PSYCHIATRIC MANAGEMENT IN PRIMARY CARE

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Areas to cover

- Mood Disorders
- Anxiety Disorders
- Miscellaneous Conditions

Objectives

- 1. Practical tips in managing them in Primary Care.
- 2. When to refer.
- 3. Overview of National Guidelines.

MOOD DISORDERS

Diagnosis-ICD 10-Depression

Key Symptoms (must have at least 2 of these)

- Low mood
- Anhedonia
- Fatigue

Other Symptoms

- Disturbed sleep
- Poor appetite
- Poor concentration
- Reduced self esteem and self confidence
- Ideas of guilt, worthless
- Ideas of self harm or suicide
- Psychomotor agitation or retardation

Duration

2 weeks

Degree- *Number, Severity*

- **Mild**= 4 symptoms
- **Mod**= 5-6
- **Sev=** 7+ (with or without psychosis)

Treatment Approach

- Bio
- Psycho
- Social

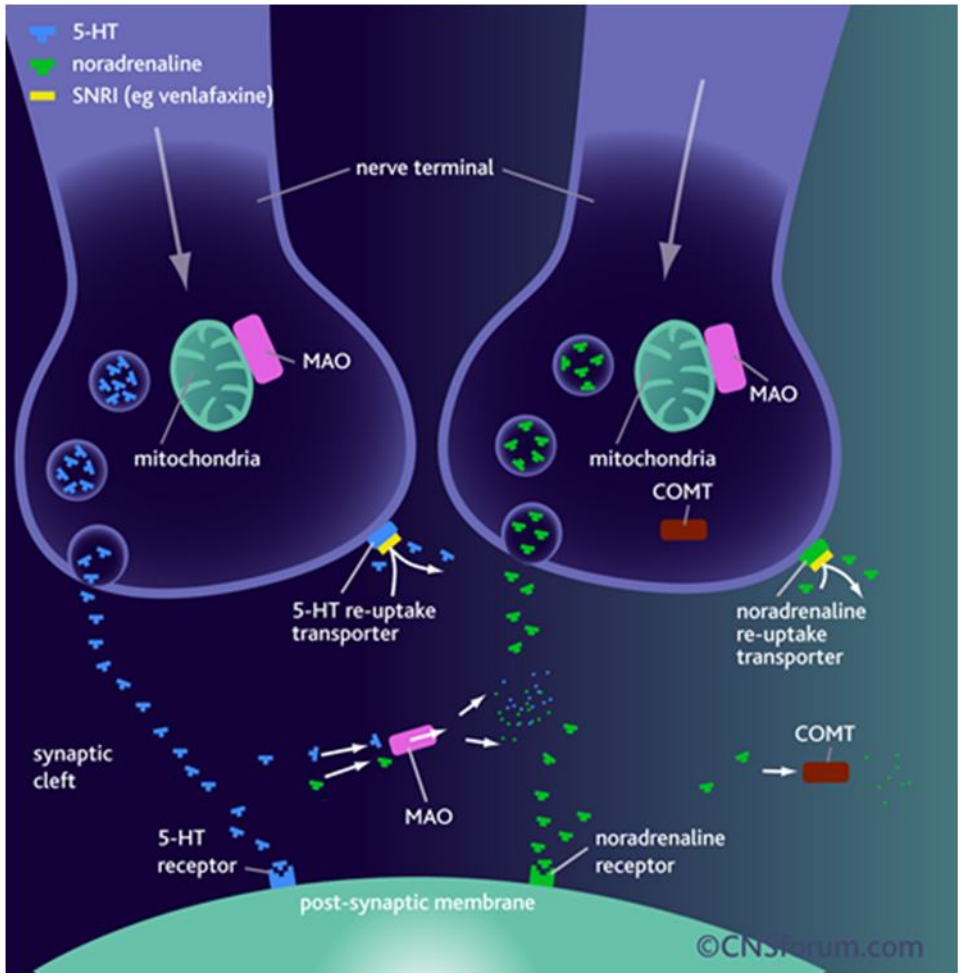
Stepped-care model -NICE

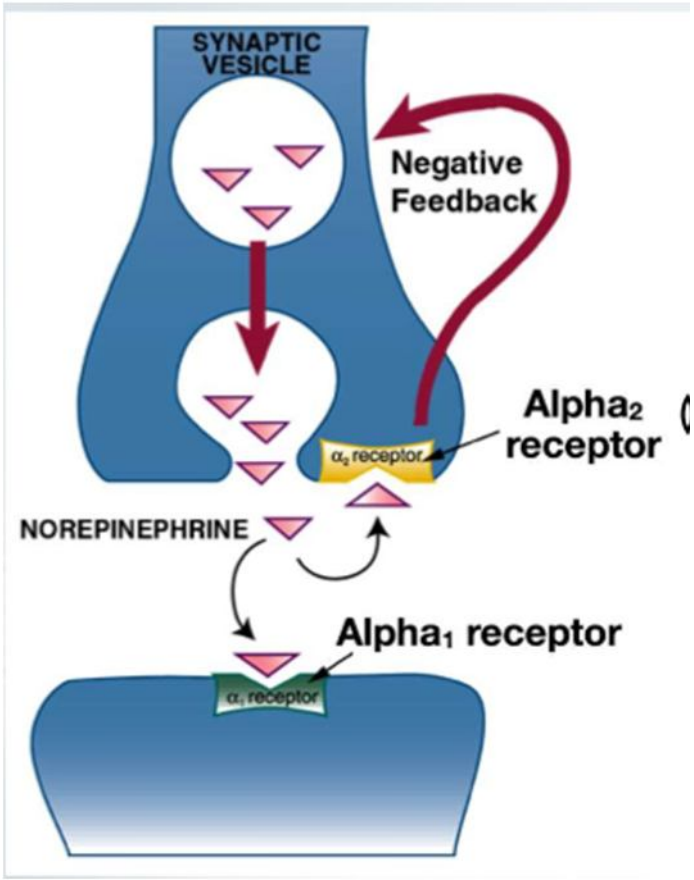
Focus of the intervention	Nature of the intervention
STEP 4: Severe and complex[a] depression; risk to life; severe self-neglect	**Medication, high-intensity** psychological interventions, **ECT**, **crisis service**, combined treatments, multiprofessional and **inpatient care**
STEP 3: Persistent subthreshold depressive symptoms **or mild to moderate depression with inadequate response** to initial interventions; **moderate and severe depression**	**Medication, high-intensity** psychological interventions, combined treatments, collaborative care and referral for further assessment and interventions
STEP 2: Persistent subthreshold depressive symptoms; **mild to moderate** depression	**Low-**intensity psychosocial interventions, psychological interventions, **medication** and referral for further assessment and interventions
STEP 1: All known and suspected presentations of depression	Assessment, support, psychoeducation, active monitoring and referral for further assessment and interventions

[a] Complex depression includes depression that shows an inadequate response to multiple treatments, is complicated by psychotic symptoms, and/or is associated with significant psychiatric comorbidity or psychosocial factors.

How do AD work?

Increase levels of Serotonin & Noradrenaline




SYNAPTIC VESICLE
Negative Feedback
Alpha2 receptor
α2 receptor
NOREPINEPHRINE
Alpha1 receptor
α1 receptor

Types of AD

- **SSRI-** Fluoxetine, Citalopram, Sertraline
- **SNRI-** Duloxetine, Venlafaxine
- **NRI-** Roboxetine
- **TCA-** Amitriptyline, Dosulepin
- **Other-**Mirtazapine

Anti Depressants

"Do not use antidepressants routinely to treat persistent subthreshold depressive symptoms or mild depression because the risk–benefit ratio is poor". **NICE**

- **1st Line:**
- SSRI

- **No effect/poorly tolerated:**
  Another SSRI or different Class

AD-Swapping & Stopping [5,6]

- When changing from one antidepressant to another, abrupt withdrawal should usually be avoided.
- Cross-tapering is preferred, in which the dose of the ineffective or poorly tolerated drug is slowly reduced while the new drug is slowly introduced.
- In some cases cross-tapering may not be considered necessary. An example is when switching from one SSRI to another.
- Potential dangers of simultaneously administering two antidepressants include pharmacodynamic interactions (serotonin syndrome, hypotension, drowsiness) and pharmacokinetic interactions (e.g. elevation of tricyclic plasma levels by some SSRIs).

changing from	to tricyclics	to citalopram/escitalopram	to fluoxetine	to paroxetine	to sertraline	to venlafaxine	to mirtazapine
tricyclics (TCA)	cross taper cautiously	halve dose and add citalopram (or escitalopram) then slow withdrawal	halve dose and add fluoxetine then slow withdrawal	halve dose and add paroxetine then slow withdrawal	halve dose and add sertraline then slow withdrawal	cross taper cautiously starting with 37.5 mg per day	cautious cross-tapering recommended (4)
citalopram/escitalopram	cross taper cautiously		withdraw citalopram (escitalopram) then start fluoxetine	withdraw citalopram (escitalopram) and then start paroxetine at 10 mg per day	withdraw citalopram (escitalopram) and then start sertraline at 25 mg per day	withdraw and then start venlafaxine at 37.5 mg per day. Increase very slowly	cautious cross-tapering recommended (4)
fluoxetine	stop fluoxetine. Start tricyclic at very low dose and increase very slowly	stop fluoxetine. Wait 4-7 days; start citalopram at 10mg per day (or escitalopram 5mg per day) and increase slowly		stop fluoxetine. Wait 4-7 days; start paroxetine at 10mg per day and increase slowly	stop fluoxetine. Wait 4-7 days; start sertraline at 25 mg per day and increase slowly	stop fluoxetine. Wait 4-7 days; start venlafaxine at 37.5 mg per day. Increase very slowly	cautious cross-tapering recommended, start mirtazapine at 15mg daily (4)
paroxetine	cross taper cautiously with very low dose of tricyclic	withdraw paroxetine then start citalopram 10mg per day (or escitalopram 5mg per day)	withdraw paroxetine then start fluoxetine		withdraw paroxetine then start sertraline at 25 mg per day	withdraw paroxetine. Start venlafaxine at 37.5 mg per day. Increase very slowly	cautious cross-tapering recommended (4)

sertraline	**cross taper cautiously with very low dose of tricyclic**	**withdraw sertraline then start citalopram 10mg per day (or escitalopram 5mg per day)**	**withdraw sertraline then start fluoxetine**	**withdraw sertraline then start paroxetine 10mg per day**		**withdraw sertraline then start venlafaxine at 37.5 mg per day**	**cautious cross-tapering recommended (4)**
venlafaxine	cross taper cautiously with very low dose of tricycli	cross taper cautiously. Start with citalopram 10 mg per day (or escitalopram 5mg per day)	crosss taper cautiously. Start with 20 mg every other day	cross taper cautiously. Start with 10 mg per day.	cross taper cautiously. Start with 25 mg per day		cautious cross-tapering recommended (4)
mirtazapine	cautious cross-tapering recommended, using very low starting dose for tricyclic (4)	cautious cross-tapering recommended (4)	cautious cross-tapering recommended (4)	cautious cross-tapering recommended (4)	cautious cross-tapering recommended (4)	cautious cross-tapering recommended (4)	
stopping/with drawing of particular antidepressants	**ticyclics** reduce over four weeks (4)	**citalopram/escitalopram** reduce over one to four weeks (4)	**fluoxetine** at 20mg per day - just stop at 40 mg per day, reduce over four weeks	**paroxetine** reduce over four weeks, or longer if necessary *	**sertraline** reduce dose gradually over one to four weeks (4)	**venlafaxine** reduce over four weeks or longer if necessary (2,4)	**mirtazapine** reduce dose gradually over 4 weeks (4)

Clinical Scenarios

- 32 years old male with moderate depression has tried fluoxetine 20mg od as first anti depressant for 4 weeks and there has been no improvement.

- What is the next best step?

- 1) Wait for another 2-4 weeks for response.
- 2) Increase the dose.
- 3) Try a different AD.

Response time for AD?

- “It is widely held that AD do not exert their effect for 2-4 weeks. This is a myth.

- All AD show a pattern of response where the rate of improvement is *highest during weeks 1-2* and *lowest during weeks 4-6”*.

The Maudsley Prescribing Guidelines, 12th edition-page-233

British Assoc Psychopharmacology

- Lack of significant improvement after 2-4 weeks treatment reduces the probability of eventual sustained response.

After 4 weeks adequate treatment:

- if there is at least *some* improvement continue treatment with the same AD for another 2-4 weeks.
- if there is *no* trajectory of improvement undertake a next step (higher dose or different AD)

After 6-8 weeks adequate treatment:

- if there is *moderate or greater* improvement continue same treatment.
- if there is *minimal* improvement undertake a next step (higher dose or different AD)

Clinical Scenario

- 40 years old female with moderate depression did not respond to citalopram. Has been now treated with fluoxetine 40mg for 4 weeks and there is no response.

- What is the next best step?

- Increase dose of fluoxetine to 60mg.
- Change to different class of AD.

Evidence of high dose SSRI in Major Depression

- High dose AD treatment for patients refractory to medium dose is not recommended for SSRI. [2]

Clinical Scenario

- 35 years old lady, has been feeling low for 8 wks, following change of role at work. She took this change as a “failure” and developed feeling of worthlessness. She started making mistakes at work and was experiencing occasional thoughts of life is not worth living, but did not made any attempts to end her life and continued to work. She is able still to complete her household chores , but does get easily tired and is struggling to look after her 6 years old son.

- She was prescribed fluoxetine 20mg od, which she stopped after 1 week due to side effects of nausea.

- What is your diagnosis and management plan?

Clinical Scenario

- 60 years old female patient, on Haloperidol for Schizophrenia, presents with major depression.

- Which AD's are contraindicated?

Clinical Scenario

- 60 years old female, with history of IHD, is currently on erythromycin, presents with major depression.

- Which AD's are contraindicated?

Clinical Scenario

- 50 years old female patient, on ritonavir (anti retroviral), presents with major depression.

- Which AD’s are contraindicated?

Clinical scenario

- 25 years old female presents to you with low mood, suicidal thoughts and intense feeling of worthlessness after splitting up with her boyfriend of 3 months. During consultation she was very emotional and hopeless. She reports to you that she has tried several anti depressants in the past without much benefit.

- What is your management plan?

DM & Depression

- 55 years old diabetic, female with history of major depression and poor response to x2 SSRI.

- Which AD should be avoided ?

HTN & Depression

- 55 years old male with Hypertension, history of major depression and poor response to x2 SSRI.

- Which AD should be avoided?

Average duration between onset and diagnosis of BPAD?

- *6 years:*
- *UNSW Australia and Italian study published in the Canadian Journal of Psychiatry, July 2016.The meta-analysis of 9,415 patients from 27 studies, the largest of its kind.*

- *Some studies have quoted up to 10 years.*

When to refer to Mental Health Services

- **NICE:** Referral to specialist mental health services should normally be for people with depression:

  who are at significant risk of self-harm,
- have psychotic symptoms,
- require complex multi-professional care, or
- where an expert opinion on treatment and management is needed.

- With history of mania and hyopmania

Anxiety Disorders

- GAD
- Panic Disorder
- PTSD
- OCD
- Social Phobia

- GAD, PD, OCD **(NICE):**
- Psychological therapy is more effective than pharmacological therapy and should be used as first line where possible.

- SSRI's & Venlafaxine across the range of Anxiety Disorders.

GAD 4

- Reassurance
- Anxiety Mx including relaxation training, exposure therapy
- CBT
- Exercise

GAD 4

- *Emergency Mx:*
- BZD (2-4 weeks)

- *First Line*
- SSRIs
- Venlafaxine
- Duloxetine
- Mirtazapine
- Pregabalin

- *Other:*
- Buspirone (negligible sedative, 4 wks of 10mg TDS)
- B- Blockers (somatic sx)
- Quetiapine

PD 4

- CBT
- Anxiety Mx including relaxation training
- Combination- not consistently better than pharmacological alone

Panic Disorders 4

- *Emergency Mx:*
- BZD (rapid effect, NICE does not recommend)

- *First Line*
- SSRIs

- *Other:*
- Venlafaxine
- Mirtazapine
- TCA (imipramine, clomipramine)

PTSD 4

- Debriefing
- Counselling
- Anxiety Mx
- CBT
- EMDR

PTSD 4

- *Emergency Mx:*
- Not usually appropiate

- *First Line*
- SSRIs

- *Other:*
- Mirtazapine
- Venlafaxine
- Duloxetine
- Clomipramine
- Anti psychotic (as augmentation)

OCD 4

- Exposure therapy
- Behavioural therapy
- CBT
- Combination- Most effective

OCD 4

- *Emergency Mx:*
- BZD (Not usually appropriate)

- *First Line*
- SSRIs
- Clomipramine

- *Other:*
- Citalopram with Clomipramine
- Anti Psychotic with AD
- Mirtazapine with AD (NICE)

Clinical scenario

- A 45 years old lady with a OCD of moderate severity, not keen on psychological therapy was prescribed fluoxetine 20mg od. She was followed up in 4 weeks time and there was no improvement.

- What will you do?

- Increase the dose *or*
- Change medication

Continue…

- The dose was increased to 40mg OD, she was followed up after 4 weeks and still reports no improvement.

- What will you do now ?

- Increase the dose *or*
- Change medication

Continue…

- She was trialled on Sertraline 50mg od for 4 weeks and still no improvement.

- What will you do now ?

- Increase the dose *or*
- Change medication

Continue…

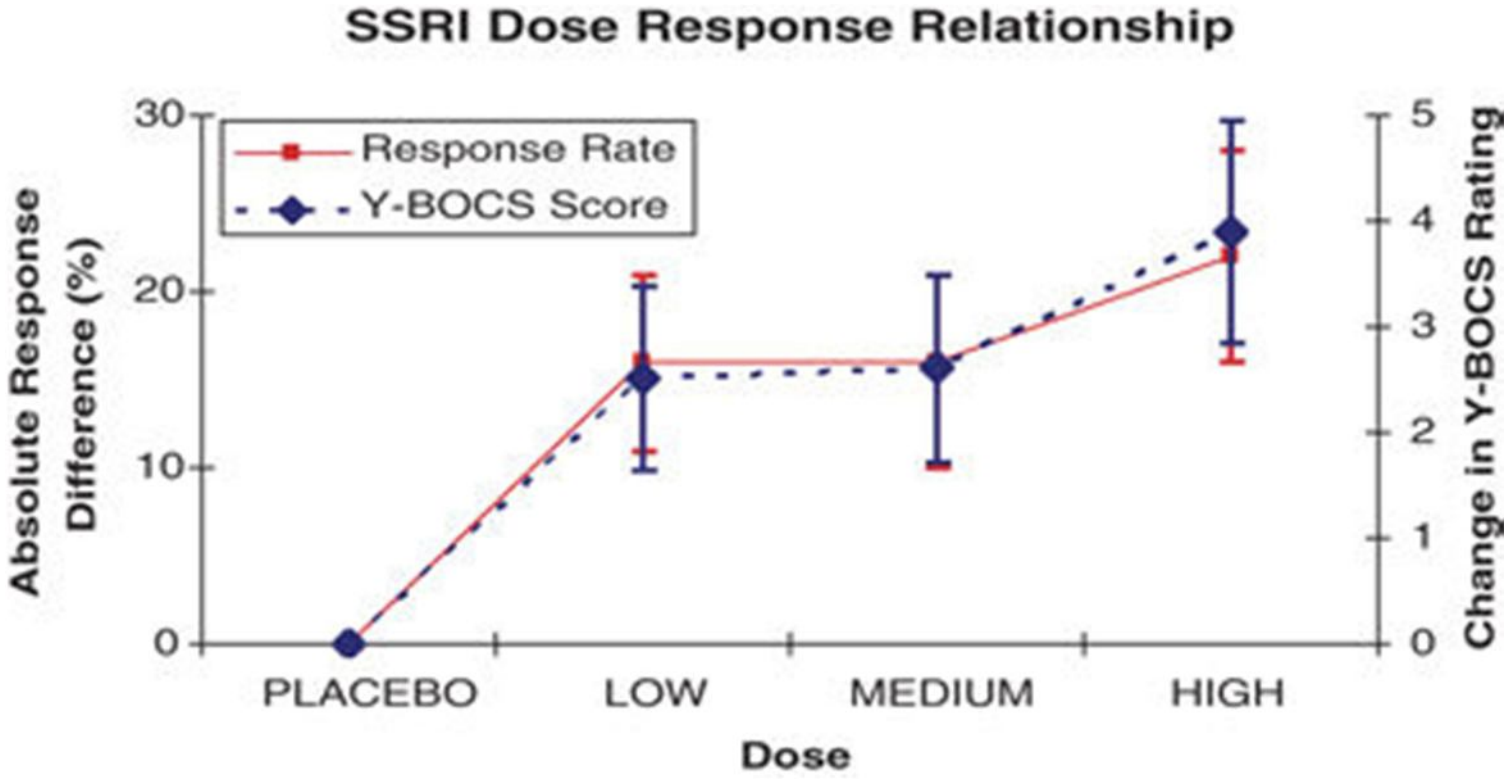
- Sertraline was gradually increased to 200mg od over 10 week period and there was not any significant improvement.

- What will you do now?

- Change medication.
- Wait longer
- Refer to Secondary Mental Health Services.

Dose response of SSRI in OCD

Compared with low or medium doses, high doses of SSRI were associated with improved treatment efficacy.[1]



- The American Psychiatric Association Practice Guidelines recommend higher target doses of SSRIs in the treatment of OCD than they do for depression. [3]

- High doses usually needed, at least 12wks for treatment response. [5]

Social Phobia 4

- CBT
- Exposure therapy
- Combination- More effective

Social Phobia 4

- *Emergency Mx:*
- BZD (PRN)

- *First Line*
- SSRIs
- Pregabalin
- Gabapentin

- *Other:*
- BZD with SSRI
- Propranolol (performance anxiety)
- Venlafaxine
- Olanzapine

Insomnia

- Difficulty in initiating and maintaining sleep.
- Symptom of underlying problem.

- Identify and Treat the cause.
- Emphasis on sleep hygiene

Sleep Hygiene

Avoid:

Excessive caffeine, alcohol, nicotine 3-6 hrs before bed.

Daytime nap.

TV/Ipad/Phones 1 hr before bed.

Strenuous exercise or mental activity near bed time.
Prolonged periods in bed if not asleep.

Promote:

Bedtime routine, comfortable environment, warm bath, light exercise.

BNF Listed

- ‘Z’: Zopiclone, Zolpidem
- BZD: Nitrazepam, Temazepam
- Anti Histamines: Promethazine (low abuse potential)
- Melatonin (Circadin 2mg, 55 and above, up to 13 wks)

Minimise Polypharamacy

- Stress Incontinence & Depression
- Duloxetine

- Diabetic Neuropathy & Depression
- Duloxetine

- Peripheral & Central Neuropathic Pain and GAD
- Pregabalin

- Seizures and GAD
- Pregabalin

- Insomnia and Depression
- Mirtazapine, TCA, Trazadone

Thank you

References

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- 6. GP Notebook