INTERVENTION | RECOMMENDATION
--- | ---
Stage I | Duration: up to 3 months
Acute Phase | Goal: Induce remission

Assessment and Treatment Planning (1 – 2 visits)

- Diagnosis of Major Depressive Disorder (MDD) made using DSM-IV TR criteria
- Possible alternative psychiatric diagnoses (e.g. anxiety, bipolar disorder, schizoaffective disorder, chemical dependency) or medical diagnoses had been ruled out
- Medical disorder or medication which may contribute to depressive symptoms:
  - Medications such as: carbidopa/levodopa, beta blockers, clonidine, benzodiazepines, barbiturates, anticonvulsants, corticosteroids, narcotics
  - Medical conditions such as: hypothyroidism, Cushing’s disease, CVA, MI, CHF, Parkinson’s, Alzheimer’s, MS, SLE, AIDS, RA, cancer
    - Treat optimally the general medical condition and re-evaluate
    - Consider concurrent treatment of depression
- Assess complaint severity, psychosis, suicide/homicide risk, inability to care for self
  - Assess initially and over the course of treatment: Presence of suicidal or homicidal ideation, intent or plans; access to means/lethality; psychotic symptoms, command hallucinations, severe anxiety; alcohol/substance abuse; history of attempts, family history or recent exposure
- Obtain history (previous episodes, family history, precipitating factors)
- Assess current and previous history of substance use disorders
- Evaluate and address functional impairments
- Education: Emphasize that condition is medical; progress is good with treatment; take medication(s) as prescribed
- Mild MDD: use either medication or psychotherapy as initial treatment
- Moderate to Severe MDD: requires medication [I. vs AJP 2002 p 1354]
- Referral to psychiatrist – consider if: psychotic or bipolar depression, comorbid substance abuse, severe psychosocial problems, suicidal, homicidal, specialized treatment required (e.g. MAOIs, ECT), additional non-mood mental disorder, clinical need for immediate response, rapid deterioration, female patient considering pregnancy

Medication Treatment

- Patients with moderate to severe symptoms, psychosis, elevated suicide or homicide risk need medication. Consider medication as initial therapy for mild MDD
- 65-70% of patients respond to the 1st antidepressant [A].
- Antidepressant effectiveness is generally comparable between and within classes [A]
- Selection of antidepressant depends on: [I, B]
  - Short/long term side effects
  - Safety, tolerability
  - Patient age, preference, convenience, concerns
Short Clinical Guidelines:
Major Depressive Disorder in Adults, Diagnosis and Management

- History of prior response of patient or family member to medication
- Concurrent medical illness
- Concomitant non-psychotropic medications (potential drug to drug interactions)
- Likelihood of adherence based on history
- Cost of medication

- Education (i.e. expected duration, side effects) may reduce premature discontinuation
- In patients > 65 years old, use lower doses of antidepressants and avoid TCAs
- Caution: Screen for bipolar disorder/family history, as 30-50% of patients with bipolar disorder will develop acute mania when started on antidepressant medication
- MAOIs: reserve for patients who do not respond to other drugs

Consideration for Psychotherapy
- Consider psychotherapy as alternative to medication for patients with mild depression [I, A], or with preference for non-pharmacological therapy
  - If no response in 6 weeks, or partial response in 12, consider medications
- Consider psychotherapy, in addition to medication, for persons with:
  - Depressive episode of 2+ years
  - History of 2+ episodes of MDD with poor inter-episode recovery
  - History of partial response to previous trials of drugs or psychotherapy
  - Prominent psychosocial issues
  - History of treatment adherence problems
  - Personality disorder

Repeat Evaluations during months 1-3
- Monitor initial acute treatment every 1-2 weeks (e.g. response, side effects, psychosocial supports, suicidal/homicidal tendencies) [D]
- By 6 weeks (or 4 weeks if severely ill):
  - If positive response – continue treatment at same dose
  - If partial or no symptomatic relief, reassess: diagnosis; adequacy of treatment; adequacy of medication dosage and adherence [I]
- Recommended options:
  - For partial or no response: Increase medication. Monitor response every 2 weeks
  - Switching antidepressant medication is preferred to adding a 2nd drug to 1st and should not be attempted until there has been an adequate trial of 1st drug
  - Augmentation with agents such as lithium, thyroid hormone (particularly in women), stimulants, atypical neuroleptics or anticonvulsants
  - Addition of psychotherapy
- If symptoms persist, do not change medication – re-evaluate at week 12
- Referral to Psychiatrist – consider if: fails 2 or more medication trials (treatment refractory depression); symptoms are intense, prolonged, or severely melancholic; marked functional impairment; psychotic symptoms present; suicide/homicide risk persists or emerges. (Elderly – highest risk for suicide of all age groups)

Adapted from United Healthcare Guidelines by the Riverside Physician Network Medical Practice Committee

Effective date: December, 2006
# Short Clinical Guidelines:
## Major Depressive Disorder in Adults, Diagnosis and Management

### Stage II

**Duration:** 4-9 months, after remission achieved  
**Goal:** Preserve remission; Prevent Relapse

- Evaluate every 1-3 months  
- Dosage remains the same for 4-9 months after achieving full remission [A]  
- For those with previous episode(s), continue treatment for at least 9 months  
- Consider psychotherapy to help prevent relapse  
- Educate patient and support system that symptoms can recur  
- Patients at low risk of relapse (MDD with 1 episode) should be considered for discontinuation with tapering and with careful monitoring for relapse

### Stage III

**Duration:** Indefinite (depends on frequency and severity of prior episodes)  
**Goal:** Prevent new episode. Protect susceptible Patients against recurrence

- Consider maintenance therapy to prevent relapse. 50-85% of patients with single episode of MDD will have at least one more episode, usually  
- Recommended for patients at high risk (2+ episodes of MDD, psychotic depression, 1st onset at age < 20 or age > 65, persistent residual symptoms, suicidality) [B]  
- Evaluate every 2-3 months, or more frequently as required  
- In general, continue same treatment that was effective in prior phases [II]  
- Although further trials needed to establish optimum length of therapy, consider:  
  - After 2nd episode (80% risk of recurrence), up to 3 years of therapy  
  - After 3rd episode (90% risk of recurrence), continue therapy indefinitely  
- Educate patient that symptoms can recur  
- Consultation with a psychiatrist – consider for patients needing maintenance therapy  
- When discontinuing active therapy, base decision on: probability of recurrence; frequency/severity of past episodes, persistence of dysthmic symptoms, presence of comorbid conditions, patient preference [I]  
- When discontinuing, taper drug over several weeks
# Short Clinical Guidelines: Major Depressive Disorder in Adults, Diagnosis and Management

<table>
<thead>
<tr>
<th>Level of Evidence</th>
<th>APA 2000</th>
<th>UMHS 1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>I=</td>
<td>Recommended with substantial clinical confidence</td>
<td>A= randomized controlled trials</td>
</tr>
<tr>
<td>II=</td>
<td>Recommended with moderate clinical confidence</td>
<td>B= controlled trials, no randomization</td>
</tr>
<tr>
<td>III=</td>
<td>May be recommended on the basis of individual circumstances</td>
<td>C= observational trials</td>
</tr>
<tr>
<td></td>
<td></td>
<td>D= opinion of expert panel</td>
</tr>
</tbody>
</table>

**NOTE:** This guideline is intended to provide information to aid health care providers and it is not a substitute for clinical judgment in treating individual patients. It is subject to updating, pending the release and review of additional data, based upon changes in scientific knowledge and technology.