The Internist Blues:
Managing Depression in Primary Care

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Objectives:

At the end of the presentation attendees will be able to describe:

- The magnitude of the problem of depression in primary care
- Strategies to effectively diagnose depression in a primary care setting
- An approach to effectively treating depression
- Newer systemic approaches to improving depression care
- How to address concerns of Bipolar disorder in a patient presenting with depression
Case

A 67yo Male with h/o claudication & COPD presents to his primary care provider with **slow speech and sadness**.

- Not shaved in several days
- Lost 4.5 kg (10 lb) in the past 3 months
- Makes poor eye contact.
- The office staff remark about his appearance.
- You have known him to be depressed in the past, but he is not currently being treated.
- Wife died 6 months ago,
  - He has not gotten back to his usual routine
  - Feels socially isolated.

When asked how he is doing, he says, “Life isn’t what it used to be and I don’t see that it ever can be.”
Poll 1

This following is the most appropriate description of this patient’s problem

A. Normal Bereavement
B. Major Depression with high suicide risk
C. Major Depression with low suicide risk
D. Dementia
Overview

- Depression in Primary care
  - Magnitude of the problem
  - Nature of the problem
- Diagnosing Depression
  - Criteria
  - Clues/Red Flags
  - Screening instruments
- Counseling for Treatment
- Course of Treatment/Follow up
- Systematic Interventions
Depression/Anxiety in Medical Settings

- **General Population** - National Comorbidity Survey-replication
  - 12 month Prevalence
    - Any MH/SUD: 26%
    - Mood Disorders: 9.5%
    - Depression 8%
  - Globally: 2nd greatest cause of disability

Kessler et al. Arch Gen Psych 2005

Depression/Anxiety in Medical Settings

- Primary care:
  - ~35% patients have some form of Psychiatric illness
  - Depression 10.4% point prevalence
  - Some settings considerably higher.
    - eg: Veterans, Lower SES

Ustun Int Rev Psych. 1994
Depression/Anxiety in Medical Settings
Do I really have to deal with it?

- 60% of treatment for Psychiatric illness occurs in Primary care
  - Epidemiologic Catchment Area Study
- Patients often prefer treatment in primary care
- Limited Access to specialty mental health
  - Limited providers
  - Geographic distribution
What if we don’t deal with it?

- Patients with depression are seen more frequently.
- Spend more time in the hospital.
- Have higher health care costs.


Kathol et al. JGIM 2005
Depression/Anxiety in Medical Settings

I got scared. Unfortunately, I was standing on a concrete floor at the time...
Depression Diagnosis in Primary Care

- Clinical diagnosis of depression in primary care: A meta-analysis.
  - Pooled sample of 50,000 primary care patients
  - Clinical Diagnosis alone
    - Sensitivity 47.3%
    - Specificity 81%

- Commonest Reasons
  - Misjudgements about severity
  - “normal reaction”
Depression Treatment in Primary Care

- Of those diagnosed with depression
  - Less than half are offered treatment
- Even when screening/assessment data provided
  - <25% start therapy

- Why so low?
  - Underestimation of severity
  - Physician perception of patients receptiveness to treatment


Depression Treatment in Primary Care

- Minimally adequate therapy
  - Antidepressant at an adequate dose
  - Continuing medication for at least 3 months
  - Adjustment of dose if remission is not achieved
- Of those starting treatment
  - Only about half receive adequate care
- Why so low?
  - Low initial doses, lack of titration (Fluoxetine 10mg)
  - Lack of follow up
Overview

- Diagnosing Depression
  - Criteria
  - Clues/Red Flags
  - Screening instruments
- Counseling for Treatment
- Course of Treatment/Follow up
- Systematic Interventions
Recognizing Depression

- Patient complaint
- Screening
  - Brief questionnaires
  - 1-2 Questions
- And....
Major Depressive Disorder

- **Mnemonics**
  - SIGECAPS
  - SPACEDIGS

- **Depressed mood**
- Markedly diminished interest in usual activities (anhedonia)

- **Sleep**

- **Appetite (weight changes)**

- **Psychomotor agitation/retardation**

- **Fatigue or Loss of Energy**

- **Worthlessness or Guilt**

- **Difficulty thinking, concentrating, making decisions.**

- **Recurrent thoughts of death or suicide**
Diagnosing Depressive disorders: Screening

- 2 item screen:
  - During the past month have you often been bothered by:
    - Feeling down, depressed or hopeless?
    - Little interest or pleasure in doing things?
  - 1 positive answer has ~96% Sensitivity for Major Depression/Dysthymia

- Follow up with diagnostic questionnaires
  - PRIME-MD
  - PHQ-9
  - DSM-4 for Primary Care
# Patient Health Questionnaire (PHQ-9)

**Name:__________________________  Date:______________________________**

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "✓" to indicate your answer)

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Slightly</th>
<th>Most of the time</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

_Hyphenated columns:_

**Total:_______**

*Note: For interpretation of TOTAL, please refer to accompanying scoring chart.*

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10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Difficulty</th>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
</table>

PHQ-9 is adopted from PRIME MD TODAY, developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr. Spitzer at rls@cumcolumbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at http://www.pfizer.com. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.
Monitoring Depression Severity

PHQ-9

- Consists of the 9 DSM depressive symptoms, each scored 0 to 3
- Validated in 6000 primary care pts
- Depression severity cutpoints:
  - 5 mild
  - 10 moderate
  - 15 moderately severe
  - 20 severe

Kroenke, JGIM 2001; Kroenke & Spitzer, Psychiatric Annals 2002
Case 2

48 y/o female with h/o lumbar laminectomy and methamphetamine abuse, now in remission presents for an urgent add-on appointment.

- C/o increasing pain x 3 months
  - left sided chest pain,
  - headaches,
  - recurrence of her back pain.
- Intermittent nausea
- Swelling on the back of her neck.
- Meds: Gabapentin, ibuprofen OTC.
- Social Hx: on probation, part time job, living with uncle to save money.
  - Denies any recent substance use.
Case Cont’d

- VS: BP 130/86, HR
- Exam: mild tachycardia and benign appearing lipoma on shoulder.

While you are examining her she breaks down crying and says that these symptoms have been making her life very difficult. She has been unable to sleep and has been missing a lot of work. She is afraid that she is going to be fired.
Poll 2

This patient probably has:

A. Major Depression
B. Adjustment Disorder
C. Relapse on her substance use disorder
D. Fibromyalgia
Recognizing Depression

- Patient complaint
- Screening
  - Brief questionnaires
  - 1-2 Questions
- Red flags
Depression “Red Flags”

- Somatization
- Difficult encounters
- High clinic utilization
- Comorbidity
  - Psychiatric (non-depressive dx)
  - Medical (cardiac, cancer, CNS)
Number of Symptoms: ESR for Psychopathologic Inflammation

- **Study 1 (n = 500):**
  - 4 - 7%: 18 - 31%
  - 2 - 3: 18 - 31%
  - 0 - 1: 4 - 7%

- **Study 2 (n = 1000):**
  - ≥ 9: 78 - 81%
  - 6 - 8: 31 - 61%
  - 4 - 5: 31 - 61%
  - 2 - 3: 18 - 31%
  - 0 - 1: 4 - 7%

Kroenke & Rosmalen, Med Clin North Am 2006
1 out of 6 primary care visits is considered “difficult”

- Hahn: Primary care, 18%
- Hahn: Primary care, 15%
- Jackson: Symptoms, 15%
- Lin: High utilizers, 37%

Hahn, Ann Intern Med, 2001
How does the Clinician Feel? Psychiatric Disorders as Predictors of a Difficult Visit (n = 627 primary care patients)

<table>
<thead>
<tr>
<th>PSYCHIATRIC DIAGNOSIS</th>
<th>ODDS RATIO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somatoform</td>
<td>8.9</td>
</tr>
<tr>
<td>Depression</td>
<td>2.9</td>
</tr>
<tr>
<td>Anxiety</td>
<td>2.8</td>
</tr>
</tbody>
</table>

Hahn, J Gen Intern Med, 1996
Depression/Anxiety & Somatization in Primary Care

- 685 Family Practice Patients
- Depression/Anxiety prevalence: 75/685 (11%)
- 73% present exclusively somatically
- Of these, 3 subtypes:
  - INITIAL (1/2): “volunteer” psychological attributions if asked cause
  - FACULTATIVE (1/3): “admit” psychological attributions if specifically asked.
  - TRUE (1/6): “reject” psychological attributions if specifically asked.
Overview

- Diagnosing Depression
- Counseling for Treatment
  - Engaging patient in treatment
  - Discussing referral
- Course of Treatment/Follow up
- Systematic Interventions
At least one-third of patients quit taking antidepressants BECAUSE...

...the patient feels

WORSE

Side effects

1-2 weeks

SAME

Poor response

3-6 weeks

BETTER

Good response

Linden et al, J Clin Psychiatry, 2000
Major Depressive Disorder

- Explain expected time course of response
  - Side effects- usually immediate, but resolve
  - Onset of action ~2 weeks
  - Peak action at 4-6 weeks
  - Adequate trial: 6-8 weeks at adequate dose
What to tell patients about antidepressant medication?

- “They are not habit-forming”
- “Improvement is gradual - may take 4-6 weeks”
- “If side effects occur, they usually disappear in a few weeks”
- “You need to take it every day”
- “Call me if you are thinking about stopping it”
Overview

- Diagnosing Depression
- Counseling for Treatment
- Course of Treatment/Follow up
  - Acute Phase
  - Continuation Phase
  - Maintenance Phase
- Systematic Interventions
Major Depressive Disorder

- Three phases of treatment
  - Acute
    - 8-12 weeks
    - Goals of treatment
      - Response by 4-6 weeks
      - Remission by 12 weeks
Monitoring
Acute Phase

- Side effects: 1-2 weeks
- Partial Response: 4-6 weeks
- Full Response: 12 weeks
Aiming for Remission

Depressed
  ↓
Response
  ↓
Remission

Unstable angina
  ↓
Stable angina
  ↓
No angina
How long should I continue the antidepressant?
Major Depressive Disorder

- Average length of episode: 4-6 months
- Recurrence rate without maintenance Rx:

![Diagram showing recurrence rates after one, two, and three episodes.](chart.png)

- After One Episode: 50%
- After Two Episodes: 75%
- After Three Episodes: 90%
How long should I continue the antidepressant?

<table>
<thead>
<tr>
<th>No. Episodes</th>
<th>Duration to Treat</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6-12 mo</td>
</tr>
<tr>
<td>2</td>
<td>1-2 yrs</td>
</tr>
<tr>
<td>3</td>
<td>5 yrs - Life</td>
</tr>
</tbody>
</table>
Major Depressive Disorder

- Three phases of treatment
  - Consolidation
    - For everybody: Prevent early relapse
    - 6 months-1 year
  - Maintenance:
    - For selected patients: Prevent recurrence
    - Long term (5yrs-lifelong)
    - Dose that gets you well keeps you well.
Overview

- Diagnosing Depression
- Suicide
- Counseling for Treatment
- Course of Treatment/Follow up
- Systematic Interventions
- Bipolar Disorder in Primary Care
Collaborative Care:

IMPACT Trial

- Team
  - Primary Care Physician
  - Depression Care Manager
  - Collaborating Psychiatrist

- Intervention
  - Screening for depression
  - Follow up with Care Manager
  - Tracking PHQ-9
  - Staffing with Psychiatrist/Internist
  - Conveying algorithm based recommendations to PCP

- Goal of Remission
  - Choice of Antidepressants or Problem Solving Therapy

IMPACT Doubles the Effectiveness of Depression Care

50 % or greater improvement in depression at 12 months

- Participating Organizations

Graph showing % improvement over 8 months for Usual Care and IMPACT.
Collaborative Care: IMPACT Trial

- Intervention Cost: $522/person
Bipolar Disorder?

- Prevalence of Bipolar Disorder
- Reasons for Misdiagnosis
- Costs of Misdiagnosis
Why should I care?

- Lifetime Prevalence of MDD vs Bipolar Disorder
  - Major Depression: 16.6%
  - Bipolar disorders
    - Type 1: 1.1%
    - Type 2: 1.5%
- Primary Care Rates
  - 0.5-4.3%
Why should I care?

- Misdiagnosis of Bipolar Disorder
  - Initial Episode is Depressive in 50-83%
  - May take 2-5 years for first Mania
  - Often (up to 1/3 of the time) correct diagnosis is delayed by 10 years

- Reasons
  - People don’t present to primary care with Mania
  - Unwillingness to discuss mania
    - Shame
    - Don’t recognize as a problem
    - Don’t remember
Why should I care?

- Costs of Misdiagnosis
  - Treated as depression
    - Antidepressants ineffective
    - Causing Switch to Mania
    - Worsening course of disease
  - Not treated with mood stabilizer/Antimanic agent
  - More episodes can actually worsen course of illness
History of Mania: Screening Questions

- A period of definite change from normal (which people around you noticed) with
  - Elevated mood/Too happy
  - So much energy that you didn’t need to sleep/Could get by with 2-3 hours of sleep
  - Had strange ideas about special powers or abilities
  - Spent money you didn’t have
  - Took excessive risks that got you into trouble
Bipolar Depression: Red Flags

- Age of onset: Younger in Bipolar (before age 15-20)
- Gender: more even distribution
- Family History of Bipolar Disorder
- Symptom Characteristics
  - Mixed features
  - Irritability/Anxiety/Agitation
  - Prominent Lability
  - Psychotic Depression
  - Post Partum Depression
  - Terminal Insomnia
  - Sudden onset/resolution
Bipolar Depression: Treatment Implications

- If unequivocal
  - Referral to Specialty Mental Health
- If suggestive history/Red Flags present
  - May treat cautiously
  - Or initiate therapy while awaiting referral
Bipolar Disorder: Treatment

- Antidepressant medications run risk of
  - Rapid Cycling
  - Inducing Mania

- Worst Culprits
  - Tricyclic Antidepressants
  - SNRIs (Duloxetine, Venlafaxine)

- If suspected, but not definite
  - Bupropion: Lowest risk of mania
  - Combination Fluoxetine/Olanzapine: Approved for Bipolar Depression
Resources

- Collaborative care implementation
  - http://aims.uw.edu/
- Review Article
  - Depression Screening, Diagnosis and Treatment across the Lifespan, Cozine and Wilkinson. Primary Care Clin Off Pract; 43(2016)
- Macarthur Toolkit
Managing Your Depression: Things you can do to help yourself

#1 Stay physically active.
- Go for a hike
- Exercise
- Go for a walk
- Go for a swim

#2 Make time for pleasurable activities.
- Watch a video
- Listen to music
- Do a hobby

#3 Spend time with people who can support you.
- Hugs help
- Talk with a friend

#4 Practice relaxing.
- Try taking a bath when you feel tense

#5 Simple goals and small steps.
- Set reasonable goals you can attain
- Acknowledge your accomplishments
- Don’t try to solve the big problems all at once.
- Break them up into smaller steps.

#6 Eat balanced nutritious meals.
- Cut down on junk food
- Include fruits and vegetables
- Avoid alcohol

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Questions?
Somatized Depression

- Of patients presenting with physical complaints
  - 13-25% have depression/anxiety
- National Ambulatory Medical Care Survey
  - 110,000 visits for physical complaints
  - Only 4% diagnosed with depression/anxiety
  - Only 2% screened

Klink et al, JAPA 2016
Mixed features

- Major Depressive Episode
  - + 3 or more Manic Symptoms
    - Elevated, expansive mood.
    - Inflated self-esteem or grandiosity.
    - More talkative than usual or pressure to keep talking.
    - Flight of ideas or subjective experience that thoughts are racing.
    - Increase in energy or goal-directed activity (either socially, at work or school, or sexually).
    - Increased or excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
    - Decreased need for sleep (feeling rested despite sleeping less than usual; to be contrasted with insomnia).
<table>
<thead>
<tr>
<th>Condition</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tension/fearfulness</td>
<td>BD &gt; MDD</td>
</tr>
<tr>
<td>Somatic complaints</td>
<td>MDD &gt; BD</td>
</tr>
<tr>
<td>Psychomotor agitation</td>
<td>BD &gt; MDD</td>
</tr>
<tr>
<td>Atypical depressive features</td>
<td>BD &gt; MDD</td>
</tr>
<tr>
<td>Depressive mixed states</td>
<td>BD &gt; MDD</td>
</tr>
<tr>
<td>Irritability</td>
<td>BD &gt; MDD</td>
</tr>
<tr>
<td>Psychotic features</td>
<td>BD &gt; MDD</td>
</tr>
<tr>
<td>Postpartum onset</td>
<td>BD &gt; MDD</td>
</tr>
<tr>
<td>Early age at illness onset (ie, before age 25)</td>
<td>BD &gt; MDD</td>
</tr>
<tr>
<td>Pain sensitivity</td>
<td>MDD &gt; BD</td>
</tr>
<tr>
<td>Appetite loss</td>
<td>MDD &gt; BD</td>
</tr>
<tr>
<td>Insomnia (initial)</td>
<td>MDD &gt; BD</td>
</tr>
<tr>
<td>Insomnia (late)</td>
<td>BD &gt; MDD</td>
</tr>
<tr>
<td>Mood lability within episode</td>
<td>BD &gt; MDD</td>
</tr>
</tbody>
</table>