Clinical Practice Guideline for Depression Management & Antidepressant Treatment

This guideline is designed to assist practitioners by providing an analytical framework for the evaluation and treatment of patients, and is not intended to replace a practitioner’s judgment.

Depression is a common health problem seen frequently in primary care and psychiatric settings. Between five and nine percent of adult patients in primary care suffer from this illness. Depression is more common in young adults and adolescents, persons with a family history or personal history of depression, those with chronic illnesses (especially those with diabetes, cardiovascular disease or chronic pain), those who perceive or have experienced a recent loss, and those with sleep disorders or multiple unexplained somatic complaints. Screening of patients should occur with yearly preventive medicine visits, or as office visits and history indicate.

Many patients with established physical diseases become depressed during the course of their illness, and recognition of depression for this population is important and can lead to improved outcomes.

**Major Depression Screening Tool**
Diagnosis of major depression should include a total of five or more symptoms for at least two weeks. One of the symptoms must be a depressed mood or loss of interest.

1. Depressed mood
2. Markedly diminished interest or pleasure in all or almost all activities
3. Significant (>5% body weight) weight loss or gain, or decrease or increase in appetite
4. Insomnia or hypersomnia
5. Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Feeling of worthlessness or inappropriate guilt
8. Diminished concentration or indecisiveness
9. Recurrent thoughts of death or suicide
10. Presence of psychotic symptoms (hallucinations, delusions or agitation)

Patients with some depressive symptoms who do not fully meet the criteria for major depression often respond positively to antidepressant medication. When antidepressant therapy is prescribed, medication adherence and completion is critical.

Healthcare Effectiveness Data and Information Set (HEDIS) define two treatment phases for those patients who were diagnosed with a new episode of major depression and treated with antidepressant medication. Those phases are: Effective Acute Phase Treatment (in which the patient remained on an antidepressant medication for at least 12 weeks), and Effective Continuation Phase Treatment (those who remained on medication for at least 6 months).
HEDIS also recommends patients who had an acute inpatient hospitalization for a mental health disorder be followed up with a mental health practitioner within 7 days of discharge. All three follow-up visits must be face-to-face.

Patients with indications of depression should be treated as deemed appropriate by the physician and may include a referral to a mental health provider.

References

Health Care Guideline: Major Depression in Adults in Primary Care, Thirteenth Edition, Institute for Clinical Systems Integration, May, 2010 @ www.icsi.org


National Guideline Clearinghouse @ www.guideline.gov, Depression clinical practice guidelines.

Treating Major Depressive Disorder: A Quick Reference Guide, American Psychiatric Association, October 2010 @ www.psychiatryonline.com
**Algorithm for Treatment of Major Depression with Selective Serotonin Reuptake Inhibitors (SSRIs)**

**Major Depressive Disorder**

**Acute Treatment Goal:** Decrease symptoms at least 50%

**Suggested Initial Dose of SSRI’s, Include**

(May need to be adjusted lower in geriatrics, debilitated, etc.)
- Citalopram hydrobromide 20 mg po daily OR
- Escitalopram oxalate 10 mg q am OR
- Fluvoxamine maleate 25 mg po bid OR
- Fluoxetine hydrochloride 20 mg q am OR
- Paroxetine hydrochloride 20 mg po daily OR
- Sertraline hydrochloride 50 mg po q am

**Practitioner should check current formulary guidelines for appropriate SSRI choices.**

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**Response**

- **Continuation**
  
  **Goal:** Complete remission
  
  **Duration for first episode:** 6-9 months before taper and stop

- **Maintenance**
  
  (Continue dosage to which patient initially responded as maintenance dosage and consider use of half tablets in Fluvoxamine maleate, Paroxetine hydrochloride, Escitalopram oxalate, Citalopram hydrobromide, Fluoxetine hydrochloride or QOD in Fluoxetine hydrochloride, if appropriate)

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**After 6 weeks**

**Partial Response**

**Increase Dose**

- Citalopram hydrobromide 20 – 40 mg po daily OR
- Fluvoxamine maleate 50 – 100 mg po bid OR
- Paroxetine hydrochloride 20 – 40 mg po daily OR
- Fluoxetine hydrochloride 20 – 40 mg po daily OR
- Sertraline hydrochloride 50 – 100 mg po q am OR
- Escitalopram oxalate 20 mg q am

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**After 6 weeks**

**Partial Response**

Change antidepressant or referral
Guideline for Outpatient Depression Treatment

Is the patient depressed?

Yes

Is the patient suicidal or displaying psychotic symptoms?

Yes

Psychiatric consultation

No

Psychiatrist consultation

Consider referral to Therapist

Yes

Psychotherapy

Yes

Does the patient have lingering unexplained somatic symptoms?

Yes

Has thorough medical eval been completed?

No

Do medical eval.

Yes

Are four other vegetative signs of depression present for at least 2 weeks?

No

Prescribe an SSRI or other appropriate anti-depressant and advance to reasonable dosage within 2 weeks.

Follow-up appointment in 2 to 6 weeks.

Follow-up every 2 to 6 weeks until responding.

Yes

Is the patient improving?

No

Switch to another antidepressant drug

Follow-up every 2 to 6 weeks

Maintain med at current dosage for 9 months (for first episode) or indefinitely for third episode.

Is the patient suicidal or displaying psychotic symptoms?

Yes

Is the patient improving?

No

Switch to another antidepressant drug

Follow-up every 2 to 6 weeks

Is the patient well, in remission after 3 months?

Yes

Maintain medication at current dosage for 9 months (for first episode) or indefinitely for third episode.

Is the patient improved?

No

Augment with another drug

Switch to another drug

Electro Convulsive Therapy

Intermediate referral to Psychiatrist

Psychiatric Consultation

Refer for Psychotherapy
Six-week evaluation: partial responders or nonresponders to medication

No or partial response at 6 weeks

Diagnosis correct? No → Treat primary problem or co-morbid problem(s)
Yes → Treatment adequate?
No → Adjust dosage, counsel adherence
Yes → Evaluate degree and nature of response

NONE
Change medication

PARTIAL
Augment medication
Consultation/referral
Largely cognitive symptoms remain
Largely vegetative symptoms remain
Re-evaluate at 6 weeks
Change/augment medication

Complete response
To continue treatment 6-9 months

Partial response
Consultation referral

Suggestions for management are based on some indirectly relevant studies, logic and clinical experience.
Six-week evaluation: responders to medication

Complete symptomatic response?

Yes

Normal psychosocial function?

Yes

Go to continuation treatment

No

Chronic severe psychosocial dysfunction?

Yes

Add psychotherapy

No

Re-evaluate 6 weeks later (if still present, add psychotherapy)
Treatment of Patients Hospitalized for Depression

1. Make diagnosis
2. Select and initiate treatment
3. Monitor acute treatment within 7 days of hospital discharge
4. Assess response within 30 days of hospital discharge
   - Clearly better
     - Continue treatment for 6 more weeks
   - Somewhat better
     - Continue treatment (adjust dosage)
   - Not better at all
     - Augment or change treatment
5. Monitor treatment (every 2 weeks)
6. Assess response (week 6)
   - Clearly better
   - No
     - Relapse?
6. Complete Remission?
   - Yes
     - Medication continued for 4-9 months. Consider maintenance treatment
   - No
     - Not better
     - Refer or consult a psychiatrist or other mental health professional
     - Change treatment