DEPRESSION AND MOOD DISORDERS: Evaluation, Management and Treatment

Disclosures

- I have no financial interests to disclose.
- I have no involvement with any pharmaceutical companies.

Objectives

At the end of this lecture, participants will be able to:
1. Recognize signs and symptoms of depression and other mood disorders
2. Use reliable screening tools and diagnostic criteria to identify and diagnosis mood disorders
3. Formulate an initial treatment plan for management of depression or bipolar disorder in the primary care setting

Prevalence of Depression

- National Survey on Drug Use and Health, 2014
  - Major depressive disorder
    - Over 15 million adults in the US
    - That’s 6.7% of all adults in the US

Mr. Jones

Mr. Jones is a 45 year old man with HTN who comes into clinic for a routine annual exam and medication refills of his HCTZ. He looks somber and when you comment on this he acknowledges that he’s been having a hard time since losing his job that he had for 5 years. “I heard my friend’s company is hiring, but I haven’t even applied. I’m such a loser. I just lay in bed all day feeling sorry for myself.”

PHQ-9

- Commonly used, quick, and free
- Can be clinician or patient administered
  - The patient self-administered version has been validated
- Useful for screening for depression, making a tentative diagnosis, and for following depression severity over time to assess effectiveness of treatment
- Scores >10 had sensitivity of 88% and specificity of 88% for major depressive disorder
Depression Screening: PHQ-2

- Screens for depression
- Consists of just the first 2 items of PHQ-9
- In a population with 7% prevalence of MDD, PHQ-2 was found to have:
  - sensitivity of 83% for MDD
  - specificity of 90% for MDD

PHQ-9: Diagnosis and Severity Rating

PHQ-9: Provisional Diagnosis

<table>
<thead>
<tr>
<th>PHQ-9 Score</th>
<th>Provisional Diagnosis</th>
<th>Treatment Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-9</td>
<td>Minimal Symptoms*</td>
<td>Support, educate to call if worse, return in one month</td>
</tr>
<tr>
<td>10-14</td>
<td>Minor depression ++</td>
<td>Support, watchful waiting, Antidepressant or psychotherapy</td>
</tr>
<tr>
<td>15-19</td>
<td>Major depression, moderately severe</td>
<td>Antidepressant or psychotherapy</td>
</tr>
<tr>
<td>&gt;26</td>
<td>Major Depression, severe</td>
<td>Antidepressant and psychotherapy (especially if not improved on monotherapy)</td>
</tr>
</tbody>
</table>

DDx of Depression

- Substance Use
- Medication Effect
- Another Medical Condition
- Bipolar Depression (hx of mania/hypomania)
- “Normal” Bereavement
- Major Depressive Disorder
- Persistent Depressive Disorder
- New to DSM 5, covers dysthymia and MDD >2 years
- Adjustment disorder with depressed mood

Treatment of Major Depression

- Psychotherapy
  - CBT, counseling
- Pharmacotherapy
  - SSRI, SNRI, mirtazapine, or bupropion = first line
- Combination of both
  - More effective than either alone
Choosing an Antidepressant for Your Patient, Mr. Jones

Mr. Jones has never taken an antidepressant or been in counseling. He’s not interested in talk therapy, but he asks you about medications. He says he is worried that “psych drugs” will change his personality or make him feel like a zombie. He is reassured when you tell him you treat many patients with modern antidepressants and don’t see those problems come up.

Choosing an Antidepressant

- No antidepressants have been clearly proven to be more efficacious than others
- Choose antidepressant agent based on:
  - Past response and any side effects when previously on antidepressant medications
  - Prominent symptoms (insomnia, low energy, anxiety, pain, psychotic features) or particular side effect concerns (sexual dysfunction, sedation)
  - Relative risks for the individual of mania, discontinuation syndrome, drug interactions

Choosing an Antidepressant

- Unique effects
  - Mirtazapine: helps sleep, appetite, and nausea
  - Bupropion: stimulating, doesn’t help anxiety, no risk of sexual side effects
  - TCAs & SNRIs (venlafaxine/duloxetine): can help pain, but higher risk to cause mania
- Discontinuation syndrome
  - Fluoxetine is low risk, b/c half-life is many days
  - Paroxetine and venlafaxine – high risk, shortest half lives

Choosing an Antidepressant

- Potent inhibition of CYP450 enzymes:
  - fluvoxamine (1A2, 3A4)
  - paroxetine, fluoxetine, bupropion, duloxetine (2D6)
- QTc prolongation:
  - TCAs, citalopram (>40mg)
- High risk in overdose: TCAs
- Higher risk for induction of mania
  - SNRIs and TCAs carry higher risks than SSRIs and bupropion

Depression Medication Choice
http://shareddecisions.mayoclinic.org

- PARQ sertraline
  - Start 25mg po qam x 3-7 days, then increase to 50mg po qam x 7 days then increase to 100mg po qam.
  - RTC in 2-4 weeks.
  - Consider further dose increases after 4-6 weeks on 100mg dose.
Depression Treatment: Long-term

- Don’t settle for a partial response. The goal of treatment is full remission.
- When treating, an absolute PHQ-9 score of less than 10 qualifies as a partial response and a score of less than 5 as remission.
- If antidepressant dose is not at max, assess for side effects and consider dose increase.
- Most common reasons for treatment failure are inadequate antidepressant dose or time on medication.
- Once in remission, continue med for at least 6 months to reduce risk of relapse.

After Failed Antidepressant Trail

- **Switch or Augment?**
  - Partial response?
  - Patient preference?

- **Switch options**
  - A 2nd SSRI is reasonable to try (STAR-D)
  - SNRI (duloxetine, venlafaxine)
  - Bupropion
  - Mirtazapine

Augmentation Options (STAR-D)

- Combine 2 antidepressants with different MOAs:
  - SSRI/SNRI + mirtazapine
  - SSRI + bupropion
  - Add buspirone
  - Add atypical antipsychotic
  - Add lithium
  - Add liothyroxine (T3)

Clinical differences in unipolar vs. bipolar depression

- Bipolar depression is more likely than unipolar to show these features:
  - Hypersomnia
  - Hyperphagia
  - Leaden paralysis
  - Psychomotor retardation
  - Psychotic features
  - Pathologic guilt
  - Mood lability
  - Longer speech latencies

Mood Disorder Questionnaire: An imperfect screening tool

- Can be filled out by patient
- Positive set at score of 7 or more was found to have sensitivity of 0.73 and specificity of 0.90 in psychiatry clinics in initial validation studies
- A later study showed that those patients that screen positive are JUST AS LIKELY to have borderline personality disorder as bipolar disorder
- Another study found positive screens to actually be PTSD, substance use disorders and eating disorders often

MDQ (Mood Disorder Questionnaire)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>If there ever been a period of time when you were not your usual self and...</td>
<td></td>
</tr>
<tr>
<td>...you felt so good or so happy that other people thought you were not your normal self or you were so happy that you got into trouble?</td>
<td>☐ ☑</td>
</tr>
<tr>
<td>...you were so irritable that you shouted at people or started fights or arguments?</td>
<td>☐ ☑</td>
</tr>
<tr>
<td>...you felt much more self-confident than usual?</td>
<td>☐ ☑</td>
</tr>
<tr>
<td>...you got much less sleep than usual and found you didn’t really miss it?</td>
<td>☐ ☑</td>
</tr>
<tr>
<td>...you were much more talkative or spoke much faster than usual?</td>
<td>☐ ☑</td>
</tr>
<tr>
<td>...thoughts raced through your head or you couldn’t slow your mind down?</td>
<td>☐ ☑</td>
</tr>
<tr>
<td>...you were so easily distracted by things around you that you had trouble concentrating or staying on track?</td>
<td>☐ ☑</td>
</tr>
<tr>
<td>...you had much more energy than usual?</td>
<td>☐ ☑</td>
</tr>
<tr>
<td>...you were much more active or did many more things than usual?</td>
<td>☐ ☑</td>
</tr>
<tr>
<td>...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night!</td>
<td>☐ ☑</td>
</tr>
<tr>
<td>...you were much more interested in sex than usual?</td>
<td>☐ ☑</td>
</tr>
</tbody>
</table>
Composite International Diagnostic Interview (CIDI) Bipolar Screening

- Clinician-administered
- Based on DSM criteria (Criterion A & B)
- Starts with 2 stem questions. If either endorsed, you screen for criterion B symptoms.
- Just 3 minutes needed to complete the full 12 questions.

CIDI Bipolar Screening Tool

Question 1: Euphoria Stem

“Some people have periods lasting several days when they feel much more excited and full of energy than usual. Their minds go too fast. They talk a lot. They are very restless or unable to sit still and they sometimes do things that are unusual for them, such as driving too fast or spending too much money.

Have you ever had a period like this lasting several days or longer?”

Question 2: Irritability Stem

“Have you ever had a period lasting several days or longer when most of the time you were so irritable or grouchy that you either started arguments, shouted at people or hit people?”

- If the answers were “no” to both the euphoria and irritability stem questions, you are done.
- If either answer was “yes,” go to the third question (criterion B screening).

CIDI Bipolar Screening Tool

Question 3: Criterion B Screening

“People who have episodes like this often have changes in their thinking and behavior at the same time, like being more talkative, needing very little sleep, being very restless, going on buying sprees, and behaving in many ways they would normally think inappropriate.

Did you ever have any of these changes during your episodes of being excited and full of energy or very irritable or grouchy?”

CIDI Bipolar Screening: 8 or 9 Symptom questions

Criterion B Symptom Questions

Think of an episode when you had the largest number of changes like these at the same time. During that episode, which of the following changes did you experience?

1. Were you so irritable that you either started arguments, shouted at people, or hit people?
2. Did you become so restless or fidgety that you paced up and down or couldn’t stand still?
3. Did you do anything else that wasn’t usual for you—like talking about things you would normally keep private, or acting in ways that you would usually find embarrassing?
4. Did you try to do things that were impossible to do, like taking on large amounts of work?
5. Did you constantly keep changing your plans or activities?
6. Did you find it hard to keep your mind on what you were doing?
7. Did your thoughts seem to jump from one thing to another or race through your head so fast you couldn’t keep track of them?
8. Did you sleep far less than usual and still not get tired or sleepy?
9. Did you spend so much more money than usual that it caused you to have financial trouble?
CIDI Bipolar Screening Tool: Interpretation

- Positive Predictive Values will vary in different settings as the prevalence of bipolar disorder varies
- Estimates below give a general idea of how likely a patient is to have true bipolar disorder depending on how many of those 8-9 criterion B screening questions were endorsed

- Very high risk (80% or more) 9 questions with positive endorsement
- High risk (50-79%) 7-8 questions with positive endorsement
- Moderate risk (25-49%) 6 questions with positive endorsement
- Low risk (5-24%) 5 questions with positive endorsement
- Very low risk (less than 5%) 0-4 questions with positive endorsement

New with DSM 5: MDD “with mixed features”

- Presence of 3 manic symptoms with MDD criteria also being met would qualify for addition of the specifier “with mixed features”
- Specifier acknowledges the increased risk of a bipolar spectrum illness
- Diagnosis of MDD is retained if person has not previously met criteria for mania or hypomania

Treatment of MDD with mixed features

- Treat like MDD basically, for now
  - Might exercise caution with agents more risky for mania (SNRI, TCA, stimulants) but not contraindicated
  - Might consider augmentation strategies that are helpful with bipolar depression more readily if initial treatments are not sufficient
- Monitor for signs of mania/hypomania and reconsider diagnosis and treatment plan if increased concerns for bipolar disorder arise

Bipolar Disorder Treatment Goals

- Bipolar mania
  - Treat mania, promote sleep
- Bipolar depression
  - Alleviate depression
- Bipolar maintenance (between mood episodes)
  - Prevent mania
  - Prevent depression

Bipolar Depression Treatment

- FDA Approved Treatments
  - Olanzapine/fluoxetine combination pill (2003)
  - Lurasidone (2013)
- Other APA recommended treatments
  - Lithium (evidence very good, also reduced suicide risk)
  - Lamotrigine (mixed data in acute bipolar depression)

Bipolar Depression: Antidepressants?

- STEP-BD 2007
  - 366 bipolar patients who were all on mood stabilizers were randomized to receive paroxetine, bupropion, or placebo
  - 26 weeks long, under clinical conditions
  - Rates of manic switching were not higher for those taking antidepressants in the study
  - Paroxetine and bupropion groups did not show higher switch rates
  - Risks with SNRIs and TCAs shown to be higher in other studies
  - Rates of recovery from depression were also not better
  - Although some bipolar patients may benefit from antidepressants, antidepressants have not been found to be effective for bipolar depression in general when studied.
Bipolar Mania Treatment

Bipolar Maintenance Phase Treatment

Resources for Clinical Use

- PHQ-9 Toolkit:

- CIDI Toolkit for Bipolar Screening:

Mental Health Resources for PCPs

integratedcare-nw.org