Chapter 33
Depression/Anxiety

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Introduction

Depression is the most common psychiatric disease worldwide in the general population with the lifetime risk being 13.23% (95% confidence interval, 12.64–13.81) [1]. It is almost twice as common in women as compared to men and more common in developed countries than the developing world [1, 2]. Depression is under recognized in the primary care setting as it presents with somatic symptoms (headache, back pain, chronic pain, etc.) in up to two-thirds of the affected patients [3]. Patients are not forthcoming about depressive symptoms unless asked directly, for various reasons including, but not limited to, fear of stigmatization, considering such symptoms to be their personal flaw rather than an illness, misconception that depressive symptoms can only be assessed by a psychiatrist, and concerns about being prescribed an antidepressant medication [4]. The comorbid state of depression with other chronic diseases incrementally worsens health when compared with depression alone, with

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any of the chronic diseases alone, and with any combination of chronic diseases without depression [5]. Patients with depression have an increased risk of mortality {1.81 (95% CI: 1.58–2.07)} [6].

Generalized anxiety disorder (GAD) is characterized by excessive and persistent worrying about everyday things and situations that is hard to control, causes significant distress or impairment, and occurs on more days than not for at least 6 months [7]. In the United States, the lifetime prevalence of GAD is about 5.1% [1]. The disorder is approximately twice as common in women as it is in men [1].

GAD frequently occurs in conjunction with either major depression or other anxiety disorders [8]. Patients with comorbid major depression and GAD tend to have a more severe and prolonged course of illness and greater functional impairment. The presence of comorbid major depressive episodes is associated with a poorer prognosis in patients with GAD [9].

Key History and Physical Exam and Differential Diagnoses

Depression may refer to a depressed state of mood in everyday language. A syndromic definition of depression looks to identify a set of specific symptoms to define a depressive disorder. The syndrome of major depressive disorder (MDD) as illustrated in Fig. 33.1 could be a consequence of one of the various disease states such as unipolar major depression, bipolar disorder, schizophrenia, substance/medication-induced depressive disorder, and depressive disorder due to another (general) medical condition [7].

Once the symptoms for depression (as listed in Fig. 33.1) have been evaluated, an assessment of the severity of impact on social, interpersonal, and occupational functionality should be carried out. In addition, clinicians should assess the duration of symptoms and inquire about previous manic or hypomanic symptoms/episodes. Patients should be asked

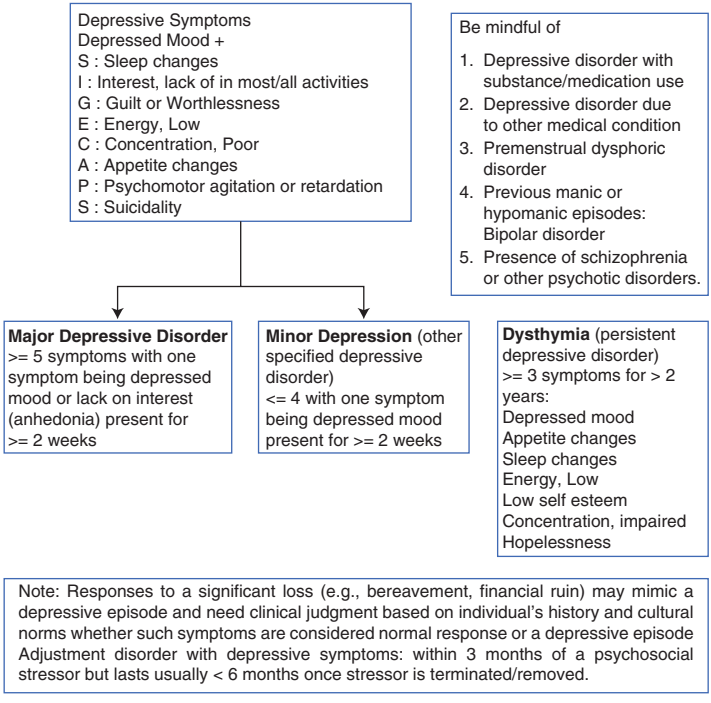

FIG. 33.1 Evaluation for syndrome of major depressive disorder

directly and specifically about any current or past suicidal ideation or thoughts. Patients reporting suicidal thoughts should be asked about specific plans, especially about access to firearms. Recent efforts in New Hampshire and elsewhere to promote temporary transfer of firearms out of the household of a suicidal person seem to be effective at preventing gun suicides [10]. General medical illnesses are present in ~70% of patients with MDD. Cardiovascular (hypertension, musculoskeletal (arthritis), and respiratory diseases (COPD) are more commonly associated with MDD although every organ system has been known to coexist with MDD [9]. The relationship between medical comorbidities and depression is bidirectional as is seen in case of obesity. Patients with

depression tend to be at an increased risk of becoming obese (odds ratio 1.6), and obese patients are at increased risk of being depressed (odds ratio 1.6) [11].

Although excessive and persistent worrying is the pathognomonic feature of GAD, the most common presenting symptoms are hyperarousal (poor sleep, fatigue, difficulty relaxing), autonomic hyperreactivity, and muscle tension (headache, neck, shoulder, and back pains). Although the worry is clearly excessive, the concerns involve the same areas of life (family and interpersonal relationships, work and finances, and health) as in non-anxious adults [12]. GAD typically has a gradual onset with subsyndromal anxiety common before the age of 20 years and eventual progression of anxiety in later years [13]. Because of the association of GAD with increased baseline heart rate, decreased heart rate variability and hypertension, there is a growing literature suggesting the association of GAD with development of coronary heart disease [14].

Patients with comorbid major depression and GAD tend to have a more severe and prolonged course of illness and greater functional impairment [15].

Treatment

The generalized anxiety disorder seven-item (GAD-7) scale can be used to screen for GAD in primary care, and it can also be used to monitor treatment response [16]. The Hospital Anxiety and Depression Scale (HADS) has the benefit of assessing and monitoring the severity of symptoms of both anxiety and depression [17]. An algorithm suggested for screening and treatment for GAD is presented in Fig. 33.2.

The US Preventive Services Task Force recommends screening all adults (age >18 years old) for depression at least once and using clinical judgment to determine whether to do additional screening for high-risk patients [18]. The PHQ-2 is a very brief, two-question instrument, which offers acceptable properties as screening tool; it should not, however, be con-

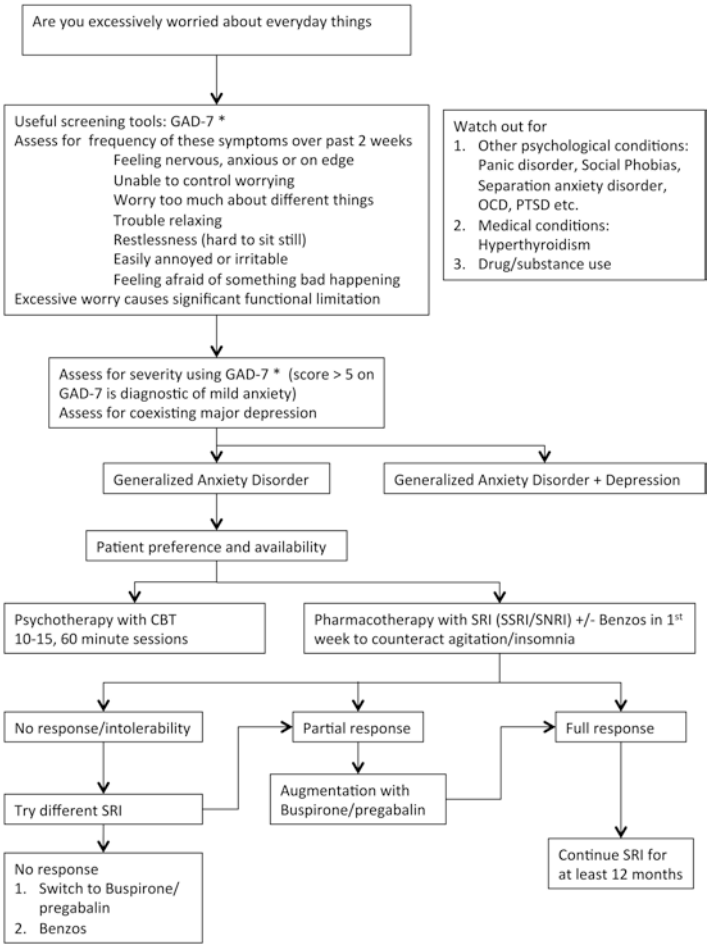

FIG. 33.2 Suggested algorithm for screening and management of generalized anxiety disorder. Reprinted with permission [23]

sidered adequate for diagnosis [19]. An algorithm for screening and treatment recommendations for major depressive disorder is shown in Fig. 33.3.

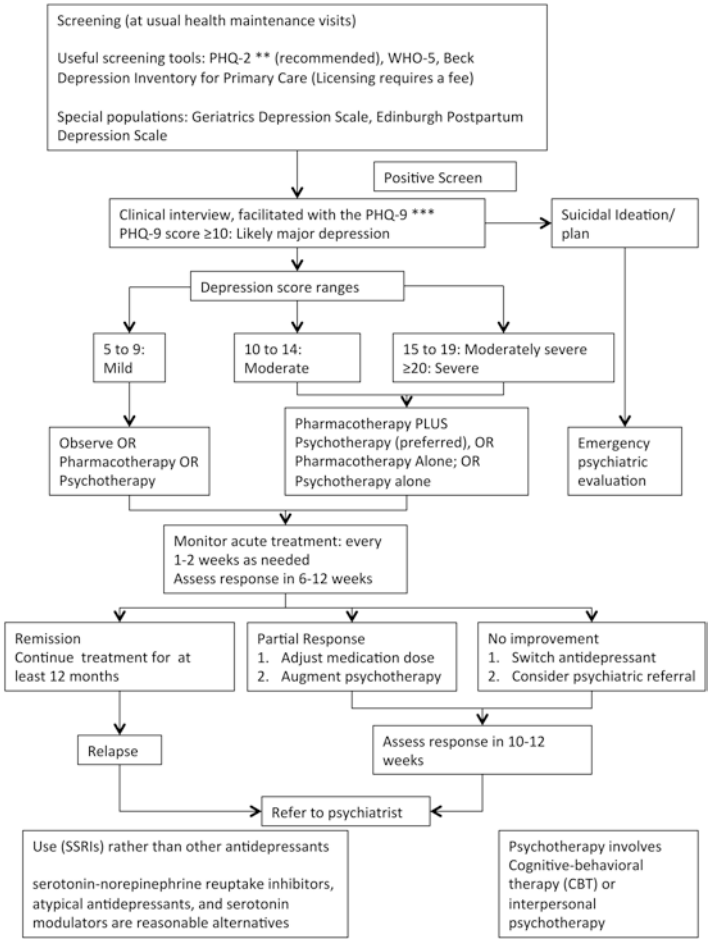

FIG. 33.3 Suggested algorithm for screening and management of major depressive disorder. Reprinted with permission [24, 25]

List of medication commonly prescribed for MDD, with their usual daily dosages and side effect profiles are listed in Table 33.1 [20].

TABLE 33.1 Commonly prescribed medications for major depressive disorder and their adverse effects

Name	Usual daily dose (mg/day)	Adverse effects
Selective serotonin reuptake inhibitors (SSRI)		
Escitalopram	10–20	Insomnia, orthostasis, QTc prolongation, GI disturbances, sexual dysfunction, weight gain
Fluoxetine	20–60	
Sertraline	50–200	
Serotonin-norepinephrine reuptake inhibitors (SNRI)		
Duloxetine	60–120	Insomnia, GI disturbances
Venlafaxine	75–375	Drowsiness, insomnia, QTc prolongation, GI disturbances, sexual dysfunction
Atypical antidepressants		
Bupropion	300	Insomnia, agitation, QTc prolongation, GI disturbances
Mirtazapine	15–45	Anticholinergic, drowsiness, QTc prolongation, weight gain, mild sexual dysfunction
Tricyclic antidepressants (TCA)		
Imipramine	150–350	Anticholinergic, drowsiness, orthostasis, QTc prolongation, GI disturbances, weight gain, sexual dysfunction
Monoamine oxidase inhibitors (MAO inhibitors)		
Selegiline	6–12 mg/24-h patch	Anticholinergic, insomnia, orthostasis

Primary GAD with secondary depressive symptoms can be difficult to distinguish from major depressive disorder or persistent depressive disorder (dysthymia), as the conditions share many features such as an insidious onset, protracted

course, prominent dysphoria, and anxiety symptoms. Broadly, individuals with depression tend to brood self-critically on previous events and circumstances, whereas patients with GAD tend to worry about possible future events. Symptoms of depression such as early morning awakening, diurnal variation in mood, and suicidal thoughts are all uncommon in GAD.

Clinical Challenges

Since patients may be reluctant to accept a diagnosis of anxiety or depression, it may be necessary to negotiate a way forward. Avoid focusing on disagreements about the diagnosis, but rather try to find ways to agree on treatment for the symptoms which are troubling to the patient [21]. In addressing these sometimes emotional subjects with patients, use empathy—the ability to understand the patient's situation, perspective, and feelings and to communicate that understanding to the patient [22]. Demonstrate empathy by using techniques like "active listening" to identify the patient's emotions, and assess the intensity of their feelings. Avoid offering false reassurances, sometimes the most important thing to a patient is the doctor's presence with them in the struggle [22].

Clinical Pearls

Depressed people may be more mindful of pain than non-depressed people. Treat depression first if the source or severity of pain is questionable.

Sleep problems and appetite changes are common in the elderly, so consider depression when hearing about these symptoms.

Don't Miss This!

Grieving and depression are similar early on. A patient with prolonged grieving should be evaluated for depression.

Hypothyroidism can masquerade as depression, especially in the elderly.

Always evaluate medications and drugs in a depressed patient.

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