Depression & Anxiety

Presenting Problem:

A participating PCP emailed a consultation request to WI CPCP regarding a 14-year-old male patient with anxiety and depression. Past records indicate he was previously prescribed fluoxetine 10mg q am and then citalopram 10mg q am, taking each for 2-3 weeks. His parent stated, "Neither of those worked." The PCP placed a referral to start Cognitive Behavioral Therapy (CBT) and requests input on how to proceed regarding medication intervention.

Consultant's Response:

1. Request **rating scales** to be completed to gather information on current target symptoms:
    a. Patient Health Questionnaire-9 (PHQ-9) for depression.
        i. PHQ-9 Scoring and Interpretation Guide
    b. Screen for Child Anxiety Related Disorders (SCARED) for five types of anxiety.
        i. SCARED Rating Scale Scoring Aide
    c. When the patient is unsure whether or not the symptoms have improved, consider repeating the PHQ-9 and SCARED to determine whether *some* symptoms have improved. Records of past ratings scales can guide potential interventions.
2. M**edication** options for depression and/or anxiety:
    a. Mild symptoms - psychotherapy, *without medication,* is the first recommendation.
    b. *Moderate-to-severe* depression and/or anxiety - medication may be started along with psychotherapy.
        i. Start with **FDA-approved options** for the disorder and the patient's age group. Options that meet at least one of those criteria.
            1. Depression:
                a. Fluoxetine age 8(+)
                b. Escitalopram age 13 (+)
            2. Generalized Anxiety Disorder (GAD):
                a. Duloxetine age 7(+)
            3. Obsessive Compulsive Disorder (OCD):
                a. Fluoxetine age 7(+)
                b. Sertraline age 6(+)
                c. Fluvoxamine age 8(+)
                d. Clomipramine age 10(+) - Rarely used tricyclic antidepressant, with a higher potential side effect profile than SSRIs.
            4. Everything else is 'off-label' but may still fall within standard of care.
3. Before considering other options, it is recommended to first have two full failed trials of at least two SSRIs:
    a. For at least four weeks at the maximum recommended dose without notable benefit.
        1. For fluoxetine - 20mg/day for at least four weeks. Higher doses are often needed, especially to target anxiety.

        a. If treating both anxiety and depression, trial until there is no benefit after taking 40mg/day for at least four weeks before it is considered a full failed trial.
    ii. For the patient described, returning to fluoxetine and finishing the full trial would be reasonable.
    iii. If the patient refuses to start back on fluoxetine, consider escitalopram or sertraline.
b. **Note**: For intolerable side effects, cut an SSRI trial 'short' at a dose lower than the maximum recommended dose and recommend trying at least one more SSRI.

4. If two or more full failed trials of SSRIs, consider moving to a trial of an anti-depressant/anti-anxiety medication with a different mechanism of action.
    a. When treating *depression alone*, consider a serotonin and norepinephrine reuptake inhibitor (SNRI) or bupropion (Wellbutrin), a norepinephrine and dopamine reuptake inhibitor (NDRI).
    b. When treating *GAD*, consider duloxetine (Cymbalta) an SNRI.
    c. When treating *anxiety and depression*, consider an SNRI:
        i. Venlafaxine ER (Effexor XR) - used 'off-label' in patients under 18, but can be the third- or fourth-line in treatment options for teens.
            1. Max dose: 225 mg/day is usual in adult patients.
        ii. Duloxetine (Cymbalta) - FDA-approved to treat GAD in kids 7 years old (+).
            1. Note: this may not be any more effective than an SSRI. However, it can help treat depression and is considered 'off-label' for this purpose.
            2. Max dose: 120 mg/day - there is no evidence that doses greater than 60 mg per day confer additional benefit.

<u>Teaching Points</u>

1. Patients commonly report past trials of medication "didn't work," but this may be due to a low dose or inadequate length of time. Gather history from past records to help clarify whether these were truly failed trials before considering moving to 'off-label' options.
2. When starting a psychotropic medication, it is important to gauge the ongoing need by outlining details of the titration plan and recommended timeframe to stay on it before tapering off.
    a. When prescribing SSRIs for depression or anxiety, start at a low dose with the plan to increase the dose every two-to-three weeks or as needed and as tolerated until reach the maximum recommended dose.
        i. Without this **explicit plan for titration**, many patients take the starting dose for a few days and then stop or continue with the starting dose *for months* without benefit.
    b. Once the target symptoms are under good control, it is recommended that patients **continue that medication dose** for at least 6 months (when treating depression) to 12 months (when treating anxiety) in effort to prevent relapse of symptoms. Then, a gradual taper off to gauge ongoing need with close monitoring for symptom recurrence.
    c. Without this **explicit plan for discontinuation**, many patients stop the medication after a few months of feeling better and then relapse or continue the medication for years after symptoms have cleared without ever attempting a trial without medications.