

D CASE STUDY
FEEDBACK

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Notes

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Acknowledgement

bpac^{nz} would like to thank the panel and guest psychiatrist for their support and contribution to the discussion provided by this case.

Feedback

bpac^{nz} welcomes comments on this case study including the format and style. Please contact Katrina Sandford at bpac^{nz}

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Case Study: Depression

Case

Jill is a 46 year old schoolteacher. She has two teenage children. She joined your practice six months ago after moving to your town. She complains of tiredness and poor concentration for some weeks, which is affecting her ability to work. On further questioning she also reveals low mood, loss of pleasure in usual activities (particularly physical exercise) and weight gain. She has been sleeping poorly, often waking early in the morning. She has not been treated for depression in the past. There are no other specific physical symptoms. She is on no regular medications, but has been trying some herbal products she has been told are good for sleep and mood.

On examination BMI 30, otherwise normal examination.

When directly questioned Jill says:

- *she feels bad enough sometimes she would rather be dead, but has no specific plans for suicide. She would never do it as it would be "too hard on her children"*
- *she has no partner, having separated from her husband one year ago*
- *she does not abuse alcohol*

Case study questions

1) Would you order any laboratory investigations?

- No
 Yes, Specify

2) How would you rate her suicide risk?

- Low Medium High

It is agreed that a trial of antidepressant medication would be appropriate.

3) Which antidepressant would you choose and at what dose?

Drug _____

Dose _____

4) What influenced your decision to prescribe this antidepressant agent?

5) What side effects would you advise Jill to be aware of?

6) Approximately how long will you advise Jill that she may have to wait until she experiences improvement in her symptoms?

- 1 week 2 weeks 4 weeks

7) Is there any other information you would give on using this drug?

8) What follow up would you plan with Jill?

9) How long would you advise Jill regarding the likely duration of drug treatment (once the depression has lifted)?

- < 6 months
 6-12 months
 Other, specify

Analysis of responses (n=470)

Q1. Would you order lab tests?



Of those who ordered tests the average number of tests ordered was 4 and included the following tests:

Most Common		Less common (<15%)
CBC	79%	U/Electrolytes
TFT	50%	Cr or RENL
TSH	38%	CRP/ESR
Glucose	36%	LH/FSH
Ferritin	25%	Lipids
LFTS	25%	
Iron Studies	24%	

Panel Comments

There was some disagreement amongst the panel on the appropriateness of tests ordered. Some felt strongly depression should be a positive diagnosis and there was no indication in this case to order any blood tests; except perhaps as a "hook" to encourage the patient to return for follow-up. Others felt a limited range of tests were appropriate, namely: CBC and TSH. Ferritin/iron studies and glucose (opportunistic screening) could possibly be justified although there was some debate about this.

All agreed there was no need for a wide range of tests as there was an absence of specific signs or symptoms that would suggest an organic cause. All agreed the ordering of FSH/LH was inappropriate, pointing out the average age of menopause is 52 and anxiety is a common feature of menopause rather than depression. All agreed ESR/CRP testing was inappropriate. All noted TSH should be used in preference to TFTs for thyroid disorder screening.

Q2. Suicide risk

High	1%
Med	34%
Low	65%

Panel Comments

The suicide risk is probably low. The main factors protective against suicide in this case are: having meaningful relationships (children), having meaningful employment, female gender. Studies show lack of meaningful relationships or meaningful employment increase suicide risk.

Q3. Drug choice

Fluoxetine	79%	
Other SSRI	3%	
TCA	18%	(amitryptiline, dothiepin, nortryptiline most common)

Drug dose

Virtually all TCA prescribers started at low doses (commonly 25mg) and noted they would titrate upwards according to effect and side effects.

95% of fluoxetine prescribers used 20mg doses, the remainder chose to start with 10mg doses.

Panel comments

Fluoxetine is an appropriate drug to use here as:

Jill needs to be able to concentrate for her job i.e. sedating drugs not ideal

Fluoxetine would tend to cause weight loss rather than weight gain, which is an issue for Jill.

TCA's could also be used, preferably starting at low doses to minimize morning sedation.

Q4. Factors influencing decision to prescribe

TCA prescribers

The overwhelming reason was beneficial effect on sleep/night sedation (95%)

Cost, efficacy and familiarity also mentioned

Fluoxetine prescribers

Favourable side effect profile	46%	(specifically no weight gain 10%)
Efficacy	42%	
Cost	38%	
No prescribing restrictions	20%	
Safety in O/D	18%	
Familiarity	9%	
Beneficial effect of long ½ life	5%	

Other SSRIs (paroxetine or citalopram) prescribers

side effect profile
not keen on generic drugs

Panel comments (also see comments Q3 above)

The favourable side effect profile (in particular no sedating effects or weight gain) was a good reason for choosing fluoxetine. Interestingly TCA prescribers tended to use them specifically for their night sedating effect; which it could be argued is appropriate. On the other hand, Jill would not appreciate any daytime sedation, so starting at low doses was reasonable. It should be noted early morning waking is a classic feature of depression, which will improve with treatment of depression; regardless of which drug/class is used.

Some SSRI prescribers noted they would consider prescribing a hypnotic such as temazepam short term (7-10 days maximum); this could be a reasonable option to discuss with Jill.

In terms of efficacy antidepressants are all equally effective with a 60-70% response rate.

Q5. Side effects advised

TCA's	
Anticholinergic effects	95%
Sedation/somnolence/drowsiness	85%
SSRIs	
Agitation/nervousness/anxiety	60%
Nausea/GI upset/diarrhoea	55%
Insomnia/sleep disturbance	47%
Headache	19%
Dry mouth:	11%
Sexual dysfunction	9%
Drowsiness/sedation/somnolence	8%

Panel comments

The most common side effect of SSRIs is sexual dysfunction. Perhaps it would have been mentioned more often had Jill had a partner or if the patient was a male. Insomnia, agitation/arousal and GI effects are the next most common symptoms. Headache is perhaps less common but worth mentioning. Sexual dysfunction may persist throughout treatment, which can be an important issue for some patients. Other side effects may be more transient.

The TCA side effects mentioned were appropriate and noted by the vast majority of prescribers.

Q6. Time to improvement

2 weeks	70%
4 weeks	25%

Panel comments

Three weeks is a realistic time frame to mention. However some patients do improve earlier, possibly indicating two weeks could help compliance. There are no significant differences in time to effect for common antidepressants. It can take up to 6 weeks for the full antidepressant effect, which has implications when deciding if the drug has been efficacious or not.

Q7. Other information given on drug

TCA prescribers

Titration of drug dose & timing of dose	30%
Caution with alcohol	20%
Caution driving	12%
Stop St John's Wort	12%

SSRI prescribers

Stop St John's Wort/herbal products	29%
Discontinuation	20%
Dosing information- time of dose	10%
Caution with alcohol	13%
Duration of prescription	10%
Time to effect	7%
Not addictive	5%

Panel comments

It was good to see a number of respondents picked up on the reference to use of "herbal products". St John's Wort is a well-known herbal product used for depression. Tryptophan is another product though perhaps not readily available. Both these products can potentially cause serotonin syndrome if used with prescription antidepressants. Serotonin syndrome is a syndrome resulting from excessive stimulation of central and peripheral serotonergic receptors. It is characterized by changes in mental status, and motor and autonomic dysfunction. It can be mild or life threatening. There is some debate about whether St John's Wort can contribute to this or not; but it seems wise to caution patients.

Tapering treatment gradually to avoid discontinuation problems is a good point to mention. Discontinuation syndrome is less common with fluoxetine than other SSRIs due to its long half-life (a point appropriately mentioned by some people in their reasons for choice of this drug).

Q8. Follow-up

As expected there was a wide variety of responses

Consult in 1 week	18%
Consult in 2 weeks	44%
Consult in 3 weeks	7%
Consult in 4 weeks	21%

Additionally 6% said themselves or practice nurse would phone within 1 week. Many people would also stress to the patient they could phone the practice at any time and come in if any concerns arose outside the recommended follow-up date.

Panel comments

The majority of people would see patients within 2 weeks of starting antidepressants; which is appropriate. A worthwhile regimen is to see the patient at 7 days to check on side effects/mental state; then again at two weeks to check for drug effect. Cost can be an issue for some patients; it is worth remembering patients with community service cards can claim a disability allowance for depression related treatment. Utilising practice nurses for phone follow-ups could also be considered.

Q9. Duration of treatment

< 6 months	4.5%
6 -12 months	87%
>12 months	3%
Formula (e.g. for twice as long as depression has been present):	1.5%

Panel Comments

It was good to see the vast majority of GPs were aware drug treatment should be continued for at least six months; some authorities now suggest 12 months.

Other comments made by respondents

Although this was not specifically asked many people said they would discuss the benefits of counseling or psychotherapy, some specifically said they would recommend this first line.
10% specifically mentioned they would give Jill crisis information e.g. PES phone number.
4 % would use a hypnotic short term in this case.

Panel comments

Non-pharmacological approaches are an important part of depression treatment; it was good to see many GPs mentioned this. Unfortunately access to psychologists for interpersonal psychotherapy or cognitive behavioral therapy, both efficacious treatments for mild/moderate depression, can be an issue due to cost and limited access.

Counseling is easier to access and is an appropriate first line therapy for mild depression, also useful in conjunction with drug treatment for moderate depression. Jill probably has moderate depression, although perhaps we need more information to quantify this.

Giving crisis information is a good idea and should be documented in the notes.



Psychiatrist Comments

This was a routine case, and it was good to see that the weight of GP opinion reflected good practice in virtually all question areas. The questions lead the clinical management down the path of medication prescription, which is a perfectly valid and correct option in this instance, where physiological symptoms of depression are clear in the history. Current evidence suggests that psychotherapy and medication are equally as effective in mild to moderate depression. The choice of treatment depends on symptom profile, availability and discussion with the patient. A more challenging set of questions would emerge if the patient did not improve with this initial treatment, but perhaps this could be a subject for a subsequent case.

I am completely comfortable with selected laboratory investigations in a 46 year old with a first episode of depression, even in the face of a normal physical examination. The list in this instance should be quite restricted, however, and a CBC and TSH are perhaps the only ones really indicated. If improvement in symptoms does not follow the expected course, this may need to be reconsidered.

The suicide risk is low to moderate currently, but in the context of physiological change, should be monitored.

I agree with the panel that in summary all antidepressants have similar effectiveness, and that the differences are in side effect profile, safety and ease of use. It was a little disappointing to see that 42% of respondents thought that SSRIs were more effective. I also agree with the panel that in the main the side effects of the medications prescribed were adequately identified, although only 8.5% of respondents raising the issue of sexual dysfunction as a consequence of SSRI treatment does not reflect the reality of the situation.

2 weeks is often too short to see improvement, although some recent work indicates that an early partial response (10 days) indicates a likely overall good outcome.

I would take a slightly different stance than the spread of responses suggest in terms of follow-up. There is some evidence that those people seen more frequently at the beginning of treatment in general practice do better in the end. Possibly this reflects the importance of the therapeutic relationship in the outcome. In this instance, there are very important life event and social issues. Even if the decision is made not to refer for expert therapy, there may be benefit in providing time for the patient to talk about her loss, her move, and how she is managing her social network in her new environment. The issue of side effects and compliance could then also be followed up at an early time. I would see her again in a week.

The recommendations about length of treatment are reasonably clear. For a first single episode of depression, 26 weeks from the time the patient improves, at the dose that brought improvement. The idea of a maintenance dose is no longer held to be valid. For recurrent depression, particularly episodes repeated within 18 months, the full doses of antidepressant should be continued for between 3 and 5 years.

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