

Prevalence

9% adults in United States meet criteria for current depression, including 3.4% who meet criteria for major depression, 13%-16% lifetime prevalence of major depressive disorder in United States adults.

Differences By Age and Race:

- Non-Hispanic white patients 17.9%
- Caribbean black 12.9%
- African American patients 10.4%)
- Adults ≥ 75 years old 4.5%-37.4%
- Hospitalized elderly patients > 65 years old admitted to 2 acute care hospitals, major depression found in 14.2% in one hospital and 44.5% in the other hospital and in nursing homes 20.3% prevalence of depression
- Young adolescents: 18% prevalence

Symptoms

Some mnemonics:

DEPRESSION (Depressed mood, Energy loss/fatigue, Pleasure lost, Retardation or excitation, Eating changed (appetite/weight) Sleep changed, Suicidal thoughts, I'm a failure (loss of confidence) Only me to blame (guilt) No concentration)

SIGECAPS (Sleep, Interest, Guilt, Energy, Cognition, Appetite, Psychomotor, Suicide)

Diagnosis

DSM-IV recommends at least 5 of following:

Depressed mood (or irritable mood in children and adolescents) significantly decreased interest or pleasure in almost all activities, significant change in weight or appetite, insomnia or hypersomnia, psychomotor agitation or retardation nearly every day (observable to others) fatigue or loss of energy, feelings of worthlessness or excessive or inappropriate guilt, indecisiveness or decreased ability to concentrate, recurrent thoughts of death or suicide.

Screening tools like HPQ-9 (among many) available online and at clinics in English/Espanol.

HPQ-9 particularly found to be moderately accurate for identifying major depression.

Note on screening (Use at your discretion):

USPSTF recommends screening for non-pregnant adults when staff-assisted depression care support is available (includes clinical staff to assist PCP with direct depression care, case management or mental health treatment).

- USPSTF recommends against routine depression screening when staff-assisted depression care support is not available
- USPSTF recommends screening adolescents aged 12-18 years for major depressive disorder in clinical practices that have systems in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up
- **Insufficient evidence to recommend for or against screening for suicide risk in general population**

Differential

Don't forget to ask about suicide, rule out S.A.D, bipolar, substance abuse disorders, medications (steroids, CCB, ACE-I, opioids, benzos, among others) bereavement, other non-psych causes (thyroid, environmental toxins, THC use)

Treatment

Non-pharmacological/Alternative:

Psychotherapy, CBT, alternative tx (relaxation, treating sleep deprivation, music therapy, exercise, yoga). Medications not found to be effective in children, but may be helpful in adolescents (SSRI>TCA). Alternative treatments such as St. John's Wort as effective as SSRIs.

Pharmacological:

First line therapy are SSRIs which have fewest side-effects and drug-drug interactions, though evidence shows similar response rates with TCAs and SNRIs, and MAOI were found to be more effective with atypical depressive disorders

Frequent side-effects:

Weight gain: mirtazapine, amitriptyline, and paroxetine

SSRI/SNRIs: jitteriness, restlessness, HA, insomnia, sexual dysfunction (delayed orgasm)

TCA: dry mouth, blurred vision, sedation, wt gain, MI, hypotension, arrhythmias, constipation, urinary retention, tachycardia, confusion, delirium (particularly in elderly)

Least sexual side-effects: Bupropion

Most drug interactions among SSRIs: fluoxetine, fluvoxamine and paroxetine

Avoid abrupt withdrawal or decrease in dose: venlafaxine

Points on switching/terminating medications: Increase dose if no improvement after 2 wks. If no response after 8-10 wks max dosing switching between same class at equivalent dose requires no taper. If partial response, consider augmenting with bupropion, another non-MAO class medication, or second generation anti-psychotic or change to another SSRI or SNRI. If two meds from same class have been ineffective, a different class should be chosen. Medications should be terminated with a 2-4 wk taper.