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Diagnosing and Treating Depression

By: James L. Holly, MD

Depression disorders are very common. They cause significant disability, psychosocial impairment, increased health care utilization, morbidity and mortality. According to the Nation Comorbidity Survey, the lifetime prevalence of major depression in the general US population is 17.1% in women. The disability caused by depression is comparable with the degree of disability related to other chronic medical conditions such as hypertension, diabetes and arthritis.

Depressive disorders are frequently associated with significant and pervasive impairments in social functioning, causing enormous personal, social and economic burden. Furthermore, depression is associated with other illness as demonstrated by recent evidence that depression is a major risk factor for both the development of cardiovascular disease and death after an initial myocardial infarction.

Major depression is almost twice as likely to occur in women and has a peak age of onset between 20 and 40 years. Nonetheless, depression is widespread among the elderly as well. Depression in late life is a serious public health concern, and its associated with other illnesses is particularly problematic in older person. Depression is mort often a recurrent disorder.

Due to advances in psychopharmacologic treatment, depression is a highly treatable illness. However, there exists overwhelming evidence that individuals with depression are being seriously undertreated, causing substantial costs it individuals and society.

Diagnosing depression can sometimes be complicated because of the multitude of signs and symptoms with which the depressed patient can present. The initial presentation of clinically significant depression can include a broad range of symptoms, from somatic complaints (fatigue, insomnia, anorexia, or various nonspecific somatic symptoms) to emotional concerns (sadness, anxiety, or feelings of guilt) and other problems (difficulty at work, marital problems, irritability, or memory impairment).

Establish the Diagnosis

Major depression is a syndrome consisting of a group of signs and symptoms. A major depressive episode is defined as a 2-week period during which 5 of 9 symptoms are present, representing a change from previous functioning. These nine symptoms are:

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report or observation made by others.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
3. Significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day.
4. Insomnia or hypersomnia nearly every day
5. Psychomotor agitation or retardation nearly every day
6. Fatigue or loss of energy nearly every day
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day
9. Recurrent thoughts of death (not just fear of dying), a recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide.

The diagnosis of major depressive disorders refers to the presence of a major depressive episode, whereas dysthymic disorder indicates a syndrome of milder symptoms and protracted duration (at least 2 years).

There are several very good questionnaires which will help you and your health care provider determine if you have a depression and the degree of it. One of those is the Beck Depression Inventory (BDI). Southeast Texas Medical Associates has that questionnaire built into the electronic medical record system which is used to document your health needs. Ask your SETMA provider to complete a BDI on you the next time you are in the clinic.

Evaluation and Differential Diagnosis

Before making a diagnosis of major depressive disorder or dysthymic disorder, a search for medical causes of the depressive disorder should be conducted. Medical conditions physiologically associated with depression are:

Endocrine disorders

- Hypothyroidism
- Hyperthyroidism
- Parathyroid disorders
- Cushing's Syndrome

Neurologic Disorders

- Cerebrovascular accidents (strokes)
- Central nervous system lesions
- Neurosyphilis
- Multiple sclerosis
- Neurosarcoidosis
- CNS vasculitis
- HIV-associated CNS pathology

Other disorders

- Vitamin deficiencies (eg. folate and vitamin B12)
- Anemia
- Hypoxia (low blood oxygen)
- En-stage renal disease
- Systemic lupus erythematosus and other connective tissue disease
- Occult malignancy (eg. pancreatic cancer, ect..)

Additionally, a variety of substances of abuse can be causally implicated in the presentation of depression. These include alcohol sedatives, and cocaine. Health care provider causes of depression include antihypertensives that alter central biogenic amine pathways such as beta blockers, reserpine, methyldopa, guanethidine, clonidine), corticosteroids, antineoplatics, interferon-Alpha and, possibly, isotretinoin. Whether the depression is substance induced or caused by a general medical condition, the underlying cause should be treated, but if improvement in depressive symptoms fails to occur after approximately 4-6 weeks, the depression should be independently diagnosed and treated.

The distinction between unipolar depression (a major depressive episode in a a patient with no history of hypomania or mania) and bipolar depression (a major depressive episode in a a patient with a history of hypomania or mania) is of vital importance and significantly affects decisions involved in treatment planning.

Symptoms of hypomania and mania include elevated, expansive or irritable mood, inflated self-esteem or grandiosity, decreased need for sleep, flight of ideas or racing thoughts, distractibility increase in goal-directed activity, pressured speech, and excessive involvement in pleasurable activities.

Patients with bipolar depression are more likely to experience a switch to hypomania or mania or an acceleration in cycling during treatment with an antidepressant in the absence of concomitant treatment with a mood stabilizer. Family history of unipolar and bipolar disorders should also b reviewed. Women have an increased incidence of depression during times of hormonal change, including pregnancy and the postpartum period.

Goals of Treatment

The primary goal of treatment should be full remission of all depressive symptoms. Partial remission is not an acceptable outcome. The continuation and maintenance phrases are important aspects of treat, due to the risk of relapse and recurrence.

Treatment

The vast majority of cases of depression can be treated with selective serotonin reuptake inhibitors (SSRIs) and other newer antidepressant medications. The SSRIs are effective in treating depression and many primary anxiety disorders (obsessive-compulsive disorder, panic disorder, posttraumatic stress disorder, social phobia) and offer several important advantages. They require minimal dose titration, and the starting dose can sometimes be an effective dose. Perhaps most importantly, these medications are safe in overdose.

Summary

Depression is a prevalent disorder that commonly presents masked by nonspecific physical concerns (eg. headaches, pain, gastrointestinal distress) or problems other than a clearly expressed complaint of depressed mood. Evaluation of depressive symptoms consists of a thorough history and physical examination, mental status examination, and a laboratory and diagnostic workup to exclude medical causes or depression induced by prescribed or abused substances. Referral to a psychiatrist may be necessary in refractory, complex or severe cases.

Being depressed does not mean that you are weak and/or crazy. The only crazy thing about being depressed is not to get help. Talk to your family, your minister and then your health care provider. Get help as there is help for depression.

Remember, it is your life and it is your health.