Depression

In the Long Case

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To cover

- Where to discuss in the long case
- Diagnostic criteria for depression
- Taking a history of depression
  - Current mood
  - Contributing factors
  - Protective factors
  - Treatment
- Issues in the long case that depression may contribute to
- Presentation
- Discussion component of the long case questions, around depression
- Treatment

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Long Case-the final product (Total of 10-12 minutes)

A holistic approach

- Opening statement
- Main active problems/Presenting complaint
- Other active problems
- Inactive problems – not many
- Allergies, other medications not mentioned in body, method of administration
- Adherence issues, including diet etc.
- Depression
- Social situation/smoking/alcohol
- Physical examination
- Summary (one line) & ISSUES

Medication, generic, as you present each condition

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Diagnostic criteria for major depression

- Pervasive depressed mood **and/or** marked loss of interest or pleasure unexplained by personal circumstances, e.g. grief, **plus** 4 or more of the following:
  - marked change in weight or appetite
  - insomnia/hypersomnia nearly every day
  - psychomotor agitation/retardation nearly every day
  - fatigue/loss of energy nearly every day
  - feelings of worthlessness, excessive/inappropriate guilt
  - indecisiveness or diminished concentration
  - feelings of hopelessness
  - thoughts of death, suicidal ideation/attempt.

In patients with malignancy, anhedonia can be a distinguishing symptoms

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Depression

- Very common in general medical patients
- Patient may be on anti-depressants
- Must take a mood history

- **History – current mood:**
- Ask about current mood (feeling down)
- Loss of interest or pleasure in most or all activities
- Social isolation
- Sleep issues e.g. insomnia or hypersomnia
- Anorexia/excessive eating
- Weight changes (loss or gain)
- Fatigue
- Decreased ability to concentrate
- Decreased decision making
- Recurrent thoughts of death or suicidal ideation (including plans and intent), or a suicide attempt

Additional history

- Prior history of depressive episodes and their course and treatment
- Impact of the depressive episode upon occupation, personal relationships, function, activities of daily living esp: self-care (e.g. can ask patient how often showering)

Additional history

- Depression may be contributed to/precipitated by the following

- **Contributing factors:**
- Steroids
- Alcohol & other substance misuse
- Chronic pain
- Chronic physical illness, esp. neurological
- Social stressors and loneliness
- Loss of job
- Financial stressors

Additional history

- Protective factors

- **Protective factors:**
- Family support
- Social network
- Religious beliefs
- Activity/purpose

Depression

- Contributes to the following issues in the long case
  - Quality of life
  - Fatigue
  - Weight loss/gain
  - Social isolation
  - Sleep issues e.g. insomnia or hypersomnia
  - Non-adherence
  - Self care
  - Side-effects of steroids/alcohol
  - If on anti-depressants then polypharmacy and risks of side effects
    - Falls risk in sedating agents

Depression

- Treatment

- Current treatment:
  - Non-pharmacological
  - Pharmacological
- Need for treatment
- Any contraindications to medications

Depression - Presentation

- Dx
- Current
- RF
- Prot
- R_x
- Impact

- History of depression, when diagnosed, any precipitating factors
- The patient's current mood
- Risk factors and protective factors
- Current/past treatments
  - Non-pharmacological
  - Pharmacological
- Factors impacted on my depression e.g. QOL, adherence etc.

Depression

- The discussion

- The issues:
- Current mood
- Impact of depression

- Management options
  - Must know current/past management
  - Can refer to psychiatrist/psychologist but have an overall management plan
- Indirectly: around factors for fatigue, QOL, improving adherence

Comparative antidepressant information

- SSRIs best given as a single daily dose each morning
  - Citalopram, escitalopram and sertraline have least potential for drug interactions mediated by inhibition of CYP enzymes
  - Escitalopram is generally the best tolerated
  - Fluoxetine long half-life
  - All can prolong QT interval (esp: citalopram and especially in elderly)
- SNRIs also best given as a single daily dose
  - Duloxetine may be useful in patients with chronic pain
  - Venlafaxine and desvenlafaxine may increase BP, particularly with high doses. Venlafaxine may cause more nausea and vomiting than SSRIs, and is toxic in overdose
  - SNRIs may cause palpitations, tachycardia, increased BP and orthostatic hypotension; they have also been associated with stress-induced (takotsubo) cardiomyopathy

Comparative antidepressant information

- Mirtazapine is sedating & often causes weight gain – given at night
- *Moclobemide*, a reversible, selective MAOI – lots of dietary restrictions
- Agomelatine has been associated with hepatotoxicity (may be fatal) but otherwise well tolerated

- TCAs are sedating. They have anticholinergic adverse effects, often result in weight gain, cause orthostatic hypotension, prolong QT interval and are very toxic in overdose – consider other potential indications

Thank you for everything you do in caring for patients and very best wishes!!

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