CCHCS/DHCS Care Guide: Major Depressive Disorder

SUMMARY | **DECISION SUPPORT** | **PATIENT EDUCATION/SELF MANAGEMENT**

GOALS

- **Ensure accuracy of diagnosis (r/o other causes of depression)**
- **Establish suicide risk**
- **Ensure safe and appropriate medication use**
- **Respond to patient care alerts (see patient registries)**

ALERTS

- **Suicidal thoughts and behaviors**
- **Potential medication interactions**
- **Risk of serotonin syndrome**
- **Risk of discontinuation syndrome**

DIAGNOSTIC CRITERIA/EVALUATION

DEFINITION

Major Depressive Episode (first occurrence) or Major Depressive Disorder (MDD) (recurrent depression) are biologic illnesses of unknown cause.

SCREENING

- In patients who self report symptoms
- Patients in whom others report symptoms or suggestive behaviors.

Inquire if patient has/is:

- Little interest or pleasure in activities
- Feeling down, depressed, hopeless
- Feeling suicidal

Depression screening in a patient with significant medical condition:

- Ask about excessive guilt regarding things done and not done.
- Ask whether patient looks forward to anything in the future (even if it is dying pain-free).
- Ask whether patient enjoys a pleasant experience or good news.

Refer to mental health if any "yes" answers to above.

Possibly suicidal: observe patient until mental health evaluation.

Observe for atypical symptoms of depression

- Somatic complaints (esp. in the elderly)
- Anxiety
- Substance Abuse
- Conversion Disorders
- Irritability/Anger
- Primary sleep difficulties
- Attention Deficit symptoms
- Complaints of memory disturbance

DIAGNOSIS (Using DSM diagnostic criteria, see page 2) requires ruling out other potential causes of depression. These include:

- Other psychiatric disorders
- Medications causing depression
- Medical diseases
- Substance abuse

PRIMARY CARE PROVIDER ASSESSMENT

Evaluate for medical conditions or medications which may mimic or worsen MDD

Assess patient for medical conditions which may cause depression (e.g., thyroid disease, cancer, DM, CVA, CAD, chronic pain) (see page 7).
Patients with medical conditions often present with many neurovegetative symptoms of major depression.

If the patient looks forward to the future and still enjoys certain things, he/she does not have a major depression, even if the patient is not sleeping, can't focus or concentrate, is chronically fatigued, and has had major weight changes.

Assess patient's medications for causes or contributors to depression (See page 8).

MENTAL HEALTH PROVIDER ASSESSMENT

- Evaluate for suicide risk.
- Evaluate for mental health condition mimicking MDD (bipolar disorder, substance abuse) or contributors by interview, health record review, past history, observations, review of physical exam (see page 6).
- Use DSM IVTR or DSM V diagnostic criteria (page 2) to diagnose MDD.

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TREATMENT OPTIONS

NONPHARMACOLOGIC

- ♦ Psychotherapy
  - Cognitive Behavioral Therapy (CBT)
    -skills exercises
  - Dialectical Behavioral Therapy (DBT)
  - Interpersonal psychotherapy (IPT)
- ♦ Group Therapy
- ♦ Self Help Activities
  - Exercise
  - Relaxation Techniques
- ♦ Sleep hygiene
- ♦ Hospitalization (for severe depression)
- ♦ Other Interventions (for refractory cases discuss other treatment options with mental health leadership)

PHARMACOLOGIC

First line Antidepressants
fluoxetine citalopram
sertraline paroxetine

Second line Antidepressants
mirtazapine venlafaxine XR

Other Antidepressants:
escitalopram, duloxetine, trazodone, vilazodone, tricyclic antidepressants (TCAs), monoamine oxidase inhibitors

Potential Augmenting Agents
lithium, liothyronine (T3), second generation antipsychotic (SGA) [olanzapine, risperidone, aripiprazole]

MONITORING

	MEDICATION CONSENTS	EKG if > 40 y/o (tricyclics only)	Blood Pressure (venlafaxine only)	Pregnancy test (F < 50 y/o)	Thyroid function (TSH or T4)
Baseline*	Yes	Yes	Yes	Yes	Yes
3 months			Yes	Yes	
Annual**	Yes	Yes	Yes	Yes	
Every 5 years					Yes

*Baseline = 90 days before and up to 14 days after medication starts
**Annual = 12 months from baseline measurement date

DIAGNOSING DEPRESSION

DSM-V CRITERIA FOR MAJOR DEPRESSIVE DISORDER (MDD)

1. Depressed mood or a loss of interest or pleasure in daily activities for more than two weeks.
2. Mood represents a change from baseline.
3. Impaired function: social, occupational, or educational.
4. Specific symptoms, at least 5 of the following have been present *nearly every day*:
   a. Depressed mood or irritable most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).
   b. Decreased interest or pleasure in most activities, most of each day, as indicated by either subjective account or observation made by others.
   c. Significant weight change (5%) or change in appetite
   d. Change in sleep: Insomnia or hypersomnia.
   e. Change in activity: Psychomotor agitation or retardation.
   f. Fatigue or loss of energy.
   g. Guilt/worthlessness: Feelings of worthlessness or excessive or inappropriate guilt (not merely self-reproach or guilt about being sick).
   h. Concentration: diminished ability to think or concentrate, or more indecisiveness.
   i. Suicidality: Recurrent thoughts of death or suicide, or has suicide plan.

OTHER CRITERIA FOR DIAGNOSIS OF MDD

- ♦ Symptoms do not meet criteria for a Mixed Episode (bipolar disorder with simultaneous MDD and manic features).
- ♦ Symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- ♦ Symptoms are not due to direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
- ♦ The symptoms are not better accounted for by Bereavement, (i.e., after the loss of a loved one), the symptoms persist for longer than 2 months, or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Note: Do not include symptoms that are clearly due to a general medical condition, mood-incongruent delusions or hallucinations.

SUMMARY	DECISION SUPPORT	PATIENT EDUCATION / SELF MANAGEMENT

ASSESSMENT FOR SUICIDE RISK

SUICIDE RISK FACTORS IN CORRECTIONS

- New to prison and/or first prison term
- Transfer to Ad Seg Unit (esp. first week)
- Received a serious disciplinary action
- Single cell housing
- Level IV institution housing
- Just after a visit
- Assault or sexual trauma
- Around time of parole hearing
- Near time of discharge/release from prison
- Received personal bad news
- Received bad medical news

SUICIDE WARNING SIGNS

Common signs that should alert medical personnel to ask more questions and/or refer to institutional mental health programs for further evaluation. (Use ISPATHWARM acronym for screening questions)

IDEATION	Thoughts of death or dying, active or passive–intent/motivation (including passive thoughts such as euthanasia or physician-assisted suicide), any evidence of self-harm
SUBSTANCE USE	Increased or excessive substance (alcohol or drug) use
PURPOSELESS	No reason for living; no sense of purpose in life
ANXIETY / PANIC	Signs/symptoms of panic or severe anxiety, especially if agitated or in pain
TRAPPED FEELING	Feeling trapped, ineffective coping; no way out
HOPELESS	No future
WITHDRAWN	Social withdrawal, alienation
ANGER	Self-loathing, aggression, rage, uncontrolled anger, seeking revenge
RECKLESS	Impulsive, reckless, acting out
MOOD CHANGES	Signs/symptoms of depression or psychosis, emotional lability, sudden mood changes

SUICIDE RISK EVALUATION (SRE)

SRE in CCHCS/DCHS is completed by a Mental Health Provider. In-depth evaluation of suicide risk is beyond the scope of non-mental health providers.

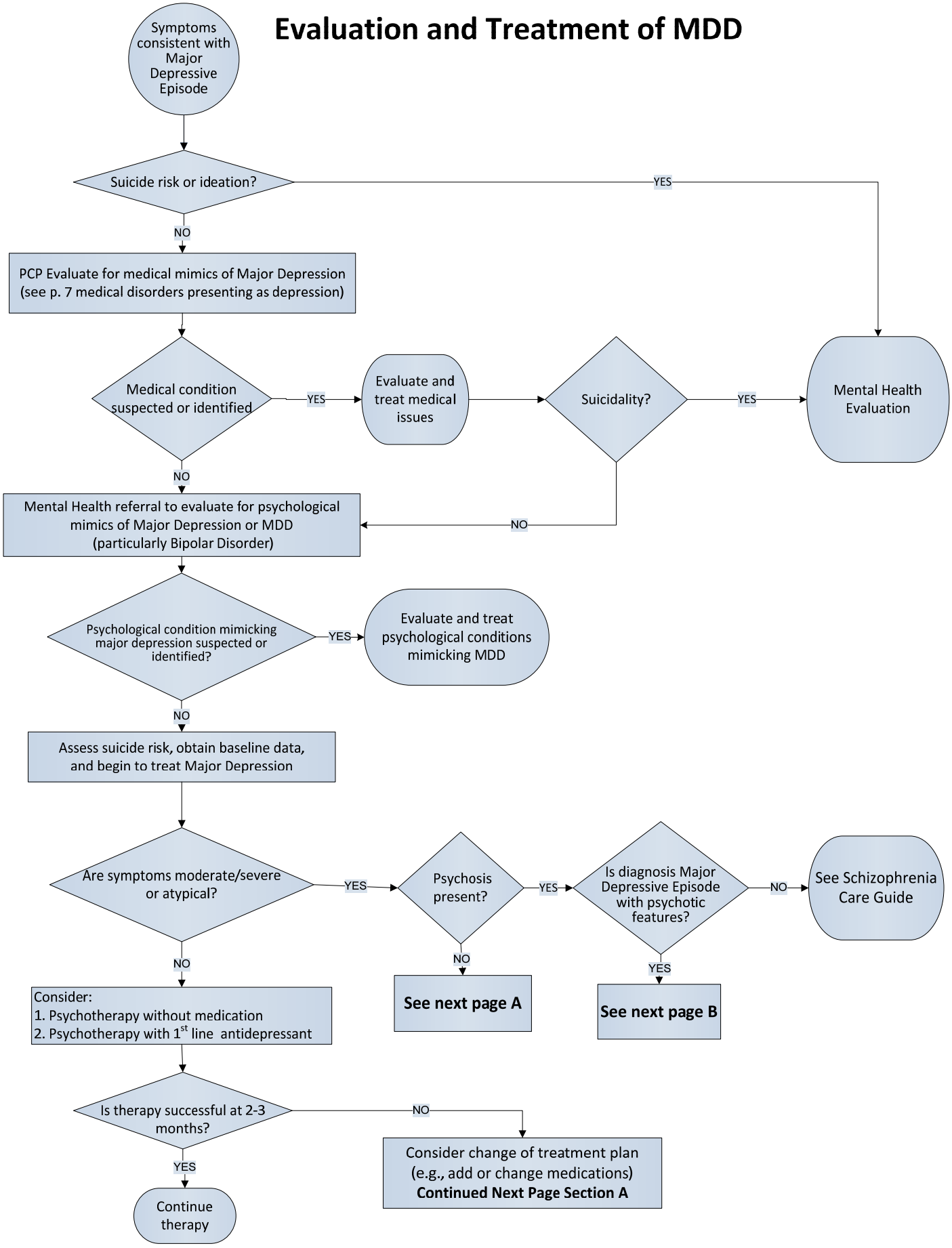
Mental Health Providers are directed to use the DHCS Suicide Risk Evaluation (SRE) and sound clinical judgment to assess for suicide risk.

SRE (CDCR 7447) Components

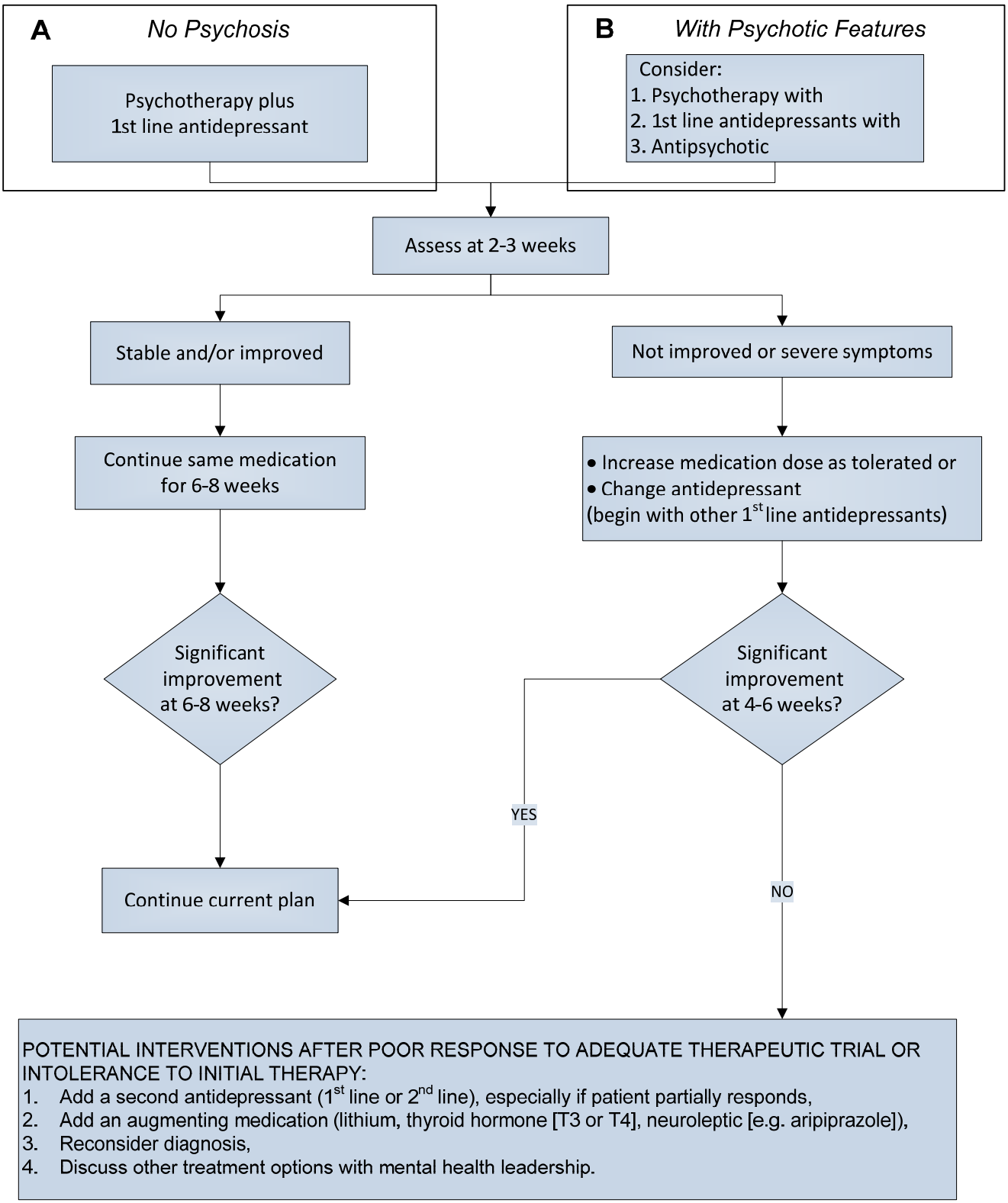
- Data Collection - Including previous suicide attempts
- Suicide Inquiry
- Intent and planning
- Mental Status Exam and Warning Signs
- Judgment and Rationale for Risk-Acute and chronic
- Treatment Plan -Target changeable risk factors

Lifeline address for SRE form:
http://intranet/Pro/dhcs/mentalhealth/Documents/CDCR%20MH-7447%20-%20Suicide%20Risk%20Evaluation%2010-13%20-A.pdf

Evaluation and Treatment of MDD



Evaluation and Treatment of MDD Continued



DIAGNOSING DEPRESSION

PSYCHIATRIC DISORDERS WHICH MAY MIMIC OR BE COMORBID WITH DEPRESSION (listed alphabetically)	
ADJUSTMENT DISORDER WITH DEPRESSED MOOD	Sadness from a stressor, but patient does not meet major depression time duration (two weeks) and usually has fewer neurovegetative signs (e.g., less sleep disturbance or appetite disturbance). Patient is often demoralized.
ANXIETY DISORDERS	Particularly PTSD and Panic (with or without agoraphobia). Anxiety disorders and major depression are not mutually exclusive and often coexist. In anxiety disorder without a mood disorder, anxiety symptoms precede the sadness and the sadness is not sufficient to diagnose major depression.
BIPOLAR DEPRESSION	MDD excludes any patient who has ever had a manic or hypomanic episode.
CYCLOTHYMIA	Exhibits no full manic or full depressive episodes, but cycle between minor depressions and hypomania.
DEMENTIA	Dementia is often comorbid with depression. A depressive-like illness may be the only early sign of dementia, often associated with white matter changes on MRI. Dementia is associated with apathy and depression and both predict progression from mild cognitive impairment to dementia. Symptoms of dementia such as depression, apparent memory loss, irritability, sleep loss, and weight changes may resemble MDD. With dementia, there is often confabulation (e.g., denying memory difficulties) while with major depression, memory disturbances and sadness may be, if anything, exaggerated by the patient.
DYSTHYMIA	Chronic continuous sadness, often over years, without meeting criteria for major depression. MDD may be superimposed on dysthymia.
EATING DISORDERS (ANOREXIA/BULIMIA)	Like depression, eating disorders have associated weight loss or gain and sadness. However, with eating disorders, the patient is usually hungry (unlike with melancholic depression) and misjudges body proportions. Major depression and eating disorders may coexist.
FACTITIOUS DISORDER	The patient pretends to have symptoms (e.g., depressive symptoms) in order to receive care when in the sick role.
GRIEF REACTIONS	Occur when there is death of a loved one or other major loss. Consider MDD if suicidality is present, and/or there is a belief that things won't improve, and/or grief reactions exceed cultural expectations or 3-6 months.
MALINGERING	The patient intentionally pretends to have a condition (e.g., depressive symptoms) in order to gain something (for example more preferred housing).
PERSONALITY DISORDERS	Particularly Borderline Personality Disorder. A lifetime of maladaptive ideas can lead to secondary depressed mood (note: if patient meets criteria for MDD, both the personality disorder and major depression can be diagnosed). With borderline personality, mood shifts are rapid (happy one minute and sad the next, often associated with parasuicidal self-mutilation).
SUBSTANCE USE/ WITHDRAWAL	Mood symptoms follow the time course of the substance use and withdrawal. In substance abuse without comorbid depression, mood symptoms are absent when the substance is no longer active (this may require up to 6 months of abstinence). Antidepressant treatment of depression induced by substances may be appropriate in some cases rather than waiting 6 months for substance clearance and resulting symptom resolution.

DIAGNOSING DEPRESSION

MEDICAL DISORDERS WHICH MAY MIMIC OR BE COMORBID WITH DEPRESSION (listed alphabetically)	
BRAIN LESIONS	Brain tumors, CNS infections (HIV, neurosyphilis, Lyme disease), degenerative CNS conditions (e.g., Huntington's Disease), subcortical changes related to CAD, HTN, diabetes, etc., may cause depression.
CANCER	25% of cancer patients experience depression; depression may be present before cancer is diagnosed.
CARDIOVASCULAR MI/CAD	1/3 of patients may become depressed after MI. Those with major depression have 2-5 times increased risk of dying at 6-months after a myocardial infarction, even when controlling for compliance, baseline disease, and smoking. Coronary artery disease can cause depression and depression is an independent risk factor for coronary artery disease and its complications.
CEREBROVASCULAR CVA (HTN/CAD)	10-27% of post stroke patients experience depression. CAD/HTN patients may have subcortical lesions which are associated with hard to treat depression.
CHRONIC INFLAMMATORY SYNDROMES	Lupus and other conditions may rarely present primarily with depressive symptoms and patients with these syndromes may develop depression.
CHRONIC PAIN/FATIGUE	Pain and depression often coexist and the combination is associated with worse clinical outcomes than either condition alone. Treatment of chronic pain with antidepressant medication should occur by the primary care provider.
DEMENTIA	Dementia is often comorbid with depression. A depressive-like illness may be the only early sign of dementia, often associated with white matter changes on MRI. Dementia is associated with apathy and depression and both predict progression from mild cognitive impairment to dementia. Symptoms of dementia such as depression, apparent memory loss, irritability, sleep loss, and weight changes may resemble MDD. With dementia, there is often confabulation (e.g., denying memory difficulties) while with major depression, memory disturbances and sadness may be, if anything, exaggerated by the patient.
DIABETES	Depression is a common occurrence in diabetics (8.5-27% of diabetics).
EATING DISORDERS	Patients with bulimia and anorexia commonly have comorbid depression.
HIV INFECTION	HIV infection can cause neurological symptoms, including depression, even with undetectable virus and normal CD4 counts, because most antiretrovirals do not penetrate the CNS well. 1 in 3 HIV patients may experience depression.
PARKINSONISM	Depression occurs in Parkinson's disease in up to 50% of patients.
SERIOUS CHRONIC DISEASE	Comorbidity of major depression with chronic medical illness is very high.
SLEEP APNEA	Daytime fatigue and poor concentration are symptoms associated with depression and sleep apnea.
SUBSTANCE USE	Substance abuse disorders (alcohol and other substances) cause depression in about 27% of users.
THYROID DISORDERS	Hypothyroidism frequently presents with depression. Hyperthyroidism often presents psychiatrically with anxiety plus depression, agitated depression, or mania.
VITAMIN B12 DEFICIENCY	May cause neuropsychiatric symptoms, including depression, especially in the elderly. Malabsorption is the leading cause. Neuropsychiatric manifestations may be the only presenting sign, even in the absence of hematologic abnormalities.

SELECTED MEDICATIONS IMPLICATED IN DRUG INDUCED DEPRESSION*

(For a complete list of medications with reported adverse effect of depression, see Lifeline: Clinical Pharmacology at http://www.clinicalpharmacology-ip.com/default.aspx?id=20186432)

Drug	Incidence	Level of Evidence ‡
ANTICONVULSANTS		
Levetiracetam	4%	A
Phenobarbital	40%	B
Primadone	70%	B
Phenytoin	NK	C
Tiagabine	3%	A
Topiramate	5-10%	A
ANTIDEPRESSANTS		
Rarely agents in this class have been reported to exacerbate depression	1-4%	A
ANTIMIGRAINE AGENTS		
Triptans	23%	B
ANTIVIRAL AGENTS		
Efavirenz	1.6-2%	A
CARDIOVASCULAR AGENTS		
Clonidine	1.5%	C
Methyldopa	3.6%	B
HORMONAL AGENTS		
Corticosteroids	1.3-18%	B
Oral Contraceptives	NK	B
GnRH agonists (e.g., leuprolide)	26-54%	B
Tamoxifen	1-20%	A
IMMUNOLOGIC AGENTS		
Interferon-α	13-33%	A
Interferon-β	0-33%	A
RETINOIC ACID DERIVATIVES		
Isotretinoin	1-5.5%	B

NK = Not known GnRH = gonadotropin releasing hormone

‡ Levels of Evidence

A. There is evidence of causality from one or more randomized, controlled clinical trials.

B. There is evidence of causality from nonrandomized clinical trials, prospective, observational studies, cohort studies, retrospective studies, case-control studies, meta-analysis, and/or post marketing surveillance studies.

C. There is evidence of causality from one or more published case reports or case series.

**Drug Induced Diseases, 2010, ASHP, ed J.E. Tisdale, D.A. Miller, Section IV, Drug-Induced Psychiatric Diseases, Chapter 18: Depression.*

MEDICATIONS: ANTIDEPRESSANTS* (SEE SIDE EFFECTS PAGE 13, DRUG INTERACTIONS PAGE 14)

MEDICATION	DOSING	ADVERSE EFFECTS*/INTERACTIONS/COMMENTS
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIs)		
Citalopram CELEXA® Tabs: 10, 20, 40mg **$**	Initial dose: 20 mg in AM (10 mg in elderly) Usual dose: 20-40 mg once daily Maintain initial dose for 4 weeks before dose increase. If no response, increase in 10 mg increments every 7 days. Max dose: 40 mg/day, 20 mg/day for pts >60y/o or hepatic impairment	• FDA warning: Do not exceed 40 mg/day due to arrhythmia risk and dose related QT interval prolongation • Taking with food may reduce side effects • Few drug interactions • Avoid use with other agents which may prolong QT interval • D/C if QTc greater than 500ms
Escitalopram LEXAPRO® Tabs: 5, 10, 20mg $	Initial dose: 10 mg/day Usual dose: 10 mg once daily, range 10-20 mg/day Maintain initial dose for 4 weeks before dose increase. Increase dose 5-10 mg if partial response after 4 weeks. Max dose: up to 30 mg/day has been used	• Escitalopram is a more potent enantiomer of citalopram, lower doses usually effective • Risk of dose-related QT prolongation present, but appears to be less compared to citalopram • Few drug interactions • Taking with food may reduce side effects • Half-life (27-32 hours, longer in elderly or with hepatic impairment)
Fluoxetine PROZAC ® Tab/Caps: 10, 20mg **$** Soln: 20mg/5ml (Keyhea Only)	Initial dose: 20 mg in AM (10 mg in elderly and those with comorbid panic disorder) Usual dose: 20-60 mg once daily Maintain 20 mg for 4-6 weeks and 30 mg for 2-4 weeks before additional dose increases. Increase in 10 mg increments at 7-day intervals. If significant side effects occur within 7 days, lower dose or change medication. Max dose: 80 mg/day	• Long half-life (acutely 1-3 days, chronic use 4-6 days) useful for poor adherence, missed doses; has fewer discontinuation symptoms • Slower to reach steady state and slower to eliminate when D/Ced • Active metabolite has half-life ~10 days and renal elimination • Avoid in hepatic impairment (prolonged half-life) • May be too stimulating, especially in elderly • Potential significant drug interactions (Caution in patients taking multiple medications) • Taking with food may reduce side effects
Paroxetine HCl PAXIL® Tabs: 10, 20, 30, 40 mg **$**	Initial dose: 20 mg once daily, usually in AM (10 mg in elderly and those with comorbid panic disorder) Usual dose: IR=20-50 mg/day Maintain initial dose for 4 weeks before dose increase. Increase in 10 mg increments at 7 day intervals. Max dose: IR= 50 mg/day(40mg in elderly)	• Sometimes sedating • Anticholinergic effects can be troublesome • Discontinuation/withdrawal symptoms may occur • May cause less nausea and GI distress • Potential for significant drug interactions
Sertraline ZOLOFT ® Tabs: 25, 50, 100mg **$**	Initial dose: 50 mg once daily, usually in AM 25 mg for elderly Usual dose: 25-150 mg/day Maintain 50 mg for 4 weeks. Increase in 25-50 mg increments at 7-day intervals as tolerated. Max: 200 mg/day	• Drug interactions less likely • Preferred SSRI post myocardial infarction
SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIs)		
Venlafaxine XR EFFEXOR XR® Caps: 37.5, 75, 150mg -24hr **$$**	Initial dose: 37.5 mg XR in AM, increase to 75 mg XR in AM after 1 week, 150 mg XR in AM after 2 weeks. Usual dose: 75-225 mg/day If partial response after 4 weeks, increase to 225 mg in AM. Higher doses may increase efficacy in refractory depression due to increased norepinephrine effect. Max: 225mg/day XR dosage form	• May increase blood pressure at higher doses (control BP before starting) • Discontinuation/withdrawal symptoms may occur • Sexual dysfunction • Risk for drug interactions similar to fluoxetine • Immediate release (short acting) venlafaxine not authorized in CCHCS
Duloxetine CYMBALTA® Delayed Release Particles Caps: 20, 30, 60mg **$$**	Initial dose: 40 (20 mg bid) or 60 mg/day as a single or divided dose (30 mg bid) [20 or 40 mg in elderly] Usual dose: 30-60 mg/day Dose can be increased after 1 week not more than 30 mg/day. Maximum dose: 120 mg/day, although doses > 60 mg/d have not been shown to be more effective	• Urinary hesitancy • Sexual dysfunction • Discontinuation/withdrawal symptoms • Adjust dose if CrCl < 30 ml/min

MEDICATIONS: ANTIDEPRESSANTS* (CONT'D) (SEE SIDE EFFECTS PAGE 13, DRUG INTERACTIONS PAGE 14)

MEDICATION	DOSING	ADVERSE EFFECTS*/INTERACTIONS/COMMENTS
SEROTONIN AND NOREPINEPHRINE ANTAGONISTS		
Mirtazapine REMERON ® Tabs: 7.5, 15, 30, 45 mg $$ SolTabs: 15, 30, 45 mg **$$$**	Initial dose: 15 mg at bedtime Usual dose: 15-45 mg/day Increase in 15 mg increments as tolerated every 1-2 weeks. (7.5 mg in elderly) Maintain 30 mg for 4 weeks before further dose increase. Max dose: 45 mg/day	• Less or no sexual dysfunction • Sedation at low doses only (≤ 15 mg) • May stimulate appetite. Weight gain due to appetite stimulation • Risk of agranulocytosis • Few drug interactions • Lower dose may be needed with CrCl < 40 ml/min or with hepatic impairment • Discontinue by tapering
NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIBITOR (NDRIs)		
Bupropion WELLBUTRIN® Tabs: 75, 100 mg $$	Initial dose: 100 mg twice a day (once a day in elderly) Usual dose: 300-450 mg (in 3 divided doses) Increase to 100 mg three times a day after 7 days (slower titration for elderly) After 4 weeks, increase to maximum of 150 mg 3 times a day if necessary. Single dose should not exceed 150 mg. Hepatic impairment: 75 mg/day	**Bupropion Restrictions**: **Bupropion is nonformulary and highly restricted in DCHS/CCHCS due to significant safety issues.** Use requires approval of mental health manager & requires thorough documentation of indications and lack of response to at least 3 other antidepressants at maximum tolerated doses for clinical trial period of no less than 6-8 weeks with blood levels which confirm adherence with clinical trials. May not be used: • if patient has history of institutional drug abuse within past 2 years • history of medication misuse or hoarding • history of bulimia • history of seizures Other comments: • Can be stimulating; may increase anxiety or insomnia • Little or no sexual dysfunction • May induce seizures at higher doses • Avoid in patients with risk of seizures such as recent head trauma or significant CNS lesions • No significant serotonergic activity but may increase levels of SSRIs • Do not split or crush SR or XL products
Bupropion SR WELLBUTRIN SR® Tabs: 100, 150, 200 mg ER-12hr $$	Initial dose: 150 mg once a day Usual dose: 300-400 mg/day (two divided doses) Increase to 150 mg twice a day after 7 days. May increase to 200 mg twice a day after 4 weeks if indicated. Single dose should not exceed 200 mg. Lower doses in elderly and with hepatic impairment	
Bupropion XL WELLBUTRIN XL® Tabs: 150, 300 mg ER-24hr $$	Initial dose: 150 mg once daily (in the morning) Usual dose: 300-450 mg/day Increase to 300 mg daily after 7 days Increase to 450 mg per day after 4 weeks if necessary Max dose should not exceed 450mg/day in hepatic impairment: 150 mg	
SEROTONIN MODULATOR		
Vilazodone VIIBRYD® Tabs: 10, 20, 30, 40 mg $$$$	Initial dose: 10 mg daily for 7 days, then 20 mg/day for 7 days, then 40 mg once daily Usual dose: 40 mg/day Max dose: not > 80 mg/day	• Take with food for maximal efficacy • Potential for significant drug interactions • Discontinuation symptoms may occur, reduce dose gradually if possible • No dose adjustment needed for age or gender, renal or hepatic disease
SEROTONIN REUPTAKE INHIBITOR/ANTAGONIST		
Trazodone DESYREL® Tabs: 50 mg, 100 mg, 150 mg, 300 mg $	Initial dose: 150 mg/day in divided doses Usual dose: 150-600 mg/day in divided doses Dose may be increased by 50 mg every 3-4 days Max dose: 400 mg/day (outpatients) 600 mg/day (inpatients)	• May cause priapism (one case in 2000-4000 exposures) • Dosing after meals may decrease lightheadedness and postural hypotension • Orthostatic hypotension • Rarely used as monotherapy for depression • Highly sedating

BOLD = FORMULARY

*See prescribing information for complete description of adverse effects and drug interactions.

MEDICATIONS: ANTIDEPRESSANTS* (SEE SIDE EFFECTS PAGE 13, DRUG INTERACTIONS PAGE 14)

MEDICATIONS	DOSING	ADVERSE EFFECTS*/INTERACTIONS/COMMENTS
TRICYCLIC ANTIDEPRESSANTS (TCAs)		
Cyclic antidepressants include tricyclic antidepressants (and tetracyclic agents such as amoxapine and maprotiline [not included in this Care Guide]). These agents inhibit reuptake of serotonin and norepinephrine. The function and activity of these agents are determined by their side chains (tertiary amines, secondary amines, and others) as outlined below. TCAs are much more lethal in overdose than SSRIs.		
TRICYCLIC ANTIDEPRESSANTS— TERTIARY AMINES		
Amitriptyline Tabs: 10, 25, 50, 75, 100, 150 mg $ formulary status–see comments	Initial dose: 25 mg at bedtime, increase dose over 1-2 weeks to target of 200-300 mg/day usually in 2-3 divided doses (may be taken all at bedtime) Usual dose: 150-300 mg/day Max dose: 300 mg/day Amitripyline ♦ **Nonformulary for psychiatric diagnoses** ♦ Formulary for medical diagnoses	TERTIARY AMINES ♦ Serotonin blocking effect greater than norepinephrine effect ♦ Tertiary amines cause more side effects than secondary amines: • Anticholinergic side effects (blockade of muscarinic (M1) receptors) (dry mouth, constipation, urinary retention, blurred vision) • Alpha adrenergic blockade: orthostasis • Central antihistaminic effects (blocks H1 receptors): significant sedation • Also cause weight gain. ♦ Must be taken at therapeutic dose for sufficient duration (6-12 weeks) to assess adequacy of response ♦ Maintenance dose after recovery usually same dose which relieved symptoms ♦ Generally given once daily at bedtime due to sedating effects and long half-life ♦ May divide dose for side effect management. ♦ Serum levels may be useful to help establish dose (esp. in rapid or slow metabolizers) and to assess adherence ♦ Discontinuation syndrome may occur, taper over days to weeks
Clomipramine ANAFRANIL® Caps: 25, 50, 75 mg $$	Initial dose: 25 mg at bedtime, increase slowly over 2 weeks to about 100 mg/day. May increase to 250 mg/day over several more weeks, entire dose at bedtime Usual dose: 100-250 mg/day Max dose: 250 mg/day	
Doxepin SINEQUAN® Caps: 10, 25, 50, 75, 150 mg $	Initial dose: 25 mg at bedtime or in morning (10 mg in elderly or those sensitive to side effects) Increase by 25-50 mg every 3-4 days as tolerated Usual dose: 150-300 mg/day Max dose: 300 mg/day	
Imipramine TOFRANIL® Tabs: 10, 25, 50 mg $	Initial dose: 25 mg at bedtime (10 mg in elderly or those sensitive to side effects) Increase by 25-50 mg every 3-4 days as tolerated Usual dose: 150-300 mg/day Max dose: 300 mg/day	
TRICYCLIC ANTIDEPRESSANTS— SECONDARY AMINES		
Desipramine NORPRAMIN® *Tabs: 10, 25, 50, 75, 100* *150 mg* *$$*	Initial dose: 25-50 mg in the morning or at bedtime (10 or 25 mg elderly or those sensitive to side effects) Increase by 25 to 50 mg every 3 to 7 days to target dose of 150 mg—300 mg over 4 weeks (75 or 100 mg elderly) Usual dose: 100-300 mg (25-100 mg in elderly) Max dose: 300 mg/day	♦ Norepinephrine blocking effect greater than serotonin effect ♦ Best overall tolerability (with nortriptyline) ♦ Compliance and effective dose can be verified by serum concentration ♦ Can be stimulating, but may also be sedating to some patients ♦ Less sedating and fewer anticholinergic effects than most cyclic antidepressants
Nortriptyline PAMELOR® Caps: 10, 25, 50, 75 mg $ formulary status–see comments	Initial dose: 25 mg (10 mg in elderly) in the evening Increase in 10-25 mg increments every 5-7 days as tolerated to 75 mg/day Obtain serum concentration after 4 weeks: target range:50-150 ng/mL Usual dose: 50-150 mg Max dose: 150 mg/day Nortriptyline ♦ **Nonformulary for psychiatric diagnoses** ♦ Formulary for medical diagnoses	♦ Best overall tolerability (with desipramine) ♦ Compliance and effective dose can be verified by serum concentration ♦ Less orthostatic hypotension than other tricyclics

BOLD = FORMULARY

*See prescribing information for complete description of adverse effects and drug interactions.

MEDICATIONS: ANTIDEPRESSANTS* (SEE SIDE EFFECTS PAGE 13, DRUG INTERACTIONS PAGE 14)

MEDICATION	DOSING	ADVERSE EFFECTS*/COMMENTS
MONOAMINE OXIDASE INHIBITORS (MAOIs)		
Phenelzine NARDIL® 15mg Tabs $$	Initial dose: 15 mg three times daily Increase to 60-90 mg/day during early phase of treatment Onset of therapeutic effect 2-6 weeks Usual dose: 15-90 mg/day; Maintenance dose: After maximum benefit achieved, reduce dose slowly over several weeks to the lowest dose that maintains effectiveness to limit cumulative MAO-I effects and serious dose-related toxicity. Max dose: 90 mg/day	• **Potential for very serious drug and food interactions** • In patients receiving contraindicated drugs known to interact with MAOIs, the interacting drug should be discontinued for at least 1-2 weeks before initiating phenelzine therapy • Educate patient to avoid alcohol, excessive caffeine, and tyramine-containing foods (e.g., aged cheese, yeast extract, protein extract, soy sauce, fava bean or broad bean pods, smoked or pickled meats, smoked or pickled fish, chicken livers, smoked or pickled poultry, fermented meats or sausage, bananas, avocados, and any overripe fruit) • Pyridoxine deficiency may occur; symptoms include numbness and edema of hands; may respond to supplementation • Mild to moderate renal impairment, phenelzine should be used with caution due to potential for drug accumulation Contraindicated in patients • with abnormal liver function tests • hepatic impairment or a history of liver disease • with severe renal impairment.

MEDICATIONS: AUGMENTING AGENTS USED IN MDD

MEDICATION	DOSING	ADVERSE EFFECTS*/INTERACTIONS/COMMENTS
SECOND GENERATION ANTIPSYCHOTICS (SGAs)		
Aripiprazole ABILIFY® Tabs: 2, 5, 10, 15, 20, 30mg $$$$$	Initial Dose: 2-5 mg/day, may increase 5 mg/week to max dose. Max Dose: 15 mg/day	• May cause more nausea than other agents • Less sedating than other agents • Monitor lipids, glucose, and weight. CBC if hx leukopenia • Monitor Abnormal Involuntary Movement Scale (AIMS**)
Quetiapine XR SEROQUEL XR® XR Tabs: 50, 150, 200, 300, 400mg $$$$	Initial Dose: 50 mg/day x2d, then increase to 150 mg/day. Max Dose: 300 mg/day	• Low risk of QT prolongation • Sedation in XR form less than Olanzapine • Monitor lipids, glucose, and weight. CBC if hx leukopenia • Monitor AIMS*
Olanzapine ZYPREXA ® **Tabs: 2.5, 5, 7.5, 10, 15, 20mg** **$** Orally Dissolving Tablet (ODT): 5, 10, 15, 20 mg $$	Initial Dose: 5-10mg each PM. May use half dose for elderly Max Dose: 20 mg/day	• ODT & Injectable formulations require NF approval • Low risk of QT prolongation • Sedation is common. Consider HS dosing • Monitor patients with fall risks • Monitor lipids, glucose, and weight. CBC if hx leukopenia • Monitor AIMS*
OTHER MEDICATIONS		
Lithium **Cap: 300mg** **$$** **Tabs: 300mg, 450mg ER** **$$** **Oral Citrate Sol'n: 8 mEq/5ml** Note: 8mEq/5ml = 300 mg **$$**	Initial Dose: 600-1200 mg/day Give cap in 3-4 divided doses, tab in 2-3 divided doses, oral solution in 3 divided doses. Max Dose: 1800-2400 mg/day Give cap in 3-4 divided doses, tab in 2-3 divided doses, oral solution in 3 divided doses Avoid plasma lithium levels above 1.5 mg/L	• May cause hyponatremia • May cause thyroid disorders • Useful in depression at less than usual doses • Half-life 18-24 hours • Renal clearance • Shown to decrease rate of suicide
Liothyronine (T3) Tabs: 5, 25, 50 mcg $	Initial Dose: 12.5 -25 mcg/day Adjuvant Tx of depression: 12.5-25 mcg PO once daily	• Renal clearance • 2-5 day half-life • Response usually within 3 weeks
Buspirone Tabs: 5, 7.5, 10, 15, 30 mg $	Initial Dose: 30 mg/day divided BID or TID. Max Dose: 60mg/day	• Generally well tolerated • May take several weeks for response

BOLD = FORMULARY

*See prescribing information for complete description of adverse effects and drug interactions.

**AIMS– Abnormal Involuntary Movement Scale: see CCHCS Schizophrenia Care Guide

ANTIDEPRESSANT ADVERSE EFFECTS: INCIDENCE AND MANAGEMENT

GENERAL PRINCIPLES OF MANAGEMENT OF ANTIDEPRESSANT ADVERSE EFFECTS*

1. Allow patient to verbalize his/her side effect complaints.
2. Encourage waiting and reassure patient. Most side effects are early onset and time limited and can be managed by temporary aids to tolerance:(e.g., SSRI induced GI distress, agitation, anxiety, headache will subside over 1-2 weeks).
3. Treat the side effects (see table below).
4. Consult with PCP to rule out underlying medical condition if side effects persist after medication cessation.
5. Adjusting dose or switching medications may be indicated (see page 15).

ADVERSE EFFECTS	SSRIs & VENLAFAXINE	TCAs	BUPROPION	MIRTAZAPINE	MANAGEMENT STRATEGY
Restlessness Jitters/Tremors	++	+/-	++	-	• Start with small doses, especially with anxiety disorder • Reduce dose temporarily • Add beta-blocker (propranolol 10-20 mg bid/tid)
GI distress Nausea	++	-	+	-	• Often improves in 1-2 weeks • Take medication with meals • Consider switching to mirtazapine
Sexual Dysfunction	++	-	-	-	• May occur with depression or medical disorders • Decrease dose • Consider drug holiday
Serotonin Syndrome	+	+	-	-	• Monitor drug combinations (especially combinations of serotonergic agents). Watch for neurologic, cardiovascular, and vasomotor symptoms • May be life-threatening • See Serotonin Syndrome page 16.
Headache	+	-	+	-	• Reduce dose
Insomnia	+	-	+	-	• Take medication in the morning • Sleep hygiene counseling • Reduce dose • Encourage exercise
Anticholinergic effects: Dry mouth/eyes, constipation, urinary retention, tachycardia	+/-	+++	-	+/-	• Increase hydration • Dietary fiber • Artificial tears • Among the SSRIs, paroxetine is the most likely to cause anticholinergic symptoms
Sedation	+/-	++	-	+	• Give medication at bedtime • Consider alternative medication • Encourage exercise
Weight gain	+/-	+/-	+/-	++	• Exercise • Diet • Consider changing medications
Seizures	-	-	+	+/-	• Discontinue antidepressant • Refer for medical evaluation
Agranulocytosis	-	-	-	+/-	• Monitor for signs of infection • Stop drug, check WBC

Key: ++ Moderate, + Mild, +/- Uncommon, - Very unlikely

*See prescribing information for complete description of adverse effects and drug interactions.

DRUG—DRUG INTERACTIONS*

All antidepressants have potential for significant drug-drug interactions which may increase or decrease efficacy or toxicity of either agent.	For complete information on significant interactions refer to CCHCS Lifeline: ♦ External Links for Epocrates CCHCS formulary or ♦ External Links for Clinical Pharmacology located at: http://lifeline/HealthCareOperations/MedicalServices/Pharmacy/Pages/Home.aspx or ♦ Consult the manufacturer's prescribing information.

THE TABLE BELOW INDICATES MEDICATIONS CONTRAINDICATED WITH SELECTED ANTIDEPRESSANTS

ANTIDEPRESSANT DRUGS	CONTRAINDICATED DRUGS	
Fluoxetine Sertraline Paroxetine	• MAOI • Duloxetine • Venlafaxine	• Serotonergic agents • TCAs • Vilazodone
Citalopram	• MAOI • Azole antifungals (eg.,fluconazole, itraconazole, keto-conazole)	• Duloxetine
Venlafaxine	• Serotonergic agents including MAOIs, TCA, SSRIs • Azole antifungals (eg.,fluconazole, itraconazole, ketoconazole)	
Mirtazepine	• Serotonergic agents	• MAOI
Duloxetine	• MAOI • TCAs	• SSRIs • Serotonergic agents
TCAs	• MAOI • Venlafaxine	• SSRIs • Duloxetine
Trazodone	• Azole antifungals (eg.,fluconazole, itraconazole, ketoconazole)	• MAOI
Vilazodone	• MAOI • TCAs	• SSRIs • Serotonergic agents
Phenelzine (MAOI)	• Do not use with any other antidepressant. • Review drug information for all other agents before prescribing with MAOI.	

DEPRESSION IN PREGNANCY

GENERAL GUIDANCE
- ♦ Avoid use of medication during pregnancy
- ♦ Increase use of psychotherapy and frequent symptom monitoring

PREFERRED MEDICATIONS (If medications are required due to the severity of depression)
- ♦ SSRIs (fluoxetine, sertraline, and citalopram) are generally agents of choice for treatment of depression in pregnancy

OTHER MEDICATIONS
- Paroxetine should be avoided during the first trimester, and has been associated with malformations (ventricular and atrial septal defects)
- TCAs have been associated with neonatal withdrawal symptoms and anticholinergic adverse effects
- There are insufficient data about other newer antidepressants
- There may be a link between bupropion and spontaneous abortion
- SNRIs may carry an increased risk of pre-eclampsia
- Maternal use of SSRIs after 20 weeks of gestation has been associated with:
  - Persistent newborn pulmonary hypertension
  - A slight decrease in gestational age
  - Lower birth weight
  - Neonatal withdrawal syndrome
- Risks and benefits of continued SSRI use must be carefully weighed after 20 weeks gestation.

*See prescribing information for complete description of adverse effects and drug interactions.

SUMMARY | DECISION SUPPORT | PATIENT EDUCATION / SELF MANAGEMENT

ANTIDEPRESSANT MEDICATIONS IN CCHCS - DHCS

MEDICATION ADMINISTRATION

Keep on Person (KOP) Medications
The SSRI antidepressants fluoxetine, sertraline, and escitalopram may be prescribed for KOP administration (self-administration in DHCS) due to their relative safety in overdose and lack of abuse potential.

Direct Observed Therapy (DOT) or Nurse Administered (NA)
All other antidepressants, including citalopram (due to danger in overdose), venlafaxine, mirtazapine, paroxetine (due to abuse potential and/or danger in overdose) require NA or DOT administration at all times in DHCS.

NONADHERENCE

A CDCR 128-C must be completed and sent to a prescriber for nonadherence when a patient has missed 3 consecutive days of medications or 50% of any medication in one week either by refusal, no show, or if patient shows an unexplained or clinically significant pattern of missed medications.

A psychiatrist will evaluate the patient within 7-days of the referral for nonadherence with a mental health medication.

DOSING ADJUSTMENTS

INITIATION: For SSRIs, venlafaxine, and tricyclic antidepressants, start at the beginning of the therapeutic dosing range.

- When side effects are troublesome, reduce dose and increase more slowly.
- In the elderly, the debilitated, or those sensitive to medications, start at lower doses.

ASSESSING RESPONSE: For all antidepressants, allow four to six weeks at a therapeutic dose for best assessment of response.

- If response is partial or slight, but the medication is well tolerated, increase the dose.
- If patient has partial response and dose cannot be increased, consider adding a second antidepressant of a different class.
- If no response, symptoms are worse, or side effects are intolerable, switch antidepressants (see below).

SWITCHING ANTIDEPRESSANTS

Three methods which can be used to switch antidepressant medications are outlined below:

1. **Stop first drug**
   - A. Employ a washout period of no medication before beginning the new drug.
   - B. For drugs that can potentially interact (MAOIs), a washout period between antidepressants is required.
2. **Cross-tapering**
   - A. Often used when switching to an antidepressant with a different mechanism of action (e.g., SSRI to venlafaxine or mirtazapine).
   - B. Cross-tapering may be considered when switching from paroxetine or immediate release venlafaxine to avoid discontinuation syndrome. In general, taper antidepressants over 1-4 weeks.
     Important note: New symptoms observed during switch may arise from three different causes:
     - Discontinuation symptoms from stopping the first drug
     - Side effects of the new drug
     - Depression or anxiety symptoms because neither drug is working
   - C. When venlafaxine needs to be switched to an SSRI, a cross-tapering method is appropriate to prevent discontinuation syndrome. Generally, the venlafaxine dose may be lowered on day 1 while the SSRI is started at a low dose on day 1. Over the next 4 weeks, the dose of venlafaxine is gradually decreased while the SSRI dose is increased to maximum tolerated dose.
3. **Direct switching**
   - A. Change from SSRI to SSRI by direct switch. Switching to Fluoxetine, given its long half-life, is often used to prevent withdrawal when other SSRIs are being stopped. After a week, Fluoxetine itself can be completely stopped because it self-tapers.

SEROTONIN SYNDROME

DIAGNOSIS

Serotonin Syndrome **is not diagnosed until all other possible causes of symptoms have been ruled out**, including infections, intoxications, metabolic and hormone problems, and drug withdrawal.

CAUSES

- Starting or increasing dose of a serotonergic agent (even just a single SSRI may be associated with the condition).
- Combinations of medications which increase

SYMPTOMS

which may be life-threatening, can occur within minutes to hours, and may include:

- Agitation or restlessness
- Diarrhea
- Tachycardia, arrhythmias and hypertension
- Hallucinations
- Hyperthermia/sweating
- Headaches
- Ataxia/muscle spasms/seizures/ loss of muscle coordination
- Goose bumps
- Nausea/vomiting
- Hyperreflexia
- Fever/shivering
- Dilated pupils
- Confusion
- Unconsciousness

TREATMENT

Mild symptoms: Reduce or stop offending medication, symptoms usually resolve in 24-72 hours, symptoms may last much longer with prolonged half-life agents.

Moderate symptoms: Stop causative agent, monitor patient in medical setting, supportive care, consider treatment.

Severe or progressive symptoms: Stop causative agent, possible hospitalization and therapies including:

- Muscle relaxants for agitation, seizures, muscle spasms
- Oxygen and IV fluids
- Cyproheptadine to block serotonin production
- Agents to control blood pressure and heart rate
- Ventilator support
- Cooling for high fever

Inform patient about symptoms of Serotonin Syndrome and provide Patient Education Sheet (PE-2, pg 18).

SEROTONERGIC AGENTS

- SSRI antidepressants e.g., citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline
- SNRI antidepressants: serotonin and norepinephrine reuptake inhibitors e.g., trazodone, duloxetine, venlafaxine
- Other antidepressants: TCAs
- Monoamine oxidase inhibitors (MAOIs)
- Mood stabilizer/Anti-migraine medications such as triptans, carbamazepine, and valproic acid, and lithium
- Pain medications such as tramadol, cyclobenzaprine, fentanyl
- Illicit drugs, including LSD, ecstasy, cocaine, and amphetamines
- Herbal supplements, including St. John's wort, ginseng, nutmeg
- OTC cough and cold medications containing dextromethorphan

DISCONTINUATION SYNDROME

Discontinuation **syndrome or antidepressant withdrawal syndrome** occurs in some people with abrupt discontinuation or intermittent nonadherence, and rarely may occur with dose reduction. Symptoms are generally mild and self-limited.

- Does not occur with fluoxetine (long half-life)
- Frequently occurs with paroxetine and venlafaxine (short half-life)
- Is rare with antidepressant treatment of less than 5 weeks duration
- Usually occurs within 1-3 days after dose reduction and usually resolves within 10 days
- Symptoms may be mistaken for adverse medication effect, other medical condition, relapse, or worsening of depression

SYMPTOMS

- Flu-like Symptoms
- Aches/pain
- Nausea
- Dizziness
- Anxiety
- Headache
- Sleep disturbances
- Lethargy
- Extreme restlessness

MANAGEMENT

- Mild symptoms: Reassure patient
- More significant symptoms:
  - Increase the dose of the discontinued agent and taper more gradually.
  - Consider tapering no more frequently than 25% of the dose per week.
  - Substitute fluoxetine and cross-taper (gradually decrease dose of one antidepressant while gradually increasing dose of new antidepressant).

INFORM PATIENT

- Discontinuation or withdrawal symptoms may occur when reducing dose or changing antidepressant medications.
- Symptoms are usually mild, short-lived, and self-limiting but may cause distress.
- Remind patient on antidepressant medication about:
  - The importance of taking medication consistently
  - The importance of not abruptly stopping medication especially after therapy exceeding 3-4 weeks

DEPRESSION: WHAT YOU SHOULD KNOW

What is depression?

- It is more than just feeling "down in the dumps" occasionally.
- It is more than feeling sad following a loss or feeling hassled by hard times.
- It is a biological medical condition (just like diabetes or high blood pressure), which is very common in adults.
- It affects your entire outlook all the time including your thoughts, feelings, physical health, and behaviors.

How can I tell if I have depression?

You may have depression if you**:**

- Feel sad or “down in the dumps”
- Have a loss of interest in things you usually enjoy
- Feel slowed down or restless
- Have trouble sleeping or sleep too much
- Have low energy or feel tired all the time
- Have an increase or decrease in appetite or weight
- Have problems thinking or concentrating
- Feel worthless or guilty
- Have thoughts of death or suicide

How is depression treated?

- Treatment may include antidepressant medication and/or psychotherapy.
- There are many effective antidepressants; you and your doctor will determine the best choice for you.
- You may need to try a couple different medications before finding the one that works best.

What side effects are common with depression medication?

All people respond differently to medications.

Side effects may include:

- Feeling tired
- Stomach upset/nausea
- Headache
- Dry mouth/eyes
- Trouble sleeping
- Feeling restless or jittery
- Constipation
- Gaining weight
- Trouble passing urine

When should I contact my mental health team?

- If you think you might be having a side effect to your medication.
- At any time if you have concerns or questions about how you are feeling.

It is especially important to contact the team if you are feeling hopeless or have thoughts of hurting yourself or others.

WHAT YOU SHOULD KNOW ABOUT "SEROTONIN SYNDROME"

What is serotonin syndrome?

Symptoms that occur with high levels in your body of a chemical called serotonin, which is a chemical your body produces needed for your nerve cells and brain to function.

What causes serotonin syndrome?

- Certain prescribed medications increase serotonin levels.
- Some illegal drugs and dietary supplements also may increase serotonin levels.
- Higher doses or combinations of agents that increase serotonin levels may cause serotonin syndrome.

How can I tell if I have serotonin syndrome?

Too much serotonin causes symptoms that can range from mild to severe.

Severe serotonin syndrome can be fatal if not treated.

SYMPTOMS - These symptoms may go away within a day of stopping the medications.

- Shakiness or muscle twitching
- Agitation or restlessness
- Confusion
- Rapid heart rate and high blood pressure
- Dilated pupils
- Loss of muscle coordination or twitching muscles
- Muscle rigidity
- Diarrhea
- Headache
- Shivering
- Goose bumps

VERY SERIOUS SYMPTOMS

- High fever
- Seizures
- Irregular heartbeat
- Passing out
- Heavy sweating
- Severe muscle spasms or rigid muscles

When to see a doctor

- If you suspect you might have serotonin syndrome after starting a new drug or increasing the dose of a drug you're already taking, contact medical services right away.
- Do not wait until you get worse to see your provider.
- Be sure to tell your provider all the medications you are taking, including vitamins and supplements.
- If you have severe or rapidly worsening symptoms, seek immediate emergency treatment.

http://www.mayoclinic.org/diseases-conditions/serotonin-syndrome/basics/definition/con-20028946. Accessed 2014-07-22

PATIENT SELF HELP:

SLEEP HYGIENE TIPS

- **Try to get rid of or deal with things that make you worry and begin rituals that help you relax each night before bed such as a few minutes of reading.**
- **Get a full night's sleep on a regular basis and get up at the same time every morning.**
- **Avoid taking naps if you can.**
  Never take a nap after 3 p.m.
- **Keep a regular schedule.**
  Regular times for meals, medications, chores, and other activities.
- **Do not have any caffeine after lunch.**
- **Do not go to bed hungry, but don't eat a big meal near bedtime either.**
- **Avoid any tough exercise within six hours of your bedtime.**

REASONS TO EXERCISE

- Reduces stress
- Makes you feel happier
- Improves sleeping patterns
- Helps prevent strokes
- Improves joint function
- Improves muscle strength
- Improves quality of life
- Strengthens your bones

- Strengthens your heart
- Improves cholesterol levels
- Lowers high blood pressure
- Lowers risk of diabetes
- Reduces feelings of depression
- Increases energy and endurance
- Improves balance and coordination

DEPRESIÓN: LO QUE USTED DEBE SABER

¿Qué es la depresión?

- Es más que sentirse ocasionalmente con "el ánimo por los suelos."
- Es más que sentirse triste tras una pérdida o sentirse molesto en tiempos difíciles.
- Es una condición biológica (como la diabetes o la presión arterial alta) que es muy común en el adulto.
- Afectando siempre su visión de todo lo que le rodea así como sus pensamientos, sentimientos, bienestar físico, y su conducta.

¿Cómo puedo que tengo depresión?

Usted podría tener depresión si saber:

- Se siente triste o con "el ánimo por los suelos."
- Ha perdido interés en cosas que usualmente goza
- Se siente lento o nervioso
- Tiene problemas durmiendo o duerme mucho
- Tiene poca energía o se siente a menudo cansado(a)
- Tiene aumento o disminución de apetito o peso
- Tiene problemas pensando o concentrándose
- Se siente sin valor o culpable
- Tiene pensamientos de muerte o de suicidio

¿Cómo se trata la depresión?

- El tratamiento incluye medicamentos antidepresivos y/o consejos de soporte.
- Existen muchos antidepresivos efectivos; usted y su proveedor medico pueden determinar cuál es el mejor.
- Quizás tendrá que probar varios medicamentos antes de encontrar el más eficaz.

¿Cuáles son los efectos secundarios mas frecuentes de los medicamentos antidepresivos?

Todas las personas responden de una manera diferente a los medicamentos.

Los efectos secundarios pueden incluir:

- Sentirse cansado
- Malestar de estómago/naúsea
- Dolor de cabeza
- Sequedad de la boca/ojos
- Problemas al dormer
- Sentimientos de inquietud y nerviosismo
- Estreñimiento
- Aumento de peso
- Problemas orinando

¿Cuándo debo comunicarme con mis proveedores de salud mental?

- Si cree que puede estar experimentando efectos secundarios a su medicamento(s).
- En cualquier momento que tenga alguna preocupación o pregunta acerca de cómo se siente.

Es muy importante que usted se ponga en contacto con el elenco tratante si siente que ha perdido toda esperanza o está pensando hacerse daño a si mismo o a otros individuos.

LO QUE DEBE SABER DEL "SINDROME DE LA SEROTONINA"

¿Qué es el síndrome de la serotonina?

Son síntomas que ocurren en su cuerpo debidos a altos niveles de serotonina, una sustancia química que su cuerpo produce y a la vez necesita para que sus células nerviosas y su cerebro funcionen bien.

¿Qué causa el síndrome de la serotonina?

- Algunos medicamentos aumentan los niveles de serotonina.
- Algunas drogas ilícitas y suplementos dietéticos también pueden aumentar los niveles de serotonina.
- Altas dosis o combinaciones de sustancias que aumentan los niveles de serotonina también pueden causar el síndrome de la serotonina.

¿Cómo puedo saber si tengo el síndrome de la serotonina?

Demasiada serotonina puede causar síntomas que pueden ser leves o severos.
El síndrome severo de la serotonina puede ser fatal ser fatal si no se trata.

SINTOMAS - Estos sintomas pueden desaparecer en un día al descontinuar los medicamentos

- Temblores o espasmos musculares
- Agitación o nerviosismo
- Confusión
- Pulso rápido y alta presión arterial
- Pupilas dilatadas
- Pérdida de coordinación o espasmos musculares
- Rigidez muscular
- Diarrea
- Dolor de cabeza
- Escalofríos
- "Carne de Gallina"

SINTOMAS MUY SERIOS

- Fibre alta
- Convulsiones
- Pulso irregular
- Desmayo
- Suduracion extrema
- Severos espasmos o rigidez musculares

¿Cuándo es necesario ver a su proveedor médico?

- Si sospecha que podría tener el síndrome de la serotonina después de comenzar un nuevo medicamento o al aumentar la dosis de una medicina que ya estaba usted tomando, contacte los servicios médicos inmediatamente.
- No espere a sentirse peor para ver a su proveedor médico.
- Informe a su proveedor de todas las medicinas que toma, incluyendo vitaminas y suplementos.
- Si tiene síntomas severos o si sus síntomas se agravan rápidamente, busque tratamiento de emergencia.

http://www.mayoclinic.org/diseases-conditions/serotonin-syndrome/basics/definition/con-20028946. Accessed 2014-07-22

AUTOAYUDA AL PACIENTE:

CONSEJOS DE HIGIENE DEL SUEÑO

- **Intente no pensar en cosas que puedan preocuparle y trate de hacer cosas que puedan ayudarle a relajarse antes de ir a dormir como por ejemplo leer por unos minutos.**
- **Duerma la noche completa con regularidad y levántese a la misma hora de la mañana.**
- **Evite tomar siestas si puede**
  Nunca debe tomar una siesta despues de las 3:00 de la tarde.
- **Mantenga un horario regular**
  Horas regulares para comidas, medicamentos, tareas habituales y otras actividades.

- **No tome cafeína después del mediodía.**
- **No se vaya a la cama con hambre, pero no coma una gran comida antes de dormir.**
- **No haga ejercicios pesados por aproximadamente seis horas antes de acostarse.**

RAZONES PARA HACER EJERCICIO

- Reduce el estrés
- Le hará sentir más feliz
- Mejora el patrón del sueño
- Ayuda a prevenir la apoplejía cerebral
- Mejora las funciones articulares
- Aumenta el poder muscular
- Mejora la calidad de vida
- Fortalece sus huesos

- Fortalece su corazón
- Mejora los niveles de colesterol
- Baja la presión arterial
- Disminuye el riesgo de diabetes
- Reduce los sentimientos de depresión
- Aumenta la energía y la resistencia física
- Mejora el balance y la coordinación