td>
<td>• Possible quicker onset in resolving panic-related symptoms</td>
<td></td>
</tr>
<tr>
<td>fluoxetine</td>
<td>10-20mg daily</td>
<td>20-80mg daily</td>
<td>• Energizing feeling</td>
<td></td>
</tr>
<tr>
<td>Prozac®</td>
<td>(Elderly dose</td>
<td></td>
<td>• Lower cost of care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10mg/day)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>paroxetine</td>
<td>10-20mg daily</td>
<td>20-50mg daily</td>
<td>• Better for agitation</td>
<td>• More problems with withdrawal</td>
</tr>
<tr>
<td>Paxil®</td>
<td>(Elderly dose</td>
<td>Maximum dose 40</td>
<td>• Usually has better pricing</td>
<td>• More anticholinergic side effects</td>
</tr>
<tr>
<td></td>
<td>10mg/day)</td>
<td>mg in the elderly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>paroxetine</td>
<td>25 mg daily</td>
<td>25-62.5 mg daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paxil® CR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>sertraline</td>
<td>25-50mg daily</td>
<td>25-200mg daily</td>
<td>More helpful in Parkinson’s patients</td>
<td>Usually needs higher doses to be effective</td>
</tr>
<tr>
<td>Zoloft®</td>
<td></td>
<td></td>
<td></td>
<td>• More titration</td>
</tr>
<tr>
<td>Vilazodone</td>
<td>10 mg daily</td>
<td>40 mg daily target dose</td>
<td>May have low sexual side effects</td>
<td></td>
</tr>
<tr>
<td>Viibryd</td>
<td></td>
<td></td>
<td>• May lead to less weight gain</td>
<td></td>
</tr>
<tr>
<td>vortioxetine</td>
<td>10 mg daily</td>
<td>20 mg daily</td>
<td>May be alternative to partial or non-responders to SSRIs due to multimodal mechanism</td>
<td></td>
</tr>
<tr>
<td>(Brintellix)</td>
<td></td>
<td></td>
<td>minimal effect on weight and sexual</td>
<td></td>
</tr>
</tbody>
</table>

Potential side effects of all SSRI’s include: agitation, nausea, diarrhea, sexual side effects, akathisia and serotonin syndrome (hyperthermia, rigidity, myoclonus, autonomic instability, and potentially delerium and coma).
II. Norepinephrine Dopamine Reuptake Inhibitors (NDRI’s)

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Initial Dose*</th>
<th>Dosing Range *</th>
<th>Positives</th>
<th>Limitations</th>
</tr>
</thead>
</table>
| bupropion       | 100mg bid     | 200-450mg daily Max dose=150mg tid | • Low sexual side effects  
• May help with nicotine addiction  
• Increases total REM time  
• Effective in many SSRI non-responders | • Seizures 0.4% (dose dependent, more common with immed. release)  
• GI upset  
• Tinnitus  
• Agitation  
• Tremor |
| Wellbutrin®     | 150mg qam     | Max 400mg in divided doses |  |                                                                            |
| Wellbutrin SR®  |               | Maximum         |  |                                                                            |
| Wellbutrin XL®  | 150 mg qam    |                |  |                                                                            |

III. Serotonin Norepinephrine Reuptake Inhibitors (SNRI’s)

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Initial Dose*</th>
<th>Dosing Range *</th>
<th>Positives</th>
<th>Limitations</th>
</tr>
</thead>
</table>
| duloxetine      | 20mg bid      | 20-30mg bid or 60mg once daily | • Benefit in neuropathic pain and depression | • Possible urinary retention and hepatotoxicity  
• Possible elevation in BP  
• Use not recommended in patients with renal insufficiency (creatinine clearance<30) or end stage renal disease  
• Use not recommended in patients with hepatic disease given potential for contributing to hepatic failure |
| Cymbalta®       |               | Max 60mg/day   |  |                                                                            |

| venlafaxine     | 75mg daily in divided doses  
Effexor®         | 150-375mg daily (w/food)  
Effexor XR®      | 225mg daily (w/food)  
 | • Possible greater efficacy  
• Low side effects  
• Possible greater efficacy w/chronic pain | • BP elevation  
• Weight gain  
• Frequent dosing  
• Sexual side effects |
| desvenlafaxine  | 50 mg daily  | 50 mg daily    | • Once daily administration | • Doses of 50-400 mg daily have been studied; no additional benefit has been observed at doses > 50 mg  
• Possible BP elevation  
• Nausea/dizziness  
• Similar side effect profile to venlafaxine |
| Pristiq®       |               |                |  |                                                                            |
Levomilnacipran  
Fetzima®  

<table>
<thead>
<tr>
<th>Levomilnacipran</th>
<th>Fetzima®</th>
<th>20 mg daily x 2 day then 40 mg daily</th>
<th>120 mg daily</th>
<th>May be more beneficial for tx of sx related to norepinephrine deficiency (decreased concentration, mental and physical slowing, decreased self care)</th>
</tr>
</thead>
</table>

Potential side effects of all SNRI’s include; agitation, nausea, diarrhea, sexual side effects, akathisia and serotonin syndrome (hyperthermia, rigidity, myoclonus, autonomic instability, and potentially delirium and coma).

IV. Serotonin Antagonist and Reuptake Inhibitors

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Initial Dose</th>
<th>Dosing Range</th>
<th>Positives</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>trazodone</td>
<td>Desyrel®</td>
<td>50mg tid (Depression) 25-50mg hs (Insomnia) 150-400mg daily in divided doses (w/food) Insomnia: 50-100mg hs (some may require antidepressant)</td>
<td>Sedative properties</td>
<td>Over-sedation and/or possible orthostasis Priapism</td>
</tr>
<tr>
<td>nefazodone</td>
<td>Serzone®</td>
<td>100mg bid 150mg bid Max 600mg/day</td>
<td>Unlikely to cause sexual dysfunction Beneficial in patients with anxiety Improves sleep Less priapism Less orthostatic hypotension</td>
<td>Many drug interactions (Xanax, Halcion, digoxin) Mania Early intolerance</td>
</tr>
</tbody>
</table>

V. Tetracyclic Antidepressants

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Initial Dose*</th>
<th>Dosing Range*</th>
<th>Positives</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>mirtazapine</td>
<td>Remeron®</td>
<td>15mg daily hs 15-45mg hs</td>
<td>Appetite stimulation Sedative properties Minimal GI side effects</td>
<td>Oversedation Weight gain Metabolic disorders</td>
</tr>
</tbody>
</table>
# VI. Tricyclic Antidepressants (TCA’s)

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Initial Dose*</th>
<th>Dosing Range *</th>
<th>Positives</th>
<th>Limitations</th>
</tr>
</thead>
</table>
| amitriptyline Elavil® | 25-75mg hs (Elderly dose 10mg/d) | 75-300mg daily | • Sedative properties  
• Efficacy in neuropathic pain  
• Well known therapeutic and toxic levels | • Weight gain  
• Cardiac arrhythmia  
• Orthostatic hypotension  
• Anticholinergic  
• Not recommended for elderly |
| nortriptyline Pamelor® | 25-50mg hs | 150 mg/day or divided doses | • Well known therapeutic and toxic levels  
• Less anticholinergic | • Cardiac arrhythmias |
| amoxapine Asendin® | 50-150mg daily | 100-400mg daily | • Potential benefit in depression with psychosis | • EPS or tardive dyskinesia (avoid in Parkinson’s)  
• Sedation  
• Orthostasis |
| desipramine Norpramin® | 25-50mg daily | 100-150mg daily | • Sedative properties | • Weight gain  
• Cardiac complications |
| doxepin Sinequan® | 25-50mg daily | 75-150mg daily | • Sedative properties  
• Patients with neurodermatitis | • Oversedation  
• Weight gain  
• Cardiac complications |
| imipramine Tofranil®, Tofranil PM | 25mg hs  
Once daily or in divided doses | 50-150mg | • Minimal drug interactions  
• Patients with insomnia  
• Patients with | • Contraindicated in post MI patients  
• Dose 30-100mg/day recommended in elderly and peds |
| protriptyline Vivactil® | 15mg tid | 15-40mg tid-qid | • Good for withdrawn or anergic patients | • Multiple daily dosing  
• Cardiac complications  
• Weight gain |
| trimipramine Surmontil® | 25mg hs | 50-150mg daily | • Patients with insomnia or anxiety | • Weight gain  
• Sedation |

# VII. Monoamine Oxidase Inhibitors (MAOIs)

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Initial Dose *</th>
<th>Dosing Range *</th>
<th>Positives</th>
<th>Limitations</th>
</tr>
</thead>
</table>
| isocarboxazid Marplan® | 10mg bid | 40-60mg/day divided bid-qid | • Patients with resistant or atypical depression or anxiety | • Dietary restrictions  
• Drug interactions  
• Hypertensive crisis  
• Avoid in patients with HTN or cardiac conditions |
| phenelzine Nardil® | 45mg/day divided tid | 60-90mg daily divided tid | • As above | • As above |
selegiline transdermal patch  
Emsam®  
6mg/24 hours  
6-12mg/24 hours  
- As above  
- Less weight gain  
- Less sexual dysfunction  
- Caution in Parkinson’s  
- As above

tranylcypromine  
Parnate®  
30mg daily in divided doses  
30-60 mg/day in divided doses  
- As above  
- As above

References

9. DeJesus, Ramona S. et al. A System-Based Approach to Depression Management in Primary Care Using the Patient Health Questionnaire-9

Identification and Management of Clinical Depression in Adults 18 years or Older
Clinical Practice Guideline initiated 1997.
Clinical Guidelines are reviewed every two years by a committee of experts in the field. Updates to guidelines occur more frequently as needed when new scientific evidence or national standards are published.
Clinical Depression Algorithm

Diagnosis of Clinical Depression is made

Referral to Mental Health Services (LCSW, Clinical Psychologist, or Psychiatrist) at anytime patient requests or has symptoms

Primary Care Physician initiates treatment with an antidepressant, psychotherapy or both

Re-evaluate periodically during first 6-8 weeks for side effects, positive response and dosage adjustments

If partial or complete remission

Continue treatment at same or adjusted dosage and re-evaluate periodically for side effects and continued positive response

If unsatisfactory or no response

Refer to Mental Health Services or switch antidepressants and repeat prior step

If candidate for medication discontinuation at 6-12 months, D/C medication gradually and advise patient and family of early signs of recurrence

If candidate for indefinite antidepressant maintenance, continue antidepressant and re-evaluate every 3-6 months
Geriatric Depression Scale

Circle your answer of YES or NO for each of the following items, do not skip any items.

1. Are you basically satisfied with your life
   YES  NO
2. Have you dropped many of your activities and interests?
   YES  NO
3. Do you feel that your life is empty?
   YES  NO
4. Do you often get bored?
   YES  NO
5. Are you in good spirits most of the time?
   YES  NO
6. Are you afraid that something bad is going to happen to you?
   YES  NO
7. Do you feel happy most of the time?
   YES  NO
8. Do you often get restless and fidgety?
   YES  NO
9. Do you prefer to stay at home, rather than going out and doing new things?
   YES  NO
10. Do you feel you have more problems with memory than most?
    YES  NO
11. Do you think it is wonderful to be alive now?
    YES  NO
12. Do you feel pretty worthless the way you are now?
    YES  NO
13. Do you feel full of energy?
    YES  NO
14. Do you feel that your situation is hopeless?
    YES  NO
15. Do you think that most people are better off then you are?
    YES  NO

Cut point for positive response: ≥ 6
Time to administer: 2-5 minutes
Can be used to monitor treatment response
Patient Health Questionnaire--2  
Name_________________________________________ DOB__________________________  
Date Completed______________________________  

Over the past two weeks, how often have you been bothered by any of the following problems?  

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little interest or pleasure in doing things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling down, depressed, or hopeless.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Total point score: ________________  

These questions, which can be used by practitioners as part of a general medical review of systems, can help identify which patients are exhibiting signs and symptoms of depression, and which of them may benefit from completing the PHQ-9.  

Score interpretation: Cut point for positive response ≥ 3  

<table>
<thead>
<tr>
<th>PHQ-2 score</th>
<th>Probability of major depressive disorder (%)</th>
<th>Probability of any depressive disorder (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>15.4</td>
<td>36.9</td>
</tr>
<tr>
<td>2</td>
<td>21.1</td>
<td>48.3</td>
</tr>
<tr>
<td>3</td>
<td>38.4</td>
<td>75.0</td>
</tr>
<tr>
<td>4</td>
<td>45.5</td>
<td>81.2</td>
</tr>
<tr>
<td>5</td>
<td>56.4</td>
<td>84.6</td>
</tr>
<tr>
<td>6</td>
<td>78.6</td>
<td>92.9</td>
</tr>
</tbody>
</table>

**Patient Health Questionnaire--9**

Patient's name: ___________________________ Date: _______________________

Over the past two weeks, how often have you been bothered by any of the following problems? (For each question, circle the number that represents the best answer.)

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than one half of the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling asleep or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself— or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Add Columns**

**SUM OF ALL COLUMNS=**

10. If you have had any of these problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people? (circle the best answer)

<table>
<thead>
<tr>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
</table>

Patient Health Questionnaire-9 (PHQ-9). The PHQ was developed by Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at
Scoring PHQ-9: Confirmation of Depression and Patient Monitoring

A. Scoring instructions: The total PHQ-9 score is the sum of the scores for the responses to questions 1 through 9.

B. If there are at least 4 checks in the gray highlighted section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

   Interpretation of Total Score
   Total Score Depression Severity
   1-4 Minimal depression
   5-9 Mild depression
   10-14 Moderate depression
   15-19 Moderately severe depression
   20-27 Severe depression

C. Consider Major Depressive Disorder
   If there are at least 5 checks in the gray highlighted section (one of which corresponds to Question #1 or #2)

D. Consider Other Depressive Disorder
   If there are 2 to 4 checks in the gray highlighted section (one of which corresponds to Question #1 or #2)

   Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

E. To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

<table>
<thead>
<tr>
<th>Initial response after Four weeks of an Adequate Dose of an Antidepressant</th>
<th>Treatment Response</th>
<th>Treatment Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drop of 5 points from baseline</td>
<td>Adequate</td>
<td>No change, follow up 4 wks</td>
</tr>
<tr>
<td>Drop of 2-4 points from baseline</td>
<td>Possibly Inadequate</td>
<td>May warrant an increase in antidepressant dose</td>
</tr>
<tr>
<td>Drop of 1 point or no change or increase</td>
<td>Inadequate</td>
<td>Increase dose; augmentation; switch medicine; psych consultation; add counseling</td>
</tr>
</tbody>
</table>
### Initial response after Six weeks of Psychological Counseling

<table>
<thead>
<tr>
<th>PHQ 9</th>
<th>Treatment Response</th>
<th>Treatment Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drop of 5 points from baseline</td>
<td>Adequate</td>
<td>No change, follow up 4 wks</td>
</tr>
<tr>
<td>Drop of 2-4 points from baseline</td>
<td>Possibly Inadequate</td>
<td>Probably no treatment change needed. Share results with psychotherapist</td>
</tr>
<tr>
<td>Drop of 1 point or no change or increase</td>
<td>Inadequate</td>
<td>If depression-specific psychological counseling (Cognitive –Behavioral Therapy, etc) discuss with therapist and consider adding antidepressant For patient satisfied with other type of counseling, consider starting antidepressant For patients dissatisfied in other psychological counseling, review treatment options and preferences</td>
</tr>
</tbody>
</table>

Adapted from MacArthur Depression Toolkit  [www.depression-primarycare.org](http://www.depression-primarycare.org)

**Initial Approval Date and Reviews:**
April 2013

**Most Recent Revision and Approval Date:**
4/2015

**Next Scheduled Review Date:**
4/2017

**Condition:**  Depression Adult