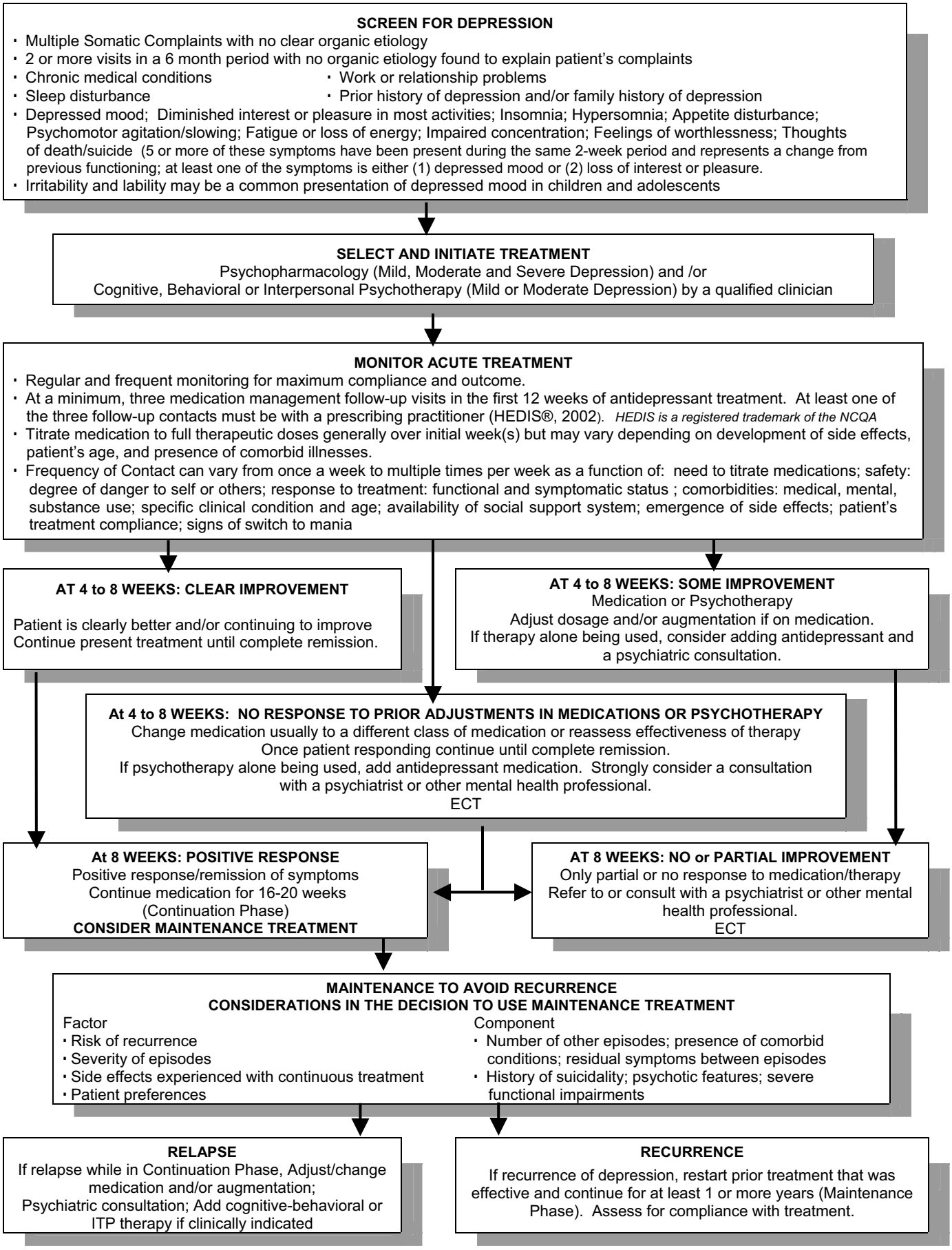
Depression Guidelines



DEPRESSION AND MEDICAL ILLNESS

- Focus on criteria for depression despite the presence of other medical disease!
- Consider disease/drugs associated with depression
- Prevalence of MDD in patients with:
  - Alzheimer's disease: 15% - 55%
  - Cancer: 25% (outpatient); 50% (inpatient)
  - Coronary artery disease: 40% - 65%
  - Diabetes mellitus: 33%
  - Dementia (all forms): 27% - 60%
  - Multiple sclerosis: 6% - 60%
  - Parkinson's Disease: 40%
  - Stroke: 30% - 50%
- Common drugs/medication associated with causing or exacerbating depression:
  - ALL ILLICIT DRUGS & ALCOHOL (32% - 53% COMORBIDITY)
  - Benzodiazepines
  - Narcotic analgesics
  - HIV medications
  - BETA blockers/cardiac medications
  - Anti-hypertension medications
  - Hormones/Steroids

(ALWAYS CHECK THE POTENTIAL SIDE EFFECTS OF PATIENT'S MEDICATION)

DUAL DIAGNOSIS

Two Axis I diagnoses or an Axis I and Axis II diagnosis

- Does patient have two independent disorders or is the psychiatric diagnosis the result of signs and symptoms brought about as a result of the patient's alcohol/drug use
- Acute and chronic substance use has profound effects on:
  - Cognitive functioning
  - Mood
  - Thought processes
  - Personality functioning
- Substance use must be treated with or prior to treatment of any comorbid psychiatric disorder
- To establish a primary psychiatric diagnosis assess if patient free of drugs/alcohol for a 3-6 week period OR by clear history of the temporal relationship between the psychiatric and substance use symptoms

TREATMENT

- Appropriate psychopharmacological interventions when indicated for comorbid psychiatric disorders, withdrawal, or cravings
- Dual diagnosis self-help/12-step groups
- Relapse prevention and medication compliance strategies
- Patient and family/significant other(s) education on the disease of addiction
- Goal – abstinence
- Reality – improvement
- Sponsor and 12-step program a MUST unless some very specific clinical contraindication

Phases of treatment for MDD

Acute phase: 4-12 weeks
Continuation phase: 16-20 weeks (in addition to the acute phase)
Maintenance phase: 1 or more years

Risk of recurrence:

- 50% after one episode
- 70% after two episodes
- 90% after three episodes

MAINTAIN A HIGH INDEX OF SUSPICION

- Pain – including headaches, abdominal pain, and other body aches
- Low energy – excessive tiredness, lack of energy or a reduced capacity for pleasure or enjoyment
- A mood of apathy, irritability, or even anxiety rather than, or in addition to, any overt sadness
- Sexual complaints – problems with sexual functioning or desire
- Prior episodes of depression
- A family history of major depressive or bipolar disorder
- A personal or family history of suicide attempt(s)
- Concurrent chronic medical illness
- Symptoms of fatigue, malaise, irritability, or sadness
- Recent stressful life events and lack of social supports (Stress, serious illness or life event should not be used to "explain away" depression)

MASKED SYMPTOMS OF DEPRESSION

- Loss of sexual desire or drive
- Intense guilt over minor events
- IRRITABILITY (especially men and adolescents); restlessness
- Various somatic complaints such as headache, back pain, muscle pain, palpitations, fainting, constipation, fatigue or insomnia with no known pathophysiology to explain any of these complaints
- Pessimism
- Multiple and frequent complaints
- SUBSTANCE USE/USE
- HIGH UTILIZERS OF SERVICES

CAGE SCREEN (CUT DOWN, ANNOYED, GUILTY, EYE OPENER, ALCOHOL & ILLICIT DRUGS)

C Have you ever felt you ought to **C**ut down on your drinking or drug use?
A Have people **A**nnoyed you by criticizing your drinking or drug use?
G Have you ever felt bad or **G**uilty about your drinking or drug use?
E Have you ever had a drink or used drugs first thing in the morning (**E**ye opener) to steady your nerves or get rid or a hangover?

Two or more affirmative answers indicate probable alcoholism or drug addiction. Any single affirmative answer deserves further evaluation.

Guidelines for Referral/Consultation:

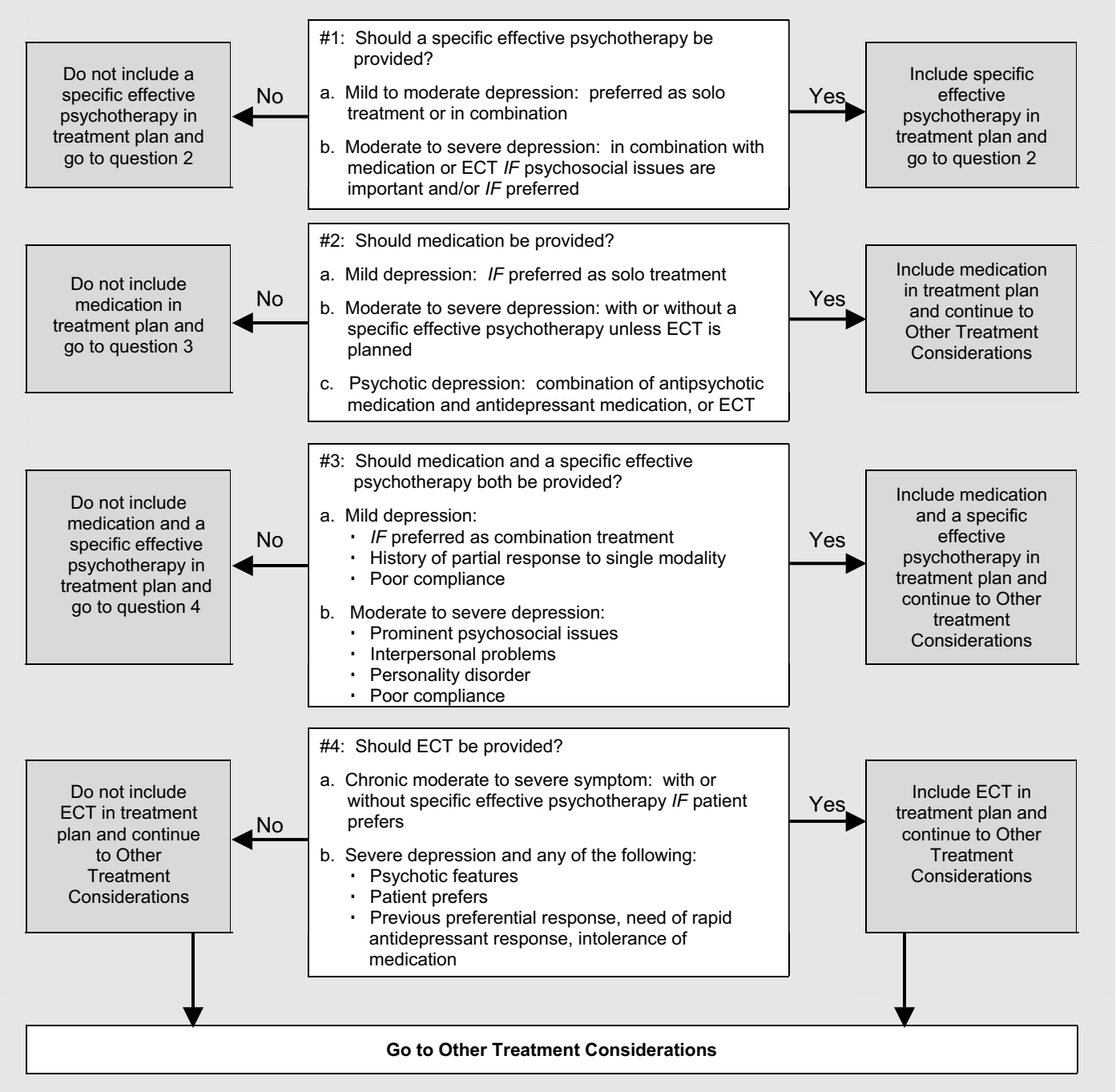
- Patient is suicidal
- Psychosis, bipolar disorder or another comorbid psychiatric illness
- Uncertain about the diagnosis or need second opinion to persuade patient to accept the diagnosis
- Enhancing treatment compliance
- Patient or family requests
- Treatment modalities not offered by present clinician
- Minimal improvement in symptoms &/or functioning after 6 weeks

Criteria for severity for current (or most recent) MDD

MILD: Few, if any symptoms in excess of those required to make diagnosis and symptoms result in only minor impairment in occupational functioning or social/relationship functioning
MODERATE: Symptoms in excess of the minimal number required for the diagnosis that often keep the person from doing things they need to do.
SEVERE: Nearly all symptoms of major depressive disorder, and symptoms markedly interfere with daily functioning (with or with out psychotic features)

Choice of Treatment Modalities for Major Depressive Disorder

The table below was taken from the APA guidelines on the APA website at www.psych.org



Components of an Evaluation for Suicidal Risk

Presence of suicidal or homicidal ideation, intent, or plans
Access to means for suicide and the lethality of those means
Presence of psychotic symptoms, command hallucinations, or severe anxiety
Presence of alcohol or substance use
History and seriousness of previous attempts
Family history of or recent exposure to suicide

The table below was taken from the APA guidelines on the APA website at www.psych.org

Commonly Used Antidepressant Medications

The following antidepressants and dosages have been shown to be effective in treating depression according to the American Psychiatric Association Practice Guideline for Major Depression Disorder in Adults.

Generic Name	Starting Dose[a] (mg/day)	Usual Dose (mg/day)
Tricyclics and tetracyclics		
Tertiary amine tricyclics		
Amitriptyline	25-50	100-300
Clomipramine	25	100-250
Doxepin	25-50	100-300
Imipramine	25-50	100-300
*Trimipramine	25-50	100-300
Secondary amine tricyclics		
Desipramine[b]	25-50	100-300
Nortriptyline[b]	25	50-200
Protriptyline	10	15-60
Tetracyclics		
Amoxapine	50	100-400
Maprotiline	50	100-225
SSRIs[b]		
Citalopram	20	20-60c
Fluoxetine	20	20-60c
*Fluvoxamine	50	50-300c
Paroxetine	20	20-60c
Sertraline	50	50-200c
Dopamine-norepinephrine reuptake inhibitors		
Bupropion[b]	150	300
Bupropion, sustained release	150	300
Serotonin-norepinephrine reuptake inhibitors		
Venlafaxine[b]	37.5	75-225
Venlafaxine, extended release	37.5	75-225
Serotonin modulators		
*Nefazodone	50	150-300
Trazodone	50	75-300
Norepinephrine-serotonin modulator		
Mirtazapine	15	15-45
MAOIs		
Irreversible, nonselective		
Phenelzine	15	15-90
Tranylcypromine	10	30-60
Reversible MAOI-A		
*Moclobemide	150	300-600
Selective noradrenaline reuptake inhibitor		
Reboxetine	-d	-d

[a] Lower starting doses are recommended for elderly patients and for patients with panic disorder, significant anxiety or hepatic disease, and general comorbidity.

[b] These medications are likely to be optimal medications in terms of the patient's acceptance of side effects, safety, and quantity and quality of clinical trial data.

[c] Dose varies with diagnosis; see text for specific guidelines.

[d] FDA approval is anticipated. When available, consult manufacturer's package insert or the Physician's Desk Reference for recommended starting and usual doses.

* These medications are not on the Cigna HealthCare formulary. For information on Cigna HealthCare benefit coverage for antidepressants, please refer to the most recent Cigna HealthCare Formulary. The full formulary listing can be found on the Cigna Web Site at: www.cigna.com/healthcare/formulary.html

Please check appropriate dosing literature for information about initial dosing, titration, usual maintenance, and maximums. Cigna HealthCare does not take responsibility for any medication decisions made by the prescriber or pharmacist.

Management of Medication Side Effects

Inform patient of potential side effects including those that require immediate attention

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Monitor for the presence of side effects

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If problematic side effects are present, consider the following:

- Watch and wait (if no immediate medical risk)
- Alter Medical dose, frequency or time of administration
- Change to a different medication
- Provide specific treatment for side effects

▼

Continue to monitor for side effects, pay special attention to the following:

- medical risk
- interference with compliance
- patient satisfaction

Augmentation Strategies with Antidepressant Treatment

- Single antidepressants with multiple actions (2 or more neurotransmitter systems)
- Combine antidepressants with actions at 2 or more neurotransmitter sites
- Combine antidepressants with simultaneous independent actions with the same neurotransmitter system
- Lithium carbonate: 600-1200mg/day
- Thyroid hormone
  - T3 (cytomel/liothyronine): 25-50mcg/day
  - T4 (synthroid/levothyroxine): 0.1mg/day
- Psychostimulants (EXCEPT with a substance use history)
- Modafinil/Provigil
- Atypical antipsychotic agents
- Buspirone (Buspar): 20-60 mg/day
- Estrogen in peri/postmenopausal women (consult with PCP or Ob-Gyn)
- If mood cycling- Lithium, Depakote, Carbamazine, Lamotrigine/Lamictal, Gabapentin/Neurontin (Note: Expert Consensus Guideline Bipolar 2000 does not recommend Neurontin alone but as an adjunctive agent)

Considerations for acute phase treatment with medication

- Severity of symptoms
- Recurrent episodes (2 prior episodes indicate treatment with medication)
- Presence of psychotic features
- Presence of melancholic symptoms (anhedonia; lack of reactivity to usually pleasurable stimuli; worse in the AM; early morning awakening; marked psychomotor retardation/agitation; significant anorexia weight loss; excessive or inappropriate guilt)
- Family history of depression
- Prior response to medication treatment
- Incomplete response to psychotherapy alone
- Patient preference

Considerations in the Decision to Use Maintenance Treatment

FACTOR	COMPONENT
Risk of recurrence	Number of prior episodes; presence of comorbid conditions; residual symptoms between episodes
Severity of episodes	Suicidality; psychotic features; severe functional impairments
Side effects experienced with continuous treatment	
Patient Preference	

Risk Factors for Recurrence of Major Depressive Disorder

- Prior history of multiple episodes of major depressive disorder
- Persistence of dysthymic symptoms after recovery from an episode of major depressive disorder
- Presence of an additional, nonaffective psychiatric diagnosis
- Presence of a chronic general medical disorder

Enhancing Compliance

- Actively engage the patient in the treatment plan
- Ask about prior use of antidepressants
- Give patient written instructions & a number to call if questions or problems
- Keep dosing regimen as simple as possible. Each increase in the frequency of dosing is associated with a 22% decrease in adherence**
- Review of medication use & side effects at each visit. If you are not the prescribing clinician contact the prescribing physician.
- Explain it may take 2-4 weeks before seeing any clinical response
- Have patient call if they are thinking about stopping medication
- Review other causes of noncompliance:
  - Perceived lack of benefit from the treatment
  - Financial & environmental obstacles
  - Motivational factors
- When in doubt get a consultation

** Morris AD, et al. Population-based adherence to prescribed medication in Type II Diabetes. Diabetes, 2000; 49(S1):abstract 307

Patient Education

- Depression is a medical illness
- Recovery is the rule, not the exception
- An effective treatment can be found for nearly all patients
- The aim of treatment is complete symptom remission, not just getting better, but getting & staying well
- The risk of recurrence is significant: 50% after one episode, 70% after two episodes, & 90% after three episodes
- Patients & family should be alert to early signs & symptoms of recurrence & seek treatment early
- Medication may take 2-4 weeks before a clinical response & longer for a complete response
- Do not stop medication(s) without first consulting with the physician who prescribed it

HEDIS® 2002 (HEDIS is a registered trademark of the National Committee for Quality Assurance or NCQA)

HEDIS scores will indicate that there is adequate treatment for recovery of depression when treatment is in accordance the following AHCPR 'Depression in Primary Care' guidelines:

1. OPTIMAL PRACTITIONER CONTACTS FOR MEDICATION MANAGEMENT: three (3) follow-up contacts in first 12 weeks after starting medications, at least 1 with prescribing practitioner. The percentage of members age 18 years and older as of the 120th day of the reporting year who were diagnosed with a new episode of depression, treated with antidepressant medication, and who had at least three follow-up contacts with a primary care practitioner or mental health practitioner during the 84-day (12-week) Acute Treatment Phase. At least one of the three follow-up contacts must be with a prescribing practitioner (e.g., licensed physician, physician assistant, or other practitioner with prescribing privileges). This process measure assesses the adequacy of clinical management of new treatment episodes for adult members with a major depressive disorder.
2. EFFECTIVE ACUTE PHASE TREATMENT: remain on antidepressants for first 12 weeks of 84 days. The percentage of members age 18 years and older as of the 120th day of the reporting year, who were diagnosed with a new episode of depression, treated with antidepressant medication, and who remained on an antidepressant drug during the entire 84-day (12-week) Acute Treatment Phase. This intermediate outcome measure assesses the percentage of adult members initiated on an antidepressant drug who received a continuous trial of medication treatment during the Acute Treatment Phase.
3. EFFECTIVE CONTINUATION PHASE TREATMENT: remain on medications 6 months or 180 days. The percentage of members age 18 years and older as of the 120th day of the reporting year, who were diagnosed with a new episode of depression, treated with antidepressant medication, who remained on an antidepressant drug for at least 180 days (6 months). This intermediate outcome measure assesses the effectiveness of clinical management in achieving medication compliance and the likely effectiveness of the established dosage regimen by determining whether adult members completed a period of Continuation Phase Treatment adequate for defining a recovery according to AHCPR Depression in Primary Care.

References and Resources:

1. American Psychiatric Association, www.psych.org (APA Practice Guidelines for Major Depression in Adults, 2nd edition, 2000)
2. American Association of Family Practice, www.aafp.org
3. American Academy of Pediatric, www.AAP.org
4. Agency for Healthcare Research and Quality, www.ahcpr.gov
5. National Institute on Drug Use, www.nida.nih.gov
6. Depression in Primary Care, Volume 2. Treatment of Major Depression. Clinical Practice Guideline, Number 5, Rockville, MD. U.S. department of Health and Human Services, Public Health Services, Agency for Health Care Policy and Research, AHCPR Publication No. 93-0551. April 1993).
7. HEDIS 2002 Technical Specifications, Volume 2. National Committee for Quality Assurance.

The clinical guidelines and information featured in this document are intended only as an analytical framework for the evaluation and treatment of your patients with depression for whom Cigna manages benefits. These guidelines are not intended to replace your best clinical judgment or establish a protocol for all patients with depression, but they do represent a thorough review of the current literature. Not all benefit plans provide coverage for all levels of treatment referenced within this guideline.