Malaysian Family Physician 2011; Volume 6, Number 1
ISSN: 1985-207X (print), 1985-2274 (electronic)

Online version: http://www.e-mfp.org/

Guidelines

MANAGEMENT OF MAJOR DEPRESSIVE DISORDER (MDD)

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A. Introduction

Major depressive disorder (MDD) is a significant mental health problem that disrupts a person's mood and affects his psychosocial and occupational functioning. It is often under-recognised and 30-50% of MDD cases in primary care and medical settings are not detected. Suicide occurs in up to 15% of hospitalised patients with severe MDD.

B. Screening

The routine use of screening instruments to identify depression is not recommended. However, the following two initial questions may be used to screen for depression:

1. **"During the past month, have you often been bothered by feeling down, depressed or hopeless?"**
2. **"During the past month, have you often been bothered by having little interest or pleasure in doing things?"**

If the answer is "Yes" to one or both questions, assess the patient for depression.

For this Two-Question Case-Finding Instrument, the reported sensitivity is 96% and specificity 57%, at a prevalence rate of 18%. Clinicians are encouraged to screen for at least these two core symptoms of depression, especially in high risk groups e.g. those with physical health problems causing disability, a past history of depression, a family history of depression and those with other mental health problems such as substance abuse or dementia.

C. Diagnosis

The diagnosis of MDD is made using internationally accepted diagnostic criteria i.e. either the 10th Revision of the International Classification of Diseases (refer Table 1) or the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders IV.

D. Referral

In the local setting, referral to the psychiatric services may be done through the Accident & Emergency Department or directly

Table 1: ICD-10 Diagnostic Guidelines for Depressive Episode/Depressive Disorder

Typical symptoms of depressive episodes:	Common symptoms of depressive episodes:
o Depressed mood o Loss of interest and enjoyment o Reduced energy o Bleak and pessimistic views of the future o Ideas or acts of self-harm or suicide o Disturbed sleep o Diminished appetite	o Reduced concentration and attention o Reduces self-esteem and self-confidence o Ideas of guilt and unworthiness
Mild depressive episode: o At least 2 typical symptoms plus 2 common symptoms; minimum duration of whole episode is at least 2 weeks o The person has some difficulty in continuing ordinary work and activities	
Moderate depressive episode: o At least 2 typical symptoms plus 3 common symptoms; minimum duration of whole episode is at least 2 weeks o The person has considerable difficulty in continuing social, work or domestic activities	
Severe depressive episode without psychotic symptoms: o All 3 typical symptoms plus at least 4 common symptoms; minimum duration of whole episode is at least 2 weeks o The person is very unlikely to continue with social, work or domestic activities	

Adapted: WHO. ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines. Geneva: WHO: 1992

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to the psychiatric clinic. There are circumstances where outpatient care may be insufficient and admission required. Locally, admission to the psychiatric unit can be voluntary or involuntary. Refer to Table 2 for Criteria for Referral and Admission.

Table 2: Criteria for Referral and Admission

Criteria for referral to psychiatric services:	Criteria for admission:
o Unsure of diagnosis o Attempted suicide o Active suicidal ideas/plans o Failure to respond to treatment o Advice on further treatment o Clinical deterioration o Psychotic symptoms o Recurrent episode within 1 year o Severe agitation o Self-neglect	o Risk of harm to self o Psychotic symptoms o Inability to care for self o Lack of impulse control o Danger to others o Any other reason that the healthcare provider deems significant

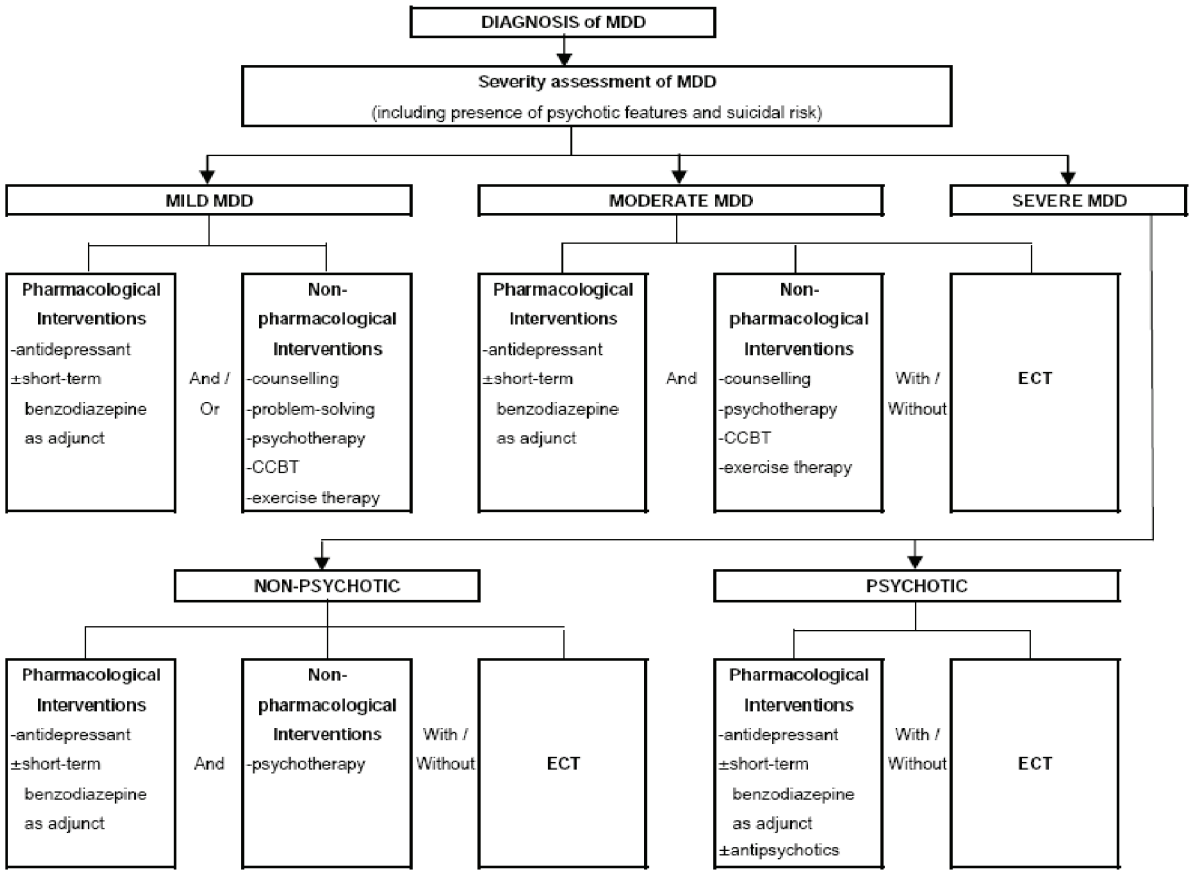
E. Treatment

Management of MDD includes non-pharmacological with/ without pharmacological measures depending on the severity of the disorder as shown in the Algorithm 1.

i. Mild Major Depressive Disorder

A substantial proportion of primary care patients have mild major depressive disorder. There is more evidence for the effectiveness of antidepressants in moderate to severe

Algorithm 1: Management of MDD



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depression than in mild depression (refer to Table 3 and Algorithm 2). Evidence supports the use of psychological interventions in the management of MDD.

Table 3: Treatment for Mild MDD

Non-pharmacological interventions should be given. The patient should be followed up closely with a follow-up appointment within 2 weeks
i. *Psychological interventions:-*
o Supportive therapy
o Problem-solving therapy
o Counselling
o Cognitive behavioural therapy (CBT)
o Interpersonal therapy (IPT)
o Computerised CBT (CCBT)
ii. *Other therapy such as exercise therapy*
Pharmacotherapy – SSRIs should be considered as the first line if medication is indicated

ii. Moderate to Severe Major Depressive Disorder

NICE found that antidepressants are efficacious for reducing depressive symptoms and that SSRIs do not differ in efficacy from tricyclic antidepressants (TCAs) or monoamine oxidase inhibitors (MAOIs) in both in-patients and psychiatric outpatients or primary care patients. However, SSRIs are better tolerated compared to other antidepressants, and therefore, make appropriate drugs of first choice. Antidepressants are as effective as psychological interventions and more easily available in this country. Therefore, it is appropriate to offer them as a first-line measure. Refer to Table 4 and Algorithm 2 for Treatment for Moderate to Severe Major Depressive Disorder.

Table 4: Treatment for Moderate to Severe MDD

Pharmacotherapy – SSRIs should be considered as the first line	
Non-pharmacological therapy	
i. Psychological interventions such as cognitive behavioural therapy (CBT)	
ii. Other therapy:	
o Exercise therapy	o Electro-convulsive therapy (ECT)

NICE also found some evidence favouring a combination of CBT plus antidepressants over antidepressants alone but there was insufficient evidence to say if this benefit persisted beyond the first few months. ECT is found to be superior to certain antidepressants in the short term but its effects are short-lived.

iii. The Role of Benzodiazepines

Benzodiazepines are not thought to have a specific antidepressant effect, and many experts believe that the depressive state is not improved by benzodiazepines alone. Clinicians may consider prescribing benzodiazepines as an adjunct to antidepressants. **Avoid giving them alone, and as far as possible they should not be given for more than two to four weeks**. Refer to Algorithm 1.

Commonly used antidepressants, their dosages and adverse effects are shown in Table 5.

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Algorithm 2: Pharmacotherapy of MDD

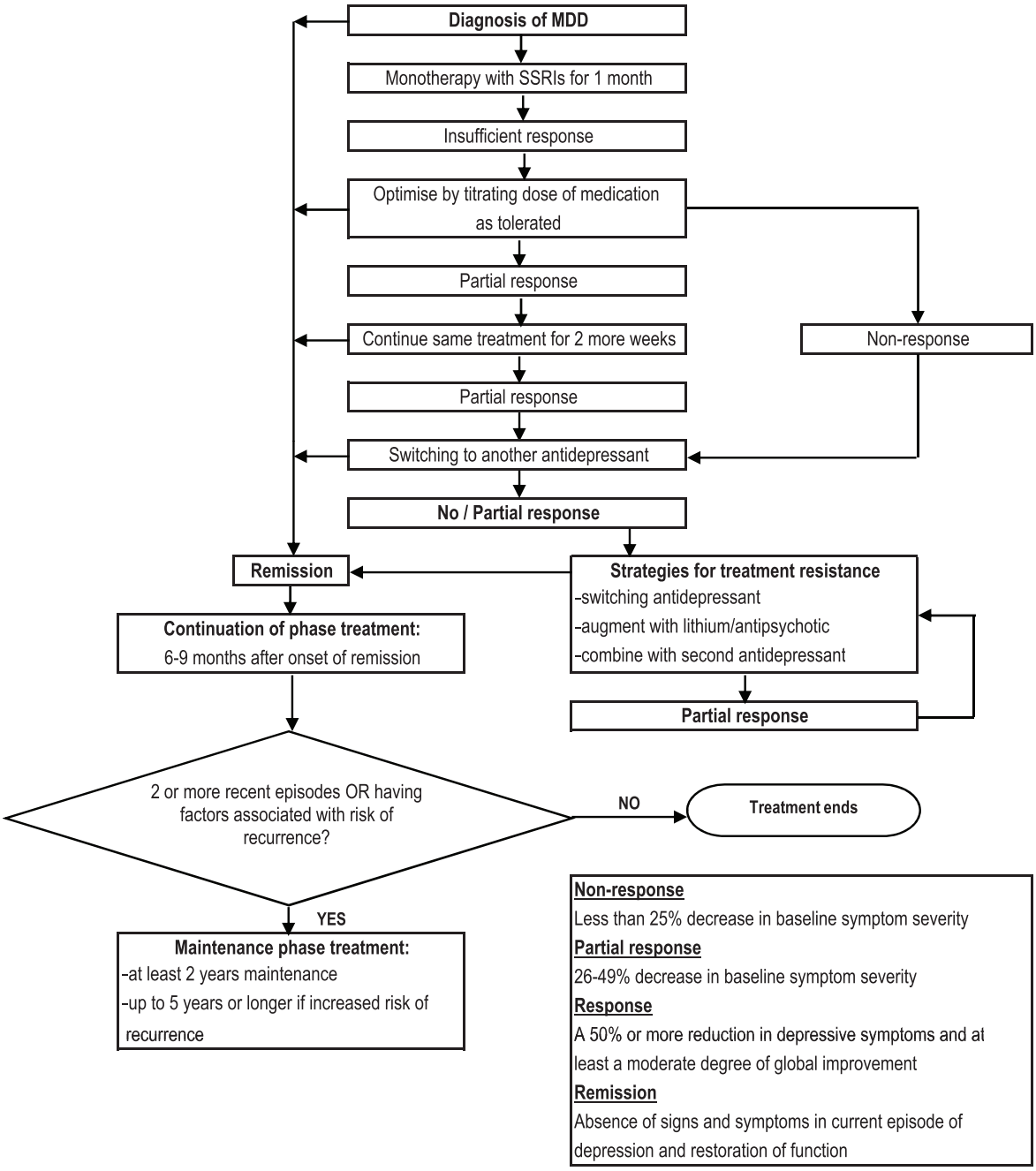

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Table 5: Suggested Antidepressant Dosages and Adverse Effects

Name	Starting Dose* (mg/day)	Usual Dose (mg/day)	Main Adverse Effects
Selective Serotonin Reuptake Inhibitors (SSRIs)			
Escitalopram	10	10-20	Nausea, vomiting, dyspepsia, abdominal pain, diarrhoea, rash, sweating, agitation, anxiety, headache, insomnia, tremor, sexual dysfunction (male & female), hyponatraemia, cutaneous bleeding disorder. Discontinuation symptoms may occur.
Sertraline	50	50-200	
Fluoxetine	20	20	
Fluvoxamine	50-100	100-200 (max 300)	
Tricyclics and Tetracyclics			
Amitriptyline	25-75	75-200	Sedation, often with hangover, postural hypotension, tachycardia/arrhythmia, dry mouth, blurred vision, constipation, urinary retention.
Clomipramine	10-75	75-150	
Dothiepin	50-75	75-225	
Imipramine	25-75	75-200 (up to 300 mg for in-patients)	
Maprotiline	25-75	75-150 (up to 225 mg for in-patients)	
Reversible Inhibitor of MAO-I (RIMA)			
Moclobemide	150	150-600	Sleep disturbances, nausea, agitation, confusion. Hypertension reported may be related to tyramine ingestion.
Serotonin and Noradrenaline Reuptake Inhibitor (SNRIs)			
Venlafaxine, extendedrelease	37.5-7.5	75-225 (up to 375 mg/day in severe depression)	Nausea, insomnia, dry mouth, somnolence, dizziness, sweating, nervousness, headache, sexual dysfunction.
Duloxetine	40-60	60 (max 120)	
Noradrenergic and Specific Serotonergic Antidepressant (NaSSA)			
Mirtazapine	15	15-45	Increased appetite, weight gain, drowsiness, oedema, dizziness, headache, blood dyscrasia. Nausea/sexual dysfunction relatively uncommon.

*Lower starting doses are recommended for elderly patients and for patients with significant anxiety, hepatic disease, or medical co-morbidity.