Management of Depression

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Depression

Depression is not uniform. Everyone does not experience the same signs and symptoms.
It varies from Person to person.




- **Does Every patient having Major depressive disorder require treatment?**

YES

Management

1)Investigation: - **CBC, BSL, RFT, LFT,**
TFT, USG, CT scan / MRI
to R/O DM/HTN/ Metabolic disorder etc.
Other organic causes

2)Treatment: - **Pharmacotherapy**
Psychotherapy
ECT (ELECTROCONVULSIVE THERAPY)
Psychosocial interventions
Combined Therapy

Choice of treatment:

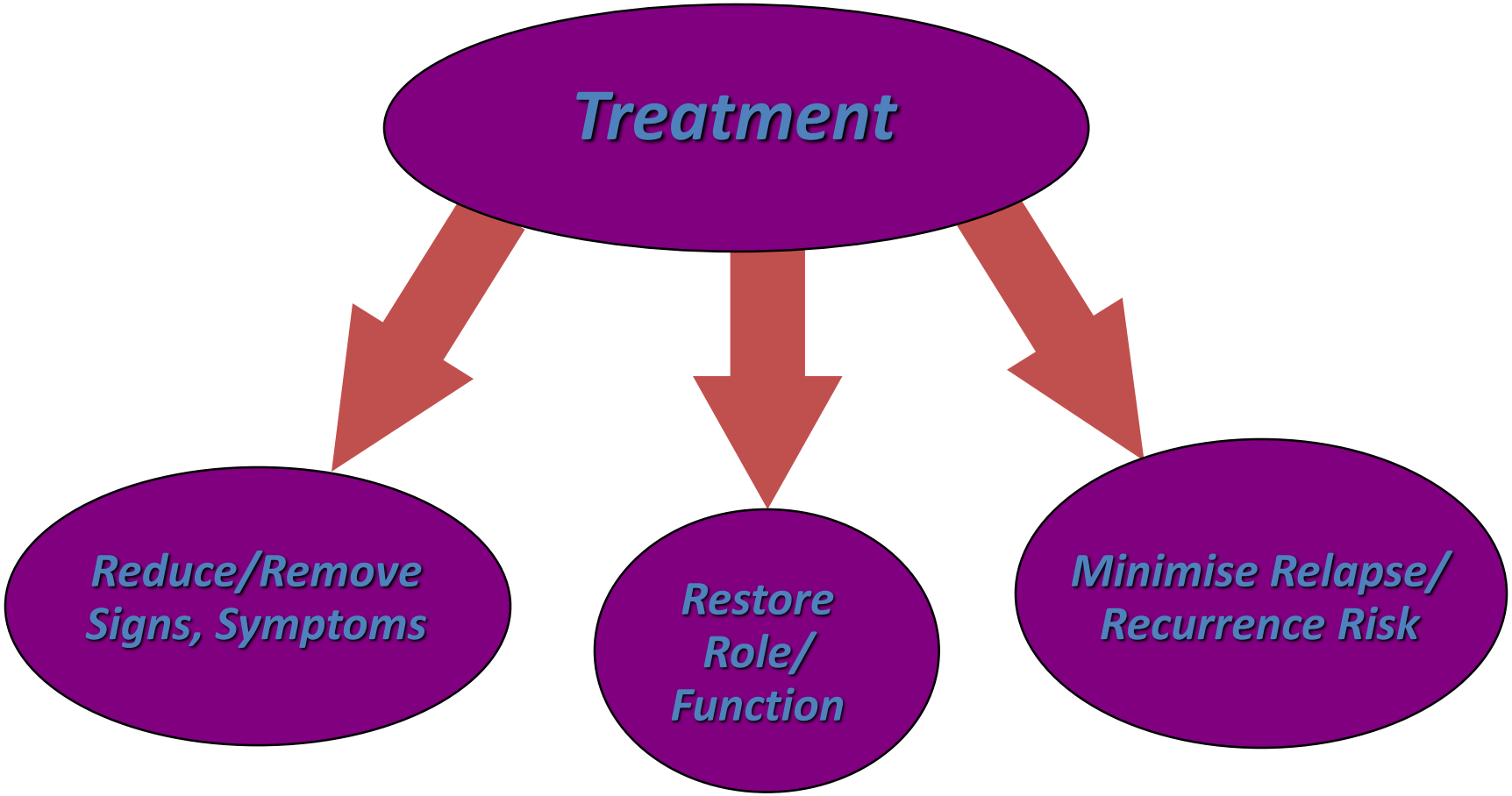
A) OPD basis

B) Hospitalization/Indoor

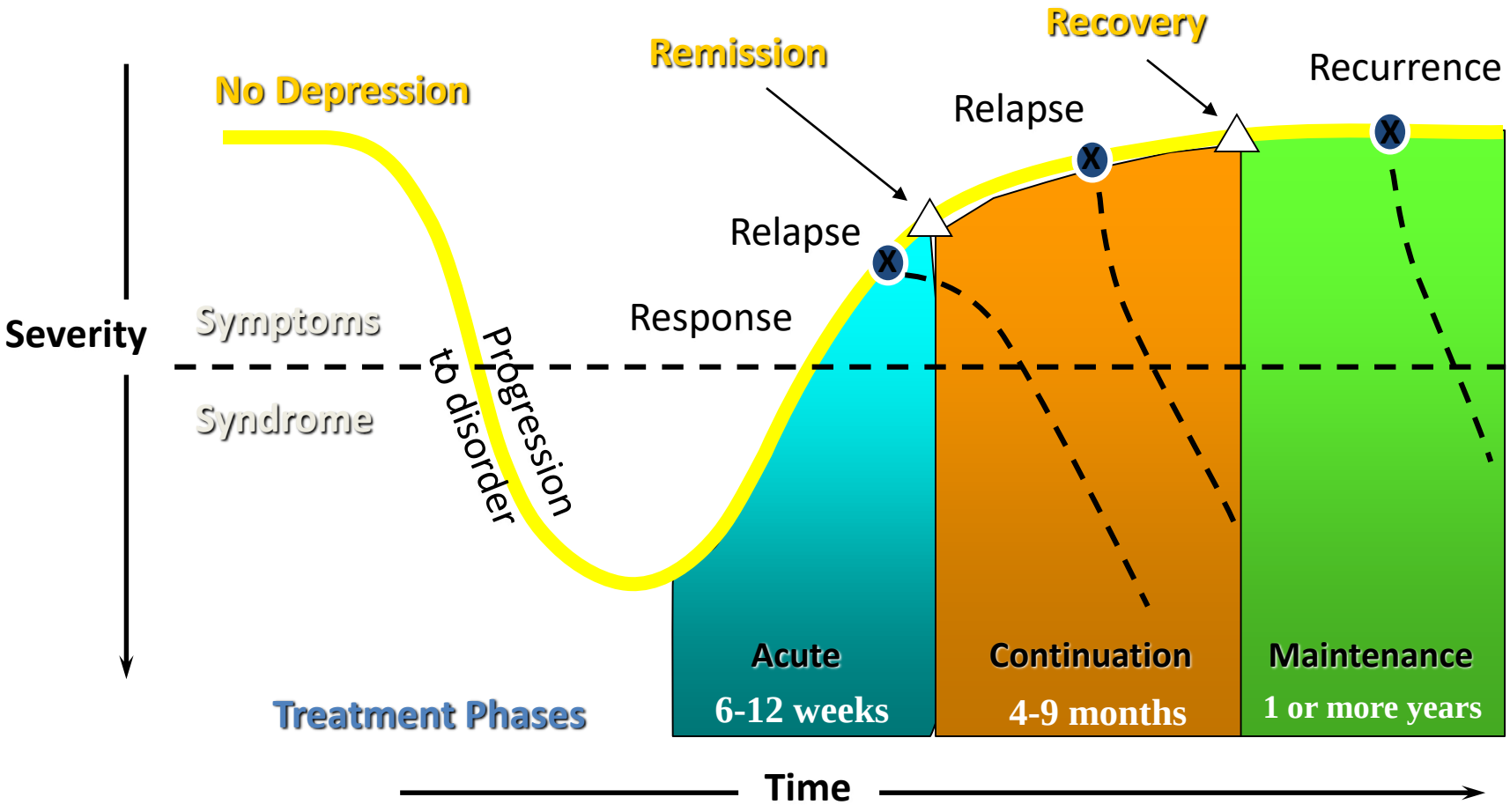
Choice depends on :

1) Risk of harm to self/Others
2) Suicidal Ideations
3) Not taking care of self
4) Presence of co-morbid physical and psychiatric conditions

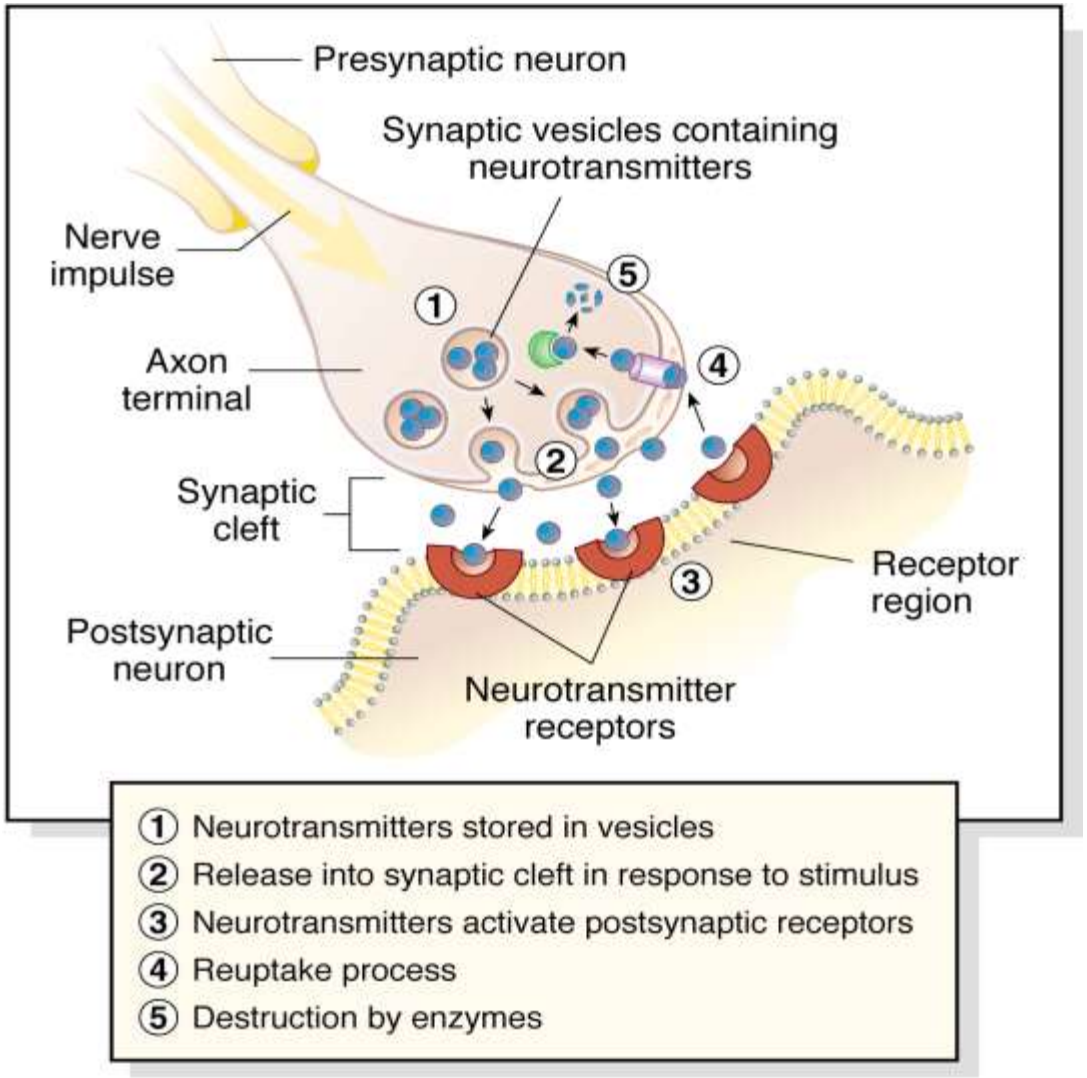
Depression: Treatment Goals



Depression: Treatment Goals



Medications for Depression



The Aim of an antidepressant is to Stabilize and normalize the neurotransmitters in our brain. Neurotransmitters such as serotonin, dopamine and norepinephrine play a role in regulating our mood.

Acute phase:

Aim –

Reduction of symptoms and risk of self harm

Improvement of functioning

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Choice of drug depends upon

1) Present Symptoms.
2) Side Effect profile.
3) Co-morbid illness.
4) Cost effectiveness

Duration of Rx- 6-12 weeks

Pharmacotherapy- Antidepressants

- Tricyclic Antidepressants (TCAs)
  Imipramine, Clomipramine

- Monoamine Oxidase Inhibitors (MAOIs)
  Tranylcypromine, Moclobemide

- Selective Serotonin Reuptake Inhibitors (SSRIs)
  Fluoxetine, Citalopram, Escitalopram, Paroxetine, Fluvoxamine.

Pharmacotherapy - Antidepressants

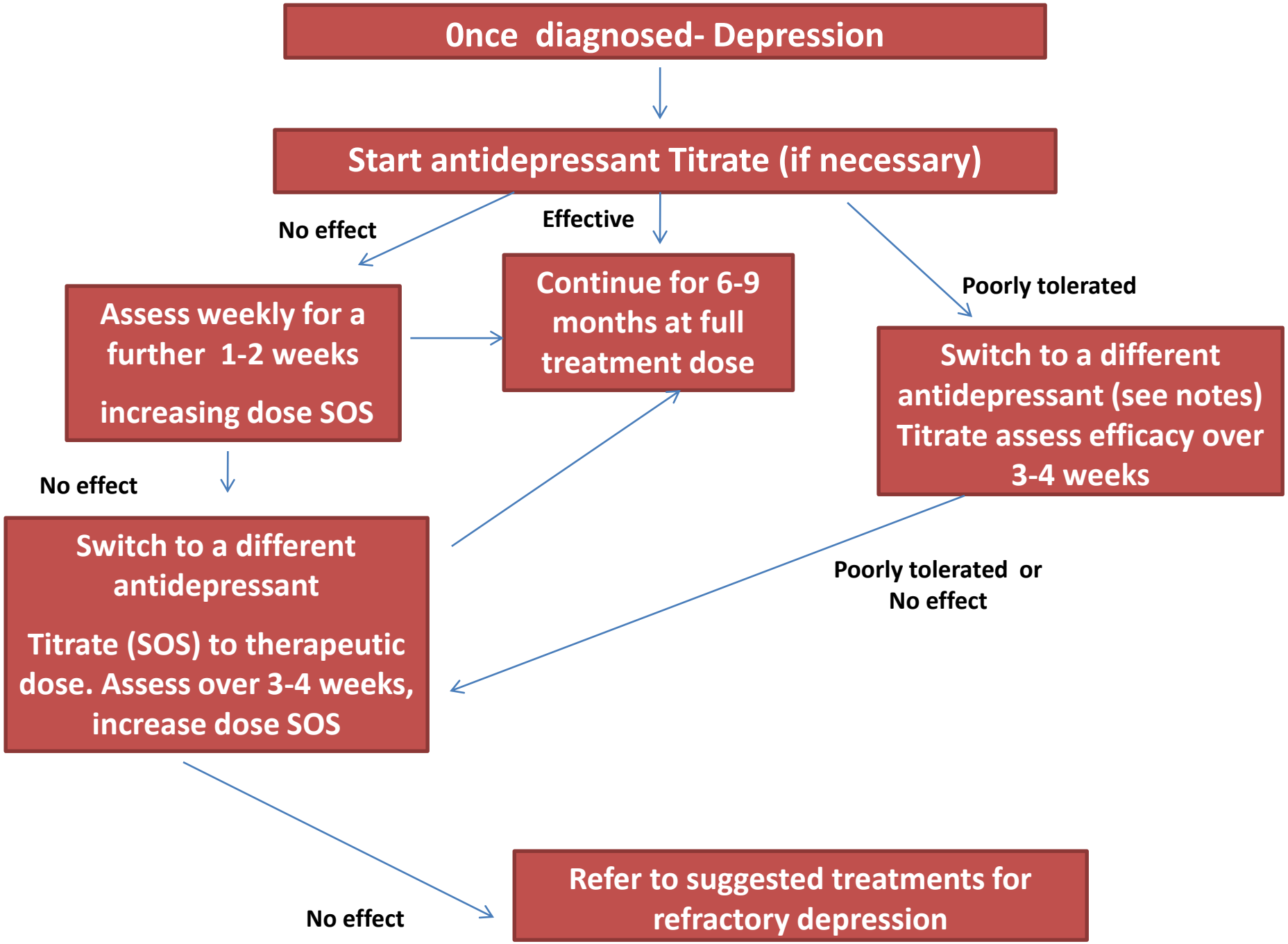
- Selective Noradrenaline Reuptake Inhibitor (NRI) Reboxetine
- Serotonin-Noradrenaline Reuptake Inhibitors (SNRIs) – Duloxetine,Venlafaxine,Desvenlafaxine
- Serotonin-2 Antagonist and Reuptake Inhibitors (SARIs) – Trazodone, Nefazodone
- Noradrenergic and Specific Serotonergic Antidepressants (NaSSA) – Mirtazapine
- Dopamine and Noradrenalin Reuptake Inhibitors (DNRI) – Bupropion

Which drug should be Preferred?

- ? **SSRI-** Fluoxetine, Citalopram, Escitalopram, Paroxetine, Fluvoxamine.

- ? **TCA** - Imipramine, Clomipramine, Amitryptyline

- **Atypical antidepressants--** Consider comorbid Illness . May or may not be used.


Once diagnosed- Depression
Start antidepressant Titrate (if necessary)
No effect
Effective
Poorly tolerated
Assess weekly for a further 1-2 weeks
increasing dose SOS
Continue for 6-9 months at full treatment dose
Switch to a different antidepressant (see notes) Titrate assess efficacy over 3-4 weeks
No effect
Switch to a different antidepressant
Titrate (SOS) to therapeutic dose. Assess over 3-4 weeks, increase dose SOS
Poorly tolerated or
No effect
No effect
Refer to suggested treatments for refractory depression

SSRI	Licensed Does	Main adverse effects	Major interactions
Fluoxetine	20 – 60 mg	As for citalopram but insomnia and agitation more common	Inhibits CYP2D6, CYP3A4, Increases plasma levels of some antipsychotics/ some benzos/ carbamazepine/ Ciclosporin/phenytoin / tricyclics.
Citalopram	20-60 mg / day	Nausea, vomiting, dyspepsia, abdominal pain, diarrhea, rash, sweating, agitation, anxiety, headache, insomnia, tremor, sexual dysfunction (hyponatraemia, cutaneous bleeding disorders	Not a potent inhibitor of most cytochrome enzymes
Escitalopram	10 – 20 / day	As for citalopram	As for citalopram

SSRI	Licensed Does	Main adverse effects	Major interactions
Fluvoxamine	**50 – 300 mg**	**As for citalopram but nausea more common**	**Inhibits CYP1A2/2C9/3A4 Increases plasma levels of some benzos / carbamazepine / ciclosporin / methadone /olanzapine / clozapine / phenytoin / propranolol/ theophylline / some tricyclics / warfarin**
Paroxetine	**20 – 60 mg / day**	**As for citalopram but antimuscarinic effects and sedation more common Extrapyramidal symptoms more common**	**Potent inhibitor of CYP2D6 Increases plasma level of some antipsychotics / tricyclics**
Sertraline	**50 – 200 mg / day**	**As for citalopram**	**Inhibits CYP2D6 Increases plasma levels of some antipsychotics / tricyclics**

Antidepressant	Licensed doses	Main adverse effects	Major interactions
Venlafaxine	**75 – 375 mg / day**	**Nausea , insomnia, dry mouth, Somnolences, dizziness, sweating , nervousness, headache, sexual dysfunction, constipation HTN Elevation of blood pressure at higher doses.**	**Metabolised by CYP2D6/3A4 - caution with drugs known to inhabit both isozymes minimal inhibitory effects on CYP2D6**
Mirtazapine	**15 – 45 mg / day**	**Increased appetite weight gain, drowsiness, oedema, dizziness headache, Blood dyscrasia Nausea / sexual dysfunction relatively uncommon**	**Minimal effects on CYP2D6 /1A2/3A4**
Reboxetine	**4 – 6 mg bd**	**Insomnia, sweating dizziness, dry mouth constipation, nausea, tachycardia, urinary hesitancy, headache erectile dysfunction may occur rarely**	**Metabolised by CYP3A4 Avoid drugs inhibiting this enzyme (e.g. erythromycin ketoconazole).**

Tricyclic	Licensed doses	Main adverse effects	Major interactions
Amitriptyline	25 – 200 mg / day	Sedation, often with hangover; postural hypotension; tachycardia/ arrhythmia; dry mouth, blurred vision, constipation, urinary retention.	SSRIs (except citalopram), phenothiazines, cimetidine - plasma levels of TCAs Alcohol, antimuscarinics, Antipsychotics, MAOIs
Clomipramine	10 – 250 mg / day	Same As Amitriptyline	As for Amitriptyline
Imipramine	10 – 200 mg / day	As for Amitriptyline but less sedative	As for Amitriptyline
Nortriptyline	30-150 mg/day	As for Amitriptyline but less sedative/ Anticholinergic/ Hypotensive Constipation.	As for Amitriptyline

Drug	Sedation	Hypotension	Antichilinergic effects
Tricyclics			
Amitriptyline	+++	+++	+++
clomipramine	++	+++	++
Dosulepin	+++	+++	++
Doxepin	+++	++	+++
Imipramine	++	+++	+++
Lofepramine	+	+	+
Nortriptyline	+	++	+
Trimipramine	+++	+++	++
Other antidepressants			
Agomelatine	+	-	-
Duloxetine	+/-	-	-
Mianserin	++	-	-
Mirtazapine	+++	+/-	+
Reboxetine	+	-	+
Trazodone	+++	++	-
Venlafaxine	+/-	-	+/-
Selective Serotonin Reuptake inhibitors (ssris)			
Citalopram	+/-	-	-
Escitalopram	+/-	-	-
fluoxetine	-	-	-
Fluvoxamine	+	-	-
paroxetine	+	-	+
Sertraline	-	-	-
Monoamine Oxidase inhibitors (Maois)			
Isocarboxazid	+	++	++
Phenelzine	+	+	+
Tranyicypromine	-	+	+
Reversible inhibitor of monoamine oxidase A (RIMA)			
Moclobemide	-	-	-

Continuation Phase

This phase begins once the acute symptoms reduce in severity or remit

Aim: **Continued reduction of symptoms**
Prevention of replapse

Duration of Rx 16 - 20 weeks following complete remission.

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Maintenance Phase :

Aim – **1. Maintaining & Improving level of Functioning**
2. Prevention of Recurrences

Indications:

1. Partial response to acute treatment
2. Poor symptom control during the continuation treatment.
3. Risk of Recurrence :
   more than 3 episodes (90% chances of recurrence).
   more than 2 episodes with early age of onset or recurrence within 2 years of stopping antidepressants,
4. Severe or life- threatening depression / chronic depression or double depression.
5. Family history of mood disorder
6. Side effect Profile of the medications .

ELECTROCONVULSIVE THERAPY

Indications for ECT

1) Severe depressive symptoms/ ideation / attempts

3) Associated Psychotic symptoms

4) Severe functional impairment

5) Post partum depression(Urgent recovery is needed)

6) Patient peferences

7) Prior responses

Can Cosider ECT in all phases of treatment .

Psychotherapy

- Psychodynamic therapy
- Interpersonal psychotherapy
- Cognitive behavior therapy
- Rational emotive Behaviour Therapy
- Marital and family therapy

Can be used in all phases of treatment

Social Interventions:
Role Of Psychiatric Social Worker

- **Family / Relative Problems.**
- **Visits Home / Work place.**

Diet

Yoga/Relaxation

Exercise

STRESS

Professional Helps

CBT/REBT

Catharsis

Sex

Hobbies- Travelling, reading,singing etc

- **Relapse of depression** :

  After one episode 50%,

  After 2 episodes 75%,

  After 3 episodes 90%

  Risk reduced if patient accesses CBT

- **Duration of antidepressant treatment** :

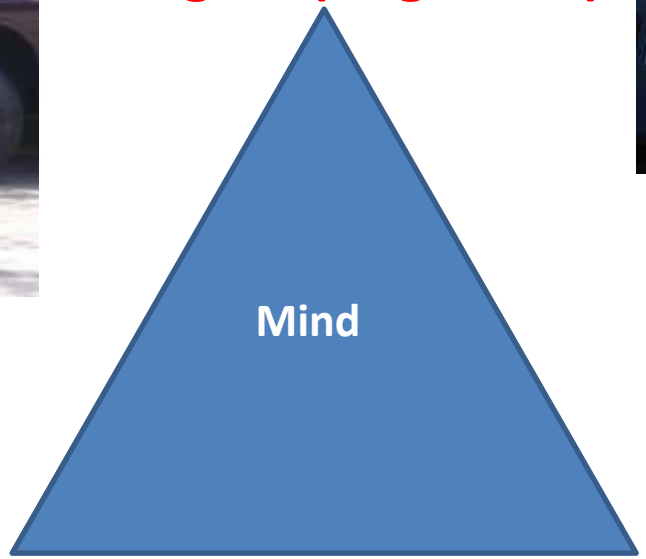
  First episode – 6-12 mths

  Second episode – 12-24 mths

  Third + episode – 24 mths plus ??long-term Rx

Cognitive Therapy/REBT

Thoughts (Cognition)



Emotion
(Feelings)

Behavior
(Action)

Mind Equilibrium Triangle
Rational / Irrational Thinking

Take home message?


THANK YOU

- Serotonin syndrome:
  - At high doses or combined with other drugs an exaggerated response can occur
    - This is due to increased amounts of serotonin
    - Alters cognitive function, autonomic function and neuromuscular function
    - Potentially fatal

- Serotonin withdrawal syndrome:
  - With discontinuation of any SSRI onset of withdrawal symptoms occur within a few days and can persist 3-4 weeks
  - Symptoms: disequilibrium, gastrointestinal problems, flu-like symptoms, sensory disturbances, sleep disturbances