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Pearl of Knowledge
Evidence-based Summary Documents

Treatment Recommendations for Depression

Summary Recommendation: Note that Treatment Options Vary Based on Depression Severity and Duration. A shared decision-making approach works best in evaluating options with patients and families.

- Patients with no clinical depression (PHQ-9 score of < 5) require no action.
- If monitoring ongoing treatment for depression – they are now in remission.

- For patients with some depressive symptoms most days and most of each day and PHQ-9 score of 5-9:
    - If symptom duration is less than 3 months, recommend education, engagement, safe aerobic exercise and behavioral activation (increasing pleasant activities and other positive interactions with their environment) Monitor progress. There is no evidence to support best frequency but suggest monthly.
    - If symptom duration is greater than 2 years – consider dysthymia, where antidepressant medication treatment is recommended.
    - If monitoring ongoing treatment, they are in partial remission, continue treatment until remission is achieved

- All patients with **major clinical depression** can benefit from engagement and education of patient and families, safe aerobic exercise and behavioral activation (increasing pleasant activities and other positive interactions with their environment). See table below for details.

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PHQ-9 Interpretation of Total Score

PHQ-9 Score	Major Depression severity	Treatment Recommendation	Follow-up Interval
10-14	Mild	Psychotherapy **or** use of antidepressant medications.	All depressed patients initially need weekly follow-up (phone or in person) for engagement in treatment, determining if following treatment plan, addressing medication side effects, and check if following through on any referrals. After first month, contacts can extend to monthly.
15-19	Moderate	Use of antidepressant medications **and/or** psychotherapy.	All depressed patients initially need weekly follow-up (phone or in person) for engagement in treatment, determining if following treatment plan, addressing side effects, and check if following through on any referrals. After first month, contacts can extend to every 2-4 weeks.
≥ 20	Severe	Use of antidepressant medications **and** psychotherapy.	All depressed patients initially need weekly follow-up (phone or in person) for engagement in treatment, determining if following treatment plan, addressing side effects, and check if following through on any referrals. Contacts should remain weekly until significant improvement is achieved. Referral to mental health specialist may be warranted by PCP or psychiatrist.

[1]ICSI Depression Guidelines
[2]Jay C. Fournier, et al. Antidepressant Drug Effects and Depression Severity: A Patient-Level Meta-analysis. *JAMA*. 2010, 303(1):47-53

If sole treatment is psychotherapy, evaluate effectiveness at 12 weeks and if no significant improvement (minimally 5-point PHQ-9 improvement), modify treatment plan.

If using antidepressants:

- Key Principles
  - Use antidepressants, not minor tranquilizers
  - Use adequate doses for an adequate amount of time
  - Start slow and work with side effects but titrate to an effective dose as needed
  - If not effective, change medication (Rule of thumb is 25% improvement by 6 to 8 weeks, then increase dose and it may take up to 12 weeks).[3]
  - If patient is improving, raise dose every 6 weeks until remission is reached (PHQ-9 <5), side effects become problematic, or maximum dose is reached.

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Is Patient at Maximum Therapeutic Dosage? Consider titrating to these doses <u>unless</u> patients do not tolerate these 'maximum doses' due to side effects

• Fluoxetine	80 mg
• Paroxetine	50 mg
• Escitalopram	20 mg
• Citalopram	60 mg
• Sertraline	200 mg
• Venlafaxine	375 mg (XR/ER 225 mg)
• Duloxetine	120 mg
• Buproprion	450 mg (SR 400, XL 450)
• Mirtazapine	45 mg
• Nortriptyline	150 mg
• Despramine	300 mg

Our best recent data comes from a large randomized controlled trial involving 4041 patients called STAR-D. Lessons learned from this include:

If first antidepressant trial fails – you should try again

- STAR-D Trial examined strategies for management of SSRI non-responders:
    - About one in four patients who are changed to another SSRI, Buproprion-SR, or Venlafaxine XR will respond to the new drug
    - 27% – 32% of patients will respond to augmentation with Buspirone or Buproprion[3,4,5]

STAR-D Remission Rates

- Based on number of TREATMENT STEPS

– First Step:	36.8%
– Second Step:	30.6%
– Third Step:	13.7%
– Fourth Step:	13.0%
– Total	687%

- More Rx steps showed higher relapse rates during naturalistic follow-up

When and How to Stop Antidepressants[6, 7]

- Consider risk of relapse
    - **50% if 1 prior episode**
    - **75% if 2 prior episodes**
    - **90% if 3 prior episodes**
    - **Also increased with dysthymia and residual depressive symptoms**

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- First Episode treat 12 months after initial response
- Second Episode treat for 3 years
- Third + Episode treat indefinitely/for life
- Maintenance treatment should be at full dose
- Make a relapse prevention plan
- Taper antidepressants slowly to avoid discontinuation syndrome

Background

A January 6, 2010 study in the Journal of the American Medical Association (Jay C Fournier et al) called into question the efficiency of antidepressants in the treatment of patients with mild or moderate depression. A subsequent story in Newsweek (Feb. 8) reported on the study's findings. Here is some additional context and facts about the study that may help you answer patient and member questions:

- The study's meta-analysis, which included studies reviewed by the FDA but not published, noted that for the acute phase treatment of depression – the first three months -- anti depressants were only statistically superior to placebo for severe depression.

- The study correctly noted that a number of other studies have found that antidepressants are effective for chronic depressions- even very mild dysthymias.

- The information in the study is not new. Our approach to the use of antidepressants (ICSI guidelines) already takes into account the issues raised in the Fournier study.

References:

[3]Rush, A. John, MD., et al. Acute and longer term outcomes in depressed outpatients requiring one or several treatment steps: A STAR*D report. *Am J. Psychiatry,* 2006: 163:1905-1917.
[4]Trivedi MH, Fava M, Wisniewski SR, et al. Medication Augmentation after the failure of SSRIs for depression. *N Engl J Med* 2006a;354:1243-52 (Class A)
[5]Trivedi MH, Rush AJ, Wisniewski SR, et al. Evaluation of outcomes with citalopram for depression using measurement-based care in STAR*D: implications for clinical practice. *Am J Psychiatry* 2006b;163:28-40 (Class A)
[6]Gilbody, S, Bower P, Fletcher J, et.al. Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. *Arch Intern Med* 2006;166:2314-21. (Class M)
[7]Greden JF. Antidepressant maintenance medications; when to discontinue and how to stop. *J Clin Psychiatry* 1993;54:39-47. (Class R)

Questions: Please reply to this e-mail, and your questions(s) will be directed to the author of this Pearl, Dr. Michael Trangle.

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All Pearl recommendations are consistent with professional society guidelines, and reviewed by HealthPartners Physician Leadership.

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