**Depression: A Primary Care Approach**

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Depression is common in primary care practice. General internal medicine physicians should be comfortable managing a range of challenging depression scenarios. While most primary care doctors are comfortable initiating first line SSRI treatment, we may be less aware of the role of novel antidepressants and a rational approach to augmenting medication for treatment failures.

In this lecture, we will focus on 5 key questions:

1. Does screening for depression work?
2. How long to treat?
3. Are newer antidepressants more effective than SSRI's?
4. How do side effect profiles differ between drugs
5. Which is better: switching or augmenting?

Screening for depression is effective and is recommended by the U.S. Preventive Health Services Task force. Screening improves the detection of patients with depression and reduces morbidity due to depression. We will discuss two screening tools: the PHQ-9 and a simple 2 question tool with similar test characteristics. Both tools have low specificity. One must ask additional questions for screen positive patients to identify those with depression warranting treatment.

Response rates to most antidepressants are 50%, while approximately 30% of patients go into remission with treatment. These rates are similar across all classes of antidepressants. A common reason for relapse is to treat for too brief a period of time. In general, antidepressant therapy should be continued for at least 9-12 months before a taper and drug-free trial. The three treatment phases that we will discuss are acute treatment, continuation treatment, and maintenance treatment for selected patients.

Side effect profiles differ substantially between drug classes and are the primary factors to consider when selecting antidepressant drugs in primary care. Nausea, sweatiness, insomnia, and sexual side effects are particularly common for SSRI's. Citalopram can cause QT prolongation; the U.S. FDA has placed restrictions on its use to minimize this risk. Anticholinergic side effects are the main side effects of tricyclic antidepressants, including dry mouth, constipation, and sedation. Tricyclics are also the most lethal among the antidepressants when taken as a deliberate overdose attempt. Mirtazapine causes sedation, weight gain, and constipation, while bupropion is activating and can cause weight loss. Bupropion causes the least sexual side effects of all the antidepressants and can reverse sexual side effects due to SSRI's when used as an augmentation strategy. For some patients, a particular side effect may be desirable. For example, in a patient who has insomnia, a sedating antidepressant such as a tricyclic or mirtazapine would be desirable.

Switching and augmentation are both acceptable strategies to treatment failure with an SSRI. In general, one selects a drug with opposing side effect profiles when augmenting. Psychotherapy is another augmentation strategy, but it is less effective and takes longer to work than augmentation with a second medication.

Primary care physicians can care for most patients with depression. Reasons for referral to a psychiatrist include treatment failure with at least two different regimens, suicidality, bipolar disorder, psychotic features, dual diagnosis with alcohol or drug abuse, and for consideration of ECT in selected patients.