Depression

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DSMV diagnosis of depression

Can easily be remembered by the mnemonic: **M-SIGECAPS**

- **M**ood low
- **S**leep disturbance: Insomnia/hypersomnia
- **I**nterested levels decreased (anhedonia)
- **G**uilt or feelings or worthlessness
- **E**nergy levels low
- **C**oncentration impaired
- **A**ppetite changes/weight changes
- **P**sychomotor slowing or agitation
- **S**uicidal ideation or thoughts of death

Depression: Must have a 2-week period of low mood and/or anhedonia for most of the day plus 4 of the other symptoms.

Dysthymia/Persistent depressive disorder: Chronic low mood for 2 years (1 year in adolescence), with no more than 2 months without symptoms. Must have 2+ of the SIGECAPS symptoms.

Greif reaction/acute stress disorder: Timing related to a stressor/loss lasting 3 days – 3 months

Adjustment disorder: A reaction to a stressor that can present as low mood or anxiety that is negatively impacting function. Timeline: <3 months duration but resolves by 6 months after resolution of the stressor

Often comorbid with anxiety, personality disorders, adjustment reaction, bipolar disorder, or schizoaffective disorder

Depression may present differently at extremes of age

a. Elderly: physical symptoms, cognitive changes
b. Children: irritability, somnolence, defiant, may not have low mood

Risk factors for depression

Note that there are only risk factors. Anyone and everyone is at risk

1. Individuals aged 15-45
2. Females
3. Low SES
4. Poor social support
5. Abuse
6. Adverse childhood events
7. Trauma
8. Stress
9. Substance use
10. Chronic medical conditions
11. Postpartum

Ask about suicide

- Be straight forward, you might be surprised
- This does NOT increase the risk of suicide
- This is a crucial step in making a safety/action plan
- Note though: YOU CANNOT PREDICT SUICIDE
- Risk factors: **SADPERSONS**
    - **S**ex: male
    - **A**ge <19 or >45
    - **D**epression
    - **P**revious attempts
    - **E**xcessive alcohol or drug use
    - **R**ational thinking lost
    - **S**eparated/divorced/widowed
    - **O**rganized or serious attempt
    - **N**o social support
    - **S**tated future intent

Ask about abuse and ensure patients safety reporting as necessary

- Report if a minor is involved
- If it is an adult patient, you need their permission for legal action

Consider the need for involuntary admission

1. Safety risk to self or others **collateral is key**
    a. Psychosis
    b. Suicidal/homicidal
2. Severity of symptoms
3. Level of function
    a. Consider if they are able to keep up with ADL's and IADL's safety

Work up for Depression

Must consider the broad differential for depression (and consider depression if considering any of the following)

Condition	History question	Physical exam	Lab to order
Anemia/iron deficiency	Diet Bleeding Medical history	Conjunctival pallor Paleness	CBC, ferritin, B12
Arrythmia	Palpitations Presyncope Chest pain Shortness of breath	Cardiac exam	ECG (also to assess for prolonged QTc which helps guide management)
Hypothyroidism	Constipation Brittle hair/dry skin Weight gain	Thyroid exam	TSH
Renal failure	Medical/family history		Creatinine, electrolytes
Diabetes	Medical/family history Polydipsia/urinary frequency	Diabetic exam if indicated	HbA1C
Hypercortisolism or adrenal insufficiency	Medical history/family history	Adrenal insufficiency: thin, dark skin Hypercortisolism: cushingoid appearance	Depending of suspicion: Midnight salivary cortisol, AM cortisol, 24 hour cortisol
Chronic infections	Risk factors i.e. risky sexual practice/IVDU Fever	Exam based on symptoms Lymphadenopathy	Based on risk factors, consider screening for HIV, hepatitis, syphilis, mono, urinalysis etc.
Obstructive Sleep Apnea	Snoring Daytime sleepiness	High risk features for sleep apnea: obesity, large neck, retrognathia	Polysomnography
Dementia	Memory Age Family history	MoCA/MMSE	Consider neuroimaging
Parkinson	Motor issues	Neurologic exam	Consider neuroimaging
Autoimmune conditions i.e. lupus	Other systemic features i.e. rash, joint pain, conjunctivitis, GI symptoms	Derm exam Systemic exam	CRP, consider more in depth rheumatologic investigation based on symptoms
Pregnancy	LMP	Abdominal exam	bHCG
Substance use	Ask about substances	Mental status exam Features of intoxication	Urine/blood tox
Medications: b-blockers, steroids, antiretrovirals, OCP/progestin containing products to name a few	Ask about medications		

Treatment of Depression

<table>
<tr><td>Non-pharmacologic</td><td colspan="2">- Cognitive-behavioral therapy
- Psychotherapy
- Counselling
- Behavioral changes including dietary changes, exercises, and sleep
- Goal setting including back to work plan if off work</td></tr>
<tr><td rowspan="3">Pharmacologic</td><td>Medication

SSRI (i.e. fluoxetine, sertraline, escitalopram)

SNRI (i.e. venlafaxine, duloxetine)

NDRI (bupropion)

NaSSA (mirtazapine)

Serotonin modulators (vortioxetine)

Antipsychotics (i.e. quetiapine)</td><td>Side effects

QTc prolongation, SIADH, headache, swating, GI upset, sexual dysfunction, increased suicidality n first weeks

Same as SSRI plus anticholinergic, diaphoresis, low BP

Anxiety, insomnia, reduced seizure threshold, anticholinergic

Increased appetite, anticholinergic

Serotonin syndrome: EMERGENCY: Altered mental status, autonomic dysfunction (think SNS overload), neuromuscular abnormalities (hyperreflexia)</td></tr>
<tr><td colspan="2">Any can be used but consider individualizing based on individual symptoms and medication side effects
- Anxious distress: SSRI
- Cognitive dysfunction: vortioxetine, bupropion
- Sleep disturbance: mirtazapine quetiapine
- Appetite loss: mirtazapine
- Chronic pain: SNRI or consider TCA
- Sexual dysfunction: bupropion, mirtazapine</td></tr>
<tr><td colspan="2">Monitor response
- Start low and go slow for the first week by starting at a half dose
- If no impact by 2 weeks, increase dose
- Full effect takes place in 4-8 weeks – consider switching medications if no benefit at an adequate dose at 8 weeks
- Physical symptoms improve before cognitive (1-3 weeks vs 4-6 weeks)
- Follow up with patients q1-2 weeks initially as many will stop medication because of the long duration to see improvement
- Use a scale such as the PHQ-9 to monitor response and consider having them rate mood on a scale of 1-10
- Monitor for symptoms of mania and antidepressants may unmask these</td></tr>
<tr><td>Augmenting agents</td><td colspan="2">- Antipsychotics (aripiprazole, quetiapine, risperidone) -> First line
- Lithium
- T3
- Bupropion
- Modafinil
- Mirtazapine</td></tr>
</table>

If medical therapy fails, consider other diagnoses that present with depression

Diagnosis	Features
Bipolar (note that antidepressants may unmask this)	**Features of mania/hypomania (DIGFAST)** **D**istractibility. **I**nhibition lost **G**randiosity/inflated self-esteem **F**light of Ideas, **A**ctivity (goal directed activity), **S**leep, decreased need for **T**alkative **DSMV Diagnosis** **Mania:** >7 days of functional disruption or requiring hospitalization **Hypomania:** 4-7 days but does not disrupt function or require hospitalization **Bipolar 1:** at least 1 episode of mania required **Bipolar 2:** at least 1 episode of hypomania and depression required (NO mania)
Schizoaffective disorder	**Features of psychosis** 1. Delusions 2. Hallucinations 3. Disorganized speech 4. Disorganized or catatonic behavior 5. Negative symptoms **DSM V Diagnosis** - Psychosis plus 2+ psychotic features including at least one of the first 3 for 1 month - Mood symptoms present for majority of illness - Delusions or hallucinations must occur at least 2 weeks without mood symptoms

Discontinuing medications

When?

- 1st episode: When there is remission of symptoms for 9-12 months
- 2nd episode: When there is remission of symptoms for 2 years
- 3rd episode: Consider lifelong therapy

How?

- Slowly! i.e. over a few weeks first decreased the dose, then the frequency
- Consider using fluoxetine to help with discontinuation symptoms as it has a shorter half life and can be used to bridge discontinuation
- Discontinuation syndrome: flu like illness associated with medication discontinuation

Returning to work for patients who have been off

1. Consider doing this during a time of stability
2. Ensure time off work has been used for treatment and counselling
3. Consider a return date when first off to help with a timeline
4. Consider a graduated return to work
5. Prepare them to re-integrate

Resources (none were provided but health link BC has many excellent resources)

https://www.healthlinkbc.ca/resources