Session 3:  
Outpatient Management of the  
Depressed Patient

Learning Objectives

1. Describe 3 signs/symptoms that suggest clinical depression in an otherwise healthy young patient.

2. Identify 3 ways to address barriers in practice to the timely diagnosis of clinical depression in the perimenopausal patient.
Dr. Chou is associate clinical professor of psychiatry at Mt. Sinai School of Medicine and senior attending at Phelps Memorial Hospital in Westchester County, NY. Dr. Chou received his undergraduate training at Harvard College then attended medical school at Tulane School of Medicine. He completed his residency in psychiatry and served as chief resident at NYU School of Medicine. Dr. Chou served as a research psychiatrist at Nathan Kline Institute for 18 years. His research interests have focused on the psychopharmacologic treatment of bipolar disorder and schizophrenia. He is a widely known expert in bipolar disorder, having received three NIMH-funded grants in bipolar disorder and over 50 industry sponsored grants in bipolar disorder and schizophrenia.

Dr. Chou has also devoted a significant portion of his career to education serving as director of CME for Mt. Sinai, directing numerous psychopharmacology, clinical, and neuroscience courses, made over 2000 presentations, and created a training program for psychiatrists preparing for the oral board exam: Pass the Boards. He has also personally supervised over 1500 psychiatrists on clinical interviewing and diagnosis in their preparation for the oral boards.

Faculty Financial Disclosure Statement

The presenting faculty reports the following:

Dr. Chou receives speaking and teaching honoraria from Bristol-Myers Squibb, Novartis Pharmaceuticals, and Sunovion Pharmaceuticals.
Learning Objectives

• Describe 3 signs/symptoms that suggest clinical depression in an otherwise healthy young patient
• Identify 3 ways to address barriers in practice to the timely diagnosis of clinical depression in the perimenopausal patient

Q1. Pre-Activity Audience Response Question

Which of the following has been studied extensively in adolescents and young adults and therefore should be considered first when treating a 22-year-old depressed patient?

1. Fluoxetine
2. Trazodone
3. Escitalopram
4. None of the above
5. 1 and 3 only

Q2. Pre-Activity Audience Response Question

Which of the following is LEAST likely to cause sexual dysfunction?

1. Trazodone
2. Buproprion
3. Mirtazapine
4. All of the above
5. 1 and 2 only

Q3. Pre-Activity Audience Response Question

Which of the following regarding vascular depression in the elderly is TRUE?

1. Vascular depression is associated with greater agitation compared to non-vascular depression
2. Vascular depression occurs in older patients compared to non-vascular depression
3. Psychotherapy is the treatment of choice
4. All of the above

Faculty Disclosures

• Dr. Chou receives speaking and teaching honoraria from Bristol-Myers Squibb, Novartis Pharmaceuticals, Otsuka, and Sunovion Pharmaceuticals.
Patient Case 1

David is a 23-year-old man with irritability, isolation, substance abuse, and anhedonia

- Parents worried, arranged office visit, and accompanied him to ensure he came
- He has returned to live at home after graduating from college 1 year ago and not finding employment in computer science
  - He has a part-time job bussing tables in a local restaurant at night
  - He is sleeping much of the day and is eating only one meal daily
  - He has little interest in anything, rarely sees friends, and avoids his parents by staying in his room in the basement
  - His parents complain he is irritable

What would be your next step?

1. Ask David about his social life
2. Have David and his parents tell each other what is bothering them
3. Ask the parents to step out so you can get additional information from David
4. Ask David to step out so you can get additional information from his parents

After his parents leave the exam room, he confirms low energy, difficulty thinking/concentrating (he is worried he has ADHD), amotivation, and feeling badly about himself due to his lack of adequate employment.

- On questioning, he admits to drinking alcohol daily, and smoking marijuana much of the time he is awake. He explains it is the only thing that helps him feel better
- He feels hopeless and can’t see his situation changing anytime soon. He denies thoughts of death, but asks, “What is the point?”
- He denies history of self-harm

Management should focus on:

1. Lack of skills for finding employment
2. Adjustment disorder due to graduating college without a job
3. Major depression
4. Substance-induced mood disorder
5. Sleep disorder

Major Depressive Disorder (MDD)

DSM-IV-TR Criteria

5 symptoms nearly every day during 2-week period that includes depressed mood and/or loss of interest/pleasure:

- Unintentional weight loss/gain or decreased/increased appetite
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Difficulty concentrating
- Recurrent thoughts of death or suicidal ideation or attempt

From Diagnostic and Statistical Manual of Mental Disorders. American Psychiatric Association 2010.
Major Depressive Disorder (MDD)

DSM-IV-TR Criteria (Cont.)

Symptoms

- cause significant distress or impaired function
- not due to a substance or medical condition
- not due to bereavement, or last > 2 mos

- are characterized by functional impairment, preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation

From Diagnostic and Statistical Manual of Mental Disorders. American Psychiatric Association 2010.

PHQ-9 - Depression Severity Measure

2. Feeling down, depressed, or hopeless

4. Feeling tired or having little energy

6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down

8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual

Not at all = 0 points
Several days = 1 point
> half of the days = 2 points
All the time = 3 points

Scores range from 0 to 27

5-9 = minimal symptoms
10-14 = mild depression
15-19 = moderate depression
≥ 20 = severe depression

David

At this point, you:

1. Recommend discontinuation of all alcohol and illicit drugs
2. Recommend family therapy
3. Start David on an antidepressant
4. Provide referral for cognitive behavioral therapy
5. Recommend he begin a structured exercise program

You recommended he stop all alcohol and illicit substance use. David skips the next appointment but returns in 6 weeks. He says he has cut back significantly on the drinking and marijuana use but none of his symptoms have changed.

At this point you:

1. Initiate antidepressant therapy
2. Initiate stimulant therapy for concentration problems and oversleeping
3. Refer to a therapist for cognitive behavioral therapy

David

Antidepressant Classes

<table>
<thead>
<tr>
<th>Selective serotonin reuptake inhibitors (SSRIs)</th>
<th>Dopamine norepinephrine RI</th>
</tr>
</thead>
<tbody>
<tr>
<td>fluoxetine, paroxetine, citalopram, escitalopram, sertraline</td>
<td>bupropion</td>
</tr>
<tr>
<td>venlafaxine, desvenlafaxine, duloxetine, mirtazapine*</td>
<td></td>
</tr>
</tbody>
</table>

Serotonin norepinephrine reuptake inhibitors (SNRIs)

<table>
<thead>
<tr>
<th>Norepinephrine-serotonin modulators</th>
</tr>
</thead>
<tbody>
<tr>
<td>trazodone, nefazodone, viloxazine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Serotonin modulators</th>
</tr>
</thead>
<tbody>
<tr>
<td>desipramine, doxepin, others</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monoamine oxidase inhibitors (MAOIs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>selegiline, phenelzine, tranylcypromine, isocarboxazid</td>
</tr>
</tbody>
</table>

* Not FDA approved for depression

Antidepressants and Suicide Risk

- Fluoxetine and escitalopram approved for MDD in adolescents (12-17 years); most data available
- 2004 FDA advisory linking a 4% absolute rate and 2-fold increase in risk of suicidality (suicidal thinking or behavior) with SSRIs used for MDD in children and adolescents
  - based on post-hoc analysis of placebo-controlled trials in which no suicides occurred
  - In 2006, warning extended to young adults <25 years of age
- A 9-year cohort study of 20,906 children demonstrated no difference among SSRIs or TCAs, suggesting drug class effect

Antidepressants and Suicide Risk (Cont.)

- Post “black box” warning, there have been fewer depression visits for children, however, the proportion of visits with antidepressant (AD) prescribed has remained the same (64-65%), indicating more severe illness among children who are evaluated
- Comprehensive review of pediatric trials suggests benefits of AD likely outweigh risks for those <18 years with MDD and anxiety disorders
- MOA for suicidality may be induction of emotional effects
  - Blunting – cognitive impairment, reduced libido, and sedation
  - Instability – increased anxiety, anger, aggression, and mood swings related to activation effects (arousal, insomnia, and agitation)
- History of non-suicidal self-injury prior to treatment is a clinical marker for subsequent suicide attempts

David: Take Home Points

- Diagnosis in adolescents/young adults may be difficult due to isolation and passive rather than active symptoms (loss of pleasure vs. depressed mood, irritability vs. sadness, etc.)
- Alcohol and illicit drugs may cause depression or lead to poor response to treatment
- Other co-morbidities may affect response to treatment: anxiety, ADHD, substance abuse/dependence
- Antidepressant therapy may be associated with increased impulsivity/suicidality in people < 24 years, so family to monitor, early follow-up with serial PHQ-9 administration, have emergency plan in place should SI occur/increase.
- Use fluoxetine or escitalopram first

Mood Disorders are Common and Undertreated

- Prevalence of mood disorders in American adults ~ 9.5%
- National Comorbidity Study (NCS)
  - Only 20% of individuals with a 12-month history of a psychiatric disorder obtained treatment
  - Only 40% of individuals with a lifetime disorder obtained treatment
- Major depression affects 1 in 20 (~15 million) annually
  - The risk of recurrence:
  - 50% after 1 episode
  - 70% after 2 episodes
  - 90% after 3 episodes

Optimizing Care for Patients with MDD

- Initiate therapy with a full therapeutic dose
  - Exception: if anxious or elderly, start low and go slow
- Alert patients to likely side effects, especially early sleep or anxiety disturbance
- Monitor for intrusive thoughts, hypomania or increased suicidal ideation, especially in younger patients
- Have patient call, or call patient within 1 week, and see within 2 weeks of starting therapy
- For patients with a history of bipolar illness, active suicidal ideation or co-morbid substance abuse: refer early

Patient Case 2

Susan is a 49-year-old woman with fatigue, anxiety, decreased libido, and menstrual irregularities

- In for routine annual exam – you have known her for years
- She is normally very pleasant, busy and successful, married and mother of 2 teenagers, but over the last 6 months she has not been herself:
  - Problems with concentration and memory, especially word-finding problems that interfere with work and social interactions
  - Fatigue and low energy, so she has reduced exercise frequency
  - Wonders if she is perimenopausal as she is having night sweats that awaken her from sleep, decreased libido, weight gain, and shorter menstrual cycles (21 days instead of 28) so menstrual migraines are more frequent
Susan

- She is worrying more, especially that she might have breast cancer or dementia
- She has trouble falling asleep plus has several awakenings each night
- She often feels overwhelmed by routine tasks, and occasionally bursts into tears unexpectedly
- Her medical history is significant for migraines, for which she takes a triptan, and postpartum depression following the birth of her second child
- Her family history is significant for early cardiac disease, diabetes, and breast cancer

Susan

At this point, you perform routine exam, mammogram, and labs including TSH, which are all normal.

What might best explain Susan’s complaints?
1. Perimenopause
2. Generalized anxiety disorder
3. Major depression
4. Early dementia
5. Normal aging

Susan

What would be your next step?
1. Start antidepressant therapy
2. Start a prn benzodiazepine to help with feeling overwhelmed
3. Recommend complementary/alternative interventions for her symptoms (e.g., soy, ginkgo, St John’s wort)
4. Further testing to rule out dementia, other serious medical conditions

Menopause and Depression

- Women are at greater risk of depression in menopausal transition with or without prior depression history
- MDD is underdiagnosed and undertreated since symptoms often attributed to menopausal causes
- Co-morbidities (medical and psychiatric) and depression have a bidirectional relationship that may complicate diagnosis and treatment

Risk Factors for MDD Associated with Menopause

- **Demographic:** ethnicity, lower educational level
- **Psychiatric:** history of depressed mood or depression, co-morbidity
- **Psychosocial:** stressful life events, unhealthy lifestyle, marital concerns, negative attitudes toward aging/ menopause
- **Menopausal symptoms:** vasomotor symptoms and other physical symptoms, premenstrual syndrome, early natural menopause, stage of menopausal transition, greater hormonal fluctuation changes during menopausal transition, longer menopausal transition, abrupt/surgical menopause

Depression or Menopause?

- Overlapping symptoms: low energy, poor concentration, sleep problems, weight changes, and decreased libido
- Important co-morbidities include migraine, chronic pain, DM, cancer, fibromyalgia, IBS, obstructive sleep apnea
- Routine screening for MDD in perimenopause: If meet DSM criteria, diagnose depression even if somatic symptoms or life stressors evident
- Generally, hormone therapy (HT) alone will not treat MDD, but some antidepressants can reduce menopausal symptoms
- SNRIs may be more effective than SSRIs for MDD through the menopausal transition
- HT plus antidepressant therapy can improve both sets of symptoms, but should be limited to the perimenopausal period

Depression Rates in Patients with Chronic Medical Conditions

<table>
<thead>
<tr>
<th>Medical Illness</th>
<th>Depression (%)</th>
<th>Medical Illness</th>
<th>Depression (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac disease</td>
<td>17-27</td>
<td>Diabetes (self-reported)</td>
<td>26</td>
</tr>
<tr>
<td>Cerebrovascular</td>
<td>14-19</td>
<td>Diabetes (diag. interview)</td>
<td>9</td>
</tr>
<tr>
<td>Alzheimer's</td>
<td>30-50</td>
<td>Cancer</td>
<td>22-29</td>
</tr>
<tr>
<td>Parkinson’s</td>
<td>4-75</td>
<td>HIV/AIDS</td>
<td>5-20</td>
</tr>
<tr>
<td>Epilepsy (recurrent)</td>
<td>20-55</td>
<td>Pain</td>
<td>30-54</td>
</tr>
<tr>
<td>Epilepsy (controlled)</td>
<td>3-9</td>
<td>Obesity</td>
<td>20-30</td>
</tr>
<tr>
<td>Migraine</td>
<td>18</td>
<td>General population</td>
<td>10.3</td>
</tr>
</tbody>
</table>


Susan

You prescribe a generic SNRI and counsel Susan with regard to her migraine medicine:

1. Triptans can reduce antidepressant effectiveness
2. SRIs can reduce triptan effectiveness
3. A potentially life-threatening interaction can occur with a triptan and an SRI
4. SRI and triptan side effects are similar and can be more pronounced when taken together

Triptans and Antidepressants

- Migraine and depression are common co-morbidities
- Patients should be cautioned that co-administration of a triptan and an SSRI, SNRI, MAOI, or TCA can rarely precipitate serotonin syndrome
  - symptoms may include mental status changes autonomic instability, neuromuscular aberrations, and/or gastrointestinal symptoms
  - onset of symptoms can occur within minutes to hours of taking a new or a greater dose of a serotonergic medication
  - seek medical attention immediately if symptoms occur

Side Effects of Antidepressant Drugs

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Drugs/Drug Classes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticholinergic</td>
<td>TCAs, SNRIs, bupropion</td>
</tr>
<tr>
<td>Sexual (ED, libido, orgasm)</td>
<td>SSRIs, SNRIs, MAOIs</td>
</tr>
<tr>
<td>Activation (esp. insomnia)</td>
<td>SSRIs, SNRIs, bupropion</td>
</tr>
<tr>
<td>Weight gain</td>
<td>SSRIs, mirtazapine, TCAs, MAOIs</td>
</tr>
<tr>
<td>Sedation</td>
<td>TCAs, trazodone, nefazodone, mirtazapine</td>
</tr>
<tr>
<td>GI, reduced appetite</td>
<td>SSRIs, SNRIs, bupropion</td>
</tr>
<tr>
<td>Seizure</td>
<td>Bupropion, TCAs, amoxapine</td>
</tr>
<tr>
<td>Arrhythmias</td>
<td>TCAs, SSRIs</td>
</tr>
<tr>
<td>Hypertensive crisis</td>
<td>MAOIs</td>
</tr>
</tbody>
</table>

Drug interactions: additive/synergistic side effects with concomitant medications; cytochrome P450 enzyme inhibition

Antidepressants Least Likely to Cause Sexual Dysfunction

<table>
<thead>
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<th>Selective serotonin reuptake inhibitors (SSRIs)</th>
<th>Dopamine norepinephrine Rl</th>
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<td>• fluoxetine</td>
<td>bupropion</td>
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<tr>
<td>• paroxetine</td>
<td>Serotonin modulators</td>
</tr>
<tr>
<td>• citalopram, escitalopram</td>
<td>• trazodone, nefazodone, mirtazapine</td>
</tr>
<tr>
<td>• sertraline</td>
<td>Norepinephrine-serotonin modulators</td>
</tr>
<tr>
<td>Serotonin norepinephrine reuptake inhibitors (SNRIs)</td>
<td>• mirtazapine</td>
</tr>
<tr>
<td>• Venlafaxine, desvenlafaxine</td>
<td>Tricyclics/tetracyclics (TCAs)</td>
</tr>
<tr>
<td>• duloxetine</td>
<td>• amitriptyline, nortriptyline</td>
</tr>
<tr>
<td>• milnacipran*</td>
<td>• desipramine, doxepin, others</td>
</tr>
</tbody>
</table>

Monoamine oxidase inhibitors (MAOIs)

- selegiline, phenelzine, tranylcypromine, isocarboxazid

*Not FDA approved for depression

Susan

Susan returns in 4 weeks and is feeling better overall, however she is concerned that she has lost all interest in sex.

What do you do now?

1. Reduce the SNRI dose
2. Prescribe a PDE-5 inhibitor
3. Switch antidepressant to bupropion
4. Add nefazodone

Selective serotonin reuptake inhibitors (SSRIs)

- fluoxetine
- paroxetine
- citalopram, escitalopram
- sertraline

Serotonin norepinephrine reuptake inhibitors (SNRIs)

- Venlafaxine, desvenlafaxine
- duloxetine
- milnacipran*
Strategies for Managing AISD

<table>
<thead>
<tr>
<th>STRATEGIES</th>
<th>PROS</th>
<th>CONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tolerance</td>
<td>Simple</td>
<td>Low success rate</td>
</tr>
<tr>
<td>Lower dose</td>
<td>Simple</td>
<td>Relapse</td>
</tr>
<tr>
<td>Drug holiday</td>
<td>No additional medications</td>
<td>Potential discontinuation symptoms; relapse</td>
</tr>
<tr>
<td>Substitution</td>
<td>Single agent successful</td>
<td>Fear of therapeutic failure</td>
</tr>
<tr>
<td>Antidotes</td>
<td>Good success rate</td>
<td>Increased side effects; cost</td>
</tr>
</tbody>
</table>

Continuation of Antidepressants After Depression Remits

• Typically, treatment should continue for at least 6-9 months after substantial improvement
• Patients who have had ≥ 2 depressive episodes or who have chronic depression have a high probability of recurrence after drug discontinuation
• These patients may require ongoing maintenance treatment

STAR*D (Sequenced Treatment Alternatives to Relieve Depression)

• A multi-site, prospective, randomized, multistep clinical trial of outpatients with nonpsychotic major depressive disorder
• Compared various secondary treatment options for patients who did not attain a satisfactory response with the SSRI citalopram
• Primary outcome: 17-item HAMD* and QIDS-SR**, administered at entry and at exit from each treatment level
• Mirrors real-world practice (effectiveness trial)

*HAMD=Hamilton Rating Scale for Depression
**QIDS-SR =quick inventory of depressive symptoms-self report

Treatment Algorithm Snapshot

STAR*D Algorithm

1. Initial treatment: citalopram
2. Switch to: bupropion SR cognitive therapy, sertraline, venlafaxine ER or augment with bupropion SR, buspirone, cognitive therapy
3. Switch to: mirtazapine or nortriptyline or augment with lithium or triiodothyronine (only with bupropion SR, sertraline, venlafaxine ER)
4. Switch to: tranylcypromine or mirtazapine combined with venlafaxine ER

STAR*D Remission Rates by Treatment Levels

Remission (N=943) vs Response (N=1,343) at level exit

Week of Treatment

0 5 10 15 20 25

Prevalence

Remission
Response
QIDS-SR<5 at level exit


Nonpharmacologic Treatments

- Cognitive behavioral therapy (CBT) may be as effective as drug therapy for acute outpatient treatment; can reduce relapse risk even after treatment is terminated
- Exercise may be helpful as adjunctive therapy for mild to moderate depression
- Sleep deprivation can have immediate but short-lived effects, but it can trigger mania in bipolar disease. Relapse usually occurs after sleep recovery
- Phototherapy (10,000 lux/30-60 min/day) may be effective as monotherapy for seasonal affective disorder and as adjunctive treatment in nonseasonal depression. Excessive exposure may trigger mania. Dawn simulators may also be effective adjuncts.
- Yoga and mindfulness-based therapies are promising but more research needed.

Susan: Take Home Points

- Women are at greater risk of depression in menopausal transition with or without prior depression history.
- Don’t just attribute symptoms to perimenopause if she meets criteria for MDD: underdiagnosed and undertreated.
- Co-morbidities (medical and psychiatric) and depression have a bidirectional relationship that may complicate diagnosis and treatment.
- Management of antidepressant side effects, treatment to remission, and adjunctive therapy rather than serial monotherapy should be standard of care.

Patient Case 3

Sylvia is a 78-year-old woman with incontinence episodes, gait disturbance, and social withdrawal

- Husband makes an appointment for her
- She is normally loving and involved in community, but she has not been herself for the last several weeks
  - Blank and vacant stare, even with grandchildren
  - Difficulty with cooking and seems disinterested
  - Remembers people but responses are slow
  - Gait is off and she takes small steps
  - Has had several urinary incontinence episodes

Sylvia

PMH
- TIA 4 years ago, some "white" areas on MRI that were dismissed as non-specific and commonly seen
- Blood transfusion postpartum 1980
- No history of murmurs, atrial fibrillation, valve disease, carotid stenosis

Interview
- Blank and limited facial expression
- Sits quietly in her chair, responds monosyllabically
- Responses to questions are slow, often begin with "I don’t know," but is able to answer most questions accurately
- When asked to describe her mood, she says fine
- No evidence of psychosis; denies visual hallucinations

Exam
- Mini-mental state exam reveals that she has difficulty with short-term recall, multi-stage commands and figure drawings
- Wide-based and small-stepped gait
- Unable to perform a Luria 3 step hand command
- Deep tendon reflexes seem normal to slightly slow in the relaxation phase
- Vitals are unremarkable; no fever, no bacteriuria
- There is no family or personal history of depression
- B12, folate levels, and TSH WNL
Sylvia

What is the most likely diagnosis?

1. Parkinson’s disease
2. Alzheimer’s disease
3. Minimal cognitive impairment
4. Vascular dementia
5. Vascular depression

Most Common Causes of Dementia

- Alzheimer’s disease 50-75%
- Vascular dementia 15-25%
- Lewy bodies
- Fronto-temporal dementia


Treatment of Patients with Alzheimer’s Disease and Other Dementias, Second Edition 2007 American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders

Clinically Defined Vascular Depression

- Two groups of consecutively recruited patients ≥60 years with major depression
- Defined as vascular versus nonvascular depression based on age at first onset of depression (> or < age 60) and score on Cumulative Illness Rating Scale – Geriatrics
- Patients with vascular depression
  - greater overall cognitive impairment and disability
  - fluency and naming were more impaired
  - had more psychomotor retardation
  - less agitation and guilt
  - greater lack of insight

Kawas C, Katzman R, vide supra.

Kawas C, Katzman R, vide supra.


Vascular Depression Studies

- Elderly depressed patients vs. elderly controls:
  - Those with late onset depression had significantly more neurologic findings, e.g., abnormal complex motor sequencing, frontal lobe abnormalities
  - More ischemic lesions in deep white matter with hyperintensities on MRI; ischemic lesions more in dorsolateral prefrontal cortex
- Depressed patients with vascular changes were older and had more late-onset depression compared to depressed patients with nonvascular changes (patients with cognitive conditions were excluded)


Sylvia

An MRI revealed more extensive white matter hyperintensity, including extension into the centrum semiovale.

What medication would you prescribe for Sylvia?

1. Low-dose TCA
2. Therapeutic dose SNRI
3. Acetylcholinesterase inhibitor
4. None

Sylvia: Additional Points

- A helpful screening tool in elderly, especially this population, is the Geriatric Depression Scale (GDS) as may be completed by caregiver, family, etc. and measures symptoms that elderly may report more than depressed mood.
- In post-stroke depression, location of stroke may help predict subsequent MDD
- Dementia with depression may be difficult to discriminate from the pseudodementia of depression except by temporal onset
- If not responsive to medication trial(s), ECT might be indicated; is a reason for referral
- Psychotherapy may be useful, but amotivation and stigma in this population may limit success
- Depression after age 60-70 requires ongoing, indefinite duration of treatment
Conclusion

• Psychiatric disorders are common in patients being managed for medical conditions by primary care clinicians

• Screening and identification of depression, anxiety, and substance use disorders can be done using office-based tools

• Treatment of depression should consider bidirectional relationship with psychiatric and medical co-morbidities

Q1. Post-Activity Audience Response Question

Which of the following has been studied extensively in adolescents and young adults and therefore should be considered first when treating a 22-year-old depressed patient?

1. Fluoxetine
2. Trazodone
3. Escitalopram
4. None of the above
5. 1 and 3 only

Q2. Post-Activity Audience Response Question

Which of the following is LEAST likely to cause sexual dysfunction?

1. Trazodone
2. Buproprion
3. Mirtazapine
4. All of the above
5. 1 and 2 only

Q3. Post-Activity Audience Response Question

Which of the following regarding vascular depression in the elderly is TRUE?

1. Vascular depression is associated with greater agitation compared to nonvascular depression
2. Vascular depression occurs in older patients compared to nonvascular depression
3. Psychotherapy is the treatment of choice
4. All of the above

Questions

?