EVIDENCE-BASED APPROACHES: IMC Case on Depression

Mel Anne Collie is a 46 year old female who presents to the IMC with multiple complaints. She states she has felt "terrible" for the last two years. Her whole body "aches all the time", she can't localize the pain, "it's just all over". Despite sleeping over 10 hours a night she is still too tired to do anything except go to work, watch TV and smoke cigarettes. She does not snore, and no one has ever told her she stops breathing at night. She states she consumes a lot of junk food, and has actually gained 20 pounds in the last 2 years. Ms. Collie's passion used to be painting, but she just doesn't feel like doing this anymore. She also used to love playing "Trivial Pursuit" with her neighbor, but could not concentrate on the questions because she is just "too tired". She complains of feeling "nauseated" all the time, but it does not stop her from eating. She has had no change in bowel habits, and reports all stools being brown and formed. Her periods are regular. Ms. Collie states "My children think I am depressed, but I think there is something really wrong with me; do you think it is cancer?" She denies any thoughts of hurting herself or others. She denies any periods of increased energy, pressured speech, or racing thoughts. No recent or remote traumatic events in her life, although she does state "it has been somewhat lonely" since her oldest son moved out two and a half years ago.

PAST MEDICAL HX: Chronic low back pain; Herpes simplex type 2 (only one flare at age 24)
PAST SURGICAL HISTORY: tubal ligation (age 30); cholecystectomy (age 28); appendectomy (age 22)
ALLERGIES: Penicillin (hives)
MEDICATIONS: Acetaminophen 650 mg TID prn back ache; Multivitamin daily
SOCIAL HX: Smokes 1 ppd for 20 years; Denies alcohol; Denies illicit drug use. Divorced (4 years ago); 2 adult children (age 20 and 22); works at local supermarket in the bakery; lives in apartment by herself; No health insurance
FAMILY HX: Mother alive age 68 – Hypertension, hyperlipidemia, anxiety; Father deceased age 30 – car accident; no siblings, children are healthy
ROS: no fever or chills; frequent "tension" headaches; no dizziness; no vision problems; no tinnitus, not hard of hearing; no sinus pain; no oral lesions or teeth problems; chronic neck ache (but full range of motion); chronic chest "ache" (no relation to activity or recumbency, " I just hurt all over, all the time. I can't describe it." No palpitations, no orthopnea or PND; no cough, wheeze or shortness of breath; Nausea as above, no vomiting, no constipation or diarrhea; positive for nonspecific abdominal discomfort unrelated to food intake; no dysuria or hematuria**;** menstrual periods regular, currently menstruating; diffuse "aches and pains" all over body, "you name it, it hurts doc", no joint swelling, no morning stiffness > 30 minutes. No rashes. Strictly denies any history (personal or family) of psychiatric illness.

VITALS: Afebrile 98.4 HR 78 BP 120/78 RR 14 Pulse Ox 99%RA Ht 68 inch Wt 190# BMI 28.9
GENERAL: A&O x 3, NAD, flat affect
HEENT: PERRL, EOMI, TM's pearly gray, turbinates pink and moist, no oral lesions

NECK: Supple, no JVD, no lymphadenopathy, no bruits, range of motion normal
HEART: RRR no murmurs, gallops or rubs
LUNGS: BCTA no wheeze, rhonchi or rales; chest wall normal; "aches" when you palpate it per patient
ABDOMEN: Soft; bowel sounds normal in pitch and frequency; no hepato-splenomegaly; non-distended, no hernia, no rebound, no guarding, no rigidity, just "aches" when you push on it per patient
UPPER EXTREMIES: No rash, joint effusion or deformities
LOWER EXTREMITIES: No edema, rash, joint effusions; all joints have normal range of motion
NEURO: CN 2-12 grossly intact; DTR +2/4 and symmetric, bilateral, upper and lower extremity; strength and sensory testing within normal limits and symmetric
VASCULAR: PPP, cap refill < 2 seconds, no bruits
SKIN: no lesions, rashes or abnormalities noted
EPIC (Hospital record) REVIEW: Pap (done 2 months ago) normal; Mammogram (done 6 months ago) normal; ER report from 1 year ago – diagnosed with influenza; chest PA and Lateral xray read as normal, CBC and BMP normal
PREVIOUS RECORDS: Patient has only followed at Women's Health Center for "annuals" and has only had the one ER visit

Please utilize the below link to the VA Clinical Practice Guideline for management of MDD to answer the following questions:

http://www.healthquality.va.gov/mdd/mdd2009full.pdf

What are the criteria to make a diagnosis of Major Depressive Disorder? (see table 1, p 15)

What are some characteristics of a patient with *Severe Major Depressive Disorder*? (see box on page 16) What are some past symptoms that could indicate an episode of mania or hypomania?(see text p 39) Does Ms. Collie have any of these?

What is the *PHQ-2 (Patient Health Questionnaire-2)*? (see box p 19, text page 20) What is the reported sensitivity and specificity for major depression for a PHQ-2 score > 2? (text page 20)

You perform a PHQ-2 on Ms. Collie and she scores a 5. What is the next step? (Answer the following questions to help.)

- What is the PHQ-9 (Patient Health Questionnaire-9)? (see text p 33 and Appendix B-4 p 153)
- What is the sensitivity and specificity for Major Depressive Disorder with a PHQ-9 score of 10 or higher? (see p 34 text)
- Can the PHQ-9 be self administered? (text p 33)
- About how long does it take to administer? (text p 33)

You have Ms Collie complete a PHQ-9. She scores 18.

- What are some of the key relevant history you should obtain from a patient with major depressive disorder? (see text pp 31-32)
- What may your physical exam uncover? (see text p 32)
- What lab tests can be considered? (text p 32--two areas-- and 33)
- Are diagnostic imaging and neuro-psychologic or psychologic testing part of the standard evaluation for depression? (see text p 33)
- Devise a lab order slip for Ms. Collie, including ECG if indicated.

You begin to staff the patient with Dr Rich, who quickly asks “should the patient be referred to psychiatry?”

- When are referral to emergency services and/or immediate consultation with a mental health professional indicated? (see text pp 24-25)
- What are some warning signs of violence? (see text p 24)

True or False: Local emergent psychiatric care are available thru PES (Portage Path emergency services) or Summa Akron City Campus ER.

If Ms. Collie was actively suicidal or homicidal, review the process you would go through to obtain appropriate help for her.

- (A microsystem question): Who is an excellent resource in the IMC to help you in these cases? *(Hint, they are not MD, DO, or PharmD)*

With the information provided above, does Ms. Collie require pink slip / emergent psychiatric care?

A PHQ-9 score of 18 would indicate what depression severity? (table p 51 or 152)

- What is the proposed treatment action for someone with this severity of depression? (table p 51 or 152)
- Should you offer the patient a choice between psychotherapy, medications, or both, or just make the decision yourself?(see text p 49)

Ms Collie has already expressed to you that she prefers to avoid counseling if possible, but would be willing to try a medication if you feel it would help.

- On what will you base your choice of antidepressant medication? (see text p 83)

- What generally are the first-line antidepressant drugs in primary care medicine? (see text p 83) Why?
- Which are available on the $4 generic discount formulary?

Note: To link to current $4 formulary, you must be using a Summa computer. Open **http://summaworks/Pages/default.aspx**
Once you have access to this page, look under Links for Physicians, Generic Discount Drug Formularies

- What are some side effects seen with commonly prescribed antidepressants? (see Appendix D2 pp 159-160)
- Should one SSRI always be chosen over other SSRIs (is there one that is more effective)? (see text p 84)
- If someone has failed to respond on an SSRI, is it appropriate to try a different SSRI?
- How about someone who has failed 2 different SSRI's? (see text p 84)

Dr Rich states he has had good success in patients with citalopram. You wish to start citalopram;

- What starting dose should you choose?(see appendix D-1 p 158)
- What is the earliest you could consider titrating the dose up? (appendix D-1)
- What is the maximum daily dose?(appendix D-1)

Ms Collie is started on citalopram 20 mg daily. You review the purpose of the medication, the potential side effects, and the expected time course to effect. You also advise her to start an exercise program (as this should help her depression as well – see pp 134-135). You ask her to call and report to you how she is doing in 2 weeks, and ask her to make a follow-up appointment in 4 to 6 weeks. You review the EKG done in office and tell her it was normal. Unfortunately the IMC phlebotomist is not in office, so you tell the patient to get her labs done at the 95 Arch Street Summa Health System outpatient lab. Ms Collie calls you in 2 weeks, she reports the citalopram made her a bit more nauseous in the first week, but since then she is starting to feel better, her energy has increased quite a bit, and she is walking one mile, three times a week. She still feels somewhat down and asks to increase her medication. You advise her to take 30 mg daily for 1 week, then 40 mg daily until the followup appointment. You also advise her to get lab work done, as you have not received results yet.

On follow-up 4 weeks later (6 weeks after initial consult), Ms. Collie reports tolerating citalopram with no current side effects, she feels better, but did not notice much of an improvement with increased citalopram dose. She does not want to stop the citalopram, but wonders if there is any other options available. She also would like to quit smoking now, but "I need some help". She apologizes for still not completing the lab work.

- When should augmentation with additional medication be considered? (see text p 97)
- What are the preferred augmentation agents? Why? (see text p 97)
- Which would you choose for Ms. Collie?

When should you consider consultation with a mental health care specialist (non-emergent referral) in Major Depressive Disorder patients? (see text p 50; see Side Bar 7, p 14)

Ms. Collie calls back 3 weeks later, she wanted to let you know she finally had the blood work done that day. She also wanted to let you know the bupropion helped her quit smoking, and she is feeling much better. She actually has been painting again, playing Trivial Pursuit with great success, and enjoying life. She wanted to thank you for your fine care.

- How long should you continue the current antidepressant doses prior to considering a taper? (see text p 73)

The labs all come back within normal limits. For a guideline review on what you would have done had the TSH been abnormal, please visit the below AACE/ATA guideline:

https://www.aace.com/files/final-file-hypo-guidelines.pdf

Bonus questions: (Further opportunities to learn)

What is the mean replacement dosage of levothyroxine in hypothyroid patients? (p 12)

On what is the initial dosage of levothyroxine based in hypothyroid patients?
(p 12 and p 21)

After new start, or when readjusting the dosage of levothyroxine, when should a patient reassessment and TSH recheck be scheduled? (p 12, 19)

What are some drug interactions you should consider when prescribing levothyroxine? (pg 13)

When should you refer a hypothyroid patient to an endocrinologist? (pg 15, 22)