Depression: selective serotonin reuptake inhibitors

Selective serotonin reuptake inhibitors (SSRIs) are considered first-line treatment for the majority of patients with depression.

- citalopram and fluoxetine are currently the preferred SSRIs
- citalopram is useful for elderly patients as it is associated with lower risks of drug interactions
- sertraline is useful post myocardial infarction as there is more evidence for its safe use in this situation than other antidepressants
- SSRIs should be used with caution in children and adolescents. Fluoxetine is the drug of choice when an antidepressant is indicated

Adverse effects

- gastrointestinal symptoms are the most common side-effect
- there is an increased risk of gastrointestinal bleeding in patients taking SSRIs. A proton pump inhibitor should be prescribed if a patient is also taking a NSAID
- patients should be counselled to be vigilant for increased anxiety and agitation after starting a SSRI
- fluoxetine and paroxetine have a higher propensity for drug interactions
- citalopram and sertraline and more suitable for patients with chronic physical health problems as they have a lower propensity for drug interactions.

Interactions

- NSAIDs: NICE guidelines advise 'do not normally offer SSRIs', but if given co-prescribe a proton pump inhibitor
- warfarin / heparin: NICE guidelines recommend avoiding SSRIs and considering mirtazapine
- aspirin: see above
- triptans: avoid SSRIs

Following the initiation of antidepressant therapy patients should normally be reviewed by a doctor after 2 weeks. For patients under the age of 30 years or at increased risk of suicide they should be reviewed after 1 week. If a patient makes a good response to antidepressant therapy they should continue on treatment for at least 6 months after remission as this reduces the risk of relapse.

When stopping a SSRI the dose should be gradually reduced over a 4 week period (this is not necessary with fluoxetine). Paroxetine has a higher incidence of discontinuation symptoms.

Discontinuation symptoms

- increased mood change
- restlessness
- difficulty sleeping
- unsteadiness
- sweating
- gastrointestinal symptoms: pain, cramping, diarrhoea, vomiting
- paraesthesia

Lithium

Lithium is mood stabilising drug used most commonly prophylatically in bipolar disorder but also as an adjunct in refractory depression. It has a very narrow therapeutic range (0.4-1.0 mmol/L) and a long plasma half-life being excreted primarily by the kidneys.

Mechanism of action - not fully understood, two theories:

- interferes with inositol triphosphate formation
- interferes with cAMP formation

Adverse effects

- nausea/vomiting, diarrhoea
- fine tremor
- polyuria (secondary to nephrogenic diabetes insipidus)
- thyroid enlargement, may lead to hypothyroidism
- ECG: T wave flattening/inversion
- weight gain

Monitoring of patients on lithium therapy

- inadequate monitoring of patients taking lithium is common - NICE and the National Patient Safety Agency (NPSA) have issued guidance to try and address this. As a result it is often an exam hot topic
- lithium blood level should 'normally' be checked every 3 months. Levels should be taken 12 hours post-dose
- thyroid and renal function should be checked every 6 months
- patients should be issued with an information booklet, alert card and record book

Sectioning under the Mental Health Act

This is used for someone over the age of 16 years who will not be admitted voluntarily. Patients who are under the influence of alcohol or drugs are specifically excluded

Section 2

- admission for assessment for up to 28 days
- a GP, psychiatrist and approved social worker is required

Section 3

- admission for treatment for up to 6 months
- nearest relative or social worker along with 2 doctors

Section 4

- 72 hour assessment order
- used as an emergency, when a section 2 would involve an unacceptable delay

- a GP and an approved social worker or relative
- often changed to a section 2 upon arrival at hospital

Section 5(2)

- a patient who is a voluntary patient in hospital can be legally detained by a doctor for 72 hours

Section 5(4)

- similar to section 5(2), allows a nurse to detain a patient who is voluntarily in hospital for 6 hours

Section 135

- a court order can be obtained to allow the police to break into a property to remove a person to a Place of Safety

Section 136

- someone found in a public place who appears to have a mental disorder can be taken by the police to a Place of Safety

Depression: switching antidepressants

The following is based on the Clinical Knowledge Summaries depression guidelines, which in turn are based on the Maudsley hospital guidelines.

Switching from citalopram, escitalopram, sertraline, or paroxetine to another SSRI

- the first SSRI should be withdrawn* before the alternative SSRI is started

Switching from fluoxetine to another SSRI

- withdraw then leave a gap of 4-7 days (as it has a long half-life) before starting a low-dose of the alternative SSRI

Switching from a SSRI to a tricyclic antidepressant (TCA)

- cross-tapering is recommend (the current drug dose is reduced slowly, whilst the dose of the new drug is increased slowly)

- an exceptions is fluoxetine which should be withdrawn prior to TCAs being started

Switching from citalopram, escitalopram, sertraline, or paroxetine to venlafaxine

- cross-taper cautiously. Start venlafaxine 37.5 mg daily and increase very slowly

Switching from fluoxetine to venlafaxine

- withdraw and then start venlafaxine at 37.5 mg each day and increase very slowly

*this means gradually reduce the dose then stop

Depression: management of unresponsive, moderate and severe depression

NICE produced updated guidelines in 2009 on the management of depression in primary and secondary care. Patients are classified according to the severity of the depression and whether they have an underlying chronic physical health problem.

Please note that due to the length of the 'quick' reference guide the following is a summary and we would advise you follow the link for more detail.

Persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions, and moderate and severe depression

For these patients NICE recommends an antidepressant (normally a selective serotonin reuptake inhibitor, SSRI)

The following 'high-intensity psychological interventions' may be useful:

Individual CBT Delivery

- typically 16-20 sessions over 3-4 months
- consider 3-4 follow-up sessions over the next 3-6 months
- for moderate or severe depression, consider 2 sessions per week for the first 2-3 weeks

Interpersonal therapy (IPT) Delivery

- typically 16-20 sessions over 3-4 months
- for severe depression, consider 2 sessions per week for the first 2-3 weeks

Behavioural activation Delivery

- typically 16-20 sessions over 3-4 months
- consider 3-4 follow-up sessions over the next 3-6 months
- for moderate or severe depression, consider 2 sessions per week for the first 3-4 weeks

Behavioural couples therapy Delivery

- typically 15-20 sessions over 5-6 months

For people who decline the options above, consider:

- counselling for people with persistent subthreshold depressive symptoms or mild to moderate depression; offer 6-10 sessions over 8-12 weeks
- short-term psychodynamic psychotherapy for people with mild to moderate depression; offer 16-20 sessions over 4-6 months

For patients with chronic physical health problems the following should be offered:

- group-based CBT
- individual CBT

Post-traumatic stress disorder

Post-traumatic stress disorder (PTSD) can develop in people of any age following a traumatic event, for example a major disaster or childhood sexual abuse. It encompasses what became known as 'shell shock' following the first world war. One of the DSM-IV diagnostic criteria is that symptoms have been present for more than one month

Features

- re-experiencing: flashbacks, nightmares, repetitive and distressing intrusive images
- avoidance: avoiding people, situations or circumstances resembling or associated with the event
- hyperarousal: hypervigilance for threat, exaggerated startle response, sleep problems, irritability and difficulty concentrating
- emotional numbing - lack of ability to experience feelings, feeling detached

from other people

- depression
- drug or alcohol misuse
- anger
- unexplained physical symptoms

Management

- following a traumatic event single-session interventions (often referred to as debriefing) are not recommended
- watchful waiting may be used for mild symptoms lasting less than 4 weeks
- military personnel have access to treatment provided by the armed forces
- trauma-focused cognitive behavioural therapy (CBT) or eye movement desensitisation and reprocessing (EMDR) therapy may be used in more severe cases
- drug treatments for PTSD should not be used as a routine first-line treatment for adults. If drug treatment is used then paroxetine or mirtazapine are recommended