Treating Depression in the Primary Care Setting

Highlights from Dr. James Westphal's CME presentation

November 20, 2019 – East Hawaii IPA Office

The treatment goal for depression is always remission which is defined as a PHQ-9 of 4 or less. If the reduction in the PHQ-9 is 20-30% in the first 2-3 weeks it is likely that the patient will respond to remission in 10-14 weeks (Wagner, Engel, Engelmann et al., 2017).

If the patient has not responded with a 20 to 30% reduction in PHQ-9 by week 4 and is tolerating the medication, a dose increase to the high end of the optimal range is indicated.

If the patient has not responded with a 20 to 30% reduction in PHQ-9 by week 6 to 8 with an increased dose or the patient cannot tolerate the increased dose, it is time to switch or augment(Kennedy, Lam, McIntyre, et al., 2016).

If there is some response to the first medication (but not to the 20 to 30% level) and the patient is tolerating the medication well, an augmentation is a reasonable option.

If there is minimal response to the first antidepressant or if it is not tolerated, switching to a second antidepressant is the best strategy.

A Simplified Algorithm:

Choose an SSRI, look up the optimal dosing, use that medication as a first choice.

Escitalopram optimal dosing is 10 to 20 mg.

If not response to Escitalopram then choose a second medication with a different mechanism of action; vortioxetine, mirtazapine, or venlafaxine are my recommendations and determine optimal dosing.

- Vortioxetine is 10-20 mgs daily (cost can be a concern)
- Mirtazapine is up to 30 mg daily
- Venlafaxine is 75-150 mg daily

Above these limits, no further increase in efficacy for SSRIs or mirtazapine occurred, but there was a slight increase in efficacy for venlafaxine. There was clear dose dependency in dropouts due to adverse effects for all drugs. (Furukawa, Cipriani, Cowen, Leucht, Egger, Salanti, 2019).

Several atypical antipsychotic medications have demonstrated efficacy in augmenting antidepressant effects: Aripiprazole, Olanzapine, Quetiapine, Risperdal.

- Augmentation of SSRIs with lithium or Atypical Antipsychotics is likely to be beneficial in people with Treatment Resistant Depression.

Combining psychotherapy with medication management is superior treatment and appears to be more effective than treatment with antidepressant medication alone in major depression, panic disorder, and OCD. These effects remain strong and significant up to two years after treatment.

Monotherapy with psychotropic medication may not constitute optimal care for common mental disorders (Cuijpers, Sijbrandij, Koole, Andersson, Beekman, Reynolds, 2014)