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 25mg 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.

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)

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 - 20mg q am

After 6 weeks
Partial Response

No Response

Change antidepressant or Referral
Guideline for Outpatient Depression Treatment

1. Is the patient depressed?
   - Yes
     - Is the patient suicidal or displaying psychotic symptoms?
       - Yes
         - Psychiatric consultation
       - No
         - Psychotherapy
   - No
     - Consider referral to Therapist

2. Does the patient have lingering unexplained somatic symptoms?
   - Yes
     - Has thorough medical eval been completed?
       - Yes
         - Do medical eval.
       - No
         - Are four other vegetative signs of depression present for at least 2 weeks?
           - Yes
             - 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.
           - No
             - Maintain medication at current dosage for 9 months (for first episode) or indefinitely for third episode.
   - No
     - Is the patient improving?
       - Yes
         - Maintain med at current dosage for 9 months (for first episode) or indefinitely for third episode.
       - No
         - Switch to another antidepressant drug
         - Follow-up every 2 to 6 weeks

3. Is the patient suicidal or displaying psychotic symptoms?
   - Yes
     - Psychiatric Consultation
   - No
     - Is the patient well, in remission after 3 months?
       - Yes
         - Psychiatric Consultation
       - No
         - Refer for Psychotherapy

4. Are four other vegetative signs of depression present for at least 2 weeks?
   - Yes
     - Is the patient improving?
       - Yes
         - Maintain med at current dosage for 9 months (for first episode) or indefinitely for third episode.
       - No
         - Switch to another drug
         - Electro Convulsive Therapy
   - No
     - Augment with another drug
     - Switch to another drug
     - Electro Convulsive Therapy
     - Refer for Psychotherapy
Six-week evaluation: partial responders or nonresponders to medication

No or partial response at 6 weeks

Diagnosis correct?

No or partial response at 6 weeks

Treatment adequate?

No

Evaluate degree and nature of response

Complete response

Partial response

Consultation referral

No response - patient is nearly as symptomatic as at pretreatment.
Partial response - patient is clearly better than at pretreatment, but still has significant symptoms. Consultation or referral may be valuable before proceeding further. 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

Make diagnosis

Select and initiate treatment

Monitor acute treatment within 7 days of hospital discharge

Assess response within 30 days of hospital discharge

Clearly better

Continue treatment for 6 more weeks

Not better at all

Augment or change treatment

Somewhat better

Continue treatment (adjust dosage)

Not better

Clear better

Assess response (week 6)

Complete Remission?

Yes

Medication continued for 4-9 months. Consider maintenance treatment

No

Relapse?

No

Refer or consult a psychiatrist or other mental health professional

Not better

Change treatment