The authors and reviewers have made every attempt to ensure the information in the Family Medicine Clinical Cards is correct – it is possible that errors may exist. Accordingly, the source references or other authorities should be consulted to aid in determining the assessment and management plan of patients. The Cards are not meant to replace customized patient assessment nor clinical judgment. They are meant to highlight key considerations in particular clinical scenarios, largely informed by relevant guidelines in effect at the time of publication. The authors cannot assume any liability for patient outcomes when these cards are used.

Canadian Family Medicine Clinical Card

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Depression

Diagnosis: DSM-V Criteria

≥**5** of the following symptoms nearly every day for >**2 wks**, causing sig.distress or impairment in social, occupational, or other area(s) of functioning

≥ 1 of	depressed mood, anhedonia
other sx	psychomotor slowing, ↓ concentration, feeling worthless/guilty, insomnia/hypersomnia, ↓ energy, recurrent thoughts of death or suicide, weight/appetite change

PHQ-9 to aid with Diagnosis and Monitoring

For each item below, answer "Over the last 2 weeks, how often have you been bothered by <the item>" with 'Not at all' = 0, 'Several days' = 1, 'More than half of days' = 2, and 'Nearly every day' = 3 points.
1. Little interest or pleasure in doing things
2. Feeling down, depressed, or hopeless
3. Trouble falling or staying asleep, or sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down
7. Trouble concentrating on things, such as reading the newspaper or watching television
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual
9. Thoughts that you would be better off dead or of hurting yourself in some way

Scoring

- 5-9: supportive care, help patient develop resilience
- 10-14: mod. dep: treatment plan, counseling, follow-up, possib. meds
- 15-19: mod/severe: active tx with pharmacotherapy and/or psychotx
- 20-27: severe: immed. meds, likely psychotx; consider inpt. care

Management Plan:

- Investigations: consider TSH and possibly CBC, ferritin, B12, folate.
- Lifestyle: daily exercise/activity, balanced diet, sleep hygiene.
  - Moderate to intense resistance and aerobic exercise has best effect.
- Psychotherapy, cognitive behavioural, or interpersonal therapy.
- Positive Action/Crisis Management Plan: for suicidal risk and intimate partner violence (IPV); if IPV present, then must assess children's safety, follow up, and notify authorities as required.
- Antidepressant Medications: if required, consult table to the right; in general, start low, ↑ over first few wks; usual 5-6 (at most 8) wks to full effect; 40% may respond to 1st med; most get ≥ 1 side-effect.

Secondary Depression

Personal/Social: alcohol use, intimate partner violence (IPV), stressful life events, social isolation, cocaine/amphetamine use
Medical Conditions: hypothyroidism, adrenal insufficiency, MI, stroke, diabetes, Parkinsons, MS, schizophrenia, chronic pain or disease/conditions
Medication Induced: glucocorticoids, interferons, anti-neoplastics, OTC sympathomimetics, older anti-HTN rs, cimetidine, hormonal therapies

Context-Based Medication Guidance

	Context	Guidance
Prominent Symptoms	not sleeping enough	mirtazapine or duloxetine; avoid bupropion, sertraline
	sleeping too much	bupropion, venlafaxine or vortioxetine; avoid mirtazapine or duloxetine
	↑ appetite, ↑ weight	bupropion, venlafaxine, sertraline, fluoxetine
	↓ appetite, ↓ weight	mirtazapine or paroxetine
	sexual dysfunction	bupropion or mirtazapine; avoid SSRIs
	nausea / GI symptoms	mirtazapine; avoid sertraline, duloxetine, venlafaxine
	psychotic features	quetiapine, or co-treatment with antidepressant and antipsychotic
	prominent cog. sx	vortioxetine; avoid paroxetine
	suicidal / self-harm	Avoid TCAs
Co-Morbid Conditions	depression in bipolar disorder	lithium, quetiapine, lurasidone; avoid TCAs, venlafaxine and antidepressant monotherapy
	features of OCD	fluvoxamine
	gen. anxiety or panic	venlafaxine, paroxetine, citalopram
	pain syndrome	duloxetine, possibly venlafaxine; avoid paroxetine and fluoxetine (strong 2D6 inhib.)
	compromised liver function	desvenlafaxine or venlafaxine; avoid paroxetine or fluoxetine
	requires warfarin	venlafaxine or desvenlafaxine; avoid citalopram and escitalopram
Stage of Life	adolescent	CBT alone or in combination with fluoxetine
	pregnancy	CBT or Interpersonal Psychotherapy or citalopram/escitalopram
	mild post-partum depression (PPD)	CBT or Interpersonal Psychotherapy
	severe PPD	citalopram, escitalopram, sertraline
	peri-menopause	desvenlafaxine or venlafaxine
	late-life depression	mirtazapine or duloxetine

Related Depressive Syndromes & Specific Scenarios

- Postpartum-Depression: must look for it; requires a comprehensive approach
- Anxiety: often comorbid with depression; may be difficult to sort out
- Dysthymia: less severe, longer duration, more treatment-resistant
- Bipolar: prior periods of ↑ mood, ↑ energy, ↓ need/desire to sleep, grandiosity
- Adjustment Disorder: linked to event, may evolve to major depressive episode

Key References: Depression: Management of depression in primary and secondary care - NICE guidance. *www.nice.org.uk/guidance*. 2009. Goodwin GM, et al. Evidence-based guidelines for treating bipolar disorder: revised second edition—recommendations from the British Association for Psychopharmacology. *J Psychopharmacol*. 2009;23(4):346-88. DSM 5, 5th Edition, *American Psychiatric Association*. 2013. AHRQ. Choosing Antidepressants for Adults: Clinician's Guide. 2007; Canadian Psychiatric Association Clinical Practice Guidelines for the Treatment of Depressive Disorders, *Can J Psych*. 2001;46(Suppl 1). Kroenke K, Spitzer RL, Williams JB. The PHQ-9: Validity of a brief depression severity measure. *J Gen Intern Med*. 2001;16(9):606-13.