

Nuts and Bolts of Depression in the Primary Care Setting

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Prevalence

“Depression” and “primary care” are now so frequently linked, one wonders whether they are truly synonymous. This is not quite the case, although depressive symptoms are exceedingly prevalent in general medical visits. It is widely accepted that as many as half of all primary care patients have some psychiatric symptoms, and a third may have diagnosable mental disorders. The vast majority of mental health problems in the primary care setting are depressive disorders (60%), followed by anxiety (20%), a distant second.

Recognition

So, why should the recognition and diagnosis of such a prevalent condition persist to be an issue? Is it because PCPs don't know depression when they see it? Or don't want, or know how, to treat it? Or, just don't want to open Pandora's box and be flooded 13 minutes into a 15 minute appointment? Well, this is not quite the case, either. Although multiple studies suggest that PCPs routinely diagnose about half the full criteria mental disorders their patients present, there are reasons why this is more difficult in the primary care setting: patients present earlier in the course of their illness, they present physical, not mental complaints, and about one in ten have significant symptoms that don't fit neatly into any recognizable, DSM-IV disorder. More recent studies, however, suggest that PCPs *do* recognize the diagnosis of more severely depressed patients. Also, it turns out that less severely depressed primary care patients actually have relatively good outcomes, even with fairly short courses of low-dose antidepressant medication.

Another reason, of course, for why the primary care recognition of depression persists to be an issue, in the words of the famous bank robber: “It's where the money is.” That is, the majority (60%) of the general population with mental health symptoms will never see a mental health professional: they will *only* present to the general medical setting. Only their PCP, or an emergency or urgent care provider, will have the opportunity to care for them.

In the past, the terms *endogenous* and *exogenous* (or reactive) were used to suggest cause and efficacy of medication treatment. The thought was that endogenous depression had a biologic component and would benefit from medication, while exogenous depression was more like feeling bad about bad things, and thus, would not benefit from medication. These terms are obsolete and have no place in modern nomenclature. **Depression is a treatable illness.** If the patient has depressed mood and meets criteria for depression, they deserve to be treated for depression. The brain does not function as well when the patient is depressed. Treating the depression will render the patient better able to cope, survive and problem solve the difficulties in their life.

Diagnosis: Sig. E. Caps

This widely recognized and easily remembered mnemonic remains the gold standard of “bedside” diagnosis of depression. The **two-week duration of depressed mood and five from Sig. E. Caps** (disruptions in Sleep, Interest, Guilt, Energy, Concentration, Appetite; Psychomotor agitation or retardation; Suicidal ideation) makes the DSM-IV diagnosis of Major Depression. However, the primary care patient may present a litany of physical complaints, yet not describe their mood as depressed. The PCP needs to be suspicious, or curious: the patient might admit to feeling sad or blue. As part of a general review of systems (or symptoms), the PCP

should ask about disruptions (increase, decrease, or change in pattern) of **sleep, energy, concentration/memory, or appetite.**

While this is fairly straight forward, determining **interest, guilt, psychomotor** symptoms or **suicidality**, is not. **Loss of interest** and anhedonia are not quite the same thing, though close. Does the patient enjoy the things s/he used to find pleasurable (including sexual activity)? Are there activities or pursuits in which s/he was previously active that seem like too much bother, now? There may be no medical pretense for asking about **guilt**, so the PCP may simply say, “This may seem a strange question, but, do you feel guilty?” Guilt may be specific, but persistent, ruminative, and/or out of proportion to the situation. Or, perhaps more commonly, the patient may be especially self-critical and feel responsible for everything that goes wrong: “This is all my fault.” **Psychomotor** symptoms are best detected through the PCP’s observational skills. Cognitive and motoric slowing (psychomotor **retardation**) may be evident from the way the patient enters the room or the amount of time s/he needs to formulate an answer. Psychomotor **agitation** is more easily recognized in the patient who seems unable to relax, has repetitive movements (e.g., hand wringing), or ruminative thoughts.

Every possibly depressed patient should be assessed for **suicidality**, including thoughts, intent, and plan. Asking about suicide does *not* increase its likelihood. The PCP should not assume to know the patient’s answer to these questions, nor should s/he avoid asking them for fear of offending the patient. If these thoughts cross the PCP’s mind, s/he may precede the questions with a serious and unapologetic opener, such as: “There are certain questions I must always ask.” As a transition, the next question might be: “Do you ever have thoughts like: ‘Life’s not worth it?’” This should be followed up, however, with direct questions, such as: “Have you ever felt like harming yourself, or taking your own life?” “Have you ever acted on those feelings?” “Do you feel that way now?”

Treatment

With the advent of the SSRIs (selective serotonin reuptake inhibitors), PCPs are more willing to initiate antidepressant medication treatment. This is generally a good thing since these medicines are the drugs of first choice, being once a day, well tolerated, easy to start and titrate, and relatively safe, even in overdose. As a group, SSRIs have minimal and transient side effects, interact with few other medications, and are often clinically effective within three to four weeks. No levels or routine labs are required.

The common wisdom is to “start low and go slow,” so that any possible side effects will be minimal, and dissipating, as the dose is increased to more likely therapeutic levels. Even though patients are warned of the delayed onset of therapeutic effects, they may be discouraged when they don’t feel a sudden change for the better. Seeing the patient back briefly after two weeks to check on side effects or other difficulties allows for trouble shooting and encouragement. If the first follow-up appointment is farther out, some patients will simply stop the medicine and wait for the appointment to discuss side effects. This delays treatment and wastes valuable time in the patient’s life, when they could be starting to feel better.

Referral

So, when is it *not* a good thing for the PCP to initiate antidepressant treatment? When the patient has, or is at risk for, **bipolar (manic-depressive) disorder**. That is, if the patient has had a manic episode or has a family history strongly suggestive of bipolar disorder. Questions about mania, or especially hypomania, are less straightforward than those pertaining to depression. A good start, however, is to ask the patient whether there has ever been a period when s/he could not sleep, but felt s/he didn’t need to sleep, and had plenty of energy. (All-nighters in college don’t count.)

Other symptoms of mania include grandiosity, irritability, pressured speech, racing thoughts, distractibility, increase in goal-directed activity, and excessive involvement in pleasurable activities with high potential of painful consequences: spending sprees, sexual indiscretions, foolish business ventures, gambling.

The risk of antidepressant medication triggering mania in a predisposed patient is serious enough to warrant specialist-, as opposed to primary care-, management of psychiatric medications. Mania can be a dangerous, even life-threatening disruption in a patient's life. No matter how stable the patient, the nature of bipolar disorder is to be unstable. Even the most organized and medication-adherent patients will have periods of mood instability. While they may present to their PCP when depressed, they are much less likely to have insight about their manic episodes, and thus, much less likely to seek help at these high-risk times.

Patients with **psychotic symptoms** (hallucinations or delusions), whether from a chronic psychotic disorder (e.g. schizophrenia) or from a primary mood disorder (e.g. major depression with psychotic features), should be referred for on-going psychiatric management. Both the condition and the treatment regimen are more complicated and less stable. They must be monitored closely and often require a network of care providers and services, including possible hospitalization.

Patients at high **risk of suicide** should not be managed solely by their PCP. This includes, but is not limited to, patients who are **elderly**, are **isolated** (single, unaffiliated, few social supports), are **medically ill** (cancer, HIV), have **psychotic symptoms, severe weight loss, or inattention to activities of daily living**. Such patients should be assisted in obtaining emergent assessment for services and possible hospitalization. **Addicted** or **substance abusing** patients who present with depression are also at increased risk of self harm, including suicide, and should not be managed by their PCP. The depressed patient with a **past suicide attempt** is also at increased risk and should be in the care of a psychiatrist. **Gender** should also be considered: **women attempt suicide three times as often as men; men complete suicide three times as often as women.**

Sometimes a patient seems appropriate for PCP medication management, but fails to respond to, or tolerate, one or two medication trials. Such patients should also be referred, at least for psychiatric consultation and stabilization. Once improved and on a stable medication regimen, such a patient may still be appropriate for on going PCP medication management.

Some patients, however, turn out not to be so easily managed, but may require frequent "fine-tuning" of their medications. The patient with concurrent **substance abuse, anxiety disorder, trauma** history, extreme **psychosocial stressors**, or a **personality disorder** often has a less dramatic response to treatment, and may require this type of more frequent medication adjustment.

These patients, and any patient who does not make a full recovery, should be referred for specialty psychiatric care. Residual symptoms are a harbinger of more frequent and rapid relapse. **The goal of treatment should be return to normal mood and function, not merely decreased severity of suffering.**

SUGGESTED READING

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