Depression

What is it all about?

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Social and economic burden of depression

Depression is common in the community

- Manic depressive illness (bipolar disorder) 2-3%
- Major depression 10-15%
- WHO estimates that roughly 20% of global population will suffer mood disorder in their lifetimes.

Depression is disabling

- World Bank: global burden of disease study
- Within the next 20 years, depression is expected to become the number 2 cause of the global burden disease

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Depression and Death

- Life time suicide rate among depression: 15-20%
- Increased deaths from 'accidents' x 3
- Increased death from other medical causes (cardiovascular, cancer) x 2

Depression and Medical Illness

- Increased rate of onset of medical condition: ischaemic heart disease

Poor outcome from certain medical disorder

- Stroke
- Cancer

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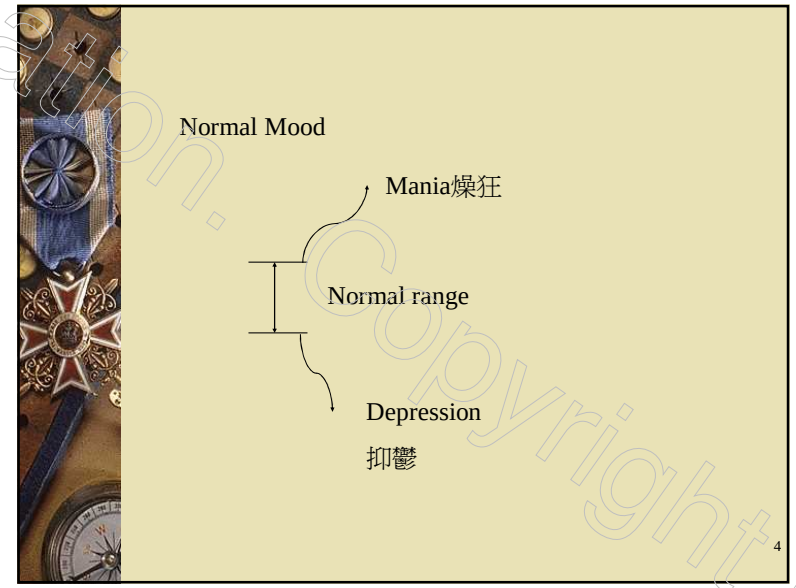

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	Epidemiology of Depression
Incidence (new cases per year)	1/100 men 3/100 women
Prevalence (existing cases)	2-3/100 men 5-10/100 women
Lifetime expectancy	10% men, 20% women 17 % overall
Sex	2:1 women/men
Age	30- median age of onset 40 – mean age men/women 10% occur after age 60 Small peak in adolescence 50% occur before age 40
Race	No difference
Sociocultural	↑Risk with family history of alcohol/depression/parental loss before age 13 slight↑risk in lower socio-economic groups Divorced and separated more than with partners
Family history	Approximately 10-13% risk for first-degree relatives Monozygotic concordance rate higher than dizygotic but ratio not as high as seen in bipolar

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Epidemiology

>90% cases of depression are encountered in general practice

10% referred to psychiatrists

1% admitted to hospital

WHY?

Diagnostic criteria were derived from psychiatric rather than GP.

Patients present with somatic rather than affective symptoms.

The depression is often associated with physical illness to which more attention is paid.

GPs have lack of knowledge of depression, unsatisfactory interviewing skill and insufficient time for psychiatric assessment.

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Recognizing Depression - Diagnosis

ICD:10

Classification of Mental and Behavioural Disorder, Diagnostic Criteria for Research, WHO (1993)

Cardinal Symptoms

- Depressed mood to a degree that is definitely abnormal for the individual, present for most of the day and almost everyday, largely uninfluenced by circumstances, and sustained for at least 2 weeks (persistent and consistent);
- Loss of interest or pleasure in activity that are normally pleasurable;
- Decreased energy or increased fatigability

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Recognizing Depression - Diagnosis

Additional Symptoms

- Loss of confidence or self-esteem
- Unreasonable feeling of self-reproach or excessive and inappropriate guilt
- Recurrent thoughts of death or suicide, or any suicidal behaviour
- Complaints or evidence of diminished ability to think or concentrate, such as indecisiveness or vacillation
- Change in psychomotor activity, with agitation or retardation (either subjective or objective)
- Sleep disturbance of any type
- Change in appetite (decrease or increase) with corresponding weight change

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Recognizing Depression - Diagnosis

Somatic Syndrome

- Marked loss of interest or pleasure in activities that are normally pleasurable
- Lack of emotional reactions to events or activities that normally produce an emotional response
- Waking in the morning 2 hours or more before the usual time
- Depression worse in the morning
- Objective evidence of marked psychomotor retardation or agitation (remarked on or reported by other people)
- Marked loss of appetite
- Weight loss (5% more of body weight in the past month)
- Marked loss of libido

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ICD 10 Diagnosis

- Mild depression: 4 s/s(2+2), continue most activities
- Moderate depression: 6 s/s(2+4), difficulties to continue activities
- Severe depression: 7 s/s(3+4), unlikely can function, somatic s/s usually present, psychotic s/s might present

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Mood s/s, feeling - diurnal variation, miserable, sad, tearful, agitation, anxious, irritable

Behaviour /activities – social withdrawal, psychomotor, retardation, stop pleasurable activities

Cognition / thought – useless, hopeless, worthless, guilt, suicidal, poor concentration

Physical / biological s/s – insomnia, loss of appetite, libido, constipation, amenorrhea, pain symptoms, fatigue

Psychotic s/s – hallucination, delusion

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John Cade

"In its melancholic form, depressive illness is the **most painful illness** known to man, equaling or exceeding even, the most exquisite physical agony. The patient is inconsolably despairing, often guilt-ridden – having committed, they imagined, the unforgivable sin – completely immersed in the internal world of misery and utter loneliness. There is no pleasure in living, no energy or interest in doing anything except agitatedly bewail or silently brood upon an unhappy fate; no hope for the future abandoned by God and man. Suicide seems the only escape from the misery."

John Cade, Mending the Mind (1979)

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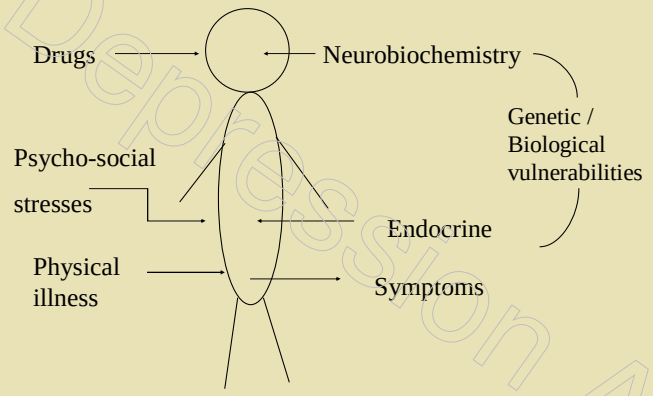
Aetiolgoy



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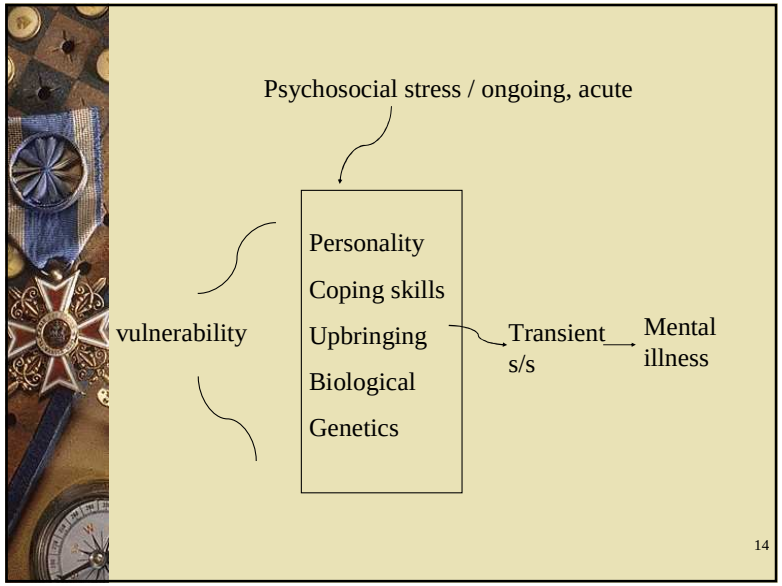

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Aetiology

Genetic/biological factors
- Family studies
- Twin studies
- Adoption studies

polygenic/ multifunctional inheritance

Life events/adversities/loss

Neurobiochemical
- Serotonin
- Noradrenaline

Endocrine
- Hypothalamic - pituitary – adrenal axis
- Thyroid function

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Aetiology

Physical illness
- Parkinson's disease
- Stroke
- Cushing's disease
- Hypothyroidism
- SLE
- Huntington's disease

Drug
- antiHT, methyldopa, propranolol
- Steriod
- Cimetidine
- Vincristine

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	Patients with B.A.D.	Patients with Depression
1st degree relative with BAD vs general population	8-18 times	1.5-2.5 times
1st degree relative with depression	2-10 times	2-3 times

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Suicide Assessment

- High risk of suicide: 15 %
  - During depression and also initial phase of recovery
- **Assess of suicide**
  - Have you had thoughts about death or about killing yourself?
  - How persistent was the thoughts?
  - Have you formulated a plan? What is it?
  - Have you actually rehearsed or practiced how you would kill yourself?
  - Do you think you would really do it? Have you told anyone?
  - Do you tend to be impulsive or can you resist the impulse to do this?
  - What have stopped you doing this?
  - Have you heard voices telling you to hurt or kill yourself?
  - History of previous attempt especially the degree of intent

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Suicide Management

- Duty to care
- See doctor ASAP
- Attend AED, hospitalization if needed
- Suggest cooling period with contract and seek help in the meantime
- Inform family

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Course

Multiple episodes > single episode

> 50% rate of recurrence

With ↑ number of previous episodes:

↑ risk of future episode

intervals ·/· episode becomes shorter

the quality of life decreases

disability increases

the response to antidepressant decreases

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Treatment

Aims
- Reduce s/s
- Restore role function
- Minimize relapse / recurrence risk

Options
1. Antidepressant
2. Psychotherapy
   - Interpersonal psychotherapy
   - Cognitive behavioural therapy (CBT)
3. ECT

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WHO treatment guidelines on antidepressant treatment

- Change dose or medication if patient does not respond in 3 weeks
- Psychotherapy may be useful in conjunction with pharmacotherapy
- Continue antidepressant medication for at least 6/12 after recovery
- Discontinue treatment gradually and see patient 3/52 after cessation of all medication
- Consider maintenance therapy inpatients with >1 depressive illness in past 5 years
- Continuation treatment helps to consolidate recovery from a depressive episode and prevent a relapse
- Maintenance (prophylactic) treatment helps to prevent a recurrence of a new episode

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Antidepressant Medications: Classes

- TCAs
  - Clomipramine
  - Imipramine
  - Amitriptyline
  - Nortriptyline
- MAOIs
  - Tranylcypramine
  - Phenelzine
- RIMA
  - Mmoclobemide
- **SSRIs**
  - **Fluoxetine**
  - **Paroxetine**
  - **Sertraline**
  - **Citalopram**
  - **Fluvoxamine**
- **SNRI**
  - **Venlafaxine**
- **NaSSa**
  - **Mitrazapine**

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Side Effects of Tricyclic Anti-depressants

- Anticholinergic
  - Confusion
  - Urinary retention
  - Precipitation / worsening of glaucoma
  - Blurring of vision
  - Dry mouth
- Antihistaminic
  - Sedation
- Anti-adrenergic
  - Postural hypotension
  - Dizziness
  - Falls
  - Sexual dysfunction

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Response Rates in Patients with Major Depressive Disorder by meta-Analysis

As a Class – TCAs and SSRIs versus Placebo					
	Drug	Placebo	Difference	N	p value
TCAs	62.8%	35.9%	26.9%	5159	$<10^{-40}$
SSRIs	66.5%	38.1%	28.4%	2216	$<10^{-40}$
Individual SSRIs versus Placebo					
Fluoxetine	60%	33%	27%	897	$<10^{-13}$
Sertraline	79%	48%	31%	545	$<10^{-12}$
Paroxetine	65%	36%	29%	649	$<10^{-11}$
Fluvoxamine	67%	42%	25%	125	$<10^{-2}$

Janick et al: Principles and Practice of Psychopharmacology (1993)

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Pharmacological treatment vs non-pharmacological treatment

- Interpersonal psychotherapy helped to decrease the recurrence rate in one study but failed to prevent relapses
- CBT decreased relapses in mild to moderate unipolar depression, increased coping skills and improved outcome
- None of the approaches are better than pharmacotherapy and there is a shortage of therapists to administer the treatment
- Twice as many relapses occur on placebo as antidepressant

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ECT

- Indicated when rapid therapeutic response is desired or when side effects of antidepressant medication must be avoided.
- ECT is underused as first line antidepressant treatment.
- It is safe and effective
- A course of 10 is usually prescribed

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Conclusion

Depression

- is common
- is agonising
- is a **medical illness**
- is not social problems, family problems, personal weakness
- is **treatable**, most effective and safe with antidepressant
- increases morbidity and mortality

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Pathway to Care – Hong Kong Scenario

Care in Hong Kong

Amount spent by most Asian governments spend on mental health: < 1% of national health budget.

Population of Hong Kong: almost 7,000,000

Qualified psychiatrists: almost 200 (1 in 35,000)

Psychiatrists working under hospital authority: 160

GPs in Hong Kong: about 4,000

Clinical Psychologists: just over 200

Waiting time, after referral: 3-24 months

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Pathway to Care – Hong Kong Scenario

Referral (GP, social worker, school, others)

↓ ↑ Outreach

Psychiatric outpatient clinic (catchment area, HA/Universities, urgency)

↓ ↑

Inpatient care (mental hospital, psychiatric ward of general hospital)

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