

Clinical Care Guidelines for: Major Depression in Adults

OBJECTIVE

Guide the appropriate diagnosis and treatment of Major Depression in adults.

DIAGNOSIS & ASSESSMENT

DSM-5 DIAGNOSTIC CRITERIA

5 or more symptoms present during a 2 week period; (1) depressed mood or (2) loss of interest or pleasure and any three of the following:

- Significant weight loss or decrease in appetite
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or lack of energy
- Feelings of worthlessness or guilt
- Decreased concentration or indecisiveness
- Recurrent thoughts of death or suicide

Symptoms cause significant distress or impairment in functioning and not due to significant loss or change in life, absence of manic/hypomanic episodes.

The PHQ9 is recommended for screening and treatment monitoring.

RULE OUT/MONITOR CO-OCCURRING MEDICAL CONDITIONS

- Ensure that a general medical evaluation has been completed
- Evaluate functional impairment and quality of life

Assess for Suicidal Ideation/Crisis

- If the patient has a plan, the means or has recently attempted, hospitalize
- If the situation is unclear and the patient is being evaluated by a medical provider, refer to a behavioral health practitioner
- Evaluate level of impulsivity and if patient can commit to not harming himself; seek help if the ideation becomes overwhelming
- Refer to a psychiatrist or behavioral health professional if symptoms are severe, there are co-morbid conditions, there are significant psychosocial stressors, and/or substance abuse
- Assess level of self-care (nutrition, hydration, ADLs)
- Establish the least restrictive environment for treatment and evaluate frequently for any need to change the level of care

TREATMENT

MEDICATION MANAGEMENT

If symptoms are moderate to severe, evaluate for medication. If medication is prescribed, patient should be seen within 1–4 weeks to assess and adjust.

At least 12 weeks continuous treatment in the acute phase.

At least one additional visit after the 4 week check in the next 4–8 weeks.

For effective continuation phase of treatment, monitor medication for the next 6 months. Visits may be less frequent.

To prevent relapse after symptom remission, stay on medication an additional 6–12 months.

Maintenance (greater than 9 months) for patients with a history of chronic symptoms, 3 or more episodes of depression, severe episodes, episodes beginning prior to age 20, or family history of bipolar disorder. Monitor at regular intervals and assess for re-emergence of symptoms. May require an additional 15–28 months on medication.

If discontinuing medication, taper slowly over several weeks and monitor for recurrence of symptoms.

Coordinate care with other clinicians involved in care.

Provide education to the family and patient.

PSYCHOTHERAPY

Cognitive behavioral therapy or individual interpersonal therapy—outpatient.

Therapy alone may be used for mild to moderate symptoms.

Frequency depends on the severity of the illness.

For moderate to severe symptoms, should be used in combination with medication.

Regular exercise and education regarding depression are recommended as adjuncts to treatment.

Severe symptoms, decline in functioning and/or suicidal ideation/intent may require a higher level of care.

If patient is discharged from inpatient hospitalization, patient needs to be seen in an outpatient setting, intensive outpatient setting or partial hospitalization by a behavioral health provider within 7 calendar days.

As depression symptoms remit, less frequent therapy sessions would be appropriate to maintain stability.

ECT is appropriate for severe depression that hasn't responded to numerous medications and/or therapy and who have significant functional impairment.

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MEDICATION THERAPY OPTIONS FOR DEPRESSION

Antidepressant medications are grouped into the following classes:

1. Tricyclic Antidepressants (TCAs)
2. Select Serotonin Reuptake Inhibitors (SSRIs)
3. Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)
4. Atypical Antidepressants
5. Monoamine Oxidase Inhibitors (MAOIs)
6. Norepinephrine Reuptake Inhibitor (NRI)
7. Dopamine Agonist (DA)

The effectiveness of antidepressant medications is generally comparable between classes and within classes of medications. Response rates typically range from 50% to 75% among all classes and agents. Antidepressants do differ in their potential to cause particular side effects such as adverse sexual effects, sedation, or weight gain. Because of this, the initial selection of an antidepressant medication regimen should strongly consider the tolerability, safety, and cost of the medication, as well as patient preference and history of prior medication treatment. Second-generation antidepressants, which include the SSRI, SNRI and Atypical Antidepressant classes are optimal and usually preferred for most patients over the older medications in the TCA and MAOI classes.

Antidepressant medication therapy is not a cure for depression. These drugs are effective in treating some of the symptoms of depression, but cannot change underlying contributions to depression in patients' lives. Studies have shown, and many experts believe, that antidepressant medications often work best in combination with psychotherapy lasting for several months. On their own, antidepressant medications are important, especially in treating patients who have difficulty, or are hesitant in, accessing a psychotherapy professional.

When initiating an antidepressant drug regimen, encourage the patient to be patient as it may take 4-8 weeks for the drug therapy to be fully effective. In addition, side effects may appear in the beginning, but most improve over time. Follow up visits are important to assess treatment response. Finally, consider changes in the drug regimen if significant improvement in symptoms does not occur after six weeks.

First Line Treatment: SSRI, TCA, SNRI, NRI, DA

Second Line Treatment: SSRI and a second anti-depressant; addition of atypical anti-psychotic

Therapeutic Class/ Brand Name	Dosage Forms	Recommended Starting Dose	FDA Maximum Daily Dose	Comments
Selective Serotonin Reuptake Inhibitors				
CELEXA® (generic) citalopram	10, 20, 40 mg tablet 10 mg/5ml solution	20mg once daily	40mg	Additive QTc prolongation 2-week washout period between MAOI and SSRI
LUVOX® (generic) fluvoxamine	25, 50, 100 mg tablet	100mg once daily	300mg	FDA indicated in OCD (off-label use for depression)
LUVOX CR® (generic) fluvoxamine	100, 150 mg capsule	100mg once daily	300mg	2-week washout period between MAOI and SSRI
PAXIL/PAXIL CR® (generic) paroxetine	10, 20, 30, 40 mg tablet 12.5, 25, 37.5 mg ER tablet	20mg once daily (tablet) 25mg once daily (ER tablet)	60mg (tablet) 75mg (ER tablet)	Avoid use in pregnancy due to CV effects (all other SSRIs or TCA preferred in pregnancy) 2-week washout period between MAOI and SSRI
PROZAC® (generic) fluoxetine	10, 20 mg tablet 10, 20, 40 mg capsule 20mg/5ml solution	20mg once daily	80mg	Long half-life = self-tapering (all other antidepressants need to be tapered over several weeks)
PROZAC WEEKLY® (generic) fluoxetine	90mg delayed release capsule	90mg once weekly	90mg weekly	Activating; take in the morning 5-week wash-out period if switching from fluoxetine to MAOI 2-week washout from MAOI to SSRI

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Therapeutic Class/ Brand Name	Dosage Forms	Recommended Starting Dose	FDA Maximum Daily Dose	Comments
ZOLOFT® (generic) sertraline	25, 50, 100 mg tablet 20mg/ml concentrate	50mg once daily	200mg	First-choice for patients with comorbid CAD 2-week washout period between MAOI and SSRI
LEXAPRO® (generic) escitalopram	5, 10, 20 mg tablet 5mg/5ml solution	10mg once daily	20mg	Additive QTc prolongation 2-week washout period between MAOI and SSRI
VIIBRYD® Vilazodone	10, 20, 40 mg tablet	10mg once daily	Not Available	Take with food Less sexual side effects 2-week washout period between MAOI and SSRI
Serotonin and Norepinephrine Reuptake Inhibitors				
EFFEXOR/EFFEXOR XR® (generic) venlafaxine	25, 37.5, 50, 75, 100 mg tablet 37.5, 75, 150 225 mg ER tablet 37.5, 75, 150 mg ER capsule	25mg TID (tablet) 75mg once daily (ER tablet) 75mg once daily (ER capsule)	375mg (tablet) 225mg (ER tablet) 225mg (ER capsule)	Additive QTc prolongation Highest risk increasing BP, especially at doses > 150 mg/day (all SNRIs have dose-dependent risk) 7-day washout period from SNRI to MAOI; 2-week washout from MAOI to SNRI
FETZIMA® levomilnacipran	40, 80, 12 mg ER capsules	40 mg once daily	120 mg	Take capsule whole, do not crush/chew 7-day washout period from SNRI to MAOI; 2-week washout from MAOI to SNRI
PRISTIQ® desvenlafaxine	50, 100 mg ER tablet	50mg once daily	Not Available. Doses up to 400mg/day have been used.	Additive QTc prolongation 7-day washout period from SNRI to MAOI; 2-week washout from MAOI to SNRI
CYMBALTA® duloxetine	20, 30, 60 mg capsule	20mg BID	60mg	Indicated for both depression and neuropathic/musculoskeletal pain 5 to 14-day washout period from SNRI to MAOI; 2-week washout from MAOI to SNRI
SAVELLA® Milnacipran	12.5, 25, 50, 100 mg tablet	12.5mg once daily	200mg	FDA indicated for fibromyalgia May cause hot flashes 5 to 14-day washout period from SNRI to MAOI; 2-week washout from MAOI to SNRI
Atypical Antidepressants				
WELLBUTRIN®/ WELLBUTRIN SR®, WELLBUTRIN XL® (generic) bupropion	75, 100 mg tablet 100, 150, 200 mg 12hr tablet 150, 300 mg 24hr tablet	75mg BID (tablet) 150mg once daily (12hr/24hr tab)	450mg (tablet) 400mg (12hr) 450mg (24hr)	Least likely to cause weight gain/metabolic abnormalities Less likely to cause sexual side effects High risk of seizures ≥ 450 mg/day 2-week washout period between MAOI and bupropion
trazodone HCl (generic)	50, 100, 150, 300 mg tablet 150, 300 mg ER tablet	75mg BID (tablet) 150mg once daily (ER tablet)	400mg (tablet) 375mg (ER tablet)	Significant sedation and weight gain Risk of priapism 2-week washout period between MAOI and trazodone

Therapeutic Class/ Brand Name	Dosage Forms	Recommended Starting Dose	FDA Maximum Daily Dose	Comments
REMERON®/REMERON SOLUTAB® (generic) mirtazapine	7.5, 15, 30, 45 mg tablet	15mg once daily	45mg	Significant sedation and weight gain 2-week washout period between MAOI and mirtazapine
nefazodone HCl (generic)	50, 100, 150, 200, 250 mg tablet	50mg BID	Not available. Doses up to 600mg have been used.	High risk of hepatotoxicity 2-week washout period between MAOI and nefazodone
BRINTELLIX® vortioxetine	5, 10, 20 mg tablets	10mg once daily	20 mg	21-day washout from vortioxetine to MAOI; 2-week washout from MAOI to vortioxetine

Disclaimer: Recommendation of treatment does not guarantee coverage of services.

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