Spring CME Event
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Referrals and Consults

- Anyone is welcome to staff message me with questions
- If you practice in a BHIP clinic or VFM, you can request that I directly evaluate a patient for a psychiatric consult
- I do NOT have a practice at Valley's Psychiatry & Counseling clinic, but I have 7 awesome colleagues to whom you can refer patients
  - Commercial insurance and older Medicare accepted; REF91

Referrals and Consults

- Other resources: UW Psychiatry Provider Consult Lines
  - Adults: 877-WA-PSYCH (877-927-7924)
  - Pediatric: 866-599-7257 (Seattle Children's)
  - Perinatal: 877-725-4666

Optimizing Depression Management

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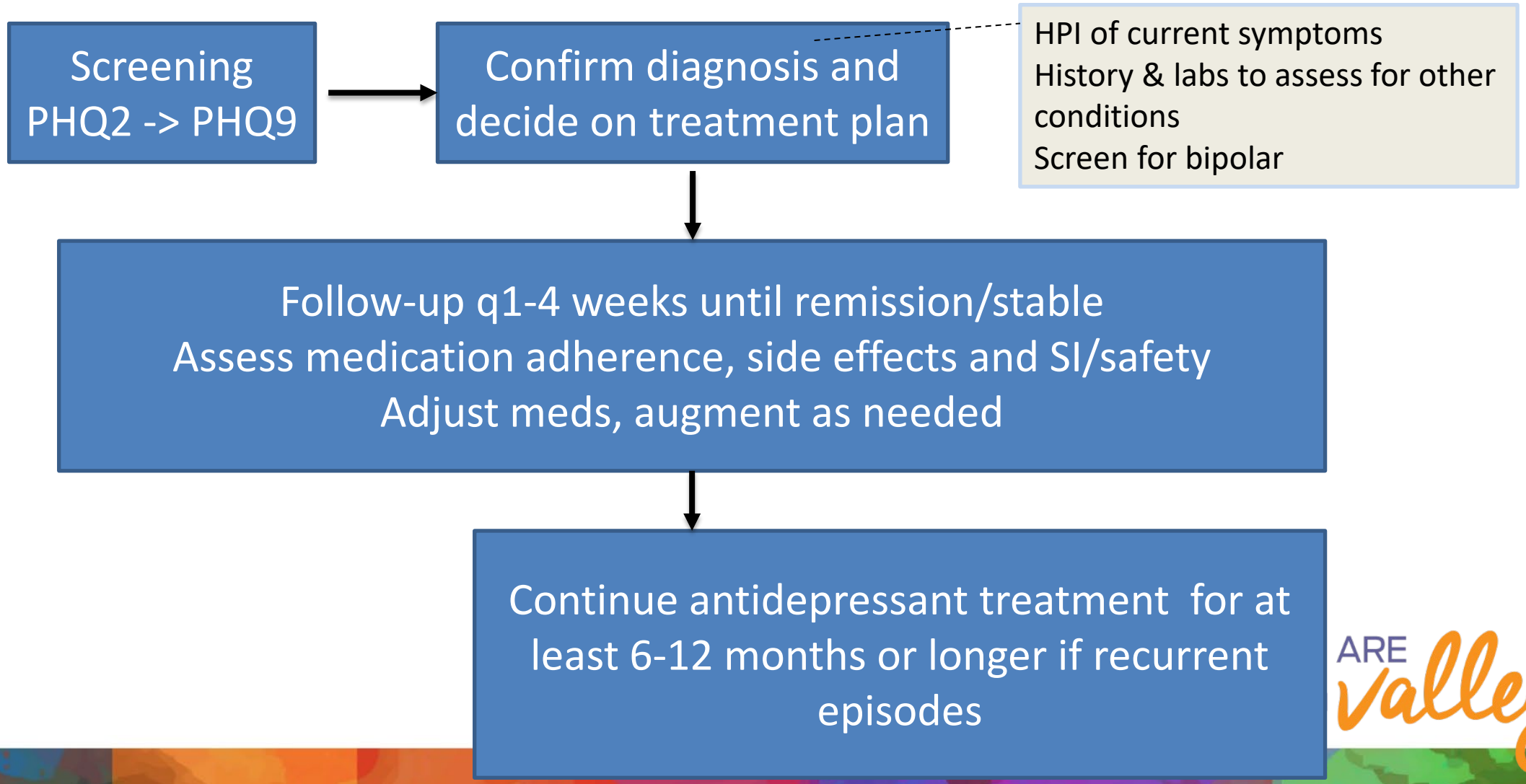
UW Medicine Valley Medical Center

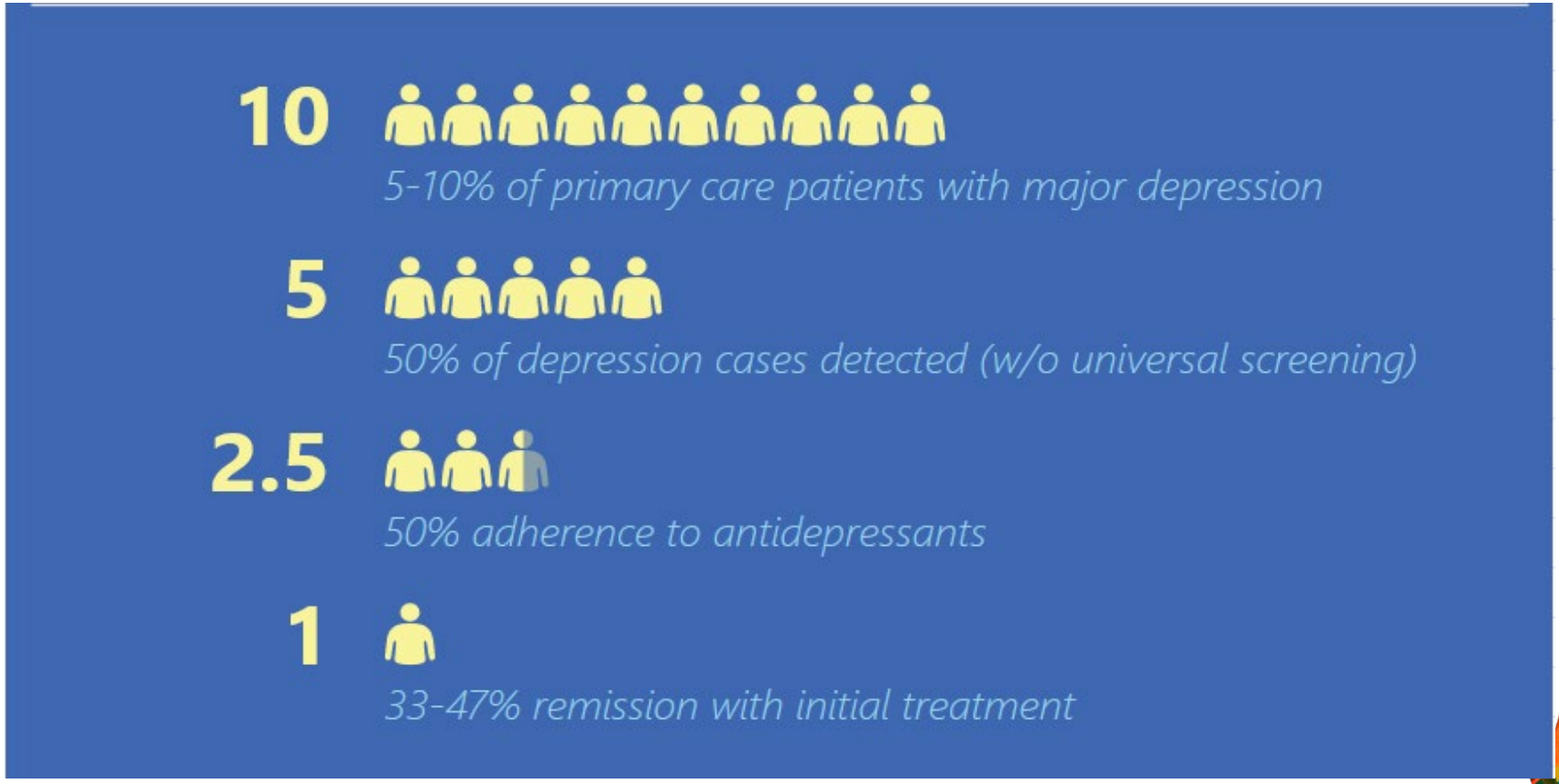
Objectives

- 1. To discuss the importance of regular follow-up, assessment and treatment adjustment when managing depression.
- 2. To describe evidence-based treatment and augmentation strategies for depression

Brief Overview of Depression CPG



Importance of Screening and Follow-up for Depression



Those with chronic medical conditions are at higher risk for depression and may have more severe or difficult to treat depression than those with depression alone.

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Depression Screening & Monitoring

- PHQ9 has been widely validated as a diagnostic measure, and as a responsive and reliable measure of depression treatment outcomes
- Other depression screeners– Edinburgh postnatal, geriatric depression scale, HAM-D
- Also consider patient's objective presentation and functioning (work, school etc…). If discrepancy with PHQ9 score, ask questions to clarify.
- In general, a **5-point reduction** in PHQ9 is considered a significant change

There are so many depression diagnoses in Epic. Which do I use?

Diagnosis	ICD10 Code	When to Use
Major depressive episode (HCC if specifiers included)	F32.x, F33.x	Approx 10+ on PHQ9, and score on question 1 (depressed mood) and/or 2 (anhedonia) =2 or 3]
Adjustment disorder with depressed mood/mixed anxiety and depressed mood	F43.21/ F42.23	Identifiable stressor and pt does not meet criteria for MDE
Depression, unspec Other depression Other recurrent depressive disorders (HCC)	F32.A/F32.89/ F33.8	Pt does not meet criteria for another diagnosis OR You lack sufficient information to make a more specific diagnosis
Major depression, recurrent, chronic (HCC)	F33.9	Major depression for 2+ years w/o full remission

Major Depressive Episode Specifiers

- Single episode vs. recurrent
  - Single -1st time ever meeting criteria for MDE
  - Recurrent – has had at least one prior episode of MDE
- Severity: Mild, moderate, severe
  - Severe, with psychotic features or without psychotic features
- Remission
  - Partial remission (no longer meeting full criteria for a MDE, but still symptomatic)
  - Full remission

- 58 year-old woman with type 2 diabetes mellitus, hyperlipidemia and obesity scores 15 on the PHQ9 and 8 on the GAD7. She is open to trying a medication for depression but is worried about weight gain. Which antidepressant would you start?

Selecting an Antidepressant

- Factors to consider – past history, side effect concerns, co-occurring medical conditions
- Usually start with an SSRI or bupropion
  - Sertraline and escitalopram are good options
- However –
  - If good experience in the past with another AD, try it again
  - If chronic pain (FM/generalized, neuropathy, back), consider duloxetine
  - Avoid bupropion if higher risk for seizures, anorexia/bulimia nervosa
  - For adolescents – Fluoxetine is first line, sertraline/escitalopram 2nd line

Antidepressant Selection: Other Tips

Patient Has	Antidepressant Consideration
Anxiety	Serotonergic antidepressants work best.
Obesity	Weight gain: Bupropion, fluoxetine <<<paroxetine, mirtazapine, TCA's
Cardiovascular disease	Sertraline - best record of CV safety Citalopram, TCA's: Discouraged in patients with or at higher risk for prolonged QTc/TDP
Concern for sexual side effects	Less likely with bupropion or mirtazapine
Pregnancy	Best safety data for fluoxetine, sertraline, citalopram, escitalopram, (tricyclic antidepressants)

Pharmacogenomic testing with decision support tools – insufficient evidence to support routine use

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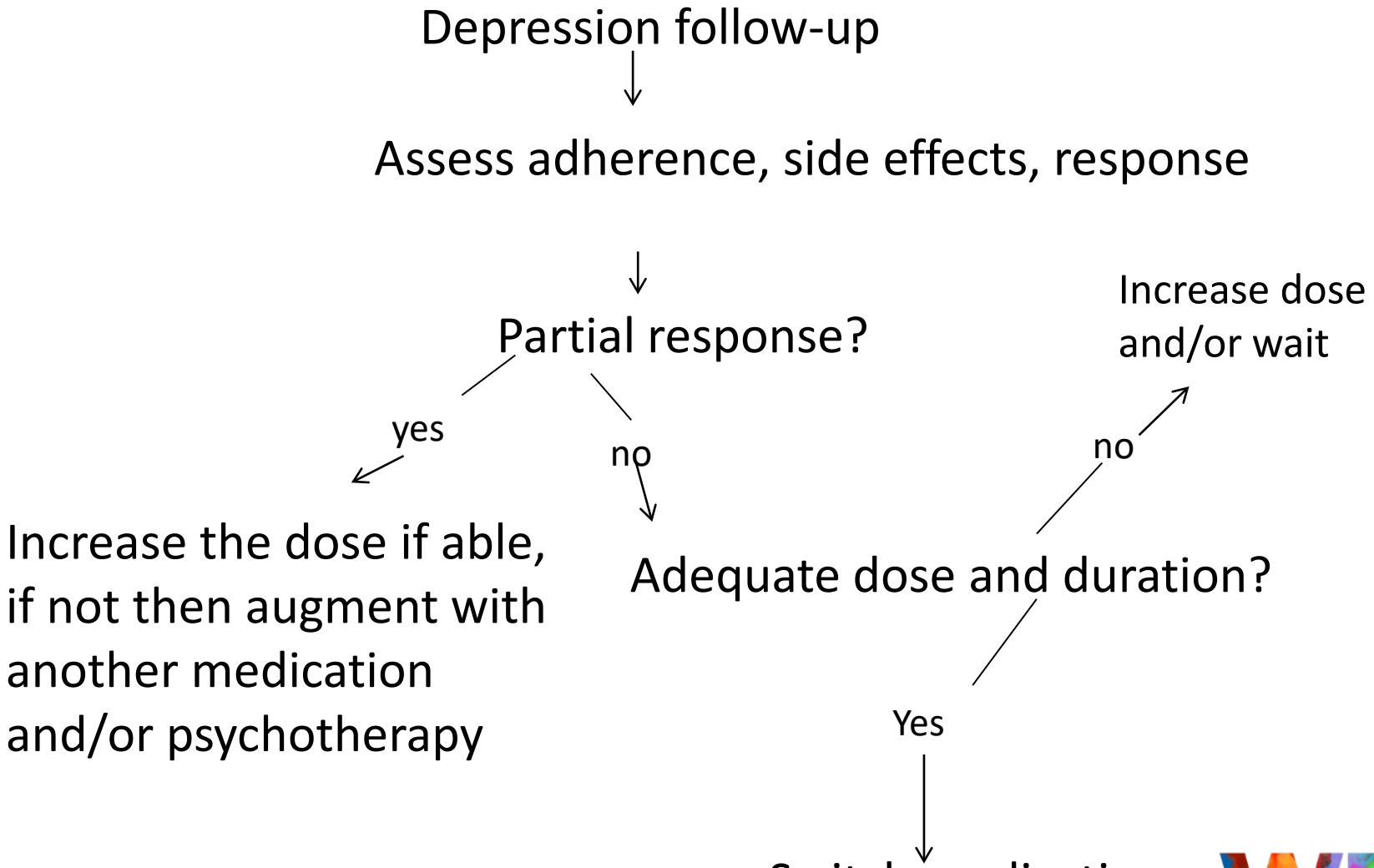
Medication adherence

- Reasons for nonadherence include side effects, no perceived benefit, forgetting, cost
- Educational interventions to improve adherence alone have not been shown to be effective
  - Best strategies involve proactive care management, telephone follow-up, and/or frequent visits, along with identifying and addressing barriers to adherence.

- 58 year-old woman with obesity, diabetes, hyperlipidemia and depression has been on escitalopram 10 mg qday for 1 month. PHQ9 score is 10 and GAD7 score is 3.
- What would you do next?


Depression follow-up
Assess adherence, side effects, response
Partial response?
yes
no
Increase the dose if able, if not then augment with another medication and/or psychotherapy
Adequate dose and duration?
no
Increase dose and/or wait
Yes
Switch medications

Antidepressant Augmentation Strategies

Treatment	Key Symptoms Addressed	Dosing
Buspirone	Anxiety is prominent	10-30mg BID
Bupropion	Depression/fatigue/poor concentration	150mg-450mg qday XL
Psychotherapy	Stressors, coping, negative thoughts	
Lithium*	Depression, anxiety, mood swings	~300-1200mg qday
T3 (Cytomel)*	Depression	25-50mcg/day
Mirtazapine	Depression/anxiety/sleep/appetite	7.5-45mg qbedtime

*Lab monitoring required

Augmenting with Atypical Antipsychotics

1-2 weeks to notice an effect

Typically lower doses than used for psychosis:

- Risperidone 0.25-2mg qday
- Aripiprazole 2-20mg qday
- Quetiapine 50-300mg qday
- Olanzapine 5-20mg qday
- Ziprasidone 20–80 mg BID
- Brexpiprazole 2-3mg qday

Quetiapine also effective as monotherapy for depression (150-300mg qday)

Other Augmentation Strategies

- Light therapy
- Exercise
- Methylfolate (Deplin) – 2 RCT's favoring 15mg qday over placebo
- SAMe – 800mg BID, one small RCT supporting
- Stimulants –used off label for residual fatigue, poor concentration; evidence better for late life depression with apathy, fatigue or general medical illness
- Lamotrigine – no evidence for unipolar depression, but good for bipolar and used off label for mood instability/lability

- 58 year-old woman with obesity, diabetes, hyperlipidemia and depression has been on escitalopram for 2 months and is now up to 20mg qday. PHQ9 score is 13 and GAD7 score is 8.
- What would you do next?

Switching Antidepressants

- Switch to another antidepressant if:
  - No significant benefit despite an adequate trial
  - Intolerable adverse effects
  - Loss of effect after years of use (tachyphylaxis) and no benefit with an increase in dose
- A washout period is needed **only** if switching to or from a MAO inhibitor
- If more recent AD/lower dose – can make a direct switch to the other AD
- If longer history on the AD/higher dose – a cross taper may be better tolerated

Switching Antidepressants

- Suggestions re med choice when switching antidepressants
  - If two failed SSRI trials – move on to an SNRI or bupropion
  - If no luck with SSRI, SNRI or bupropion --- Appropriate to seek psychiatric consultation!
    - From a medication standpoint, other options include mirtazapine, TCA, quetiapine, or a newer antidepressant such as Viibryd or Trintellix
- Adolescents – fluoxetine is first line, then sertraline, escitalopram. After that, other SSRI's, bupropion, mirtazapine

Other Strategies for Difficult to Treat Depression

- ECT
  - Electrical current → seizure
  - 60-80% remission rate; relapse 38% at 6 months
  - Cons – General anesthesia, cognitive side effects, stigma
  - Typically given MWF, ~6-12 treatments; for some – monthly maintenance
- rTMS
  - Magnetic field generated below a coil, usually positioned over the patient's dorsolateral prefrontal cortex
  - 50% response rate, 33% remission rate; relapse in ~35%
  - Treatments typically 5 days per week for 4-6 weeks

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Other Strategies for Difficult to Treat Depression

- Esketamine
  - NMDA antagonist, opioid receptor agonist, AMPA activation
  - Response typically w/in 2-4 hours in 25-65%
  - Administered onsite: 2x per week for weeks 1-4, tapering down to once every 1-2 weeks

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