Improving Our Care of Patients with Depression and Anxiety

Seoul, South Korea, October 20, 2018

Objectives for Today

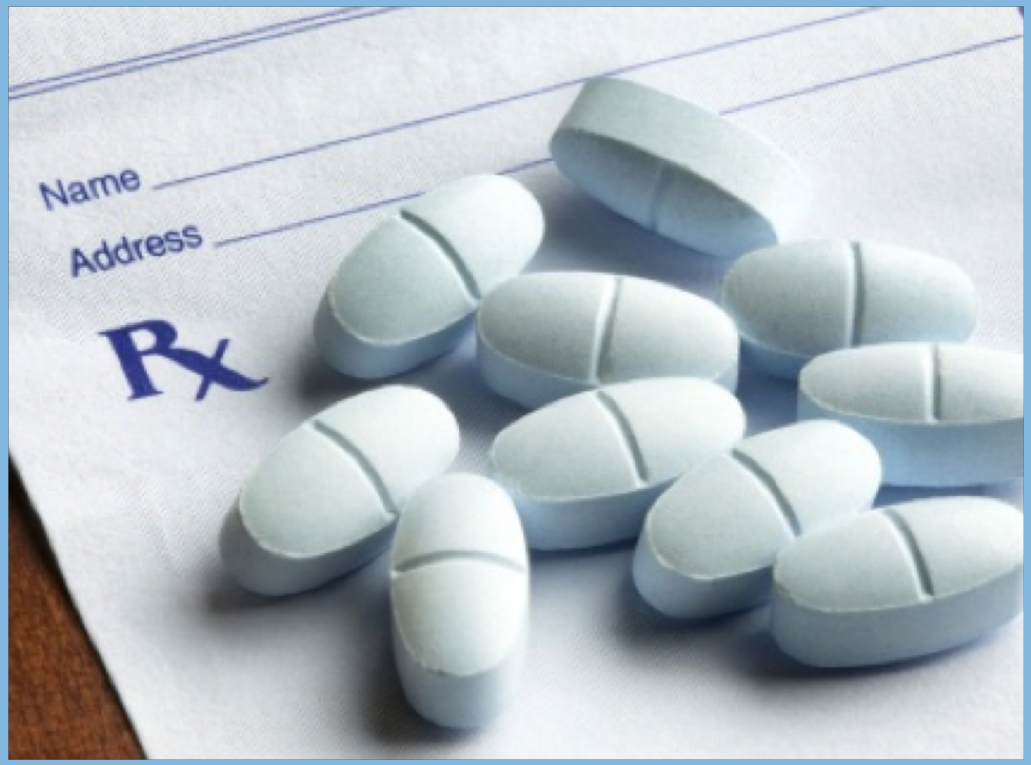
- Review and discuss the pharmacologic treatment options for patients with depression and anxiety
- Report back on work being done in your communities
- Tour the web portal

Managing depression and anxiety

Pharmacologic treatment options for your patient

Pharmacological interventions

- When to prescribe
- What to prescribe
- How to prescribe



Pharmacological interventions: When NOT to prescribe

DO NOT prescribe an antidepressant if/when …
The symptoms do not amount to depression (i.e., when the symptoms do not last two weeks and/or do not involve impaired functioning)
There is a recent history of bereavement or major loss
The depression is due to a physical cause
The person is pregnant/breastfeeding; as a first-line treatment offer psychosocial intervention
The child is younger than 12 years of age
Adolescents are 12-18 years of age; as a first-line treatment offer psychosocial intervention

- Usually, DO NOT prescribe medication at the first consultation – many patients' symptoms will improve after an empathetic consultation
- DO arrange follow-up appointment in one or two weeks to discuss treatment options

When to consider prescribing …

- Moderate to severe depression
- Mild to moderate depression with inadequate response to initial treatments
- Generalised anxiety disorder with inadequate response to initial treatments
- Persistent subthreshold depressive symptoms with functional impairment
- Patient preference

Which antidepressant?

Most Effective	Most Acceptable
Agomelatine	Agomelatine
Amitriptyline	Citalopram
Escitalopram	Escitalopram
Mirtazapine	**Fluoxetine**
Paroxetine	Sertraline
Venlafaxine	Vortioxetine
Vortioxetine	

Cipriani et al, Lancet 2018

TABLE 1: Antidepressants

MEDICATION	DOSING	SIDE EFFECTS	CONTRAINDICATIONS / CAUTIONS
AMITRIPTYLINE (a tricyclic antidepressant (TCA))	**Start** 25 mg at bedtime. **Increase** by 25-50 mg per week to 100-150 mg daily (maximum 300 mg). Note: Minimum effective dose in adults is 75 mg. Sedation may be seen at lower doses. **Elderly/Medically Ill:** Start 25 mg at bedtime to 50-75 mg daily (maximum 100 mg). **Children/Adolescents:** Do not use.	**Common:** Sedation, orthostatic hypotension **(risk of fall)**, blurred vision, difficulty urinating, nausea, weight gain, sexual dysfunction. **Serious:** ECG changes (e.g. QTc prolongation), **cardiac arrhythmia, increased risk of seizure.**	Avoid in persons with **cardiac disease**, history of seizure, hyperthyroidism, urinary retention, or narrow angle-closure glaucoma, and bipolar disorder (can trigger mania in people with untreated bipolar disorder). **Overdose can lead to seizures, cardiac arrhythmias, hypotension, coma, or death.** Levels of amitriptyline may be increased by anti-malarials including quinine.
FLUOXETINE (a selective serotonin reuptake inhibitor (SSRI))	**Start** 10 mg daily for one week then 20 mg daily. If no response in 6 weeks, increase to 40 mg (maximum 80 mg). **Elderly/medically ill:** preferred choice. **Start** 10 mg daily, then increase to 20 mg (maximum 40 mg). **Adolescents** **Start** 10 mg daily. Increase to 20 mg daily if no response in 6 weeks (maximum 40 mg).	**Common:** Sedation, insomnia, headache, dizziness, gastrointestinal disturbances, changes in appetite, and sexual dysfunction. **Serious: bleeding abnormalities** in those who use aspirin or other non-steroidal anti-inflammatory drugs, low sodium levels.	**Caution in persons with history of seizure.** **Drug-Drug interactions:** Avoid combination with **warfarin** (may increase bleeding risk). May increase levels of TCAs, antipsychotics, and beta-blockers. Caution in combination with tamoxifen, codeine, and tramadol (reduces the effect of these drugs).

Let's talk about what you can realistically prescribe.

What medications are available in your community?

Precautions for Tricyclic antidepressants (TCAs)

Avoid use of TCAs in:

- The elderly, people with cardiovascular disease and people with dementia
- People with ideas, plans or previous acts of self-harm or suicide to minimise the risk of overdosing

Monitoring people on antidepressants

It is expected that people will have a positive response, but there are some results that will require action.

- If the person shows:
  - Symptoms of mania
  - Inadequate response
  - No response

What do you do when symptoms worsen or do not improve after 4-6 weeks?

Take THREE important steps before increasing the dose:

1. Ensure that the assessment is correct
2. Ensure that the person is taking the medication as prescribed
3. Ensure the dose is adequate

If there is no improvement after 4-6 weeks at maximum dose, consult a specialist.

When and how to stop an antidepressant

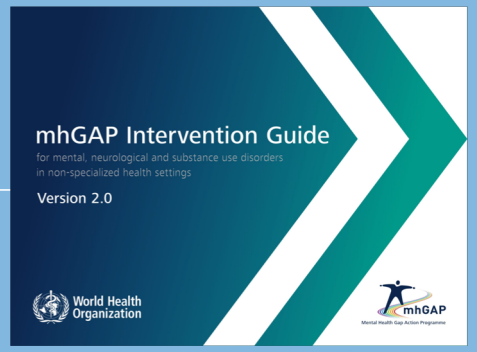
If after 9-12 months on therapy the person reports no or minimal symptoms:

- Discuss the plan with the person before reducing the dose
- Describe early symptoms of relapse
- Plan routine and emergency follow-up
- Reduce doses gradually over at least 4 weeks

Antidepressants: Summary

- Time for response to antidepressants is 4-6 weeks
- Treatment should continue for 9-12 months
- Taper slowly if ceasing medication
- Do not prescribe antidepressants to:
  - A functioning person
  - Someone recently bereaved
  - Children under 12 and pregnant/breastfeeding women
- Avoid TCAs if:
  - The person is elderly, has dementia or cardiovascular disease

Resources for this curriculum



WHO

mhGAP IG 2.0

http://www.who.int/mental_health/mhgap/mhGAP_intervention_guide_02/en/

WONCA

Core competencies

http://www.globalfamilydoctor.com/site/DefaultSite/filesystem/documents/Groups/Mental%20Health/Core%20competencies%20January%202018.pdf

Non-drug interventions

https://www.wonca.net/site/DefaultSite/filesystem/documents/Groups/Mental%20Health/WPMH%20role%20of%20FPs%20in%20non%20drug%20interventions.pdf

First depression consultation

http://www.globalfamilydoctor.com/site/DefaultSite/filesystem/documents/Groups/Mental%20Health/depression%20evidence%20based%20cons%20layout.pdf

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