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GUIDELINES FOR THE TREATMENT OF DEPRESSION IN ADULTS

Medication is not first line treatment or the only treatment for depression. It should be considered as part of a stepped care approach in the management of depressive disorders. It may be used in combination with psychological therapies, for example – Cognitive Behavioural Therapy (CBT) or Interpersonal Therapy (IPT).

The most current NICE guidance should be consulted wherever possible to obtain the most up to date information. (CG90 – Depression in adults – recognition and management (October 2009) and CG91 - Depression in adults with chronic physical health problem: recognition and management (October 2009).

Medication should be considered where :

- there is a past history of moderate to severe depression,
- initial presentation of subthreshold depressive symptoms that have been present for a long time (two years or more),
- Subthreshold depressive symptoms or mild depression that persists after other interventions,
- Mild depression that complicates the care of a chronic physical health problem.

When depression is accompanied by symptoms of anxiety, the first priority should usually be to treat the depression. When the person has an anxiety disorder and comorbid depression or depressive symptoms, consider treating the anxiety disorder first (since effective treatment of the anxiety disorder will often improve the depression or the depressive symptoms).

First choice antidepressant should normally be an SSRI in a generic form because SSRIs are equally effective as other antidepressants and have a favourable risk–benefit ratio. Citalopram and sertraline are recommended first line as they are associated with fewer drug interactions than fluoxetine, fluvoxamine and paroxetine. Paroxetine also has a higher incidence of discontinuation symptoms.

SSRIs are associated with an increased risk of bleeding, especially in older people or in people taking other drugs that have the potential to damage the gastrointestinal mucosa or interfere with clotting. In particular, consider prescribing a gastroprotective drug in older people who are taking non-steroidal anti-inflammatory drugs (NSAIDs) or aspirin.

Second choice would usually be fluoxetine or a different SSRI or mirtazapine if patient has significant loss of appetite or severe insomnia.

Third choice would be antidepressant of a different class such as venlafaxine (caution in patients with cardiac history), tricyclic antidepressant (TCA) - least cardiotoxic is lofepramine, trazodone, agomelatine or vortioxetine. *(Vortioxetine is recommended by NICE as an option for treating major depressive episodes in adults whose condition has responded inadequately to two antidepressants within the current episode.)*

Refractory depression – consider combining or augmenting an antidepressant with: lithium an antipsychotic such as aripiprazole, olanzapine, quetiapine or risperidone or another antidepressant such as mirtazapine.

Vortioxetine is recommended as an option for treating major depressive episodes in adults whose condition has responded inadequately to two antidepressants within the current episode (specialist prescribing only).

REFERENCES/BIBLIOGRAPHY

NICE Guidance CG90 Depression in Adults, Recognition and Management (October 2009)

NICE Guidance CG91 Depression in Adults with Chronic Physical Health Problems: Recognition and Management (October 2009)

NEP Traffic Lights for the Prescribing of Psychotropics

http://intranep/TeamCentre/pharm/PublishedDocuments/Traffic%20Lights%20for%20the%20prescribing%20of%20psychotropics%20updated%20Feb%202016.pdf

APPENDIX 1

Suggested Depression Treatment plan

Mild depression – generally antidepressant drugs not recommended – offer if simpler methods, such as lifestyle advice, guided self-help or exercise have failed.

Discuss medication and treatment options with the patient before prescribing, including side effects and risk of suicidal thoughts during onset of treatment, discontinuation effects, give written information where appropriate.

When switching be aware of interactions between antidepressants and the risk of serotonin syndrome

1st Line – in moderate to severe depression. Use a generic form of an SSRI

Citalopram or Sertraline are often first choice for most patients. Titrate to therapeutic doses. Assess efficacy over 3-4 weeks. If effective continue for at least 6 months at full treatment dose after remission of symptoms . Consider longer-term treatment in recurrent depression (see below)

2nd line – choose a different generic SSRI, or mirtazapine

Ensure a recognised therapeutic dose is used. Assess efficacy over 3-4 weeks. If effective continue for at least 6 months at full treatment dose after remission of symptoms. Consider longer-term treatment in recurrent depression (see below)

3rd line – mirtazapine, escitalopram*, an SNRI e.g Venlafaxine (up to 300mg) or duloxetine, tricyclic antidepressants (TCAs) or trazodone, agomelatine, vortioxetine*. (Consider augmentation therapy if severe)

Ensure a recognised therapeutic dose is used. Assess efficacy over 3-4 weeks. If effective continue for at least 6 months at full treatment dose after remission of symptoms. Consider longer-term treatment in recurrent depression (see below)

Choice of treatments in refractory depression. To be considered if standard treatment has failed.

Augment one antidepressant with another. Some evidence for SSRIs plus mirtazapine and venlafaxine plus mirtazapine. Caution re serotonin syndrome

or

Other augmentation strategies, e.g. lithium, CBT, atypical antipsychotics, liothyronine

or

Venlafaxine up to 375mg. Treatment should only be implemented by specialist practitioners for those requiring doses of 300mg or above.

Recurrent depression: Continue maintenance therapy for at least two years and longer in some cases. Consider use of psychological therapies

Psychotic depression: Usually augment with an antipsychotic. ECT is effective and maybe protective against a relapse.

Atypical depression: Consider phenelzine (MAOI) if failed to respond to alternatives. Care with side effects and dietary restrictions. Stabilise, provide information to GP on co-prescribing risks and on dietary advice before asking them to prescribe

* Please check with your local CCG traffic light formulary for prescribing advice and responsibility