

## 2008 – Diagnosing and Treating Depression in Adults in Primary Care

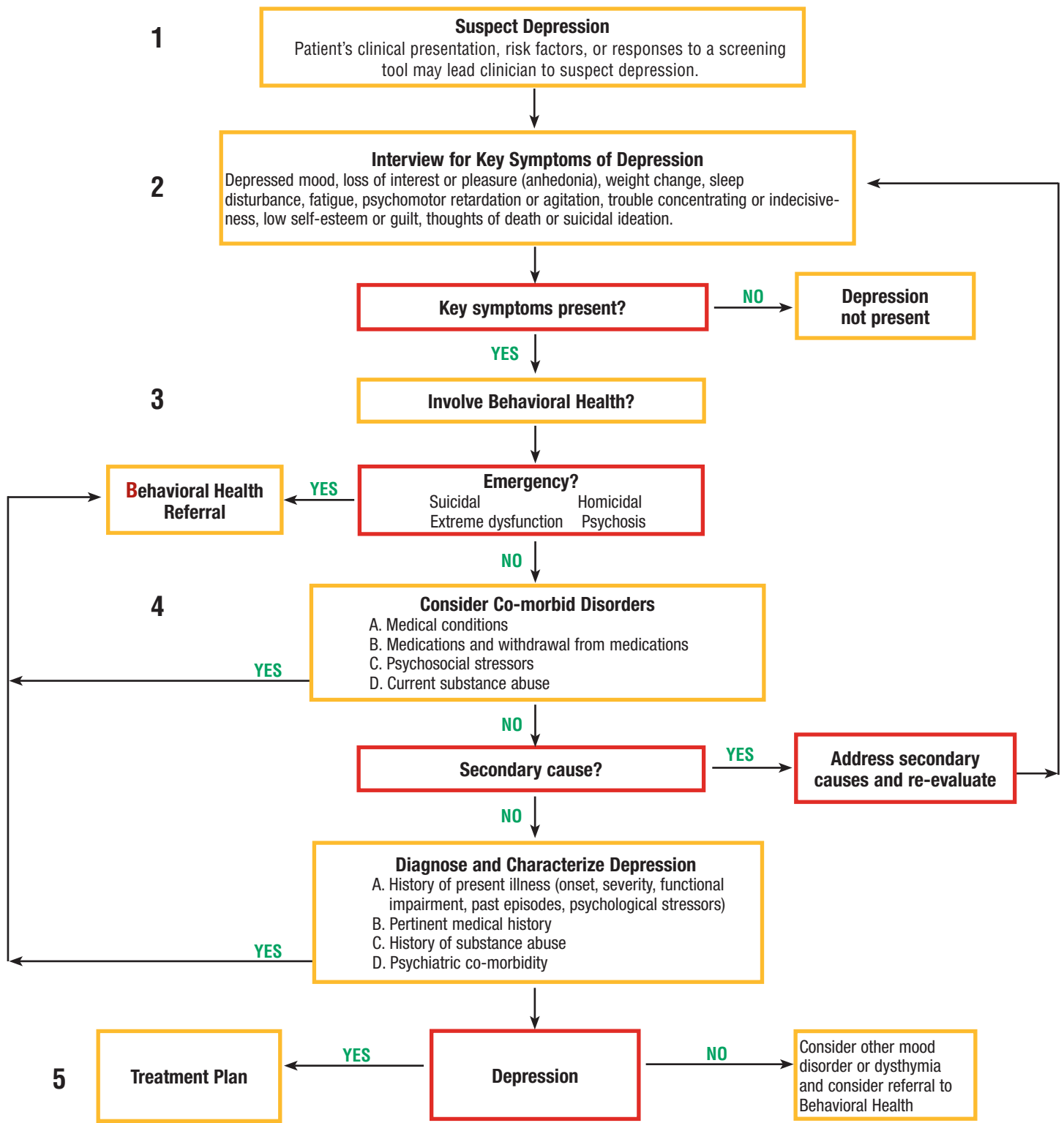
A guideline is designed to assist clinicians by providing a framework for the evaluation and treatment of patients. This guideline outlines the preferred approach for most patients. It is not intended to replace a clinician’s judgement or to establish a protocol for all patients. It is understood that some patients will not fit the clinical condition contemplated by a guideline and that a guideline will rarely establish the only appropriate approach to a problem.

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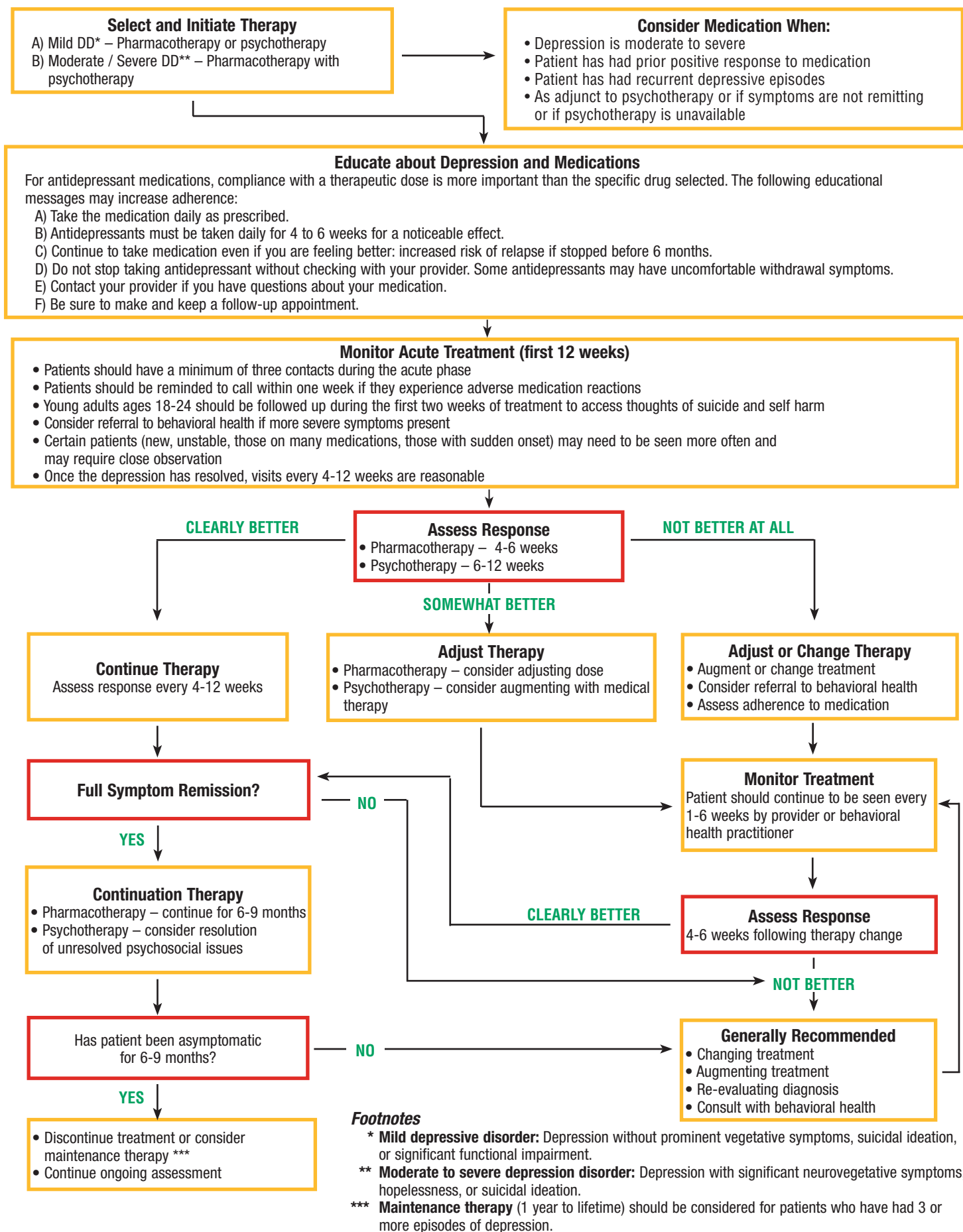
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# 1. Diagnosing Depression in Adults – Flow Chart



## 2. Treatment Plan for Depression in Adults – Flow Chart



**There are three types of depression that should be recognized by primary practitioners.**

**Depression** is the most important because of its associated disability and its treatability.

- Depression is characterized by a persistent disturbance in mood of at least two weeks duration that is usually accompanied by diminished interest in life, and significant impairment in the individual's social, occupational, and physical functioning.
- The point prevalence of depressive disorder in the Western industrialized nations is 2.3-3.2% for men and 4.5-9.3% for women. The lifetime risk for depressive disorder is 7-12% for men and 20-25% for women.<sup>1</sup>

**Chronic minor depression (dysthymia)** is also common but more difficult to treat than a primary depression.

**Adjustment disorder with depressed mood** is by far the most common depressive disorder in primary care, but much less is known about its prevalence, associated disability, and treatment.<sup>5</sup> Occasionally this is known as pathological grief, if symptoms persist beyond 3 months or worsen, depression should be considered.

## 1. Suspect Depression

Physical complaints are extremely common in depression and are often the primary manifestation of the illness. Somatic manifestations of depression include fatigue, insomnia, anorexia, weight loss, gastrointestinal disturbances, and a variety of pain complaints. Anxiety and agitation are common as secondary symptoms.<sup>5</sup>

**Common Presentations** of patients with depression include:

- multiple office visits
- numerous unexplained symptoms
- work or relationship dysfunction
- sleep disturbance
- multiple worries and distress

**Risk Factors** for depression include:

- prior episodes
- family history of depressive disorder
- female gender
- postpartum period
- peri/postmenopausal period
- medical co-morbidity
- lack of social support

**Screening Instruments** have been developed for use in various clinical settings, including ambulatory primary care.

The primary objective of these well-tested tools is to obtain input from the patient regarding their symptoms related to depression. These tools tend to be fairly sensitive, but not too specific in the recognition of depression. These are generally self-administered and then reviewed by the practitioner. Screening patients is recommended when depression is suspected.

Information on several tools is listed below. One simple means of screening is to ask two questions while completing an exam:

- 1) Over the past two weeks have you ever felt down, depressed, or hopeless?  
and
- 2) Have you felt little interest or pleasure in doing things?

Depression Screening Tools	Contact	Cost
Beck Depression Inventory – Fast Screen for Medical Patients	Psychological Corporation Harcourt Brace PO Box 839954 San Antonio, TX 78283-3954 800-211-8378	\$\$49.00 / pad 50 (discount for quantity)
CES-D, Center for Epidemiological Studies Depression Scale	Tool included in this guideline	No charge
EPDS, Edinburgh Postnatal Depression Scale	<a href="http://www.perinatalweb.org">http://www.perinatalweb.org</a> Tool included in this guideline	No charge
Geriatric Depression Scale	<a href="http://www.stanford.edu/~yesavage/GDS.html">http://www.stanford.edu/~yesavage/GDS.html</a>	No charge
PHQ-9, Patient Health Questionnaire	<a href="http://www.phqscreeners.com">http://www.phqscreeners.com</a>	No charge
Zung	See your GlaxoSmithKline or Lilly pharmaceutical representative	No charge

## 2. Interview for Key Symptoms of Depression

**A Detailed Clinical Interview** is used to confirm the diagnosis of depression. Questions include:

- Are you often sad, down, blue or teary?
- Do you have your usual interest in and look forward to enjoyable activities?
- Are you able to have fun or joy?
- Do you have sleep disturbances, changes in appetite and energy level?

### DSM IV Symptoms<sup>3</sup>

The diagnosis of depression requires that the patient have five or more of the nine symptoms. Symptoms must be present during the same two-week period of time, nearly every day, and represent a change from previous functioning.

*At least one of the symptoms must be either 1) depressed mood or 2) loss of interest or pleasure.*

At least five of the following:

1. Depressed mood
2. Loss of interest or pleasure
3. Weight loss or gain (or appetite loss or gain)
4. Sleep disturbance
5. Fatigue
6. Psychomotor retardation or agitation
7. Trouble concentrating or indecisiveness
8. Low self-esteem or guilt
9. Thoughts of death or suicidal ideation

**History of the Present Illness** should detail the onset and severity:

- **Mild** – five or six depressive symptoms with minor impairment in functioning
- **Moderate** – symptoms and functional impairment between mild and severe
- **Severe** – most depressive symptoms present with clear-cut impairment of functioning

### 3. Involve Behavioral Health

**Emergency “Same Day” Behavioral Health Consultation/Evaluation** should be considered for:

- suicidal thoughts and/or plans that make the patient’s safety uncertain
- assaultive and/or homicidal plans which make the safety of others uncertain
- loss of touch with reality (psychosis)
- significant or prolonged inability to work and care for self and/or family

**Referral to a Behavioral Health Specialist** is recommended when there is:

- psychiatric co-morbidity (for example, mania or hypomania, obsessive compulsive disorder, or eating disorders)
- concern regarding the possibility of suicide and/or homicide
- alcohol or substance abuse
- psychosis with the depression
- a patient who is pregnant or wants to become pregnant
- diagnostic uncertainty
- no improvement with medications prescribed by the primary physician

### 4. Consider Co-morbid Disorders

In evaluating patients with the symptoms of depression, the primary care practitioner must determine if the depression is a primary process or is a symptom of other medical conditions. Screening for other medical conditions should be based on clinical judgement

**Medical Conditions:** Many medical conditions (cancer, coronary artery disease, diabetes mellitus, cerebral vascular accident, hypothyroidism, hyperthyroidism) are risk factors for depression. Depressive disorder, when present, should be considered an independent condition and specifically treated. Treatment may include optimizing treatment for the medical condition and/or providing specific treatment for the depression. When depression and a medical condition co-exist, there are several plausible explanations:

- The medical disorder biologically causes the depression (for example, hypothyroidism may cause depression).
- The medical disorder triggers the onset of depression in those who are genetically predisposed to depression.
- The perceived severity of the illness causes depression (for example, a patient with cancer becomes depressed as a psychological reaction to prognosis and pain).
- The medical disorder and the depression are not causally linked.

It is important for the physician to differentiate among these several explanations in patients with concomitant medical disorder(s) and depression.<sup>2</sup>

**Medications:** Some medications may cause depressive symptoms:

<b>Drug Causing Depression</b>	<b>Potential Alternatives</b>
Clonidine, Methylidopa, Reserpine	Other antihypertensive agent (diuretics, ACE-I, CCB, ARB, etc)
Lipophilic beta blockers (propranolol)	Atenolol or metoprolol
Corticosteroids	Minimize dose as allowed
Sedatives/Hypnotics	Consider taper off
Benzodiazepines	Minimize use
Estrogens/Progestones	Addition of Vitamin B6, use lower progestin
Anti-Parkinson Medications	No alternatives
Anti-convulsants	Consider diagnosis and alternatives
Indomethacin	Other NSAIDS
Interferons (HepC, MS)	No alternatives

**Other Psychiatric Disorders:** Patients with depressive symptoms or in a depressive episode may have a co-existent non-mood psychiatric disorder.

- **Substance abuse:** depressed patients with concurrent substance abuse should discontinue the abused substance and their depression should be reevaluated 4-8 weeks later when they are drug-free. If depressive disorder is still present, it should be treated as a primary mood disorder. Alcoholism is rarely a consequence of depression, but many alcoholics develop depressive symptoms or the syndrome of depression.
- **Anxiety, panic, obsessive-compulsive, or phobic disorders** are often accompanied with depressive symptoms. Depression can also mask underlying psychiatric disorders. Anxiety symptoms are frequent in depressive episodes. The depression may precede the panic or anxiety disorder, or the anxiety disorder may be part of the longitudinal course of the mood disorder. When a patient has anxiety symptoms, the existence of depressive symptoms should be evaluated. For those patients whose disorder has some obsessive features, the mood disorder is the initial focus of treatment.
- **Eating disorders:** young women who present with any mood disorder should be interviewed for symptoms of anorexia nervosa and/or bulimia. One-third to one-half of patients with eating disorders have a concurrent depressive syndrome. If both depression and an eating disorder are present, the eating disorder, generally, should be the principal therapeutic target.

**Grief Expression:** Bereavement is depressive symptoms beginning within 2-3 weeks of the death of a loved one.<sup>3</sup> Bereavement is considered a normal, relatively benign state that most often resolves without treatment. In those bereaved patients who meet the diagnostic criteria for a depression two months following the loss, the diagnosis of a depressive disorder may be made.

## 5. Treatment Plan

**The Initial Objectives of Treatment**, in order of priority, are:

1. Reduction and ultimately removal of all signs and symptoms of the depressive syndrome.
2. Restoration of psychosocial and occupational function to that of the asymptomatic state.
3. Reduction of the likelihood of relapse or recurrence.

### **The Four Treatment Domains For Depressive Disorder**

Factors considered in making treatment recommendations are the severity of symptoms, presence of psychosocial stressors, presence of co-morbid conditions, and patient preferences.

1. **Psychotherapy** alone is not recommended for the acute treatment of patients with severe and/or psychotic depressive disorders.
2. **Medication:** for essentially all patients, the practitioner who provides the medication also provides support, advice, reassurance, and hope, as well as, medication monitoring. This “clinical management” is critical with depressed patients whose pessimism, low motivation, low energy, and sense of social isolation or guilt lead them to give up, not comply with treatment, or to drop out of treatment.

Selection of a particular medication should take into consideration:

- Prior positive/negative response to medication
- History of first degree relatives’ responses to medication
- Concurrent medications that make selected medications more or less risky

**See cost and drug information on antidepressant therapies at the end of this guideline.**

In 2005, the FDA required labeling of all SSRI’s and SNRI’s be updated with the following:

- Adult and pediatric patients with a major depressive disorder may experience worsening of their depression, emergence of suicidal ideation and suicidality, whether or not they are taking antidepressants and this may persist until significant remission occurs.
- Patients should be monitored closely for clinical worsening and suicidality, especially upon initiation of treatment and with dose modifications.

In 2007, the FDA proposed manufacturers of antidepressant medications update product labeling to include the following:

- Young adults ages 18-24 should be followed up during the first two weeks of treatment to assess thoughts of suicide and self harm.

**3. Combination of psychotherapy and medication** – Psychotherapy can help reduce recurrence by teaching coping skills and has superior long-term outcomes and a higher rate of compliance than medication alone.<sup>9</sup>

**4. Electroconvulsive Therapy (ECT)** – Most commonly recommended for people with severe depression accompanied by psychosis, suicidal intent or refusal to eat. It may be tried when medications are not tolerated or other forms of therapy haven't proved effective.

Although other somatic treatments including repetitive transcranial magnetic stimulation, vagal nerve stimulation and deep brain stimulation have also been studied over the past five years, evidence is not yet sufficient to recommend their use in routine clinical practice.

**Patient Education** on the treatment of depression is important for patient compliance with therapy. For antidepressant medications, compliance with a therapeutic dose is more important than the specific drug selected. The following educational messages may increase adherence:

- Take the medication daily as prescribed.
- Antidepressants must be taken daily for 2-4 weeks for a noticeable effect.
- Continue to take medication even if you are feeling better, increased risk of relapse if stopped before 6 months.
- Do not stop taking antidepressant without checking with your provider. Some antidepressants may have uncomfortable withdrawal symptoms.
- Contact your provider if you have questions about your medication.
- Be sure to make and keep follow-up appointments.

### **Treatment Plan Phases**

**1. Acute Treatment (first 12 Weeks)** aims to remove all signs and symptoms of the current episode of depression and to restore psychological and occupational functioning (a remission).

The patient should be seen a minimum of three times during the acute phase. At least one of those encounters should be with the prescriber. Patient non-compliance is high in those with depression, and the practitioner must assertively engage the patient in follow-up care and assessments.

- Patients should have a minimum of three contacts during the acute phase (first 12 weeks)
- Patients should be reminded to call within one week if they experience adverse medication reactions
- Consider referral to behavioral health if more severe symptoms present.
- Certain patients (new, unstable, those on many medications, those with sudden onset) may need to be seen more often and may require close observation
- Once the depression has resolved, visits every 4-12 weeks are reasonable.

Treatment response should be assessed every 4-6 weeks for drug therapy and every 6-12 weeks for psychotherapy. See sample flow sheet to assess response to therapy. Most patients respond partially to medication within 2-3 weeks and full symptom remission is typically seen in 6-8 weeks. If the patient does not respond at all by 6 weeks (4 weeks in severely ill), or responds only partially by 12 weeks, other treatment options should be considered including:

- Assess medication adherence
- Continue medication at a corrected dose
- Change medication
- Augment with a second medication (not advised until initial trial adequate in time and dosage)
- Refer for professional psychotherapy. Most patients receiving time-limited psychotherapy respond partially by 5-6 weeks and fully by 10-12 weeks.
- Obtain a behavioral health consultation

**2. Continuation Therapy (next 6 - 9 months)** is intended to prevent relapse.

- The patient should remain on medication for at least 6 months after symptoms resolve.
- Once the patient has been asymptomatic for at least 6 to 9 months following an episode, recovery from the episode is declared. At recovery, treatment may be stopped.

**3. Maintenance Therapy (1 Year to lifetime)** is aimed at preventing a new episode. Patients who have had three or more episodes of depression should be considered for long-term maintenance medication therapy.

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## 6. Detection and Treatment During Pregnancy

The incidence of depression during pregnancy is similar to the incidence of depression in postpartum periods, i.e. 8-10% of women.<sup>23</sup> Diagnosing depression in pregnant women is difficult because many common 'normal' symptoms during pregnancy may be misconstrued as depressive symptomatology. Depressive symptoms may also falsely be interpreted as pregnancy related. Examples include changes in appetite, sleep, libido and loss of energy.

Depression during pregnancy does not differ from depression during other periods of life. Therefore, screening tools such as the CES-D or EPDS should be administered if the woman has risks for depression or depression is suspected. The EPDS scale was developed to detect women with postnatal depression, but has also been validated for use in pregnancy.<sup>23</sup>

### Treatment

Psychotherapy has been considered to be particularly useful for patients with mild to moderate depression during pregnancy in that it directly addresses issues associated with role transitions and relationship with the partner.

Depression in pregnancy may have a negative effect on self care and pregnancy outcomes that affect the mother directly and child indirectly. Therefore, some women may require pharmacological treatment.

Most SSRI's are a FDA pregnancy risk Category C. Exception is sertraline which is a category B and paroxetine which is a category D. **Paroxetine should not be used in women who are planning to become pregnant or are in the first trimester of pregnancy, as it may be associated with an increased risk of fetal cardiac effects.**

When treating pregnant women with an SSRI and SNRI during the third trimester, carefully consider the potential risk and benefits of treatment.

- Neonates exposed to SSRIS or SNRIS late in the third trimester have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding.
- In one study, persistent pulmonary hypertension (PPHN) was six times more common in babies whose mothers took an SSRI antidepressant after the 20th week of pregnancy compared to babies whose mothers did not take an antidepressant.<sup>26</sup>
- Reported clinical findings have included
  - respiratory distress
  - cyanosis
  - apnea
  - seizures
  - temperature instability
  - feeding difficulty
  - vomiting
  - hypoglycemia
  - hypotonia
  - hypertonia
  - hyperreflexia
  - tremor
  - jittery
  - irritability
  - constant crying
- These features are consistent with either a direct toxic effect of SSRIS and SNRIS or possibly, a drug discontinuation syndrome. In some cases, the clinical picture is consistent with serotonin syndrome.

## 7. Postpartum Depression: Detection and Treatment

**Postpartum depression (PD) occurs in approximately 8-10% childbearing women. Many medical professionals rely on their clinical impressions alone to determine whether a woman appears depressed, but several studies have shown that up to 50% of mothers with major depression are missed by primary care physicians when screening instruments are not used.<sup>23</sup> If left untreated, the disorder can have serious adverse effects on the mother and her relationship with others, and on the child's development.**

PD may begin 24 hours to 1 year after delivery. When its onset is abrupt and symptoms are severe, women are more likely to seek help early in the illness. In cases with an insidious onset, treatment is often delayed, if it is ever sought. Untreated, PD may resolve within several months but can linger into the second year postpartum. After the initial episode, women who have had PD are at risk for both nonpuerperal and puerperal relapses.

A simple screening instrument can be used to increase the detection of postpartum depression. The EPDS or CES-D instruments included in this guideline is appropriate to use in postpartum assessment and diagnosis. The EPDS screening tool addresses anxiety which frequently co-occurs with depression. It was developed specifically to identify significant depressive symptoms among pregnant women and new mothers.

The **mainstay of treatment** should be psychotherapy and medication if suicidal, psychotic symptoms or severity of symptoms indicate need.<sup>23</sup>

## 8. Recognizing Postpartum Depression

### Risk Factors

- 1) Previous history of depressive episode
- 2) Family history of mood or anxiety disorders
- 3) Depression or anxiety during pregnancy
- 4) Dissatisfaction with the amount of social support from a spouse or significant other

### Screening for PD

The detection of PD is often complicated by several factors.

- Most women expect a period of adjustment after having a baby.
- Societal pressures to be a "good mother."
- Concern that sharing depressive thoughts might mean that their child could be taken from them.
- Delayed detection of PD by providers' minimizing a woman's distress in an effort to be reassuring.

**Anxiety may be a prominent feature and more readily apparent than traditional depressive symptoms.** Co-morbid anxiety has been found to be present in 60% of women with major depression in the postpartum period. Other co-morbid disorders often present may include: social phobia, agoraphobia, obsessive compulsive and avoidant personality disorders, all of which may contribute to social isolation.

### Distinguishing PD

#### • Postpartum Blues

The "baby blues" are the most common disorder affecting 50-80% of new mothers. They are subclinical mood fluctuations characterized by mild depressive symptoms that typically peak 3 to 5 days after delivery and resolve by the 10th postnatal day.

These include:

- tearfulness
- irritability
- fatigue
- anger
- anxiety
- mood lability
- sensitivity
- insomnia

- **Postpartum Depression**

The criteria for diagnosing depression apply to the diagnosis of PD as well.

Depression symptoms include:

- Lack of pleasure or interest
- Agitation or retardation
- Frequent thoughts of death or suicide
- Weight loss
- Sleep disturbance (insomnia or hypersomnia)
- Loss of energy
- Feelings of worthlessness or inappropriate guilt
- Diminished concentration or indecisiveness
- Symptoms that may be confused with normal sequelae of childbirth

- **Postpartum Psychosis**

PD must be distinguished from postpartum psychosis, which occurs in 0.2% of childbearing women.

Most puerperal psychoses have their onset within the first month of delivery and are manic in nature. Warning signs heralding the onset of puerperal psychosis include:

- An inability to sleep for several nights
- Agitation
- Irritable mood
- Avoidance of the infant
- Delusion or hallucinations often involve the infant
- Racing thoughts
- Rapid speech

## 9. Treatment of Postpartum Depression

Psychotherapy, particularly Individual Interpersonal Therapy (IPT) has been shown to be an effective treatment for Postpartum Depression and does not hold the risk to breastfeeding that medication can, making it a preferable first order of treatment. While there are not absolute contraindications to using a particular antidepressant medication while breastfeeding, there are no specific FDA approved antidepressants labeled for peripartum use.<sup>6</sup>

### Medications and Lactation

The majority of expert opinion feels the benefit outweighs the risk in treatment with a SSRI. SSRI's should be a first choice recommendation.

- The goal is to effectively treat the depression.
- Initiating or continuing therapy should not interfere with the decision to start or continue to breastfeed.
- Breastfeeding should not interfere with the decision to initiate treatment of depression.

If the woman is breastfeeding, some agents may be preferred over others.

- **Sertraline or paroxetine** may be preferred SSRIs, since no adverse effects have been reported thus far in nursing infants.<sup>11,12</sup> Several studies have shown infant serum levels of sertraline to be nondetectable or less than 5ng/ml and its metabolite concentration to be less than 10ng/ml.<sup>7,8</sup> In six reports, paroxetine serum concentrations were measured in 27 infants and were found to be nondetectable in 24 infants and less than 20 ng/mL in the remaining three.<sup>8,12</sup>
- The remaining SSRIs, as well as, bupropion and venlafaxine are not known to be contraindicated in nursing women, but less information is known about these medications during lactation. A decision to use these medications should be based on a patient-specific risk-benefit evaluation, and the infant should be observed closely for side effects.<sup>14</sup>

Fluoxetine is not considered a first-line agent for women who are breastfeeding.

- **Fluoxetine** has had several case reports of adverse effects in the infant, including colic, delayed weight gain, irritability, and disturbed sleep.<sup>13,22</sup> For this reason, fluoxetine should generally not be considered first line treatment with a new diagnosis of depression.

Women with severe depression, suicidal ideation, or psychosis should be referred for psychiatric care. Such women require a comprehensive, multifaceted approach to treatment, including crisis intervention, pharmacotherapy, psychotherapy, and strengthening social support networks.

**Support groups** available to women include:

- Postpartum Support International (telephone: 805-967-7636) (<http://www.chss.iup.edu/postpartum/>)
- UW Postpartum Depression Treatment Program and Information Center 608.263.5000 or <http://www.psychiatry.wisc.edu/ppd>

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# EPDS – Edinburgh Postnatal Depression Scale

## EPDS

Circle the number for each statement, which best describes how often you felt or behaved this way **in the past 7 days...**

### I have been able to laugh and see the funny side of things.

- 0 As much as I always could
- 1 Not quite so much now
- 2 Definitely not so much now
- 3 Not at all

### I have looked forward with enjoyment to things.

- 0 As much as I ever did
- 1 Rather less than I used to
- 2 Definitely less than I used to
- 3 Hardly at all

### I have blamed myself unnecessarily when things went wrong.

- 0 No not at all
- 1 Hardly ever
- 2 Yes, sometimes
- 3 Yes, very often

### I have been anxious or worried for no good reason.

- 3 Yes, quite a lot
- 2 Yes, sometimes
- 1 No, not much
- 0 No, not at all

### I felt scared or panicky for no very good reason.

- 3 Yes, quite a lot
- 2 Yes, sometimes
- 1 No, not much
- 0 No, not at all

### Things have been getting on top of me.

- 3 Yes, most of the time I have not been able to cope at all
- 2 Yes, sometimes I have not been coping as well as usual
- 1 No, most of the time I have coped quite well
- 0 No, I have been coping as well as ever

### I have felt so unhappy that I have had difficulty sleeping.

- 3 Yes, most of the time
- 2 Yes, sometimes
- 1 Not very often
- 0 No, not at all

### I have felt sad and miserable.

- 3 Yes, most of the time
- 2 Yes, quite often
- 1 Not very often
- 0 No, not at all

### I have been so unhappy that I have been crying.

- 3 Yes, most of the time
- 2 Yes, quite often
- 1 Only occasionally
- 0 No, never

### The thought of harming myself has occurred to me.

- 3 Yes, quite often
- 2 Sometimes
- 1 Hardly
- 0 Never

**Column Total = \_\_\_\_\_**

**Column Total = \_\_\_\_\_**

**Total = \_\_\_\_\_**

Total all answers chosen. (Scoring may be eliminated when tool is reproduced for use.)

- Validation studies have utilized various threshold scores in determining which women were positive and in need of referral.
- Cut-off scores ranged from 9-13 points. Therefore, to err on safety's side, a woman scoring 9 or more points or indicating any suicidal ideation should be referred immediately for follow-up.
- The EPDS is only a screening tool, it does not diagnose depression.

Cox, J.L., Holden, J.M, Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, 150: 782-786.

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## The Center for Epidemiologic Studies Depression (CES-D) Scale

Please select the choice, for each item below, that best describes how you <b>felt over the past week</b> :		Rarely or none of the time (<1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of the time (3-4 days)	Most or all of the time (5-7 days)
1	I was bothered by things that usually don't bother me.	0	1	2	3
2	I didn't feel like eating, my appetite was poor.	0	1	2	3
3	I felt that I could not shake off the blues even with help from my family and friends.	0	1	2	3
4	I felt that I was not as good as other people.	0	1	2	3
5	I had trouble keeping my mind on what I was doing.	0	1	2	3
6	I felt depressed.	0	1	2	3
7	I felt that everything I did was an effort.	0	1	2	3
8	I felt hopeless about the future.	0	1	2	3
9	I thought my life had been a failure.	0	1	2	3
10	I felt fearful.	0	1	2	3
11	My sleep was restless.	0	1	2	3
12	I was unhappy.	0	1	2	3
13	I talked less than usual.	0	1	2	3
14	I felt lonely.	0	1	2	3
15	People were unfriendly.	0	1	2	3
16	I did not enjoy life.	0	1	2	3
17	I had crying spells.	0	1	2	3
18	I felt sad.	0	1	2	3
19	I felt that people disliked me.	0	1	2	3
20	I could not get "going."	0	1	2	3

Total all answers chosen. **(Scoring may be eliminated when tool is reproduced for use.)**

Total score of 22 or higher, indicates possible major depression

Score 15-21, indicates possible mild to moderate depression

Score 14 and below, indicates no depression

For original work on this scale: Radloff, LW. (1977). A self-report depression scale for research in the general population. Applied Psychological Measurement 1(3), 385-401.

## Consideration of Concurrent Conditions

Depression With	First Line Therapeutic Options Best Economic Choice in Bold	May be Problematic
No Additional Comorbid Conditions	<b>Fluoxetine, Citalopram</b> , Escitalopram, Paroxetine, <b>Sertraline</b> , Trazodone, Mirtazapine, Venlafaxine, Desvenlafaxine, Bupropion	TCA-side effect profile less desirable Nefazodone-hepatotoxicity
Alcohol Use		Duloxetine=Liver injury, as manifested by ALT and total Bilirubin elevations, with evidence of obstruction have occurred with coadministration of alcohol and Duloxetine.
Anxiety or Panic Disorder	Paroxetine, Fluoxetine, Mirtazapine, Sertraline, Citalopram, Escitalopram	TCA-ineffective for anxiety Bupropion-may increase anxiety Venlafaxine, Desvenlafaxine
Cardiac Condition	Mirtazapine, <b>Paroxetine</b>	TCA Venlafaxine Desvenlafaxine
Decreased Appetite	TCA, Mirtazapine	Venlafaxine Desvenlafaxine SSRI
Dementia, Head Injury, Post-Stroke Patients	<b>Citalopram</b> , Escitalopram, <b>Sertraline</b> , Bupropion	TCA's Paroxetine Mirtazapine
Diabetes	<b>Fluoxetine, Citalopram</b> , Escitalopram, Paroxetine, <b>Sertraline</b>	TCA's Mirtazapine (may increase carbohydrate cravings) Duloxetine (causes slowed gastric emptying)
Eating Disorders (anorexia, bulimia)	<b>Fluoxetine</b> , Paroxetine, Sertraline	Bupropion Mirtazapine
Glaucoma	<b>Fluoxetine, Citalopram</b> , Escitalopram, <b>Sertraline</b> , Bupropion	TCA, Paroxetine, Duloxetine
Lactation	<b>Sertraline</b> , Paroxetine (See Post Partum Depression)	Fluoxetine
Liver Disease	<b>Sertraline</b> , Venlafaxine, Desvenlafaxine	TCA Fluoxetine Paroxetine Citalopram Escitalopram Trazodone Mirtazapine Nefazodone Duloxetine (hepatotoxic with ETOH)
Obsessive Compulsive Disorder	<b>Fluoxetine, Citalopram</b> , Escitalopram, <b>Sertraline</b> , Paroxetine	TCA
Parkinsons	Bupropion, Trazodone, Desipramine, Amoxapine, Nortriptyline, Protryptiline	SSRIs Venlafaxine Desvenlafaxine Nefazodone Mirtazapine
Pheochromocytoma		Selegiline patch
Renal Disease	<b>Fluoxetine, Citalopram</b> , Escitalopram, <b>Sertraline</b>	Mirtazapine Paroxetine Venlafaxine Desvenlafaxine TCA-levels not predictive
Seizures/Seizure Disorder	<b>Fluoxetine, Citalopram</b> , Escitalopram, <b>Sertraline</b> Paroxetine	Bupropion, Maprotiline, TCA (in overdose), Duloxetine, Venlafaxine Desvenlafaxine
Symptoms of: insomnia, weight loss, or overstimulation	Bupropion, <b>Fluoxetine, Sertraline, Citalopram</b> , Escitalopram, Paroxetine, Venlafaxine, Desvenlafaxine	Mirtazapine TCA Trazodone
Symptoms of: oversedation, weight gain, or lethargy	Mirtazapine, Trazodone	Venlafaxine Desvenlafaxine SSRI

Due to potential for drug-drug interaction and a long half-life, elderly patients and other patients using many medications may not be candidates for fluoxetine.

**Paroxetine should NOT be used in women who are planning to become pregnant or are in the first trimester of pregnancy.**

**Physicians should carefully consider the potential risks and benefits of treatment when treating pregnant women during the third trimester. Neonates exposed to Effexor XR, Cymbalta, other SNRIs or SSRIs late in the third trimester have developed complications requiring prolonged hospitalization, respiratory support and tube feeding.**

## Depression Side Effect Profiles

Side effects may be observed early in treatment and improve over time. If side effects persist, alternatives may be considered.

Presenting Symptom	First Line Therapeutic Options	May Be Problematic
Agitation/Insomnia	Trazodone, Mirtazepine, <b>TCA</b>	Selegiline Patch, Fluoxetine, Sertraline, Paroxetine, Citalopram, Escitalopram, Bupropion, Venlafaxine, Desfenlafaxine
Anticholinergic Side Effects (dry mouth, blurred vision, constipation, urinary retention)	<b>Citalopram</b> , Escitalopram, <b>Fluoxetine</b> , <b>Sertraline</b> , Venlafaxine, Desvenlafaxine, Bupropion	TCA, Mirtazapine, Paroxetine, Duloxetine, Selegiline Patch
GI Sensitivity	Bupropion, <b>TCA</b> , Mirtazapine	Fluoxetine, Sertraline, Paroxetine, Citalopram, Escitalopram, Nefazodone, Venlafaxine, Desfenlafaxine, Duloxetine (20% pts nausea)
Headache	<b>TCA</b> , Mirtazapine	Fluoxetine, Sertraline, Paroxetine, Citalopram, Escitalopram, Nefazodone, Venlafaxine, Desfenlafaxine, Bupropion, Selegiline Patch
Orthostatic Hypotension	<b>Fluoxetine</b> , <b>Sertraline</b> , Paroxetine, <b>Citalopram</b> , Escitalopram, Venlafaxine, Desfenlafaxine, Bupropion	TCA, Mirtazapine, Selegiline Patch
Sedation	<b>Fluoxetine</b> , <b>Sertraline</b> , Paroxetine, <b>Citalopram</b> , Escitalopram, Venlafaxine, Desvenlafaxine, Bupropion	TCA, Nefazodone, Trazodone, Mirtazapine, Duloxetine, Selegiline Patch
Sexual Dysfunction	Bupropion, <b>Mirtazapine</b>	Fluoxetine, Sertraline, Paroxetine, Citalopram, Escitalopram, Venlafaxine, Desfenlafaxine, Bupropion, Trazodone
Weight Gain	<b>Fluoxetine</b> , <b>Sertraline</b> , Paroxetine, <b>Citalopram</b> , Escitalopram, Venlafaxine, Desfenlafaxine, Bupropion	TCA, Mirtazapine, Trazodone

## Antidepressant Drug Interactions

Interactions below are established in well-controlled studies. This is not a comprehensive listing of all potential interactions. The chart continues on page 18 - 19.

Antidepressant Drug Interactions			
Interacting Medication	First Line Therapeutic Options Most Economic Choice in Bold	May Be Problematic	Problematic Effect
Anesthesia		Selegiline Patch	Patients taking MAOIs should not undergo elective surgery requiring general anesthesia. Do not give cocaine or local anesthesia containing sympathomimetic vasoconstrictors. Keep in mind the possible combined hypotensive effects of MAOIs and spinal anesthesia. Discontinue the MAOI at least 10 days before elective surgery.
Antivirals (Ritonavir)	<b>Citalopram</b> , Escitalopram, <b>Sertraline</b> , Mirtazapine	Bupropion	Ritonavir may inhibit the metabolism of Bupropion. Large increases of Bupropion levels.
Atypical Antipsychotics (Clozapine)	<b>TCAs</b>	Citalopram, Fluoxetine, Fluvoxamine, Sertraline	Certain SSRIs inhibit the hepatic metabolism of Clozapine. Monitor Clozapine levels and adjust dose appropriately.
Azole Antifungals	<b>Citalopram</b> , Escitalopram, <b>Sertraline</b> , Paroxetine, Venlafaxine, Desvenlafaxine#, Mirtazapine, Bupropion	TCAs	Inhibition of TCA metabolism by fluconazole (CYP2C) and ketoconazole (CYP3A4). Elevated TCA levels and increased therapeutic and adverse effects, including cardiac arrhythmias.
Beta Blockers (Metoprolol, Carvedilol, Propranolol)	Bupropion, <b>Mirtazapine</b>	SSRIs, Selegiline Patch	Certain SSRIs may inhibit the metabolism of certain Beta Blockers (CYP2D6). Excessive beta blockade may occur. Interaction may be less likely with sotalol or atenolol. Bradycardia may develop during concurrent use of certain MAOIs and B-blockers
Carbamazepine / Oxcarbazepine	<b>Citalopram</b> , Escitalopram, <b>Sertraline</b> , Paroxetine, Venlafaxine, Desvenlafaxine#, Mirtazapine	TCAs, Bupropion, Fluoxetine, Nefazodone Selegiline Patch is Contraindicated.	Induction of CYP3A4 by Carbamazepine may decrease levels of Bupropion, Nefazodone and TCAs. Fluoxetine and TCA's may inhibit the hepatic metabolism and increase blood levels of Carbamazepine. Hypertensive crises, severe convulsive seizures, coma, or circulatory collapse may occur in patients receiving carbamazepine and selegiline.
Cimetidine	<b>Citalopram</b> , Escitalopram, <b>Sertraline</b> , <b>Fluoxetine</b> , Paroxetine, Venlafaxine, Desvenlafaxine#, Bupropion, Mirtazapine	TCAs	Increased TCA concentrations. Decrease TCA dose as needed. Ranitidine may be substituted.
Clonidine	<b>Citalopram</b> , Escitalopram, <b>Sertraline</b> , Fluoxetine, Paroxetine, Venlafaxine, Desvenlafaxine#	TCAs	Theoretical TCA inhibition of central alpha 2 adrenergic receptors. Loss of blood pressure control and possibly life threatening elevations in blood pressure. Avoid concomitant use.
Cyclosporine	<b>Citalopram</b> , Escitalopram, Bupropion, Mirtazapine, Venlafaxine, Desvenlafaxine#	Fluoxetine, Fluvoxamine, Paroxetine, Sertraline, Nefazodone	SSRI may increase Cyclosporine concentrations and toxicity (via CYP3A4). Monitor blood levels of Cyclosporine and adjust dose accordingly.
Cyproheptadine	<b>TCAs</b> , <b>Mirtazapine</b> , <b>Bupropion</b>	SSRIs, Nefazodone, Venlafaxine, Desvenlafaxine#	Cyproheptadine is a serotonin antagonist and may reduce the antidepressant effect of the SSRI.

## Antidepressant Drug Interactions (continued)

Antidepressant Drug Interactions			
Interacting Medication	First Line Therapeutic Options Most Economic Choice in Bold	May Be Problematic	Problematic Effect
Fluoxetine, Paroxetine (potent 2D6 inhibitors)	<b>Citalopram</b> , Escitalopram, <b>Sertraline</b> , <b>Secondary TCAs</b> , Fluvoxamine, Mirtazepine.	Duloxetine	Concomitant use of Duloxetine with potent inhibitors of CYP2D6 may result in higher concentrations of Duloxetine. Paroxetine 20 mg daily increased the concentration of Duloxetine 40 mg QD by approximately 60%
Fluvoxamine	Nefazodone, Bupropion, Mirtazepine, <b>Citalopram</b> , Escitalopram, Venlafaxine, Desvenlafaxine#	Duloxetine	Concomitant use of Duloxetine with Fluvoxamine results in approximately 6-fold increase in AUC and approximately 2.5 fold increase in Cmax of Duloxetine.
Levodopa	<b>SSRIs</b> , Bupropion	TCAs, Selegiline Patch	Hypertensive reactions occur if levodopa is given to patients receiving MAOIs.
Methadone	<b>Citalopram</b> , Escitalopram, Sertraline	Fluvoxamine, Selegiline Patch is contraindicated	Fluvoxamine may inhibit the hepatic metabolism of methadone elevating methadone levels.
Phenothiazines (Promethazine, Thioridazine, <b>Risperidone</b> )	Bupropion, Nefazodone, <b>Citalopram</b> , Escitalopram, <b>Sertraline</b>	Duloxetine, Fluoxetine, Paroxetine	Elevated Phenothiazine levels may increase adverse effects due to inhibition of CYP2D6 by Paroxetine. Life-threatening arrhythmias with Thioridazine and Paroxetine have been reported. There is a risk of serious ventricular arrhythmias and sudden death associated with elevated levels of Thioridazine. (Level 1 Suspected Major Delayed interaction).
Phenytoin	<b>Citalopram</b> , Escitalopram, Mirtazepine, Venlafaxine, Desvenlafaxine#	Fluoxetine, Paroxetine	Fluoxetine may inhibit the metabolism of hydantoin resulting in elevated Hydantoin blood levels.
Propafenone	<b>Citalopram</b> , Escitalopram, <b>Sertraline</b>	Fluoxetine, Paroxetine, Sertraline	Certain SSRIs may inhibit the metabolism (CYP2D6) of propafenone resulting in elevated propafenone levels. Monitor cardiac function.
Quinolones	Nefazodone, Bupropion, Mirtazepine, <b>Citalopram</b> , Escitalopram, Venlafaxine, Desvenlafaxine#	Duloxetine	Use of Quinolones with Duloxetine should be avoided. There may be an increase in Duloxetine and an increase in the Quinolone level.
Rifampin	<b>Citalopram</b> , Escitalopram, <b>Sertraline</b> , <b>Fluoxetine</b> , Paroxetine, Venlafaxine, Desvenlafaxine#, Bupropion, Mirtazepine	TCAs	Hepatic metabolism of TCA may be increased resulting in decreased pharmacological effect of TCA. Adjust dose as needed.
Other Antidepressants & Buspirone	None	Selegiline Patch is contraindicated for concurrent use of SSRIs, SNRIs, TCAs, Bupropion, Mirtazepine, Buspirone	Do not administer MAOIs together with or immediately following these agents (see Warnings). There have been reports of serious, sometimes fatal, reactions (including hyperthermia, rigidity, myoclonus, autonomic instability with possible fluctuations of vital signs, and mental status changes that include extreme agitation and confusion progressing to delirium and coma). Do not administer MAOIs together or in rapid succession with other MAOIs.

## Antidepressant Drug Interactions (continued)

Antidepressant Drug Interactions			
Interacting Medication	First Line Therapeutic Options Most Economic Choice in Bold	May Be Problematic	Problematic Effect
Cyclobenzaprine	<b>SSRIs</b> , Bupropion	TCAs, Selegiline Patch is contraindicated for concurrent use	Because cyclobenzaprine is structurally related to the tricyclic antidepressants, use with caution with MAOIs (see MAOIs/Antidepressants).
Meperidine, Tramadol, Propoxyphene	<b>TCA</b>	Selegiline Patch is contraindicated for concurrent use	Coadministration or use within 2 to 3 weeks of one another may result in agitation, seizures, diaphoresis, and fever, and progress to coma, apnea, and death. Adverse reactions are possible weeks after MAOI withdrawal. Avoid this combination; administer other narcotic analgesics with caution.
Dextromethorphan	Any other	Selegiline Patch is contraindicated for concurrent use	Hyperpyrexia, abnormal muscle movement, psychosis, bizarre behavior, hypotension, coma, and death have been associated with Selegiline and Dextromethorphan
St. John's Wort	Bupropion, Mirtazapine, TCAs	SSRIs, Nefazodone, Venlafaxine, Desvenlafaxine#, Selegiline Patch is Contraindicated.	Possible additive serotonin reuptake inhibition. Increased sedative hypnotic effects.
Sympathomimetics (Phenylephrine, Dextroamphetamine)	Use caution	SSRIs, TCAs, Selegiline Patch is Contraindicated with Sympathomimetics	Coadministration with Selegiline may cause hypertensive crisis. SSRIs increase sympathomimetic effects and increase risk of 'serotonin syndrome' with Phenylpropanolamine and Dextroamphetamine. TCAs potentiate pressor response of direct acting sympathomimetics (Phenylephrine), dysrhythmias have occurred. The pressor response of indirect acting sympathomimetics (Ephedrine) has been decreased by TCAs.
Tacrine	<b>Citalopram</b> , Escitalopram, <b>Sertraline</b> , <b>Fluoxetine</b> , Paroxetine, Venlafaxine, Desvenlafaxine#, Mirtazapine, Bupropion	Fluvoxamine	Fluvoxamine may inhibit the hepatic metabolism (CYP1A2) of Tacrine. Monitor for hepatotoxicity, elevated pharmacological and adverse effects of Tacrine.
TCAs	<b>Citalopram</b> , Escitalopram, <b>Sertraline</b>	Duloxetine, Fluoxetine, Paroxetine, Selegiline Patch	Fluoxetine may inhibit TCA hepatic metabolism. Coadministration of Duloxetine with drugs extensively metabolized by 2D6 are not recommended. Theoretical risk of ventricular arrhythmias - use narrow therapeutic index drugs (TCAs) and Duloxetine with caution.
Triptan Migraine Agents (Sumatriptan)	<b>TCAs</b> , <b>Mirtazapine</b> , <b>Bupropion</b>	SSRIs, Nefazodone, Venlafaxine, Desvenlafaxine#, Selegiline Patch	Possibly rapid, excessive accumulation of serotonin in the CNS - risk of serotonin syndrome. Systemic exposure to sumatriptan may be increased, producing toxicity.

Source: Drug Interactions Facts and Comparisons, eFacts, <http://www.efactsweb.com/2008>

# Relative lack of information on the drug interaction because agent has not been on the market for a significant period to facilitate reporting.

## Product and Dosage Chart

Product	How Supplied	Dosage Range/ Comments	Relative Cost
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITORS</b>			
citalopram	10mg, 20 mg, 40mg scored tab 10mg/5ml soln	20-60mg daily	\$
escitalopram (Lexapro)	5 mg unscored, 10 mg, 20mg scored tab 5mg/5ml	10-20mg daily	\$\$\$
fluoxetine	10 mg, 20 mg, 40mg cap 10 mg, 20mg tab 20mg/5ml susp	10-80mg daily	\$ \$\$-\$\$\$ 40mg cap
paroxetine (generic)	10, 20, 30, 40mg tab	10-60mg daily	\$\$
paroxetine (Paxil, CR)	10mg, 20mg scored tab 30mg, 40mg tab 10mg/5ml susp 12.5mg, 25, 37.5mg CR	10-60mg IR or 62.5mg CR daily lower for anxiety	\$\$\$\$ \$\$\$\$-\$\$\$\$\$
sertraline	25 mg, 50 mg, 100mg scored tab 20mg/ml	50-200mg daily	\$\$\$
<b>NOREPINEPHRINE SEROTONIN ANTIDEPRESSANTS</b>			
bupropion	75mg, 100mg IR tab 100mg, 150mg, 200mg SR tab 150mg, 300mg XL tab	200mg SR BID IR TID = SR BID=XL daily	\$\$
desvenlafaxine (Pristiq)	50mg, 100mg	50-100mg daily (100mg not shown more effective)	\$\$\$\$-\$\$\$\$\$
duloxetine (Cymbalta)	20mg, 30mg, 60mg cap	40-60mg daily	\$\$\$\$
nefazodone	50mg, 100mg, 150mg, 200mg, 250mg tab	200-600mg daily in divided doses	\$\$
mirtazapine	7.5mg, 15mg, 30mg, 45mg tab 15mg, 30mg, 45mg ODT	15-45mg daily	\$\$ tab \$\$\$ ODT
trazodone	50, 100, 150, 300mg tab	100-600mg daily in divided doses	\$
venlafaxine (Effexor, XR)	IR 25mg, 37.5mg, 50mg, 75mg, 100mg tab ER 37.5mg, 75mg, 100mg cap	75-225mg QD in divided doses 37.5mg IR BID = 75mg ER	\$\$\$\$-\$\$\$\$\$
<b>TRI-CYCLIC ANTIDEPRESSANTS</b>			
amitriptyline	10mg, 25mg, 50mg, 75mg, 100mg, 150mg tab	50-150mg daily in divided doses	\$
amoxapine	25mg, 50mg, 100mg, 150mg	50mg BID-TID maximum 300mg	\$\$
desipramine	10mg, 25mg, 50mg, 75mg, 100mg, 150mg coated tab	100-300mg daily in divided or single doses	\$
doxepin	10mg, 25mg, 50mg, 75mg, 100mg, 150mg cap 10mg/mL conc	75-300mg daily in divided or single doses	\$
imipramine	10mg, 25mg, 50mg, 75mg, 150mg tab 75mg, 100mg, 125mg, 150mg cap 25mg/5mL syrup	150-300mg daily	\$
maprotiline	25mg, 50mg, 75mg	25-75mg BID-TID maximum 150 mg	\$\$-\$\$\$
nortriptyline	10mg, 25mg, 50mg, 75mg cap 10mg/5mL soln	60-150mg daily in divided or single doses	\$
<b>MONOAMINE OXIDASE INHIBITORS</b>			
phenelzine (Nardil)	15mg tab	60-90mg daily in divided doses	\$\$\$
selegiline transdermal (Emsam)	6mg, 9mg, 12mg patch	6mg/24hr patch may be used without food restrictions	\$\$\$\$\$
tranylcypromine (parnate)	10mg tab	30mg daily in divided doses	\$\$\$

Relative Cost: \$ = \$0-20    \$\$ = \$20-40    \$\$\$ = \$40-60    \$\$\$\$ = \$60-80    \$\$\$\$\$ = > \$100

# Depression Monitoring Flow Sheet #1

Patient Name \_\_\_\_\_

DOB/age \_\_\_\_\_

Date of Diagnosis \_\_\_\_\_

Date/Type of Contact						
<b>Assessment of Progress:</b> Score 1 if symptoms are worse Score 2 if there is no change in symptoms Score 3 if symptoms have improved						
CES-D Scale score/ Assessment score	/	/	/	/	/	/
Thoughts of death or suicidal ideation						
Patient impression of progress						
New stressors						
Other concerns or Assessments						
<b>Assessment of Treatment</b>						
Current Medication						
Medication compliance	Y N	Y N	Y N	Y N	Y N	Y N
Medication side-effects <sup>1</sup> :						
Sedation/agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/GI distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other						
Psychotherapy						
Initials of Provider						

<sup>1</sup>Place check mark for presence of side-effect. Track progress by noting ongoing presence of side-effect.

# Depression Monitoring Flow Sheet #2

Patient Name \_\_\_\_\_

DOB/age \_\_\_\_\_

Scoring Guide: 1 = poor/no change in symptoms  
 2 = OK/some improvement in symptoms  
 3 = good/much improved.

Date of Diagnosis \_\_\_\_\_

Date/Type of Contact						
Mood						
Interest in activities						
Appetite						
Sleep						
Psychomotor agitation or lethargy						
Energy level						
Self-esteem						
Concentration						
Thoughts of death or suicidal ideation						
Patient impression of progress						
Medication side-effects <sup>1</sup> :						
Sedation/agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/GI distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other concerns or assessments						
Initials of Provider						
Completing Assessment						

<sup>1</sup>Place check mark for presence of side-effect. Track progress by noting ongoing presence of side-effect.