Depression in Primary Care

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Outline

- Background
  - Epidemiology and impact
  - Chronic illness and depression
- Diagnosis and monitoring: PHQ-9
- Treatment: STAR-D
- Quality of care
- Well-being

Epidemiology of Depression in Primary Care

- Prevalence of 10~15%
- Depression/MH one of top 3 reasons for physician visits
- “Hidden mental health system” (50%-70% of the outpatient care for depression)

Regier D. Arch Gen Psych. 1981.

Global Burden of Disease
Percent of Total DALYs Worldwide

- Year 2020
  - Ischemic heart disease
  - Unipolar major depression
  - Traffic accidents
  - Cerebrovascular disease
  - Chronic Obstructive Pulmonary Disease (COPD)

**Functional Impairment in Depression and Other Chronic Conditions**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Physical Functioning Score</th>
<th>p-Value vs Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>75</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Hypertension</td>
<td>80</td>
<td>&lt;.005</td>
</tr>
<tr>
<td>Diabetes</td>
<td>85</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Arthritis</td>
<td>100</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>No Chronic Condition</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

A score of 100 represents perfect functioning. p-Values vs depression. Wells KB, et al. JAMA. 1989;262(7):914-919.

**The Economic Impact of Depression:** $83 Billion/Year

- $26.1 billion
- $51.5 billion
- $5.4 billion

Direct medical
Suicide
Workplace


**Absenteeism and “Presenteeism”**

- Mental/behavioral disorders account for more incapacity benefit claims than musculoskeletal disorders
- Although present at work, performance may be substantially reduced in MDD

**Chronic Illness and Depression**

- Higher prevalence of depression in patients with medical co-morbidities
  - Pain syndromes, diabetes mellitus, heart disease, neurological disorders, HIV
  - Prior depression appears to be a risk factor for development of CAD and diabetes mellitus
  - Depression present in 30%-40% of pts with CHF and in 50% s/p CABG and ACS.

Late-Life Depression

- 10% of adults > 65 in primary care settings have clinically significant depression
- More common in pts with persistent insomnia and after stressful life events
- Often undetected, especially in men and URM persons
- Older men have highest rates of completed suicide

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Case Vignette

“My Back Hurts...and I Feel Frazzled”

- Mr. P is a 52-year-old small business owner with a history of hypertension and AODM
- He reports 2-3 months of fatigue and chronic, occasionally debilitating back pain treated with OTC analgesics
- He feels “frazzled” by his work and does not do anything for fun anymore
- He denies feeling sad
- The remainder of the history is unremarkable
- On physical examination, he has no spinal tenderness and neurological exam is normal

Primary Care Patients With Depression Usually Present With Physical Symptoms

- 69% presented only with physical symptoms
- N=1146 patients with major depression

Primary Care Patients With Physical Symptoms Often Have Depression or Anxiety

About 1/3 of patients with chief complaint of a physical symptom have either a depressive or anxiety disorder.


“Grief that finds no vent in tears makes other organs weep.”

Henry Maudsley, MD

Diagnosis of Depression Often Missed When the Presentation Is Physical

22% of patients with MDD/Anxiety Disorder are recognized and diagnosed.


2 Question Depression Screen

During the past 2 weeks, have you had any of the following:

- Little interest in doing things?
- Felt down, depressed, or hopeless?

Yes | No
--- | ---
[ ] | [ ]
[ ] | [ ]
Mr. P. Initial Screen: The PHQ-2

During the past 2 weeks, have you had any of the following:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little interest in doing things?</td>
<td>X</td>
</tr>
<tr>
<td>Felt down, depressed, or hopeless?</td>
<td>□</td>
</tr>
</tbody>
</table>

Based on these PHQ-2 results you:

1. Consider this a negative screen and drop further questioning about depression.
2. Consider this a positive screen and pursue further evaluation.
3. Consider this a positive screen and initiate antidepressant Rx or referral for counseling.

UCSF Depression Screening

Available at: http://www.depression-primarycare.org.
Mr. P. PHQ-9 Depression Scale

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by the following problems?</th>
<th>Not at All 0</th>
<th>Several Days 1</th>
<th>More Than Half the Days 2</th>
<th>Nearly Every Day 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>6. Feeling bad about yourself, or that you are a failure</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>8. Moving or speaking too slowly</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Subtotals: 1 10 6

Total=17

PHQ-9

- Patient self-administered
- Validated in Spanish and Chinese
- Association between increasing PHQ-9 scores and likelihood of MD
- Useful for monitoring change over time


PHQ-9 Score

(HgbA1C for Depression)

- Remember 5, 10, 15, 20
- Cut points for depression severity
  - ≥5 mild
  - ≥10 moderate
  - ≥15 moderately severe
  - ≥20 severe
- Significant improvement = 5 point ↓
- Response = 50% ↓ or score < 10
- Remission = score < 5

Depression Stages of Treatment:

*Five “R”s*

Depression Treatment
Planning with PHQ-9

<table>
<thead>
<tr>
<th>PHQ-9 Severity</th>
<th>Provisional Diagnosis</th>
<th>Treatment Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;10</td>
<td>Mild/minimal depressive symptoms</td>
<td>Reassurance and/or supportive counseling</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate</td>
<td>Watchful waiting, Supportive counseling, If no improvement after 1 month, consider antidepressant</td>
</tr>
<tr>
<td>15-19</td>
<td>Moderately severe</td>
<td>Patient preference for antidepressant and/or counseling</td>
</tr>
<tr>
<td>&gt;20</td>
<td>Severe major depression</td>
<td>Antidepressants alone or in combination with counseling</td>
</tr>
</tbody>
</table>

Adapted from MacArthur Foundation Depression in Primary Care Initiative.

Case Vignette
“My Back Hurts...and I Feel Frazzled”

- Mr. P is a 52-year-old small business owner with a history of hypertension and AODM
- He reports 2-3 months of fatigue and chronic, occasionally debilitating back pain treated with OTC analgesics
- PHQ-9 = 17

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How would you treat Mr. P?

1. SSRI (sertraline)
2. SSRI (escitalopram)
3. SNRI (venlafaxine or duloxetine)
4. Other (bupropion or mirtazapine)
5. Refer for CBT
Medication Algorithm

- Usually start with SSRI
- Start low, titrate slowly
- Assess every few weeks
- Titrate dose until remission

Monitor progress using the PHQ-9

- Wouldn’t treat blood pressure without measuring it at every visit
- Wouldn’t prescribe hypoglycemic agents without following the HgbA1c
- Why accept casual, imprecise monitoring in depression?

Mr P was started on lexapro and is now taking 20 mg/day. He returns 3 months later and is a little better but not at baseline (PHQ-9 = 11).

What should you do now?

1. Increase lexapro to 30 mg
2. Switch to different SSRI
3. Add another medication (eg buproprion)
4. Continue lexapro, refer for CBT

The STAR*D Trial
(Sequenced Treatment Alternatives to Relieve Depression)
STAR-D*

- National consortium 23 psychiatric and 18 primary care clinics
- 4 levels of treatment, 14 wks each
- Level 1 = Citalopram; if no remission by 14 weeks patients moved to next level to switch or augment the medication

STAR-D* Treatment Levels

- **Level 1**: 30% achieved remission on citalopram (40 mg/day)
- **Level 2 Switch**: 1/4 achieved remission on bupropion SR (283 mg/day); sertraline (135 mg/day); or venlafaxine-XR (193 mg/day)
- **Level 2 Augmentation**: 30% achieved remission: bupropion SR 267 mg/day or buspirone 40 mg/day
- Switching or augmenting with cognitive therapy was equally effective to medication

STAR-D* Take Home Points

- Measurement based care is essential -- use PHQ-9!
- Inadequate response in 4-6 weeks and side effects tolerable, increase the dose
- No remission by 8-12 weeks: 1) augment with bupropion or 2) switch to another agent
- Likelihood of improvement after 2 medication trials is low: 6% additional remission step 3-4
- Remission associated with better prognosis

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Improving the Quality of Depression Treatment in Primary Care

Social Influences on Practice Study (SIP)

**Design**
- Randomized trial using *unannounced* Standardized Patients (SPs)
- 152 physicians from 4 physician collectives in 3 cities
  - Sacramento, CA
  - San Francisco, CA
  - Rochester, NY

Antidepressant Advertising

SP Roles

- “Louise Parker” (Major Depression)
  - 48 yo divorced Caucasian woman
  - Depressed mood for a month,
  - Worse past 2 weeks
  - Low energy, early awakening, no suicidality

- “Susan Fairly” (Adjustment Disorder)
  - 45 yo divorced Caucasian woman
  - Insomnia and low energy
  - No sleep/appetite disturbances and no significant interference with functioning
Distribution of SP Visits

<table>
<thead>
<tr>
<th>Major depression</th>
<th>n=51</th>
<th>n=50</th>
<th>n=48</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjustment disorder</td>
<td>n=49</td>
<td>n=49</td>
<td>n=51</td>
</tr>
</tbody>
</table>

Results: Impact on Prescribing

<table>
<thead>
<tr>
<th>Major depression</th>
<th>Brand specific request (n=51)</th>
<th>53%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>General request (n=50)</td>
<td>76%</td>
</tr>
<tr>
<td></td>
<td>No request (n=48)</td>
<td>31%</td>
</tr>
<tr>
<td>Adjustment disorder</td>
<td>Brand specific request (n=49)</td>
<td>55%</td>
</tr>
<tr>
<td></td>
<td>General request (n=49)</td>
<td>39%</td>
</tr>
<tr>
<td></td>
<td>No request (n=51)</td>
<td>10%</td>
</tr>
</tbody>
</table>

Adjusted Results

<table>
<thead>
<tr>
<th>Disease Type</th>
<th>Major Depression</th>
<th>Adjustment Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Request Type</td>
<td>AOR (95% CI)</td>
<td>AOR (95% CI)</td>
</tr>
<tr>
<td>Brand Specific</td>
<td>2.7 (1.1-6.8)</td>
<td>13.3 (4.2-42.1)</td>
</tr>
<tr>
<td>General</td>
<td>8.0 (3.0-21.6)</td>
<td>6.3 (2.0-20.1)</td>
</tr>
</tbody>
</table>

Patient Requests Improve Quality of Depression Care

- Standardized patients’ requests increased:
  - Antidepressant prescribing
  - Depression history taking
  - Inquiries about suicide
  - Guideline based care
  - Recognition of depression

- Patient requests a two-edged sword
  - Patient less likely to be under-treated if depressed
  - Patients more likely to be over-treated if not depressed

Kravitz RL, Epstein R, Feldman MD. JAMA 2005

Feldman MD et al. Medical Care. 2006
Feldman MD et al. Annals Fam Med. 2007
Depression and Suicide

Primary care physicians assess for suicide in patients with depression in only about 1/3 of visits*

Assess suicide risk
- Ideation, intent, plan, availability, lethality
- Consider “no suicide contract”

*Feldman MD et al. Annals Fam Med. 2007

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Well-being

“The secret of the care of the patient is caring for the patient.”
Peabody 1927

“The secret of the care of the patient is caring for oneself while caring for the patient.”
Candib 1995

Value Determination

“Well-being arises in part from the personal values that we develop and cherish, as well as the choices we make in our attempts to honor those values.”

Feldman and Christensen, 2001
Mindfulness

“Mindfulness means paying attention, on purpose, to one’s own thoughts, feelings and judgments . . . It is the practice of being fully present in our attention to where we are, what we are doing, and what is happening at the moment.”

(Epstein, 2001)

Thank You!

“Meaning is not something you stumble across, like the answer to a riddle or the prize in a treasure hunt. Meaning is something you build into your life. You build it out of your own past, out of your affections and loyalties . . . out of your own talent and understanding, out of the things you believe in, out of the things and people you love, out of the values for which you are willing to sacrifice something.”

John Gardner