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Review Article

DEPRESSION IN PRIMARY CARE PART 2: MANAGEMENT

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ABSTRACT
The management of depression in the primary care setting should ideally take a biological, psychological, and sociological approach. Antidepressants are the most commonly used biological agents in the treatment of depression. Psychological therapies and psychosocial interventions improve the outcome of treatment when combined with pharmacotherapy. Clinical depression is treatable and thus efforts should be made to alleviate the suffering of patients with depression.
Key words: *Depression, antidepressants, psychotherapy*
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INTRODUCTION

Managing depression in the primary care and general practice setting is challenging.[1,2] The common reasons leading to this challenge are:

- The constraints of time
- Insufficient training at the undergraduate level
- Somatisation of symptoms

The use of pharmacological agents often enables the physician to circumvent time constraints. Difficulties arise when knowledge about the properties and use of these agents is lacking.[3] The other factor that often hinders the management of the depressed patient is that psychological and social issues are inadequately addressed. Psychological and social interventions should accompany pharmacological therapy in order to bring about remission of symptoms in the depressed patient.[4,5]

Appropriate management of depression requires knowledge of the severity and type of depressive disorders.[5] Depressive disorders can be categorised as mild, moderate or severe. Severe depression can result in psychosis. A chronic mild to moderate depression lasting more than two years is termed dysthymia. Depression can also be part of bipolar disorder. There is a variation in the management of each of the above.

The National Institute of Clinical Excellence (NICE) in the UK has guidelines for the management of depression in primary and secondary care.[6] These guidelines use a stepped care model which matches resources to the severity of the illness.

Mild depression can be handled in primary care and does not need pharmacological therapy. The NICE guidelines suggest watchful waiting, guided self-help, exercise and brief psychological interventions. Moderate to severe depression can also be handled in the primary care setting with medication, psychological interventions and social support. Severe depression with psychosis and risk of suicide, recurrent atypical and treatment-resistant depression should be managed by mental health specialists.

Pharmacological therapies

Most depressive disorders require treatment with antidepressants.[7] There is a tendency for general practitioners in Malaysia to use benzodiazepines like alprazolam to treat depression. There is no evidence to show that benzodiazepines have antidepressant properties. They are useful in alleviating symptoms of anxiety and providing sedation in depressed patients[4].

Tricyclic and tetracyclic antidepressants (TCAs) and the selective serotonin reuptake inhibitors (SSRIs) are the commonly used antidepressants in clinical practice. The main advantages of the SSRI group over the TCA group are that they produce fewer side effects and are safe in overdose. On the other hand, patented SSRIs are much more expensive than TCAs. There are also other newer antidepressants like the SNRIs (serotonin and noradrenaline reuptake inhibitors), mirtazapine and escitalopram.

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TABLE 1: COMPARISON OF CLASSES OF COMMONLY USED ANTIDEPRESSANTS IN MALAYSIA

Anti-depressants	Action	Common side effects	Cost
Tricyclic antidepressants (amitryptiline, imipramine, dothiepin)	Blockade of serotonin and noradrenaline uptake	o Sedation o Anticholinergic effects (dry mouth, blurred vision, constipation, urinary retention) o Postural hypotension o Weight gain o Sexual dysfunction o Toxic in overdose	Generic – RM 0.50 to RM 1.50 per tablet (lowest dose)
SSRIs (sertaline, fluoxetine, citalopram, fluoxamine, paroxetine)	Blockade of serotonin uptake	o Transient increase in anxiety or nausea in increasing dose o Sexual dysfunction	o RM 3.00 to RM 6.00 per tablet (lowest dose) o Generic is cheaper costing RM 1.00 to RM 2.00 (lowest dose)
SNRIs (venlafaxine, duloxetine)	Blockade of serotonin and noradrenaline uptake	o Initial increase in anxiety and nausea o Sexual dysfunction o Hypertension (venlafaxine)	o RM 4.00 to RM 6.00 per capsule (lowest dose)

CHOOSING ANTI-DEPRESSANTS

Factors to consider when choosing a first-line antidepressant medication:[7]

- Anticipated side effects and tolerability
- Safety in overdose
- History of prior response in patient
- Patient preference
- Cost of medication

The SNRIs and escitalopram can be utilized as second line antidepressants when the first line antidepressants are ineffective or fail to bring about the desired outcome. When sedation is required it is preferable to use a sedating antidepressant like mirtazapine or the TCAs. Alternatively a non-sedating antidepressant can be prescribed with a benzodiazepine or a non-benzodiazepine sedative hypnotic like zolpidem. The sedative hypnotic should be taken only for short periods of time because of the risk of dependence. Most of the SSRIs are non-sedative but some patients may complain of drowsiness with fluvoxamine and paroxetine.

Side effect tolerability depends on the individual patient. Some individuals tolerate side effects better than others. It must be remembered that no anti-depressant is devoid of side effects.

In patients with co-morbid medical illness, an antidepressant with fewer drug-to-drug interactions should be prescribed.[4] Citalopram, sertraline, venlafaxine and mirtazapine fall into this category.

If the patient has been successfully treated with antidepressants in the past, the same antidepressant often proves to be effective in a recurrent episode of depression.[8]

The patient with thoughts of self-harm should be assessed for suicide risk. Patients with low suicide risk can be treated in primary care with safe antidepressants namely SSRIs.[8]

THERAPEUTIC CONSIDERATIONS

Symptoms of depression do not start to resolve until the patient has received an adequate dose of medication for a period of two to four weeks and full remission of symptoms may take up to four months. Patients who feel better or well often discontinue antidepressant treatment prematurely. International guidelines for the management of depression recommend that patients with a first episode depression should continue to use antidepressant treatment for six months from the point of full remission of symptoms.[4] The other principle is 'the dose that makes the patient well keeps the patient well'. Thus, the patient has to be on an adequate dose of antidepressants for an adequate period of time. Relapses can occur if antidepressant treatment is discontinued or if the dose of the antidepressant is reduced prematurely. Recurrent episodes of depression require longer periods of treatment. A second episode of illness may require up to two years of antidepressant treatment and three or more episodes signal an indefinite period of pharmacotherapy.

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If a patient does not respond to an adequate trial of antidepressants, a switch to an antidepressant of a different chemical class should be contemplated. Augmentation can be tried with mood stabilisers like lithium, valproate or lamotrigine.[7]

In treating the elderly depressed one has to use the tenet, 'start low and go slow'. Treatment should begin with low doses of antidepressants, slowly titrated upwards to an adequate dose.

PSYCHOLOGICAL INTERVENTIONS

Evidence shows that the two most effective therapies for depressive disorders are Cognitive Behavioural Therapy (CBT) and Interpersonal Psychotherapy (IPT).[4,9,10] These therapies require about 12 to 16 sessions to bring about a significant reduction of symptoms and each session may last from 45 minutes to an hour. Furthermore, the doctor has to be trained under supervision in order to institute this therapy. These pose serious challenges to primary care physicians. Simple interventions based on techniques used in CBT and IPT like 'encouragement of affect', 'distraction', 'problem solving' and 'scheduling activities in a graded manner' have proven to be effective in primary care.[2] These techniques are not time consuming and easy to learn. The physician can conduct the interventions during consultation and the patient can use them to help him- or herself outside consultation.

Problem solving is effective in tackling problems related to interpersonal issues such as relationships at home and at work. The following are guidelines for problem solving:

- Identify the problem area with the patient
- Prioritize and choose one problem if there are more than one
- Brainstorm for options or possible solutions to the problem
- Choose a preferred option or solution
- Work out steps to tackling the problem using the option
- The patient is to carry out the task (the steps)
- Review the implementation of the task
- Decide next steps depending on progress made

Encouragement of affect allows the patient to express his/her emotions and the content linked with these emotions. An example would be a patient who sheds tears and expresses sadness and talks of being verbally and emotionally abused by her husband to her empathetic physician.

'Distraction' enables the patient to distract attention from the pessimistic thoughts that are part of the cognition of a depressed person. For example, a depressed man who normally enjoys tinkering with his car is encouraged to do so when he is preoccupied with negative thoughts. This helps him focus his thoughts on the car and draws attention away from the pessimistic thoughts.

Scheduling activities in a graded manner helps the patient resume activities that she or he normally undertakes but has stopped doing because of the illness. 'Scheduling' instils regularity whereas 'grading' builds competency by encouraging the completion of a simple task followed by the undertaking of more complex activities.

A patient with complex issues may require referral to a psychologist or psychiatrist who is able to do psychotherapy. These issues would include significant psychosocial stressors, interpersonal difficulties, intrapsychic conflicts and co-morbid personality disorders.[6] Marital and family therapy may be required for marital discord and family conflict which are a cause or effect of the depressive illness.

SOCIAL SUPPORT AND PSYCHO-EDUCATION

It is important to assess the patient's social support and availability of this resource. Supportive relationships assist the depressed patient to recover. Understanding and gentle encouragement from family and friends contribute to recovery. Family members are also instrumental in helping the patient comply with treatment.

Psycho education of both patient and family is essential. Depression should be seen as an illness that can be treated. The changes that occur in the depressed person like lack of motivation and impaired functioning can be mistaken for laziness or weakness. Thus awareness should be instilled that these symptoms will subside with adequate treatment. Patient psycho-education should include discussion about the treatment for depression. The properties and side effects of medication should also be discussed.

It needs to be emphasised that the primary care physician can provide a much needed supportive role which includes empathy, effective listening and a relationship with the patient's family.[3]

Other Treatments

There are other treatments that can be utilised in the primary care setting. Transcranial magnetic stimulation has been used effectively for some patients with depression.[11] It is not invasive and does not require administration of anaesthesia. However, more knowledge regarding the characteristics of patients who benefit from this treatment is required. St. John's Wort, an extract of the herb *Hypericum perforatum*, is prescribed in some countries[12]. It is considered to be safe and effective for relief of mild to

moderate depression in adults. Preparations generally are standardised with dosages ranging from 500 to 1,800 mg daily.

CONCLUSION

Managing depression in primary care benefits the patient in many ways. It addresses the suffering and disability which are a consequence of the illness. Furthermore, the stigma associated with being treated by a psychiatrist is reduced. Primary care physicians and general practitioners should be encouraged to embrace this challenge.

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SSRIs effective for premature ejaculation?

Waldinger MD, Zwinderman AH, Schweitzer DH, Olivier B. Relevance of methodological design for the interpretation of efficacy of drug treatment of premature ejaculation: a systematic review and meta-analysis. *Int J Impot Res.* 2004;16(4):369-81

This is a systematic review of 79 studies published from 1943 to 2003 on drug treatment of premature ejaculation (43 studies concerned selective serotonin reuptake inhibitors [SSRIs] and clomipramine). The investigator retrieved data on intravaginal ejaculatory latency time (IELT) as a measure of drug efficacy. Considerable variability was noted in the study design, especially in the methods used to measure IELT. Only eight studies were randomised, double-blind studies with prospective real time (stopwatch) assessment of the IELT at each intercourse. The concluded that, "at daily treatment, the overall efficacy of paroxetine, clomipramine, sertraline and fluoxetine is comparable, but paroxetine exerts the strongest ejaculation delay."