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Treatment Guidelines for Depression

Depression treatment is highly variable. There are many treatment guidelines available for depression. The Depression in Primary Care Program uses the well-developed **Texas Medical Algorithm Project (TMAP) guideline**. The DPC program's psychiatric liaison, Dr. Kevin Kerber, explains some common information and misconceptions regarding treating patients with depression.

- The **goal of depression treatment is remission**- that is, 75-100% improvement.
- A common source of poor outcomes in depression treatment is the use of inadequate doses for too short a period of time.
- A medication trial should not be considered a failure until at least moderate doses (e.g. 40 mgs of citalopram) have been tried for 4 weeks or clearly unacceptable side effects arise.
- Another problem can come from starting with the usual dose (e.g. 20 mgs of citalopram) in anxious patients or patients expected to be sensitive to medication side effects. It is better with these patients to start with 10 mgs and to proceed slowly.
- If there has been **at least some initial response to lower doses** of the medication, then higher doses should be tried before going to the next step and changing medication.
- If response to the first agent is partial, then augmentation or combination with another agent may be tried, instead of switching to a different agent.
- Augmentation or combination should not be done until full doses (e.g. 60 mgs of citalopram) of the first agent have been tried, except when one achieves a partial response but the dose cannot be raised because of limiting side effects. **An example of this is when a patient has a partial response to citalopram 40 mgs, but refuses to go higher because of sexual side effects. Combination with bupropion (Wellbutrin) may enhance mood response and possibly help with the sexual side effects. Alternatively, augmentation with lithium may help improve mood response.**

TMAP Protocol

STEP 1: Use an SSRI (fluoxetine and citalopram are the UMHS preferred agents), venlafaxine (Effexor XR), bupropion (Wellbutrin SR or XL), or mirtazepine (Remeron).

STEP 2: Switch to another SSRI, or tricyclic antidepressants (TCA). Among TCAs, nortriptyline and desipramine are preferred. In step 2, it is probably a good idea to try a second SSRI even if the first one fails. *Many patients may go on to have a good treatment response to the second SSRI*

STEP 3: Use of any of the agents in Step 1 or a TCA or a Monoamine Oxidase Inhibitor (MAOI). If SSRIs were tried in step 1 and 2, then choose an agent from a different class.

STEP 4: Use of lithium or thyroid hormone to augment antidepressant response. *Although this augmentation step has support in older research, these days this step often is used after the combination strategies in step 5.*

STEP 5: Use of combination treatments (combining two antidepressants) such as an SSRI plus bupropion, an SSRI plus a TCA, an SSRI plus mirtazepine.

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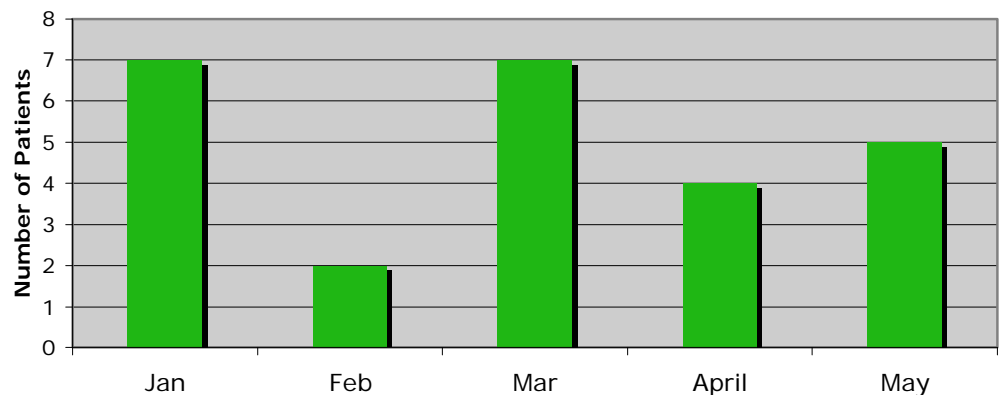
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Key Points to Remember

- Aim for remission (75-100% improvement)
- **Allow 4-6 weeks at solid doses** (e.g. 40-60 mgs of citalopram) before switching to a new antidepressant (assuming that side effects are not forcing the change).
- By step 3, be sure to choose an agent from a different class than used in steps 1 and 2.
- Augmentation with lithium may be tried at any step, especially if the patient is benefiting from the primary antidepressant but needs additional effect.
- TMAP guidelines permit skipping of steps as clinically indicated. If the patient refuses lithium augmentation, combination with a second antidepressant (as in step 5) may be tried. Since this is often more acceptable to patients than use of lithium, in current clinical practice step 5 often precedes step 4.
- If the patient fails to remit with all these efforts, consider referral for specialty care, as step 6 involves electroconvulsive therapy (ECT).

The UMHS Depression Center's website has additional info on depression treatment guidelines for health professionals at:
<http://www.med.umich.edu/depression/guideadultden.htm>

BHC monthly referrals for 2005



Brighton Health Center's Top Referring Clinicians for April and May were **Dr. Cooke and Dr. DiMagno**. Thank you for your support!

Please contact your care managers at their new email address: MDOCC-referrals@med.umich.edu or call at (734)