2010 – Diagnosing and Treating Depression in Adults in Primary Care

A guideline is designed to assist clinicians by providing a framework for the evaluation and treatment of patients. This guideline outlines the preferred approach for most patients. It is not intended to replace a clinician's judgment or to establish a protocol for all patients. It is understood that some patients will not fit the clinical condition contemplated by a guideline and that a guideline will rarely establish the only appropriate approach to a problem.

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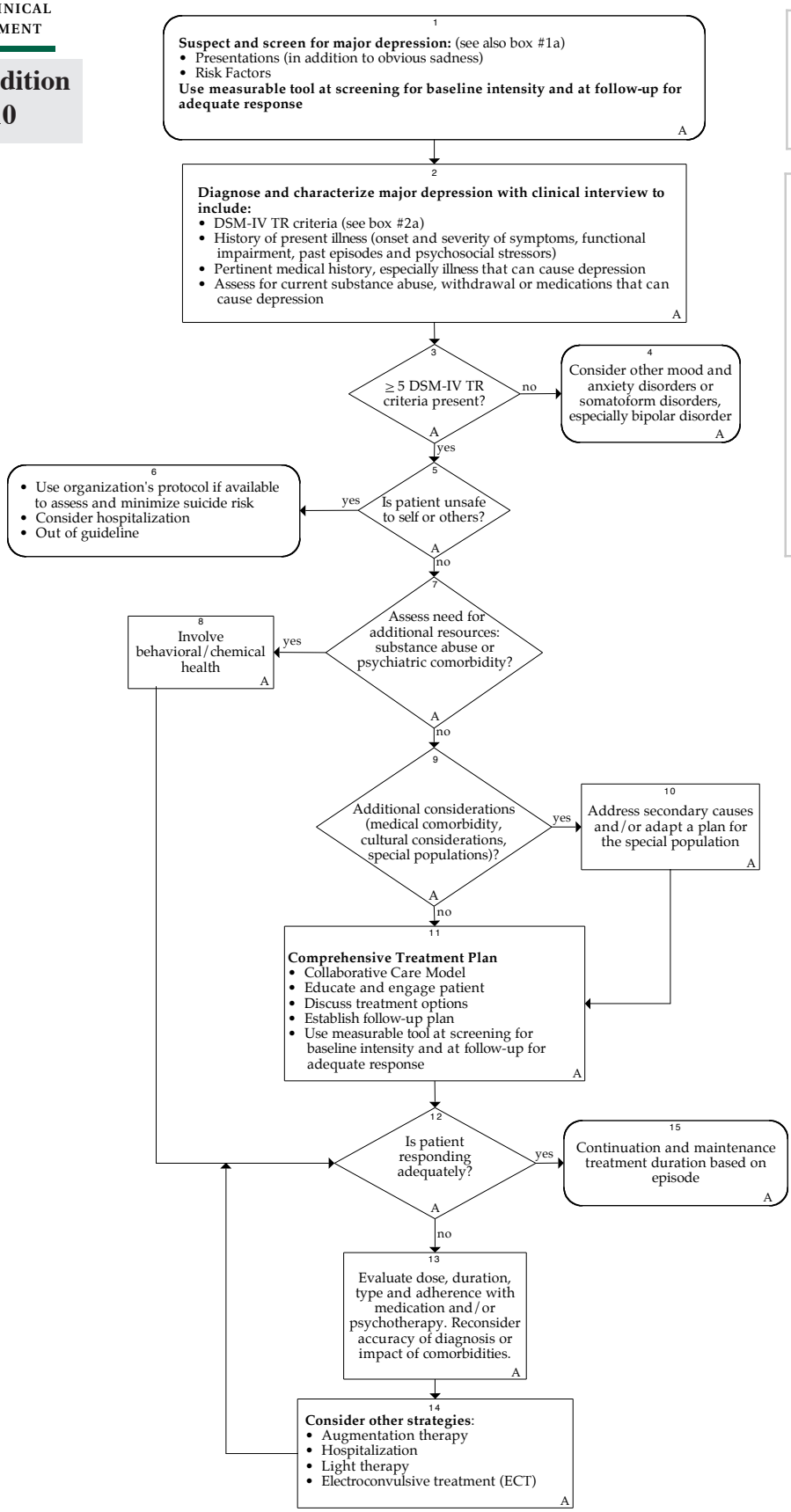
Health Care Guideline:
Major Depression in Adults in Primary Care



1a

The two-question screen:
Over the past two weeks have you been bothered by:
1. Little interest or pleasure in doing things?
2. Feeling down, depressed or hopeless?

2a

DSM-IV TR Criteria for Major Depressive Episode:
Must have a total of 5 symptoms for at least 2 weeks. One of the symptoms must be 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 increase or decrease 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.

A = Annotation

Treatment Plan for Depression in Adults – Flow Chart

Select and Initiate Therapy

A) Mild Depressive Disorder* - Psychotherapy or Pharmacotherapy
B) Moderate / Severe Depressive Disorder** - Psychotherapy with Pharmacotherapy

* **Mild depressive disorder:** Depression without prominent vegetative symptoms, suicidal ideation, or significant functional impairment.
** **Moderate to severe depression disorder:** Depression with significant neurovegetative symptoms, hopelessness, or suicidal ideation.

Consider Medication When:

- Depression is moderate to severe
- Patient has had prior positive response to medication
- Patient has had recurrent depressive episodes
- As adjunct to psychotherapy or if symptoms are not remitting or if psychotherapy is unavailable

Educate about Depression and Medications

For antidepressant medications, compliance with a therapeutic dose is more important than the specific drug selected. The following educational messages may increase adherence:

A) Take the medication daily as prescribed.
B) Some treatment response may occur in 10 – 14 days, but full effect requires continuous treatment for four to six weeks.
C) Continue to take medication even if you are feeling better: increased risk of relapse if stopped before 6 months.
D) Do not stop taking antidepressant without checking with your provider. Some antidepressants may have uncomfortable withdrawal symptoms.
E) Contact your provider if you have questions about your medication.
F) Be sure to make and keep an appropriate follow-up appointment. This is important to ensure full response to your medication.
G) The medication is not mood altering. Depression alters brain functioning and the medication helps restore normal patterns, so you eat and sleep more normally, think more clearly and have more energy.
H) The medication should help you benefit from the psychotherapy you are receiving.

Monitor Acute Treatment (first 12 weeks)

- Patients should have a minimum of three contacts during the acute phase
- Patients should be reminded to call as needed if they experience adverse medication reactions or suicidal ideation
- Ask patient whether psychotherapy has been started, if that was recommended
- Young adults ages 18-24 should be followed up during the first two weeks of treatment to assess thoughts of suicide and self harm
- Consider referral to behavioral health if more severe symptoms present (i.e.. risk of harm to self or others, presence of major psychosocial stressors likely to require psychotherapy, patients with history of antidepressant failure in the past, or already on complex medication regimens)
- Certain patients (new, unstable, those on many medications, those with sudden onset) may need to be seen more often and may require close observation

Assess Response

- Pharmacotherapy: 4 weeks
- Psychotherapy: After 3-4 visits if not on medications

CLEARLY BETTER

Continue Therapy

- Assess response every 4-12 weeks

SOMEWHAT BETTER

Adjust Therapy

- Pharmacotherapy – consider adjusting dose
- Psychotherapy – consider augmenting with medical therapy, have conversation with specialist

NOT BETTER AT ALL

Adjust or Change Therapy

- Augment or change treatment
- Consider referral to behavioral health
- Assess adherence to medication

Monitor Treatment

- Patient should continue to be seen every 1-6 weeks by provider or behavioral health practitioner

Full Symptom Remission?

YES

Continuation Therapy

- Pharmacotherapy – continue for 6-9 months
- Psychotherapy – consider resolution of unresolved psychosocial issues

Has patient been asymptomatic for 6-9 months?

YES

Consider **medication taper** over a period of weeks to several months for patients who have had only one prior episode of major depression, have no significant family history, no severe symptoms.

NO

Consider **maintenance therapy** for patients who have had two previous episodes of major depression, or who have had two episodes of major depression but have also had rapid recurrence of episodes, or are older in age at the onset of major depression (more than 60 years of age), have had severe episodes of major depression or a family history of a mood disorder, at-risk patients with double depression and patients with comorbid anxiety disorder or substance abuse, or patients whose major depression has a seasonal pattern
For maintenance medication, contacts can occur every 3 to 12 months if everything else is stable.

NO

CLEARLY BETTER

Assess response 4-6 weeks following therapy change

NOT BETTER

Generally Recommended

- Changing treatment
- Augmenting treatment
- Re-evaluating diagnosis
- Consult with behavioral health

It is important to recognize the prevalence of depressive disorder in the Western industrialized nations. The lifetime risk for depressive disorder is 7-12% for men and 20-25% for women.[1]

Depression is characterized by five or more of the following symptoms having been present and documented during the same two-week period and representing a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
Note: Do not include symptoms that are clearly due to a general medical condition, or mood-congruent delusions or hallucinations.

- depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful)
- markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
- significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day
- insomnia or hypersomnia nearly every day
- psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
- fatigue or loss of energy nearly every day
- feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
- diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
- recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

There are multiple depressive disorders to be aware of ie. unipolar, bipolar type I or II, major depressive episode, dysthymic disorder, or psychothymic disorder

Suspect and Screen for Major Depression

Physical complaints are extremely common in depression and are often the primary manifestation of the illness. Somatic manifestations of depression include fatigue, insomnia, anorexia, weight loss, gastrointestinal disturbances, and a variety of pain complaints. Anxiety and agitation are common as secondary symptoms.[5]

Common Presentations of patients with depression include:

- multiple office visits
- numerous unexplained symptoms
- work or relationship dysfunction
- sleep disturbance
- multiple worries and distress

Risk Factors for depression include:

- prior episodes
- family history of depressive disorder
- female gender
- postpartum period
- peri/postmenopausal period
- medical co-morbidity
- lack of social support
- major life stressor

Screening Instruments have been developed for use in various clinical settings, including ambulatory primary care. The primary objective of these well-tested tools is to obtain input from the patient regarding their symptoms related to depression. These tools tend to be fairly sensitive, but not too specific in the recognition of depression. These are generally self-administered and then reviewed by the practitioner. Screening patients is recommended when depression is suspected.

Information on several tools is listed below. One simple means of screening is to ask two questions while completing an exam:

1) Over the past two weeks have you ever felt down, depressed, or hopeless?
   and,
2) Have you felt little interest or pleasure in doing things?

Depression Screening Tools	Contact	Cost
Beck Depression Inventory – Fast Screen for Medical Patients	Psychological Corporation Harcourt Brace PO Box 839954 San Antonio, TX 78283-3954 800-211-8378	$49.00 / pad 50 (discount for quantity)
CES-D, Center for Epidemiological Studies Depression Scale	Tool included in this guideline	No charge
EPDS, Edinburgh Postnatal Depression Scale	http://www.perinatalweb.org Tool included in this guideline	No charge
Geriatric Depression Scale	http://www.stanford.edu/~yesavage/GDS.html	No charge
PHQ-9, Patient Health Questionnaire	http://www.phqscreeners.com	No charge
Zung	See your GlaxoSmithKline or Lilly pharmaceutical representative	No charge

Interview for Key Symptoms of Depression

A Detailed Clinical Interview is used to confirm the diagnosis of depression. Questions include:

- Are you often sad, down, blue or teary?
- Do you have your usual interest in and look forward to enjoyable activities?
- Are you able to have fun or joy?
- Do you have sleep disturbances, changes in appetite and energy level?

DSM IV Symptoms[3]

The diagnosis of depression requires that the patient have five or more of the nine symptoms. Symptoms must be present during the same two-week period of time, nearly every day, and represent a change from previous functioning.

At least one of the symptoms must be either 1) depressed mood or 2) loss of interest or pleasure.

At least five of the following:

- Depressed mood
- Loss of interest or pleasure
- Weight loss or gain (or appetite loss or gain)
- Sleep disturbance
- Fatigue
- Psychomotor retardation or agitation
- Trouble concentrating or indecisiveness
- Low self-esteem or guilt
- Thoughts of death or suicidal ideation

History of the Present Illness should detail the onset and severity:

- **Mild** – five or six depressive symptoms with minor impairment in functioning
- **Moderate** – symptoms and functional impairment between mild and severe
- **Severe** – most depressive symptoms present with clear-cut impairment of functioning

Involve Behavioral Health

Emergency "Same Day" Behavioral Health Consultation/Evaluation should be considered for:

- suicidal thoughts and/or plans that make the patient's safety uncertain
- assaultive and/or homicidal plans which make the safety of others uncertain
- loss of touch with reality (psychosis)
- significant or prolonged inability to work and care for self and/or family

Referral to a Behavioral Health Specialist is recommended when there is:

- psychiatric co-morbidity (for example, mania or hypomania, obsessive compulsive disorder, or eating disorders)
- concern regarding the possibility of suicide and/or homicide
- alcohol or substance abuse
- psychosis with the depression
- a patient who is pregnant or wants to become pregnant
- diagnostic uncertainty
- no improvement with medications prescribed by the primary prescriber

Consider Co-morbid Disorders

In evaluating patients with the symptoms of depression, the primary care practitioner must determine if the depression is a primary process or is a symptom of other medical conditions. Screening for other medical conditions should be based on clinical judgment.

Medical Conditions: Many medical conditions (i.e. cancer, coronary artery disease, diabetes mellitus, cerebral vascular accident, hypothyroidism, hyperthyroidism, chronic pain) are risk factors for depression. Depressive disorder, when present, should be considered an independent condition and specifically treated. Treatment may include optimizing treatment for the medical condition and/or providing specific treatment for the depression. When depression and a medical condition co-exist, there are several plausible explanations:

- The medical disorder biologically causes the depression (for example, hypothyroidism may cause depression).
- The medical disorder triggers the onset of depression in those who are genetically predisposed to depression.
- The perceived severity of the illness causes depression (for example, a patient with cancer becomes depressed as a psychological reaction to prognosis and pain).
- The medical disorder and the depression are not causally linked.

It is important for the practitioner to differentiate among these several explanations in patients with concomitant medical disorder(s) and depression.[2]

Medications: Some medications may cause depressive symptoms:

Drug Causing Depression	Potential Alternatives
Clonidine, Methyldopa, Reserpine	Other antihypertensive agent (diuretics, ACE-I, CCB, ARB, etc)
Lipophilic beta blockers (propranolol)	Atenolol or metoprolol
Corticosteroids	Minimize dose as allowed
Sedatives/Hypnotics	Consider taper off
Benzodiazepines	Minimize use
Estrogens/Progesterones	Addition of Vitamin B6, use lower progestin
Anti-Parkinson Medications	No alternatives
Anti-convulsants	Consider diagnosis and alternatives
Indomethacin	Other NSAIDS
Interferons (HepC, MS)	No alternatives

Other Psychiatric Disorders: Patients with depressive symptoms or in a depressive episode may have a co-existent non-mood psychiatric disorder.

- **Substance abuse:** depressed patients with concurrent substance abuse should discontinue the abused substance and their depression should be reevaluated 4-8 weeks later when they are drug-free. If depressive disorder is still present, it should be treated as a primary mood disorder. Alcoholism is rarely a consequence of depression, but many alcoholics develop depressive symptoms or the syndrome of depression.
- **Anxiety, panic, obsessive-compulsive or phobic disorders** are often accompanied with depressive symptoms. Depression can also mask underlying psychiatric disorders. Anxiety symptoms are frequent in depressive episodes. The depression may precede the panic or anxiety disorder, or the anxiety disorder may be part of the longitudinal course of the mood disorder. When a patient has anxiety symptoms, the existence of depressive symptoms should be evaluated. For those patients whose disorder has some obsessive features, the mood disorder is the initial focus of treatment.
- **Eating disorders**: young women who present with any mood disorder should be interviewed for symptoms of anorexia nervosa and/or bulimia. One-third to one-half of patients with eating disorders has a concurrent depressive syndrome. If both depression and an eating disorder are present, the eating disorder, generally, should be the principal therapeutic target.

Grief Expression: Bereavement is depressive symptoms beginning within 2-3 weeks of the death of a loved one.[3] Bereavement is considered a normal, relatively benign state that most often resolves without treatment. In those bereaved patients who meet the diagnostic criteria for a depression two months following the loss, the diagnosis of a depressive disorder may be made.

Treatment Plan

The Initial Objectives of Treatment, in order of priority, are:

1) Reduction and ultimately removal of all signs and symptoms of the depressive syndrome.
2) Restoration of psychosocial and occupational function to that of the asymptomatic state.
3) Reduction of the likelihood of relapse or recurrence.

The Four Treatment Domains For Depressive Disorder

Factors considered in making treatment recommendations are the severity of symptoms, presence of psychosocial stressors, presence of co-morbid conditions, and patient preferences.

1) **Psychotherapy** alone is not recommended for the acute treatment of patients with severe and/or psychotic depressive disorders.

2) **Medication:** for essentially all patients, the practitioner who provides the medication also provides support, advice, reassurance, and hope, as well as, medication monitoring. This "clinical management" is critical with depressed patients whose pessimism, low motivation, low energy, and sense of social isolation or guilt lead them to give up, not comply with treatment, or to drop out of treatment.

   Many drug interactions occur with antidepressant therapy. To determine if the interaction is clinically important, refer to Epocrates, Micromedex or eFacts for details or discuss concerns with a pharmacist.

   Selection of a particular medication should take into consideration:
   - Prior positive/negative response to medication
   - History of first degree relatives' responses to medication
   - Concurrent medications that make selected medications more or less risky

   See cost and drug information on antidepressant therapies at the end of this guideline.

   In 2005, the FDA required labeling of all SSRIs and SNRIs be updated with the following:
   - Adult and pediatric patients with a major depressive disorder may experience worsening of their depression, emergence of suicidal ideation and suicidality, whether or not they are taking antidepressants and this may persist until significant remission occurs.
   - Patients should be monitored closely for clinical worsening and suicidality, especially upon initiation of treatment and with dose modifications.

   In 2007, the FDA proposed manufacturers of antidepressant medications update product labeling to include the following:
   - Young adults ages 18-24 should be followed up during the first two weeks of treatment to access thoughts of suicide and self harm.

3) **Combination of psychotherapy and medication** – Psychotherapy can help reduce recurrence by teaching coping skills and has superior long-term outcomes and a higher rate of compliance than medication alone.[9]

4) **Electroconvulsive Therapy (ECT) –** Most commonly recommended for people with severe depression accompanied by psychosis, suicidal intent or refusal to eat. It may be tried when medications are not tolerated or other forms of therapy haven't proved effective. Recommend full psychiatric assessment before considering.

Although other somatic treatments including repetitive transcranial magnetic stimulation, vagal nerve stimulation and deep brain stimulation have also been studied over the past five years, evidence is not yet sufficient to recommend their use in routine clinical practice.

Patient Education on the treatment of depression is important for patient compliance with therapy. For antidepressant medications, compliance with a therapeutic dose is more important than the specific drug selected. The following educational messages may increase adherence:

- Take the medication daily as prescribed.
- Antidepressants must be taken daily for 2-4 weeks for a noticeable effect.
- Educate on side effects
- Continue to take medication even if you are feeling better, increased risk of relapse if stopped before 6 months.
- Do not stop taking antidepressant without checking with your provider. Some antidepressants may have uncomfortable withdrawal symptoms.
- Contact your provider if you have questions about your medication.
- Be sure to make and keep follow-up appointments. This is important to ensure full response to your medication.
- The medication is not mood altering. Depression alters brain functioning and the medication helps restore normal patterns, so you eat and sleep more normally, think more clearly and have more energy.
- The medication should help you benefit from the psychotherapy you are receiving.

Treatment Plan Phases

1) **Acute Treatment (first 12 Weeks)** aims to remove all signs and symptoms of the current episode of depression and to restore psychological and occupational functioning (a remission).

   The patient should be seen a minimum of three times during the acute phase. At least one of those encounters should be with the prescriber. Patient non-compliance is high in those with depression, and the practitioner must assertively engage the patient in follow-up care and assessments.

   - Patients should have a minimum of three contacts during the acute phase (first 12 weeks)
   - Patients should be reminded to call within one week if they experience adverse medication reactions
   - Consider referral to behavioral health if more severe symptoms present.
   - Certain patients (new, unstable, those on many medications, those with sudden onset) may need to be seen more often and may require close observation
   - Once the depression has resolved, visits every 4-12 weeks are reasonable.

Treatment response should be assessed every 4-6 weeks for drug therapy and every 6-12 weeks for psychotherapy. See sample flow sheet to assess response to therapy. Most patients respond partially to medication within 2-3 weeks and full symptom remission is typically seen in 6-8 weeks. If the patient does not respond at all by 6 weeks (4 weeks in severely ill), or responds only partially by 12 weeks, other treatment options should be considered including:

- Assess medication adherence
- Continue medication at a corrected dose
- Change medication
- Augment with a second medication (not advised until initial trial adequate in time and dosage)
- Refer for professional psychotherapy. Most patients receiving time-limited psychotherapy respond partially by 5-6 weeks and fully by 10-12 weeks.
- Obtain a behavioral health consultation

2) **Continuation Therapy (next 6 - 9 months)** is intended to prevent relapse.
   - The patient should remain on medication for at least 6 months after symptoms resolve.
   - Once the patient has been asymptomatic for at least 6 to 9 months following an episode, recovery from the episode is declared. At recovery, treatment may be stopped.

3) **Maintenance Therapy (1 Year to lifetime)** is aimed at preventing a new episode. Patients who have had three or more episodes of depression should be considered for long-term maintenance medication therapy.

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Detection and Treatment during Pregnancy

The incidence of depression during pregnancy is similar to the incidence of depression in postpartum periods, i.e. 8-10% of women.[23] Diagnosing depression in pregnant women is difficult because many common 'normal' symptoms during pregnancy may be misconstrued as depressive symptomatology. Depressive symptoms may also falsely be interpreted as pregnancy related. Examples include changes in appetite, sleep, libido and loss of energy.

Depression during pregnancy does not differ from depression during other periods of life. Therefore, screening tools such as the CES-D or EPDS should be administered if the woman has risks for depression or depression is suspected. The EPDS scale was developed to detect women with postnatal depression, but has also been validated for use in pregnancy.[23]

Treatment

Psychotherapy has been considered to be particularly useful for patients with mild to moderate depression during pregnancy in that it directly addresses issues associated with role transitions and relationship with the partner. It is important to engage patient and significant others in discussion about what is best for their situation, that there are different options, that the issue is for the patient and the baby to be as safe as possible. The decision will depend on the patient's history before the pregnancy and their previous experience with medications, the severity of the depression, support available, response to alternative treatment modalities, etc.

Depression in pregnancy may have a negative effect on self care and pregnancy outcomes that affect the mother directly and child indirectly. Therefore, some women may require pharmacological treatment.

Most SSRI's are a FDA pregnancy risk Category C. Paroxetine is a category D. **Paroxetine should not be used in women who are planning to become pregnant or are in the first trimester of pregnancy, as it may be associated with an increased risk of fetal cardiac effects.**

When treating pregnant women with an SSRI and SNRI during the third trimester, carefully consider the potential risk and benefits of treatment.

- Neonates exposed to SSRIS or SNRIS late in the third trimester have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding.
- In one study, persistent pulmonary hypertension (PPHN) was six times more common in babies whose mothers took an SSRI antidepressant after the 20th week of pregnancy compared to babies whose mothers did not take an antidepressant.[24]
- Reported clinical findings have included

- respiratory distress	- cyanosis	- apnea	- seizures
- temperature instability	- feeding difficulty	- vomiting	- hypoglycemia
- hypotonia	- hypertonia	- hyperreflexia	- tremor
- jittery	- irritability	- constant crying	

- These features are consistent with either a direct toxic effect of SSRIS and SNRIS or possibly, a drug discontinuation syndrome. In some cases, the clinical picture is consistent with serotonin syndrome.

Postpartum Depression: Detection and Treatment

Postpartum depression (PD) occurs in approximately 8-10% childbearing women. Many medical professionals rely on their clinical impressions alone to determine whether a woman appears depressed, but several studies have shown that up to 50% of mothers with major depression are missed by primary care practitioners when screening instruments are not used.[23] If left untreated, the disorder can have serious adverse effects on the mother and her relationship with others, and on the child's development.

PD may begin 24 hours to 1 year after delivery. When its onset is abrupt and symptoms are severe, women are more likely to seek help early in the illness. In cases with an insidious onset, treatment is often delayed, if it is ever sought. Untreated, PD may resolve within several months but can linger into the second year postpartum. After the initial episode, women who have had PD are at risk for both nonpuerperal and puerperal relapses.

A simple screening instrument can be used to increase the detection of postpartum depression. The EPDS or CES-D instruments included in this guideline is appropriate to use in postpartum assessment and diagnosis. The EPDS screening tool addresses anxiety which frequently co-occurs with depression. It was developed specifically to identify significant depressive symptoms among pregnant women and new mothers.

The **mainstay of treatment** should be psychotherapy and medication if suicidal, psychotic symptoms or severity of symptoms indicate need.[23]

Recognizing Postpartum Depression

Risk Factors

- Previous history of depressive episode
- Family history of mood or anxiety disorders
- Depression or anxiety during pregnancy
- Dissatisfaction with the amount of social support from a spouse or significant other

Screening for PD

The detection of PD is often complicated by several factors.

- Most women expect a period of adjustment after having a baby.
- Societal pressures to be a "good mother."
- Concern that sharing depressive thoughts might mean that their child could be taken from them.
- Delayed detection of PD by providers' minimizing a woman's distress in an effort to be reassuring.

Anxiety may be a prominent feature and more readily apparent than traditional depressive symptoms. Co-morbid anxiety has been found to be present in 60% of women with major depression in the postpartum period. Other co-morbid disorders often present may include: social phobia, agoraphobia, obsessive compulsive and avoidant personality disorders, all of which may contribute to social isolation.

Distinguishing PD

- **Postpartum Blues**

  The "baby blues" are the most common disorder affecting 50-80% of new mothers. They are subclinical mood fluctuations characterized by mild depressive symptoms that typically peak 3 to 5 days after delivery and resolve by the 10th postnatal day. These include:

  - tearfulness
  - irritability
  - fatigue
  - anger
  - insomnia
  - anxiety
  - mood liability
  - sensitivity

- **Postpartum Depression**

  The criteria for diagnosing depression apply to the diagnosis of PD as well.
  Depression symptoms include:

  - Lack of pleasure or interest
  - Agitation or retardation
  - Frequent thoughts of death or suicide
  - Sleep disturbance (insomnia or hypersomnia)
  - Weight loss
  - Loss of energy
  - Feelings of worthlessness or inappropriate guilt
  - Diminished concentration or indecisiveness
  - Symptoms that may be confused with normal sequelae of childbirth

- **Postpartum Psychosis**

  PD must be distinguished from postpartum psychosis, which occurs in 0.2% of childbearing women. Most puerperal psychoses have their onset within the first month of delivery and are manic in nature. Warning signs heralding the onset of puerperal psychosis include:

  - An inability to sleep for several nights
  - Irritable mood
  - Agitation
  - Avoidance of the infant
  - Delusion or hallucinations often involve the infant
  - Racing thoughts
  - Rapid speech

Treatment for Postpartum Depression

Psychotherapy, particularly Individual Interpersonal Therapy (IPT) has been shown to be an effective treatment for Postpartum Depression and does not hold the risk to breastfeeding that medication can, making it a preferable first order of treatment. While there are not absolute contraindications to using a particular antidepressant medication while breastfeeding, there are no specific FDA approved antidepressants labeled for peripartum use.[6]

Medications and Lactation
The majority of expert opinion feels the benefit outweighs the risk in treatment with a SSRI. SSRI's should be a first choice recommendation.

- The goal is to effectively treat the depression.
- Initiating or continuing therapy should not interfere with the decision to start or continue to breastfeed.
- Breastfeeding should not interfere with the decision to initiate treatment of depression.

If the woman is breastfeeding, some agents may be preferred over others.

- **Sertraline or paroxetine** may be preferred SSRIs, since no adverse effects have been reported thus far in nursing infants.[11,12] Several studies have shown infant serum levels of sertraline to be nondetectable or less than 5ng/ml and its metabolite concentration to be less than 10ng/ml.[7,8] In six reports, paroxetine serum concentrations were measured in 27 infants and were found to be nondetectable in 24 infants and less than 20 ng/mL in the remaining three.[8,12]

- The remaining SSRIs, as well as, bupropion and venlafaxine are not known to be contraindicated in nursing women, but less information is known about these medications during lactation. A decision to use these medications should be based on a patient-specific risk-benefit evaluation, and the infant should be observed closely for side effects.[14]

Fluoxetine is not considered a first-line agent for women who are breastfeeding.

- **Fluoxetine** has had several case reports of adverse effects in the infant, including colic, delayed weight gain, irritability, and disturbed sleep.[13,22] For this reason, fluoxetine should generally not be considered first line treatment with a new diagnosis of depression.

Women with severe depression, suicidal ideation, or psychosis should be referred for psychiatric care. Such women require a comprehensive, multifaceted approach to treatment, including crisis intervention, pharmacotherapy, psychotherapy, and strengthening social support networks.

Support groups available to women include:

- Postpartum Support International (telephone: 805-967-7636) (http://www.chss.iup.edu/postpartum/)
- UW Postpartum Depression Treatment Program and Information Center 608.263.5000 or http://www.psychiatry.wisc.edu/ppd

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EPDS – Edinburgh Postnatal Depression Scale

Circle the number for each statement, which best describes how often you felt or behaved this way ***in the past 7 days....***

I have been able to laugh and see the funny side of things.

0 As much as I always could
1 Not quite so much now
2 Definitely not so much now
3 Not at all

I have looked forward with enjoyment to things.

0 As much as I ever did
1 Rather less than I used to
2 Definitely less than I used to
3 Hardly at all

I have blamed myself unnecessarily when things went wrong.

0 No not at all
1 Hardly ever
2 Yes, sometimes
3 Yes, very often

I have been anxious or worried for no good reason.

3 Yes, quite a lot
2 Yes, sometimes
1 No, not much
0 No, not at all

I felt scared or panicky for no very good reason.

3 Yes, quite a lot
2 Yes, sometimes
1 No, not much
0 No, not at all

Things have been getting on top of me.

3 Yes, most of the time I have not been able to cope at all
2 Yes, sometimes I have not been coping as well as usual
1 No, most of the time I have coped quite well
0 No, I have been coping as well as ever

I have felt so unhappy that I have had difficulty sleeping.

3 Yes, most of the time
2 Yes, sometimes
1 Not very often
0 No, not at all

I have felt sad and miserable.

3 Yes, most of the time
2 Yes, quite often
1 Not very often
0 No, not at all

I have been so unhappy that I have been crying.

3 Yes, most of the time
2 Yes, quite often
1 Only occasionally
0 No, never

The thought of harming myself has occurred to me.

3 Yes, quite often
2 Sometimes
1 Hardly
0 Never

Column Total: _____	**Column Total: _____**	**Total: _____**

(Scoring may be eliminated when tool is reproduced for use)

- Validation studies have utilized various threshold scores in determining which women were positive and in need of referral.
- Cut-off scores ranged from 9-13 points. Therefore, to err on safety's side, a woman scoring 9 or more points or indicating any suicidal ideation should be referred immediately for follow-up.
- The EPDS is only a screening tool, it does not diagnose depression

Cox, J.L., Holden, J.M, Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, 150: 782-786.

The Center for Epidemiologic Studies Depression (CES-D) Scale

Please select the choice, for each item below, that best describes how you felt **over the past week:**		Rarely or none of the time (<1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of the time (3-4 days)	Most or all of the time (5-7 days)
1	I was bothered by things that usually don't bother me.	0	1	2	3
2	I didn't feel like eating, my appetite was poor.	0	1	2	3
3	I felt that I could not shake off the blues even with help from my family and friends.	0	1	2	3
4	I felt that I was not as good as other people.	0	1	2	3
5	I had trouble keeping my mind on what I was doing.	0	1	2	3
6	I felt depressed.	0	1	2	3
7	I felt that everything I did was an effort.	0	1	2	3
8	I felt hopeless about the future.	0	1	2	3
9	I thought my life had been a failure.	0	1	2	3
10	I felt fearful.	0	1	2	3
11	My sleep was restless.	0	1	2	3
12	I was unhappy.	0	1	2	3
13	I talked less than usual.	0	1	2	3
14	I felt lonely.	0	1	2	3
15	People were unfriendly.	0	1	2	3
16	I did not enjoy life.	0	1	2	3
17	I had crying spells.	0	1	2	3
18	I felt sad.	0	1	2	3
19	I felt that people disliked me.	0	1	2	3
20	I could not get "going."	0	1	2	3

Total all answers chosen. ***(Scoring may be eliminated when tool is reproduced for use.)***
Total score of 22 or higher, indicates possible major depression
Score 15-21, indicates possible mild to moderate depression
Score 14 and below, indicates no depression

For original work on this scale: Radloff, LW. (1977). A self-report depression scale for research in the general population. Applied Psychological Measurement 1(3), 385-401

Consideration of Concurrent Conditions

Depression With	First Line Therapeutic Options	May be Problematic
No Additional Comorbid Conditions	Fluoxetine, Citalopram, Escitalopram, Paroxetine, Sertraline, Trazodone, Mirtazapine, Venlafaxine, Desvenlafaxine, Bupropion	TCA-side effect profile less desirable Nefazodone-hepatotoxicity
Alcohol Use		Duloxetine=Liver injury, as manifested by ALT and total Bilirubin elevations, with evidence of obstruction have occurred with coadministration of alcohol and Duloxetine.
Anxiety or Panic Disorder	Paroxetine, Fluoxetine, Mirtazapine, Sertraline, Citalopram, Escitalopram	TCA-ineffective for anxiety Bupropion-may increase anxiety Venlafaxine, Desvenlafaxine
Cardiac Condition	Mirtazapine, Paroxetine	TCA Venlafaxine Desvenlafaxine
Chronic Pain	Desipramine, Nortiptiline, Duloxitine	TCA, SNRI
Decreased Appetite	TCA, Mirtazapine	Venlafaxine Desvenlafaxine SSRI
Dementia, Head Injury, Post-Stroke Patients	Citalopram, Escitalopram, Sertraline, Bupropion	TCAs Paroxetine Mirtazapine
Diabetes	Fluoxetine, Citalopram, Escitalopram, Paroxetine, Sertraline	TCAs Mirtazapine (may increase carbohydrate cravings) Duloxetine (causes slowed gastric emptying)
Eating Disorders (anorexia, bulimia)	Fluoxetine, Paroxetine, Sertraline	Bupropion Mirtazapine
Fibromyalgia	Duloxetine	
Glaucoma	Fluoxetine, Citalopram, Escitalopram, Sertraline, Bupropion	TCA, Paroxetine, Duloxetine
Lactation	Sertraline, Paroxetine (See Post Partum Depression)	Fluoxetine
Liver Disease	Sertraline, Venlafaxine, Desvenlafaxine	TCA Fluoxetine Paroxetine Citalopram Escitalopram Trazodone Mirtazapine Nefazodone Duloxetine (hepatoxic with ETOH)
Obsessive Compulsive Disorder	Fluoxetine, Citalopram, Escitalopram, Sertraline, Paroxetine	
Parkinsons	Bupropion, Trazodone, Desipramine, Amoxapine, Nortriptyline, Protryptyline	SSRIs Venlafaxine Desvenlafaxine Nefazodone Mirtazapine
Pheochromocytoma		Selegiline patch
Renal Disease	Fluoxetine, Citalopram, Escitalopram, Sertraline	Mirtazapine Paroxetine Venlafaxine Desvenlafaxine TCA-levels not predictive
Seizures/Seizure Disorder	Fluoxetine, Citalopram, Escitalopram, Sertraline Paroxetine	Buproprion, Maprotiline, TCA (in overdose), Duloxetine, Venlfaxine Desvenlafaxine
Symptoms of: insomnia, weight loss, or overstimulation	Mirtazapine, Trazodone	Venlafaxine Desvenlafaxine SSRI
Symptoms of: oversedation, weight gain, or lethargy	Bupropion, Fluoxetine, Sertraline, Citalopram, Escitalopram, Paroxetine, Venlafaxine, Desvenlafaxine	Mirtazapine TCA Trazodone
Pregnancy		Paroxetine, Effexor XR, Cymbalta, SNRIs, SSRIs
Elderly patients		fluoxetine

*Prior to selecting an individual agent for therapy, prescribers should screen for other medications and supplements that may cause problematic effects for the patient.

Depression Side Effect Profiles

Side effects may be observed early in treatment and improve over time. If side effects persist, alternatives may be considered.

Presenting Symptom	First Line Therapeutic Options	May Be Problematic
Agitation/Insomnia	Trazodone, Mirtazepine, TCA	Selegiline Patch, Fluoxetine, Sertraline, Paroxetine, Citalopram, Escitalopram, Bupropion, Venlafaxine, Desfenlafaxine
Anticholinergic Side Effects (dry mouth, blurred vision, constipation, urinary retention)	Citalopram, Escitalopram, Fluoxetine, Sertraline, Venlafaxine, Desvenlafaxine, Bupropion	TCA, Mirtazapine, Paroxetine, Duloxetine, Selegiline Patch
GI Sensitivity	Bupropion, TCA, Mirtazapine	Fluoxetine, Sertraline, Paroxetine, Citalopram, Escitalopram, Nefazodone, Venlafaxine, Desfenlafaxine, Duloxetine (20% pts nausea)
Headache	TCA, Mirtazapine	Fluoxetine, Sertraline, Paroxetine, Citalopram, Escitalopram, Nefazodone, Venlafaxine, Desfenlafaxine, Bupropion, Selegiline Patch
Orthostatic Hypotension	Fluoxetine, Sertraline, Paroxetine Citalopram, Escitalopram, Venlafaxine, Desfenlafaxine, Bupropion	TCA, Mirtazapine, Selegiline Patch
Sedation	Fluoxetine, Sertraline, Paroxetine, Citalopram, Escitalopram, Venlafaxine, Desvenlafaxine, Bupropion	TCA, Nefazodone, Trazodone, Mirtazapine, Duloxetine, Selegiline Patch
Sexual Dysfunction	Bupropion, Mirtazapine	Fluoxetine, Sertraline, Paroxetine, Citalopram, Escitalopram, Venlafaxine, Desfenlafaxine, Bupropion, Trazodone
Weight Gain	Fluoxetine, Sertraline, Paroxetine, Citalopram, Escitalopram, Venlafaxine, Desfenlafaxine, Bupropion	TCA, Mirtazapine, Trazodone

Product and Dosage Chart

Product	How Supplied	Dosage Range/Comments	Relative Cost
SELECTIVE SEROTONIN REUPTAKE INHIBITORS			
citalopram	10, 20, 40mg scored tab 10mg/4ml soln	20-60mg daily	$
escitalopram (Lexapro)	5mg unscored, 10, 20mg scored tab 5mg/ ml	10-20mg daily	$$$
fluoxetine	10, 20, 40, 90mg cap 10 mg, 20mg tab 20mg/5ml susp	10-80mg daily 90mg weekly	$ $$$ 90mg cap
paroxetine (Paxil, CR)	10, 20mg scored tab 30, 40mg tab 10mg/5ml susp 12.5mg, 25, 37.5mg CR	10-60mg IR or 62.5mg CR daily lower for anxiety	$$ $$$$
sertraline	25, 50, 100mg scored tab 20mg/ml	50-200mg daily	$$
NOREPINEPHERINE SEROTONIN ANTIDEPRESSANTS			
bupropion (Aplenzin)	75, 100mg IR tab 100, 150, 200mg SR tab 150, 300mg XL tab	200mg SR BID IR TID = SR BID = XL daily 174, 348, 522mg	$$ $$$$$
desvenlafaxine (Pristiq)	50, 100mg	50-100mg daily (100mg not shown more effective)	$$$$-$$$$$
duloxetine (Cymbalta)	20, 30, 60mg cap	40-60mg daily	$$$$
nefazodone	50, 100, 150, 200, 250mg tab	200-600mg daily in divided doses	$$
mirtazapine	7.5, 15, 30, 45 mg tab 15, 30, 45mg ODT	15-45mg daily	$$ tab $$$ ODT
Trazodone* (Oleptro)	50, 100, 150, 300mg tab ER 150, 300mg	10-600mg daily in divided doses	$ $$$$
venlafaxine (Effexor, XR)	IR 25, 37.5, 50, 75, 100mg tab ER 37.5, 75, 150, 225mg tab ER 37.5, 75, 150mg cap	75-225mg QD in divided doses 37.5mg IR BID = 75mg ER	$$$$$
TRI-CYCLIC ANTIDEPRESSANTS*			
amitriptyline	10, 25, 50, 75, 100, 150 mg tab	50-150mg daily in divided doses	$
amoxapine	25, 50, 100, 150mg	50mg BID-TID maximum 300mg	$$
desipramine	10, 25, 50, 75, 100, 150mg coated tab	100-300mg daily in divided or single doses	$$$
doxepin	10, 25, 50, 75, 100, 150mg cap 10gm/mL conc	75-300mg daily in divided or single doses	$
imipramine	10, 25, 50, 75, 150mg tab 75, 100, 125, 150mg cap 25mg/5mL syrup	150-300mg daily	$
maprotiline	25, 50, 75mg	25-75mg BID-TID maximum 150mg	$$-$$$
nortiptyline	10, 25, 50, 75mg cap 10mg/5mL soln	60-150mg daily in divided or single doses	$
MONOAMINE OXIDASE INHIBITORS			
phenelzine (Nardil)	15mg tab	60-150mg daily in divided doses	$$$
selegiline transdermal (Emsam)	6, 9, 12mg patch	6mg/24hr patch may be used without food restrictions	$$$$$
Tranylcypromine (parnate)	10mg tab	30mg daily in divided doses	$$$

Relative Cost: $ = $0-20 $$ = $20-40 $$$ = $40-60 $$$$ = $60-80 $$$$$ = > $100

- *For TCA's and trazadone, there are therapeutic blood levels that should be done if patient does not respond to therapeutic dose.
- Insurance coverage for antidepressants varies. Refer to ePocrates for local plan listings. Patients are less likely to take their medication if they cannot afford it.

Depression Monitoring Flow Sheet #1

Patient Name: _____ DOB/Age: _____

Date of Diagnosis: _____

Date/Type of Contact						
Assessment of Progress: Score 1 if symptoms are worse Score 2 if there is no change in symptoms Score 3 if symptoms have improved						
CES-D Scale score / Assessment Score	/	/	/	/	/	/
Thoughts of death or suicidal ideation						
Patient impression of progress						
New stressors						
Other concerns or Assessments						
Assessment of Treatment						
Current Medications						
Medication compliance	Y N	Y N	Y N	Y N	Y N	Y N
Medication side-effect * Sedation/agitation Dry mouth Headache Nausea/GI distress Constipation Diarrhea Dizziness Sexual dysfunction Other_____	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Psychotherapy						
Initials of Provider Completing the Assessment						

* Place check mark for presence of side-effect. Track progress by noting ongoing presence of side-effect.

Depression Monitoring Flow Sheet #2

Patient Name: _____ DOB/Age: _____

Scoring Guide: 1 = poor/no change in symptoms
2 = OK/some improvement in symptoms
3 = good/much improved

Date of Diagnosis: _____

Date/Type of Contact						
Mood						
Interest in activities						
Appetite						
Sleep						
Psychomotor agitation or lethargy						
Energy level						
Self-esteem						
Concentration						
Thoughts of death or suicidal ideation						
Patient impression of progress						
Medication side-effect * Sedation/agitation Dry mouth Headache Nausea/GI distress Constipation Diarrhea Dizziness Sexual dysfunction Other_____	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Other concerns or assessments						
Initials of Provider Completing the Assessment						

* Place check mark for presence of side-effect. Track progress by noting ongoing presence of side-effect.

HEDIS Measure Information Related to Depression

The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported.

- *Effective Acute Phase Treatment.* The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks).
- *Effective Continuation Phase Treatment.* The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).