Educational Objectives:

1. Classify the variety of pharmacologic and non-pharmacologic approaches to managing patients with major depressive disorder
2. Describe the essential issues that should be addressed in follow-up visits when treating patients with depression
3. Anticipate challenges that might emerge during the treatment of depression and describe strategies to address them

CASE ONE:

Mrs. J is a 52-year-old middle school social studies teacher with a history of type 2 diabetes and hypertension, with no prior history of mental illness, who presents to your office after a six-month hiatus from care. You note that she ought to have run out of refills for her metformin, sitagliptin, and amlodipine several months ago. When you broach this subject with her, she glumly responds “I just don’t care anymore.” You decide to screen her for depression, and a PHQ-9 yields a score of 14. She denies any thoughts of self-harm and has no history of manic symptoms in the past. She adds that she has lost her love for teaching and knows her students have taken notice. After screening her for substance use disorders and thyroid disease, you inform her that she meets criteria for a moderate major depressive episode and ask her if she would be willing to hear about treatment options.

Questions:

1. Broadly describe the categories of treatment for major depressive disorder (MDD), and which factors might influence treatment selection.

2. Mrs. J initially leans towards pharmacotherapy. Describe the first-line medications used to treat MDD, including common side effects for representative members of each drug class, expected time course for efficacy, and relevant drug-drug interactions.
3. After hearing about potential side effects of SSRIs, Mrs. J is now somewhat reluctant to start a new medication. What can you tell her about the evidence for non-medication options?

CASE ONE CONTINUED:

After a lengthy discussion of treatment options with Mrs. J, she remembers that her sister had taken sertraline in the past and had tolerated it well. She decides to see if it will also work for her. After screening her for bipolar disorder, you prescribe sertraline 50mg daily.

4. When would you schedule her next appointment? What issues should be addressed at this next visit?

CASE ONE CONTINUED:

At her two-week follow-up appointment, Ms. J reports that she has been taking her sertraline as prescribed, but has had minimal improvement in her symptoms and also notes that she has gained two pounds since her last appointment. She denies experiencing any racing thoughts, impulsive behaviors, or suicidal ideation. Her PHQ-9 is now 13.

5. What do you tell her?
CASE ONE CONTINUED:

You both decide to stay the course without changes. Ms. J now presents another two weeks later with some modest improvement in her mood. Her PHQ-9 is 11. She has gained five pounds since starting sertraline. She has been fully adherent and has not experienced any other side effects.

6. What are your options at this point?

CASE ONE CONTINUED:

Ms. J remains on sertraline at her current dose and experiences a clinical remission with her PHQ-9 falling to less than 8 for the next eight months. She now asks how long she should remain on treatment, and how to prevent future relapses.

7. What do you tell her?

CASE TWO:

Mr. B, a 64-year-old retired accountant, presents to your office with his daughter. He is somewhat disheveled, with an unkept beard and mismatched socks. His affect is flat. PHQ-9 is a 21. When asked about suicidal thoughts, he blandly replies that the world would be better off without him. He does not have any specific plan, nor any firearms in the home. He does not exhibit any delusions or other psychotic features. His daughter reports that her father has had bouts of depression throughout his life, but this is the worst she has seen him. He is not currently taking any medications.

8. How would you manage this patient?
Primary References:


Additional References:


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CME Questions:

1. A 38-year-old man with no significant past medical history presents to your clinic with his first episode of MDD. He dislikes the idea of taking anything made by “Big Pharma” and is only willing to embrace complementary and alternative medicine options. Based on available evidence, which of the following is most likely to reduce your patient’s depressive symptoms?

   a. S-adenosyl methionine
   b. Omega-3 fatty acids
   c. Acupuncture
   d. Meditation

2. A 62-year-old woman with a history of insomnia presents to your office to follow-up after eight weeks of treatment with citalopram. She has had a partial response to treatment, but also has a history of diarrhea-predominant irritable bowel syndrome and feels like the citalopram has exacerbated her symptoms. She also takes tramadol 50mg twice daily as needed for sciatica. Which of the following is a reasonable next step in her treatment?

   a. Taper off the citalopram and start sertraline instead
   b. Taper off the citalopram and start venlafaxine ER instead
   c. Taper off the citalopram and start bupropion SR instead
   d. Cut the dose of citalopram in half, and augment with mirtazapine

3. Based on currently available evidence, which of the following statements about the treatment of major depressive disorder is false?

   a. CBT and second-generation antidepressants are equally effective at achieving clinical remission.
   b. The primary limitations on the use of psychotherapies in treating MDD are cost and access to care.
   c. Interpersonal therapy has consistently been shown to be superior to psychodynamic therapy approaches in the treatment of MDD.
   d. Psychotherapy, when compared to pharmacotherapy, is associated with fewer relapses during the maintenance phase of MDD treatment.