Recognizing and Managing Depression in Primary Care

Charles E. Irwin, Jr., MD
Division of Adolescent Medicine
Department of Pediatrics
University of California, San Francisco
May 2009

USPSTF Recommendation
• Screening of adolescents (12-18 yrs) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (CBT or interpersonal) and follow up.
  – March 2009
  http://www.ahrq.gov/clinic/uspstf09/depression/chdeprrs.htm

Outline
• General Overview
• How to Make the Diagnosis
  – Hx taking
  – Physical exam
  – Screening Instruments
• Epidemiology
• Management

Major Depressive Disorder
• Primary care clinicians say of the teens they see:
  - 9-21% have MDD
• Impact school performance
• Substance use/abuse
• Associated with increased risk of suicidal behavior

Possible symptoms of MDD
• Appetite disturbance
• Sleep disturbance
• Fatigue or loss of energy
• Cardiopulmonary symptoms
• GI symptoms
• Neuromuscular symptoms
• Gynecological symptoms
• Dermatological symptoms
• Behavioral symptoms

History and Physical Exam
• Patient history
  – HEADSSS
• Family history (may need to ask parents separately)
• Complete physical exam
• BMI
• Neuro exam
• Consider labs
SIGECAPS looks for criteria for Major Depressive Disorder

S - Sleep disturbance: insomnia or hypersomnia
I - Interest or pleasure: diminished in almost all activities
G - Guilt: feelings of excessive worthlessness or guilt
E - Energy: fatigue or energy loss nearly every day
C - Concentration: diminished.
A - Appetite: weight loss or decreased appetite
P - Psychomotor agitation or retardation
S - Suicide: recurrent thoughts of death or suicidal ideation

Symptoms and Criteria for a Major Depressive Episode

- Depressed mood or loss of interest for a 2-week period (or irritability among children and adolescents), plus:
- Four or more of the following symptoms in the same 2-week period:
  - Weight loss or weight gain
  - Insomnia or hypersomnia
  - Being restless or being slow (psychomotor agitation or retardation)
  - Fatigue or loss of energy
  - Feelings of worthlessness or inappropriate guilt
  - Inability to concentrate
  - Recurrent thoughts of death or suicide ideations or plans

Symptoms in Adolescents

DMM IV ex of MDD
- Depressed mood most of the day
- Loss of interest in once favorite activities
- Weight loss/gain
- Insomnia/hypersomnia
- Psychomotor agitation/retardation
- Fatigue, loss of energy
- Decreased concentration, indecisive
- Loss of self esteem, guilt

As seen in teens
- Irritable or cranky mood
- Loss of interest in sports, video games, activities with friends
- Somatic complaints, failure to gain weight
- Excess late night TV, refusal to wake for school
- Talk of running away from home, Persistent boredom
- Poor school performance, frequent absences
- Oppositional/negative behavior

Depressive symptoms in Teens

- More sleep and appetite disturbances, delusions, suicidal ideation and attempts, and impairment of functioning than younger children with MDD
- More behavioral problems and fewer neurovegetative symptoms than adults with MDD
Differential diagnosis of depression

- Anemia
- Mononucleosis
- Hypothyroidism
- Hyperthyroidism
- Inflammatory bowel disease
- Collagen vascular disease

Major Depression & Co-morbidity

- 76% with major depression also had other diagnoses, two thirds of which preceded the depression diagnosis.
- Previous diagnoses among the 76% include:
  - Anxiety disorders (40%)
  - Conduct disorders (25%)
  - Addictive disorders (12%)

Source: Kessler, 1998

Symptoms of Bipolar disorder in adolescence:

- Markedly labile mood
- Agitated behavior
- Pressured speech
- Racing thoughts
- Sleep disturbances
- Reckless behaviors
- Illicit activities
- Spending sprees
- Psychotic symptoms such as hallucinations, delusions, irrational thoughts

Risk factors for Depression

- Genetics
  - 20% have + family hx; female gender
- Biology
  - puberty, premenstrual, postpartum
- Environment
  - Family conflict, substance use at home
- Negative life events
  - Divorce, loss of parent
- Individual factors
  - Poor self esteem, poor school performance
- Co morbidities
  - Mental health
  - Chronic medical conditions

Epidemiology of Depression

- Prevalence of MDD in children (< 13 y.o.) is 2.8%, with 1:1 ratio of girls to boys
- In adolescence (13-18 y.o.), prevalence is 5.6%, with a higher prevalence for girls than boys (5.9% vs. 4.6%)
- Lifetime prevalence among adolescents is 20%

Depression: Broad Measure

Sadness or Hopelessness which Prevented Usual Activities by Gender and Race/Ethnicity, High School Students, 2007

- White: 34.6%, 34.5%, 42.3%, 35.8%
- Black: 17.8%, 24.6%, 30.4%, 21.2%

Source: Grunbaum et al., 2008; YRBS; Self-report
Suicide: Seriously Considered
Gender and Race/Ethnicity, High School Students, 2008

Epidemiology of depression
• At any given time, up to one in 13 adolescents have major depression making it more common than asthma
• Each successive generation since 1940 is at greater risk of developing depression, and is identified at a younger age

Prognosis
• 70% of youth with a major depressive episode will have another episode in next 5 years
• Youth with depression have a 4x increased risk of an adult depressive disorder
• 20-40% of children with major depression will develop bipolar disorder eventually
• Can lead to impaired functioning in relationships, school etc…

Principles of Treatment
• Ensure safety
• Develop an alliance with the teen and parents
  – Confidentiality?
• Psycho-education
  – Addresses signs and symptoms of depression
  – Stresses importance of psychotherapy and psychiatric medications
  – Addresses misconceptions

Indications for PCP Care vs Specialist in Adolescents with Depression

Indications for PCP
• Initial episode of depression
• Absence of coexisting conditions
• Ability to make a no suicide contract

Indications for Specialist
• Chronic, recurrent depression
• Lack of response to initial treatment
• Coexisting substance abuse
• Recent suicide attempt or current suicidal ideation
• Psychosis
• Bipolar
• High level of family discord
• Inability of family to monitor patient’s safety

Depression-Treatment Options
• Cognitive Behavioral Therapy (CBT)
• Interpersonal therapy
• Pharmacotherapy
  – First line therapy, SSRI’s
  – Others– SNRI’s, Bupropion, TCA’s,
• Combinations of the above methods works best
• Family therapy
ABCs of CBT

You cannot control how you feel, but you can control what you think about, and this can influence how you feel.

Cognitive Behavioral Therapy

- Treatment targets patient’s thoughts and behaviors to improve mood
- Essential elements of CBT include:
  - increasing pleasurable activities
  - reducing negative thoughts
  - and improving assertiveness and problem-solving skills to reduce feelings of helplessness.

Interpersonal therapy for depression

- Interpersonal problems may cause or exacerbate depression and that depression, in turn, may exacerbate interpersonal problems.
- Treatment will target patient’s interpersonal problems to improve both interpersonal functioning and his/her mood.

Pharmacological Treatment

- Selective Serotonin Reuptake Inhibitors (SSRIs) are first line for medication for adolescents for depression and anxiety
- Fluoxetine, only drug approved for treatment of MDD among youth.

What is a “Black Box Warning?”

- It is a required statement on the package insert that accompanies every prescription
- It is the strongest warning from the FDA to prescribers and patients regarding possible adverse effects of a medication
- HOWEVER, it is not a contraindication for use of a medication

Black Box Warning

- FDA put on all antidepressants in 2004.
- “...increase the risk of suicidal thinking and behavior (suicidality) in children and adolescents with major depressive disorder (MDD) or other psychiatric disorders.”
- Rx with SSRI’s leads to 1-2% absolute increase in risk of suicidality
If starting an antidepressant

• Confirm your diagnosis
  – BDI, PHQ-A
• Start low and advance slowly
• Follow up frequently—the black box warning recommends weekly for the first 4 weeks and when a dosage change is made
• If no improvement after 6 weeks consider changing meds and reconfirm diagnosis
• If the patient has a family member who has had a good response to a particular SSRI, that may be helpful in selecting a medication.

Talking points to patients and families about SSRI’s

• Need to supervise medication administration;
• If your child has threatened or attempted suicide, keep medication in a secure location.
• Likely duration of medication treatment 6 months to 1 year after symptoms improve and sometimes longer
• Medication should be stopped gradually under doctor’s supervision, due to the possibility of withdrawal symptoms

SSRI’s Side Effects

• Nausea
• Loss of appetite
• GI upset
• Minimal weight loss
• Headache
• Agitation
• Akasthesia
• Sexual dysfunction
• Increased clotting time
• Hypomania or mania
• Sedation or insomnia
• Vivid dreams

Questions at follow up

• Missed doses
• Stomachaches/Headaches
• Restlessness
• Unsettled thoughts
• Suicidal thoughts
• Positive effects

Initial strategies

• Know the resources in your community
• Education for patients and families
• No suicide contracts
• Removing firearms, medications, sharp objects from where they are accessible.

Summary

• Major burden—disabling condition
• Hx taking/Screening tests are effective in making dx of MDD
• Effective treatment leads to decrease in symptoms & improved functioning
• Harm from treatment—minimal
References


Kessler RC, Walters EE. Epidemiology of DSM-III-R major depression and minor depression among adolescents and young adults in the National Comorbidity Survey Replication. JAMA 2003;289:2469-75


March JS, Silva S, Petrycki S, et al. Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents With Depression Study (TADS) randomized controlled trial. JAMA 2004;292:807-20


