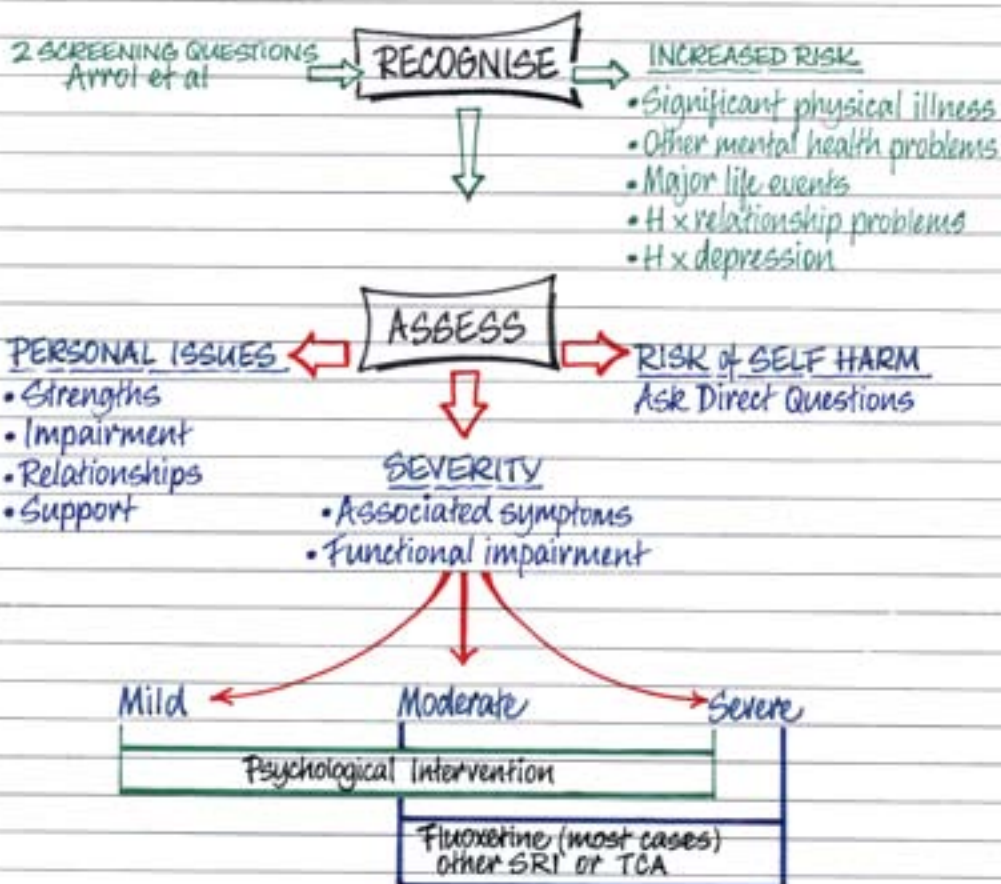


DEPRESSION REMINDER

Depression Reminder



Medications have similar efficacies

Choice based on —

- side effects
- drug interactions
- co-morbidities
- risk of self harm
- cost

Recommended Screening Questions for depression - ask both these questions:

1. During the last month, have you often been bothered by feeling down, depressed or hopeless?
2. During the last month have you often been bothered by having little interest or pleasure in doing things?

Recommendations for diagnosing, grading and monitoring depression - Use PHQ-9

The diagnosis of depression requires a detailed assessment of a patient's current mental health status, functional impairment and risk of harm to self and others. This can be assisted by the use of the PHQ-9 questionnaire. This is a validated and reliable tool for primary care and has the advantage that it can also be used to grade depression and assess response to treatment. A copy of the PHQ-9 is included with this mail-out. It can be filled in by the patient using a whiteboard marker whilst you are writing up notes from the earlier part of the consultation. It includes questions which are useful springboards for questions about social support, functional impairment and suicide risk.

Key recommendations on medication for depression

Do not routinely use an antidepressant in the initial management of mild depression as the risk-benefit ratio is poor.

When an antidepressant is indicated usually choose an SSRI because they are as effective as tricyclic antidepressants, are less likely to be discontinued because of side effects and are less dangerous in overdose. However if someone has responded well in the past to a tricyclic without adverse effect and there are no safety issues it may be appropriate to choose the same drug again.

Consider using fluoxetine as first choice because it is fully subsidised, low-cost and is associated with fewer discontinuation / withdrawal symptoms. However note the possibility of drug interactions.

Warn patients about the possibility of SSRI related agitation which is usually transient. If it is troublesome either:

Add a benzodiazepine for two weeks and review, or

Change to a different antidepressant.

Review in person or by proxy at or within two weeks.

Use objective measures to assess response (e.g. PHQ-9) at four weeks.

If there is no response check adherence to medication regimen and consider increasing the dose (e.g. to fluoxetine 40mg per day in 10mg steps).

Allow a further six weeks to assess response if there is only a partial response at four weeks.

If there is still no response consider changing to another SSRI or a tricyclic.

Continued...

Allow the appropriate wash out period before starting the new medication.

After remission continue medication at the same dose for at least six months (18 months to 2 years if depression has been recurrent) to reduce the risk of relapse.

If someone fails to respond to this initial treatment plan consider referral for collaborative management with secondary care.

Your Prescribing of Antidepressants

Prepared for Doctor A

Choice of antidepressant by class

April 2003 - March 2004

April 2004 - March 2005

Choice of SSRI

April 2003 - March 2004

April 2004 - March 2005

Important interactions with SSRIs

All SSRIs can cause drug interactions. Many of the interactions involve a change in the plasma concentration of the interacting drug but some are pharmacodynamic (e.g. serotonin syndrome, CNS depression) and do not involve alteration in drug concentrations. Some interactions are a mixture of the two mechanisms.

Interacting substance	Possible result
Alcohol	Sedative effects possibly increased when SSRIs given with alcohol.
Anticonvulsants	Possible lowered seizure threshold and increased plasma concentration of phenytoin and carbamazepine.
Benzodiazepines	Possible increased sedation. Concentrations of some benzodiazepines may be increased.
Clozapine	Possible increased plasma concentration of clozapine.
Haloperidol	Possible increased haloperidol concentration or toxicity.
Flecainide	Increased plasma concentration of flecainide.
*Lithium	Increased risk of CNS toxicity.
MAOIs	CNS effects of SSRIs increased by MAOIs (risk of serious toxicity).
NSAIDs and aspirin	Possible increased risk of bleeding.
St Johns Wort (available without prescription)	Increased risk of serotonin syndrome -avoid concomitant use.
*Tricyclic antidepressants (TCAs)	Increased plasma concentration and toxicity of some TCAs. Increased risk of serotonin syndrome (especially clomipramine).
Sibutramine	Increased risk of CNS toxicity when SSRIs given with sibutramine (manufacturer of sibutramine advises avoid concomitant use).
Tramadol	Possible lowered seizure threshold or serotonin syndrome.
Tryptophan	Agitation and nausea may occur when SSRIs given with tryptophan.
Warfarin (and other coumarins)	Possible enhanced anticoagulant effect of warfarin. NB increased bleeding can occur with or without an increase in INR

Clinical Features of CNS toxicity and Serotonin Syndrome: mental status changes (confusion, hypomania), agitation, myoclonus, hyperreflexia, sweating, shivering, tremor, diarrhea, incoordination, fever.

*Lithium and TCAs are sometimes combined with SSRIs. The risk of adverse effects is increased significantly. Extreme care and specialist advice is advised.

References

- NHS, National institute for clinical excellence. Depression. Clinical Guideline 23:2004 www.nice.org.uk/CG023NICEguideline or in an abridged version www.nice.org.uk/CG023quickrefguide
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- Arroll B, Khin N, Kerse N. Screening for depression with two verbally asked questions: cross sectional study. *BMJ*2003;327:1144-6.
- Kroenke K, Spitzer RL, Williams JBW. The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med.* 2001;16:606-13.