MSO OF PUERTO RICO

DIAGNOSING AND MANAGING MAJOR DEPRESSIVE DISORDER (MDD)

IDENTIFICATION | **ASSESSMENT &TRIAGE** | **MANAGEMENT**

Patient with suspected MDD

Risk assessment and diagnostic work-up (Box 1)

Is there an acute safety risk?

YES → Inpatient or emergent care to stabilize

Stable → Risk assessment and diagnostic work-up (Box 1)

NO

Does the patient meet criteria for MDD? (Box 2)

YES → Assess Severity Level using PHQ-9 Score

NO

Other treatment as necessary (includes other forms of depression and other diagnoses)

Box 1
Risk Assessment and Work up

1. Evaluate for suicidal and homicidal ideation, history of suicide attempts, presence of psychotic features
2. Rule out causes of secondary MDD (e.g. hypothyroidism, B-12 deficiency, substance use, chronic diseases, and medication side effects)

Box 2 DSM-5 Criteria (Major Depressive Episode-MDE)

- 5 or more symptoms during the same 2-week period (1 symptom must be depressed mood or diminished interest/pleasure):
  - Depressed mood
  - Diminished interest or loss of pleasure
  - Significant weight change or appetite disturbance (increase or loss)
  - Sleep disturbance (insomnia or hypersomnia)
  - Psychomotor agitation or retardation
  - Fatigue or loss of energy
  - Feelings of worthlessness
  - Diminished concentration
  - Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide
- Impairment in social, occupational or other important areas of functioning.
- Symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- The disturbance is not better explained by a persistent schizoaffective disorder, schizophrenia, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorders.
- There has never been manic or a hypomanic episode.

Assess Severity Level using PHQ-9 Score

Minimal 0-4	Mild 5-9	Moderate 10-14	Moderately Severe 15-19 0-4	Severe >20
Watchful waiting Provide Psychoeducation about MDD	Supportive Counseling Educate to call if deteriorates	Psychotherapy if no improvement after one or more months, consider use of antidepressant	Patient preference for antidepressant and/or psychotherapy	Antidepressant + Psychotherapy combination
Follow-up at least annually	Follow-up every other month	Follow-up monthly	Follow-up every 2-4 weeks	Follow-up every 1-2 weeks until PHQ-9 improves >5 points or 50% reduction from baseline score is achieved

Starting Antidepressant Medication? (Box 3)

Bipolar by screening or history?

NO → Start SSRI Trial (If prominent anxiety, use 50% of recommended SSRI dose)

YES → STOP! Get Psychiatrist Consult

Increased agitation?

YES → STOP! Get Psychiatrist Consult

NO → 50% reduction from baseline or PHQ-9 Score 5?

NO → Optimize antidepressant according to recommended titration schedule and follow up according to level of severity

YES → Continue Tx for 6-12 months before considering tapering down antidepressant (if patient continues in full remission)

50% reduction from baseline or PHQ-9 Score ≤5?

YES → Continue Tx for 6-12 months before considering tapering down antidepressant (if patient continues in full remission)

NO → If SSRI has been on optimal dose for 4-8 without improvement, consider a second SSRI trial, changing to bupropion or an SNRI or get a Psychiatric Consult

Box 3 Antidepressants

- Should be taken daily and wait at least 2-4 weeks before initial improvement.
- Clinical response (50% reduction on PHQ-9 score from baseline) expected 2-12 weeks at a therapeutic dose.
- Full remission should be the goal (PHQ-9 score <5 sustained for 2 months) within 4-8 months from Tx start.
- Tx should continue for 6-12 months once full remission is achieved and before antidepressant tapering down is considered.
- If >2 MDEs within 5 years, long-term preventive treatment is suggested.