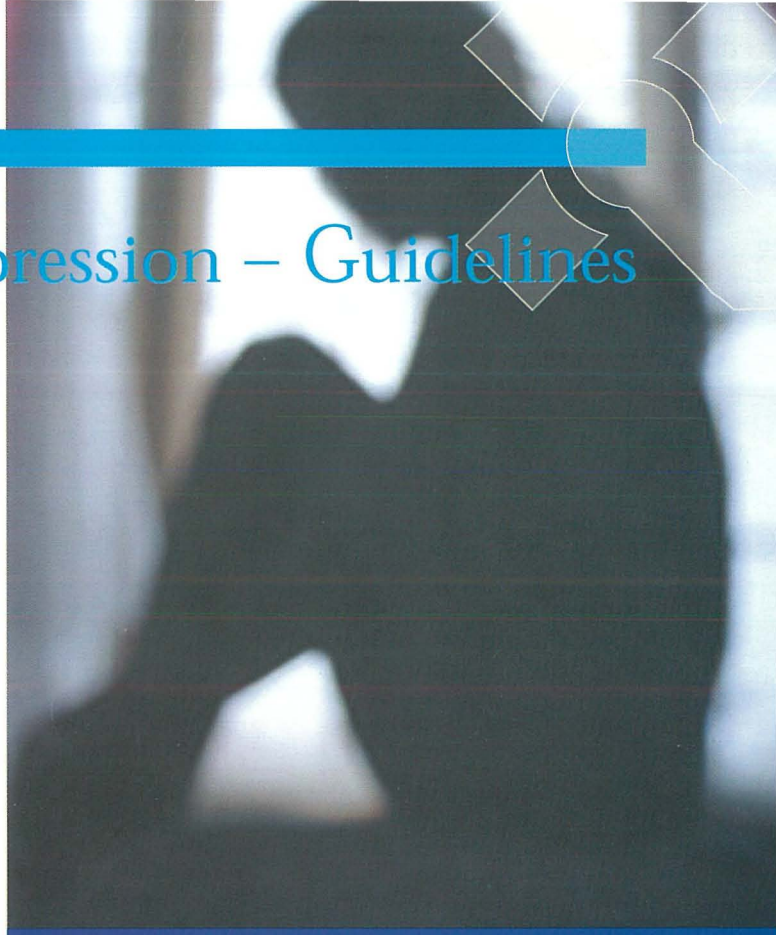
Management of Depression – Guidelines



by **Peter Muscat** *MD LRCP MRCS MRCPsych.*
Consultant Psychiatrist & Psychotherapist
Senior Lecturer – University of Malta

1. Make an accurate diagnosis and elicit the signs and symptoms accompanying the depressive disorder

Is the depression basically endogenous or mainly reactive? Many also suffer from coexisting anxiety which may overshadow the depression. One should exclude other psychiatric conditions such as obsessive compulsive disorder, schizophrenia or personality disorder. Endocrine disturbances and occult carcinomas are notorious for initially presenting with depression. Patients with psychoactive substance abuse are often depressed. Although many patients complain of a miserable mood, others may only complain of apathy, loss of interest and enjoyment, reduced energy, which in turn causes tiredness, reduced activity and withdrawal. With some patients the main problems are reduced attention, concentration and consequent memory difficulties. Others have ideas of guilt, worthlessness and lowered self esteem. Several patients also complain of obsessive thoughts and behaviours.

Biological symptoms are usually more associated with endogenous depression and seasonal affective disorder. Previous severe mood swings and periods of elation are indicative of bipolar mood disorder. One should also assess for morbid ideation and suicide risk in a tactful way.

2. Adopt a biopsychosocial approach to management

It is better to hospitalise a suicidal patient on an emergency order rather than run the risk of a tragedy. Patients who are neglecting themselves, especially if they live alone, usually need admission.

Most patients with less severe depression can be treated by Family Doctors in the community. The support of other family members and or friends is invaluable and should always be sought.

The biological treatments of depression are essentially antidepressant medications.

Anxiolytic and antipsychotic medication may also be necessary in certain cases.

Although there are many antidepressant drugs available, I shall limit this presentation to drugs commonly available in Malta.

Since the 1950's the tricyclic antidepressants have been widely used with much success and are still useful nowadays. Amitriptyline and trimipramine can be used in patients who are agitated or who suffer from initial insomnia. Clomipramine is particularly useful when obsessive symptoms dominate the depressive picture. Patients who are very lethargic and apathetic do well with the less sedative tricyclics such as imipramine. The tricyclic antidepressants block the reuptake of the monoamines noradrenaline and 5-HT. They cause numerous side effects and are potentially fatal in overdose. The antimuscarinic action of these drugs, such as dry mouth, blurred vision, nausea, constipation, urinary retention and postural hypotension are the side effects which patients often do not tolerate and which lead to non compliance. Since they may impair alertness, patients should be warned not to drive, operate machinery or drink alcohol. Moreover they are toxic in overdose causing cardiac conduction defects, arrhythmias, convulsions, respiratory failure, coma and death.

To avoid side effects one should start at a low dose of about 25mg daily and gradually increase the dose to a more therapeutic dose of about 150mg daily over a 2-3 week period and according to the patient's symptoms and severity of depression. Besides, patients should be informed that the side effects may initially make them feel worse but that these will gradually improve over a few weeks, and that it may take about 2-3 weeks before a therapeutic response is felt.

The tetracyclic antidepressants mianserin and maprotiline are also rather sedating and useful in the elderly because of less cardiotoxic side effects. However mianserin can cause haematological and hepatic reactions.

Over the past fifteen years, the selective serotonin inhibitors (SSRIs) have become very popular and easy to use because of a lower side effect profile, quicker onset of action, and relative safety in overdose. When compared to tricyclics, a lower number of pills is usually necessary to achieve the same therapeutic effect. However they are more likely to cause some internal agitation, tremor, insomnia, nausea, vomiting and sometimes diarrhoea in the first two weeks of treatment. Sexual dysfunction, particularly delayed ejaculation and anorgasmia, are common complaints and often lead to a request for alternative medication.

The SSRIs are also successfully used in the treatment of obsessive compulsive disorder, bulimia nervosa, general anxiety disorders, panic and phobic disorders.

The commonest SSRIs used are citalopram, escitalopram (which is now replacing citalopram because of a lower side effect profile and quicker onset of action), fluoxetine, fluvoxamine, paroxetine and sertraline. Escitalopram is particularly useful in the elderly. Along with fluvoxamine it is reputed to cause less sexual side effects especially in the male. Fluoxetine is often used with much success especially where there is comfort eating accompanying the depression. Paroxetine is especially useful where obsessive symptoms accompany the depression. Sertraline seems to cause less agitation.

continues on page 6

Management of Depression – Guidelines

continued from page 3

A more recent introduction are the selective noradrenaline and serotonin reuptake inhibitors (SNRIs), such as venlafaxine. This seems to have a quicker onset of action than the SSRIs. The side effect profile is similar but may cause more problems in overdose due to sinus tachycardia, ventricular tachycardia, bradycardia and seizures.

The patient should be treated for at least six months with antidepressants following the end of the depressive episode and followed up regularly.

The use of benzodiazepines as anxiolytics and hypnotics has been steadily declining since the 1980s, due to dependence and tolerance. However they can be prescribed for a short period of time as an adjunct to the antidepressant when agitation, anxiety and insomnia are very troublesome.

The antipsychotic drugs, such as trifluperazine, chlorpromazine, haloperidol and the newer generation ones such as risperidone, olanzepine and quianeptine are used when the patient is deluded, hallucinated, aggressive or suicidal. When the depression is of such a severity, the involvement of a psychiatrist is often needed.

In bipolar disorder and chronic relapsing depression, lithium carbonate and the anticonvulsant drugs, carbemezapine, sodium valproate and lamotrigine are usually prescribed by psychiatrists to control these disorders. It is important for Family Doctors to know when this is done so as to be careful when prescribing other medications for other physical disorders so as not to cause inadvertent drug interactions.

Electroconvulsive therapy is often carried out on an out patient basis and therefore the involvement of the patient's Family Doctor is required to deal with any other difficulties that the patient or relatives present.

The psychological treatments include a number of different types of psychotherapies, useful for mildly or moderately depressed patients. Most Family Doctors can and should offer supportive psychotherapy. The basic requirements are time and a good deal of empathy. Other more specialised therapies such as cognitive behaviour therapy, marital and family therapy are offered by psychiatrists, clinical psychologists and psychotherapists. In cognitive behaviour therapy the patient is taught to deal with personal depressive cognitions and behaviour. Group therapy is only starting to be practised in Malta and mostly by support groups. Alcoholic anonymous and Gamblers anonymous are invaluable groups for patients who either become depressed by their addiction or who actually resort to such behaviours because of their depression.

The social treatment of depression has been recognised for a long time. The patient should be encouraged to meet other people and develop confiding relationships, as this has a protective function in preventing relapse. Returning to work boosts one's self confidence and esteem. One should be encouraged to adopt a healthier lifestyle that includes healthy eating, exercise and enough rest, hobbies and recreational activities.