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
PLATO (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:

https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFINAL82916.pdf

1. What percentage of the US population has had a depressive episode in the last year? (pg. 6)

2. What is the *PHQ-2 (Patient Health Questionnaire-2)*? (table 1, pg. 22) How often, and in whom, should the PHQ-2 be performed (pg. 21)

You perform a PHQ-2 on Ms. Collie and she scores a 5.

3. What is the next step?

4. What is the PHQ-9 (Patient Health Questionnaire-9)? What are the cut offs for mild, moderate, and severe depression? (table B1, pg. 90)

5. What are the criteria to make a diagnosis of Major Depressive Disorder? (table 3, pg. 25 or table D-1, pg. 100)

6. What are some co-occurring conditions or alternative diagnoses that may complicate the diagnosis and treatment of depression? Should any lab tests or be considered; if so, what? When is neuropsychological testing indicated? (pg. 24)

7. What are some characteristics of a patient with Severe Major Depressive Disorder who need urgent/emergent referral for mental health intervention? (pg. 23 and 26) Does Ms. Collie have any of these?

Ms. Collie scores a 16 on her PHQ-9. You explain that she has Major Depressive Disorder (MDD) that is currently moderate in nature and that depression occurs because of a chemical imbalance in the brain. You also explain that it is very treatable with a wide range of talk therapy (psychotherapy) and medication therapy (pharmacotherapy)

options. Ms. Collie is tearful regarding her new diagnosis, but grateful for your excellent patient-centered care and asks, “So what is the next step?”.

8. What is the first line treatment for mild to moderate MDD (be specific)? (pg. 30)

9. When is combination therapy considered? (pg. 31 and 38)

Ms. Collie decides to pursue both psychotherapy and pharmacotherapy because her depression has been on for so long. You ask Kayla (BHC) to talk with her about resources for psychotherapy as well as continue to support her in her decision while you talk to Dr. Rich about what medication to start.

10. What are some side effects seen with commonly prescribed antidepressants? (table C-2, pg. 97)

11. Should one evidence-based pharmacotherapy always be chosen over another (i.e. is there one that is more effective)? (pg. 84)

    - Which medications are appropriate for…
        - Pregnancy?
        - Smoking cessation?
        - Breast feeding?
        - Sexual dysfunction from SSRI’s?

12. If someone has failed to respond to an SSRI, when is it appropriate to try a different SSRI? (pg. 84)

13. What do you do if someone has failed 2 different SSRI’s? (pg. 84)

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

14. What starting dose should you choose?(table C-1, pg. 93)

15. What is the earliest you could consider titrating the dose up? (table C-1)

16. What is the maximum daily dose?(table C-1)

As soon as you are done talking with Dr. Rich, you get a page from Kayla that she is ready to talk with you about Ms. Collie. She tells you that she is going to start exercising (see pg. 30) as well as start seeing a counselor. You ask about on-line options, but Kayla reminds you that the new computer-based cognitive behavioral therapy program currently offered is only available for patients with mild depression or anxiety. 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 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.

17. When should augmentation with additional medication be considered? (pg. 33)

18. What are the preferred augmentation agents? Why? (pg. 34-35)

19. Which would you choose for Ms. Collie?

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.

20. When is an episode of major depression disorder considered to be in remission? (pg. 101) Recovery? (pg. 102)

21. How long should you continue the current antidepressant doses prior to considering a taper? (pg. 40)

22. What if she is high risk for recurrent depressive episodes? (pg. 41)

23. What are the indications for maintenance therapy? (pg. 42)

The labs all come back within normal limits. Dr. Rich congratulates you on your excellent management of your patient.

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