

ABSTRACT

Depressive disorder affects the quality of life, increases the economic burden from cost of treatment or loss of employment, and may lead to suicidal tendency. Depressive disorder is the commonest psychiatric problem in primary care practice. However, it is often undetected and the under-diagnosis is partly because the depressed person is preoccupied with physical complaints of pain or aches, this could mislead the attending doctor. The early symptoms of depressive disorder are low mood, loss of energy, anhedonia, poor sleep, poor appetite and loss of interest in work or activities (Table 1). These symptoms will be present daily and may affect quality of life.

SFP2010; 36(1): 19-21

INTRODUCTION

Transient feeling of sadness is a normal emotional reaction to any loss, e.g. financial crisis or bereavement. In depressive disorder, the emotional change is prolonged, profound and pervasive. People with mild depressive disorder can still continue vocational function, but those with moderate to severe disorder often manifest marked lethargy, poor concentration and inability to work. Depressive disorder affects the quality of life, increases the economic burden from cost of treatment or loss of employment, and may lead to suicidal tendency.

In the Singapore National Mental Health Survey (Fones, et al 1998)¹, the prevalence of depressive disorder in the adult population was estimated at 8% and in elderly people 7.5% (Kua, 1992)². Depressive disorder is the commonest psychiatric problem in primary care practice. However, it is often undetected and the under-diagnosis is partly because the depressed person is preoccupied with physical complaints of pain or aches, this could mislead the attending doctor.

Table 1: Symptoms of Depressive Disorder

Low mood
Loss of interest or pleasure in activities
Loss of confidence or self-esteem
Poor concentration
Pessimism
Sleep disturbance
Reduced energy or activity
Poor appetite
Social withdrawal
Recurrent suicidal thoughts

KUA EE HEOK, MBBS, MD, FRCPsych, PBM, Senior Consultant Psychiatrist, NUHS

HISTORY AND ASSESSMENT

The early symptoms of depressive disorder are low mood, loss of energy, anhedonia, poor sleep, poor appetite and loss of interest in work or activities (Table 1). These symptoms will be present daily and may affect quality of life.

In the history taking, it is important to explore predisposing factors such as a family history of depression and poor social skills or support. In the Singapore practice, precipitating problems are commonly family or work conflicts, recent bereavement and physical illness like cancer. It's equally important to assess possible problems which may perpetuate the depressive disorder, e.g. disturbed family background or difficult work relationship.

There is wisdom in investing some time to uncover any history of substance abuse including alcohol, smoking and illicit drugs. Some medications like steroids, levodopa and reserpine may trigger depression.

In the mental state examination, besides assessment of mood, it is crucial to elicit any suicidal ideation. Responses and thinking process will be slowed. There may be a sense of helplessness and hopelessness with guilt feelings. In severe depression, the patient may experience delusion of persecution and sometimes auditory hallucination.

All patients must be given a physical examination to exclude associated illness like hypothyroidism, Parkinson's disease, etc.

(For a more detailed assessment of depression, read 'Psychiatric interview', by Professors Goh Lee Gan / Kua Ee Heok, chapter 7 in Psychiatry for Doctors, 3rd edition. Armour Publishing, Singapore)

TREATMENT

In primary care setting, the treatment of depression is not just prescribing an antidepressant. There are psychological techniques - which should not take too much time - to encourage adherence or compliance in medication and conflict resolution.

In mild depression, psychological therapy will suffice. A low dose of benzodiazepine for sleep difficulty made be the only prescription necessary for a week. In moderate to severe depression when work and quality of life is very much affected, antidepressant treatment is needed.

A. Pharmacotherapy

1. Selective Serotonin Reuptake Inhibitors (SSRIs) have been widely used in the treatment of depressive disorder (Table 2). The common side effects of the SSRIs are nausea, somnolence, sedation, headache, and dizziness.

2. Tricyclic Antidepressants (TCAs) have been used for decades (Table 3). By blocking cholinergic muscarinic receptors, TCAs can cause dry mouth, constipation, urinary retention, sinus tachycardia and blurred vision. Through a blockade of histamine H1-receptors, TCAs can also produce sedation, increased appetite, weight gain and hypotension. Finally, by blocking α 1-adrenergic receptors, TCAs can cause postural hypotension, dizziness, tachycardia, and potentiation of the antihypertensive effect of drugs. TCAs are contraindicated in the treatment of patients with narrow-angle glaucoma and prostatic hypertrophy.

Most side effects tend to subside after a few weeks, particularly if dosage escalation has been slow and gradual. The side-effect profile of TCAs may be advantageous in the treatment of depressed patients with insomnia and weight loss.

Table 2. Selective Serotonin Reuptake Inhibitors (SSRIs)

Generic Name	Brand Name	Initial dose	Titrate dose up to
Fluoxetine	Prozac	10-20 mg/day	20-40 mg/day
Sertraline	Zoloft	50 mg/day	100-150 mg/day
Escitalopram	Lexapro	5-10 mg/day	20 mg/day
Fluvoxamine	Faverin	50-100 mg/day	150-200 mg/day

Table 3. Tricyclic Antidepressants (TCAs)

Generic Name	Brand Name	Initial dose	Titrate dose up to
Amitriptyline	Elaxil	25 mg tds	150-200 mg in divided doses
Clomipramine	Anafranil	25 mg tds	150-200 mg daily
Imipramine	Tofranil	25 mg tds	150-200 mg in divided doses

3. A number of atypical antidepressants (bupropion, mirtazapine) have been used in the treatment of depression. They are all relatively safe as they lack significant cardiac effects. Mirtazapine have significant antihistamine H1-receptor blocking activity which accounts for the sedation, drowsiness, increased appetite, and weight gain.

B. Psychological Therapy

This is key in the management of depression. There are different techniques and an approach in primary care is the Brief Integrative Psychological Therapy (BIPT) discussed in the Singapore Family Physician. (Cheong PY, Goh LG, 2008³ Rather than following orthodox dynamic psychotherapy or cognitive therapy which are difficult to practice in primary care, BIPT explores techniques which are short-term and focuses on the “here and now”. Asian practice of meditation is encouraged especially in those with associated anxiety and insomnia.

C. Combined Psychological Therapy and Pharmacotherapy with Antidepressant

Most patients in Singapore are treated with combined psychological therapy plus an antidepressant. Psychological therapy can encourage medication adherence or compliance.

Change in Drug Treatment: When and How Should One Do It?

A. Circumstances in which prescribers should change pharmacologic strategy:

- Patients do not experience significant improvement with continuing current medication at full dose for an additional 4 weeks.
- B. Switching antidepressants is usually carried out by the following means:
 - Switching to an agent of the same class (i.e., from an SSRI to another SSRI)
 - Switching to an agent of a different class (i.e., from an SSRI to a TCA).
 - Switching to an atypical agent (i.e., mirtazapine).

Maintenance Therapy

Acute therapy last for 8 to 12 weeks and maintenance therapy refers to pharmacologic-treatment extending beyond and being administered for long periods of time (months or years) to prevent recurrences.

Since some patients are likely to suffer a recurrence, maintenance antidepressant treatment is important. Antidepressants, in dosages comparable to those used during the acute phase, have been found to be effective in preventing recurrent depressive episodes in populations at risk. The combination of maintenance pharmacotherapy with psychotherapy appears to be a promising strategy.

When Should One Refer a Patient to a Psychiatrist?

Primary care doctors should consider referring a patient to a psychiatrist under the following circumstances:

- The patient presents a significant suicidal risk.
- The patient is pregnant or plans to become pregnant.
- The patient has certain comorbid conditions (i.e., substance abuse, panic disorder, obsessive-compulsive disorder, dementia).
- The patient fails to respond to one or two adequate trials of antidepressants.

DISCUSSION

Many of the elderly Chinese in the 1992 study preferred to see traditional healers whenever they were unwell. The traditional

healers are popular with the elderly not only because of the accessibility of their service but also because they share the same socio-cultural beliefs about illness and health. A powerful therapeutic factor is the rapport between the patient and the healer - this is something doctors can learn.

For those with moderate or severe depression, seeking psychiatric treatment early will certainly lead to a better prognosis. In a study on the treatment outcome of depressive disorder, 47 young patients were compared with 58 elderly patients admitted to a general hospital psychiatric ward (Ko, Kua, Chow 1997)⁴. At one year follow-up, more elderly patients (46%) recovered compared with the young patients (23%) ($p < 0.05$).

The prognosis of depressive disorder with treatment is not bleak. An out-patient naturalistic study comparing elderly depressed patients on antidepressant medications plus psychological therapy versus psychological therapy showed that 72% of patients on the former regime recovered compared to 62% on psychological therapy alone (Kua, 2000)⁵.

The consequences of untreated depression include suffering

and despair, increased medical morbidity and utilization of medical services, inappropriate institutionalisation and caregiver burden. Treatment can improve the quality of life of patients and their caregivers, enhance function, improve physical health status, reduce the rate of death from medical illness and suicide, and lower health care costs.

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LEARNING POINTS

- **In the history taking, it is important to explore predisposing factors such as a family history of depression and poor social skills or support.**
 - **In the mental state examination, besides assessment of mood, it is crucial to elicit any suicidal ideation. In severe depression, the patient may experience delusion of persecution and sometimes auditory hallucination.**
 - **In primary care setting, the treatment of depression is not just prescribing an antidepressant. There are psychological techniques to encourage adherence or compliance in medication and conflict resolution.**
 - **Since some patients are likely to suffer a recurrence, maintenance antidepressant treatment is important.**
 - **The consequences of untreated depression include suffering and despair, increased medical morbidity and utilization of medical services, inappropriate institutionalisation and caregiver burden.**
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