Diagnosis and Treatment of Depression in the Internal Medicine Patient

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Conflict of interest

- None to declare.
After this workshop, participants will:

- Recognize the signs and symptoms of Major Depressive Disorder (MDD), and become familiar with diagnostic approaches in the medically ill patient.
- Be familiar with some common pharmacologic agents useful in treating MDD in the medically ill patient.
- Be aware of psychotherapeutic modalities used in treatment of MDD.
You are taking care of a 78 year old female admitted with urosepsis.

Her daughter comes up to you and says, “I think my mom’s depressed.”

She tells you her mother is “not herself”, has not been talking, just staring at the TV a lot of the time, and not sleeping at night. She seems forgetful, not recalling that her daughter had visited, and forgets what day it is.

The other day, she also said, “just kill me already” and her daughter is very worried that she is suicidal.

Is she depressed?
In your outpatient clinic, you see a 50 year old man with resistant hypertension, diabetes and obesity.

He tells you that over the past couple of months, he has been “off”. He has trouble falling asleep and wakes up around 4 a.m. He has not lost weight, but “food isn’t tasting as good”. At work, his boss has been “riding” him because he has been having trouble making decisions, and it takes him longer to get his work done.

He feels extremely guilty about his work performance, and because he is “not a good enough dad” because he goes to his son’s hockey games, but just can’t enjoy them like before.

You notice it takes him a while to answer your questions, and he seems to have difficulty, saying “I don’t know” a great deal.

Is he depressed?
Criteria for MDE

- 5 or more of the following for at least 2 weeks:
  - Sad mood
  - Interest, diminished
  - Guilt or feelings of worthlessness
  - Energy low/fatigue
  - Concentration poor or indecisiveness
  - Appetite (decreased or increased)
  - Psychomotor change (slowing or agitation)
  - Sleep disturbance (insomnia or hypersomnia)
  - Suicidal thinking
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Approaches to Diagnosis

• Inclusive approach
  • Take all symptoms at face value
  • Most sensitive approach

• Exclusive approach
  • Eliminating anorexia and fatigue
  • Requiring 4 of the remaining symptoms
  • Mostly in research rather than clinical practice
## Approaches to Diagnosis

- **Substitutive approach (Endicott’s criteria)**
- Replace physical symptoms with psychological symptoms

<table>
<thead>
<tr>
<th>Physical</th>
<th>Psychological</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appetite/weight change</td>
<td>Tearfulness, depressed appearance</td>
</tr>
<tr>
<td>Sleep disturbance</td>
<td>Social withdrawal, decreased talkativeness</td>
</tr>
<tr>
<td>Fatigue, loss of energy</td>
<td>Brooding, self pity, pessimism</td>
</tr>
<tr>
<td>Diminished concentration</td>
<td>Lack of mood reactivity, blunting</td>
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</tbody>
</table>
Multiple screening tools exist for depression
- Beck Depression Inventory II (BDI)
- Hospital Anxiety and Depression Scale (HADS)

Single-item screening question, “Are you depressed?” has been shown to be as effective as longer screening instruments in terminally ill patients

Diagnosing depression

- Keep in mind “mimickers” of MDD
  - Hypoactive delirium (Case #1)
  - Dementia
  - Symptoms of physical illness
  - Medications
How do you choose which one?

- SSRIs generally well tolerated, relatively safe, effective and first line in MDD
  - Case reports of hyponatremia 7-10 days after start esp. in over 65 y.o.

- In medically ill, often take advantage of side effects
  - e.g. Mirtazapine for sleep disturbance, weight loss, anxiety
  - e.g. Venlafaxine or duloxetine (SNRIs) for neuropathic pain
## Common Agents

<table>
<thead>
<tr>
<th>Medication</th>
<th>Starting dose</th>
<th>Titrate in</th>
<th>Therapeutic Range</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Citalopram (SSRI)</strong></td>
<td>10 mg</td>
<td>10 mg/week*</td>
<td>20-40 mg</td>
<td>40 mg</td>
</tr>
<tr>
<td><strong>Sertraline (SSRI)</strong></td>
<td>25 mg</td>
<td>25-50 mg/week*</td>
<td>100-200 mg</td>
<td>200 mg</td>
</tr>
<tr>
<td><strong>Venlafaxine XR (SNRI)</strong></td>
<td>37.5 mg</td>
<td>37.5-75 mg/week*</td>
<td>150-225 mg</td>
<td>225 mg</td>
</tr>
<tr>
<td><strong>Mirtazapine (α2-adrenergic receptor antagonist)</strong></td>
<td>7.5-15 mg</td>
<td>7.5-15 mg/week*</td>
<td>15-45 mg</td>
<td>60 mg</td>
</tr>
</tbody>
</table>

*In hospital inpatients can titrate more quickly, e.g. every 3-4 days, if not having side effects.
Psychotherapy

- For severely depressed and ill, may not have cognitive resources to participate.

- For mild to moderate depression, psychotherapeutic modalities have been as effective as medications.

- Current guidelines list Cognitive Behaviour Therapy (CBT) and Interpersonal Psychotherapy (IPT) as first line treatments for acute MDD.
Psychotherapy

- Cognitive Behaviour Therapy (CBT)
  - Structured, time limited
  - Emotions, thoughts and behaviours all effect one another
  - Focus on restructuring of cognitive distortions
  - Behavioural activation can be part of treatment
  - Involves homework between sessions
  - Individual or group
Psychotherapy

- Interpersonal Psychotherapy (IPT)
  - Structured, time limited
  - Depression can be precipitated and perpetuated by combination of biological and interpersonal factors
  - 4 specific areas of focus:
    - Role transition**
    - Role dispute
    - Unresolved grief
    - Interpersonal deficits
  - Can involve homework between sessions
  - Usually individual, can be done in groups

**Can be especially important for patients with chronic illness diagnosis
References


All images obtained through Microsoft clipart.