

10 MINUTE CLINICAL PODCAST

DEPRESSION

Dr. Roger Henderson

- Depression is the commonest psychiatric disorder
- 80% of UK cases treated in primary care
- 5% of adults will have a depressive episode at some time
- More common in women but men are at greater risk of suicide
- Primary care screening is helpful (such as PHQ-9)
- Clinicians choice regarding whether investigations are required in each case
- When treating, review after two weeks (incl. telephone/video currently)
- For mild cases, CBT is first line treatment (availability/waiting time issues)
- If suicidal risk/ideation and/or under 30 review in one week.
- Ideally review every 2-4 weeks for three months.
- If no improvement after one month, check compliance. If good, consider increasing the dose or changing Rx.
- If improving, continue for 6 months
- Mild cases have a high chance of spontaneous recovery.

- 10% of cases have persisting symptoms. Prognosis worse in personality disorders / anxiety / psychosis features.
- Average depressive episode lasts 6/12. Recurrence risk increases with repeat episodes (50% after one).
- Consider antidepressants in mild cases if symptoms persist despite IAPT, especially in people with a previous history of worsening depression and/or symptoms present for more than 2 years
- In moderate or severe cases use antidepressants + CBT and can consider a psychiatric opinion (can include ECT)
- SSRIs are as effective as TCA's but with less risk in overdose and a better side effect profile. Look at what has worked previously if applicable.
- Choice of SSRI is usually prescriber preference. Should be generic due to efficacy equivalence (but Cochrane review suggests escitalopram *may* be most effective, with highest likelihood of remission).
- Remember that sertraline has fewer drug-drug interactions, so can consider in polypharmacy. Also, increased bleeding risk with SSRIs so consider PPI if aspirin/NSAID also being taken.
- Always explain time to work (typically 2-3 weeks)
- When stopping, reduce gradually over 4-8 weeks and remember the long half-life of Fluoxetine – may be stopped more quickly
- Explain possible withdrawal symptoms and reassure if mild. If significant, add back and withdraw more gradually.

References and resources

- [Overview | Depression in adults: recognition and management | Guidance | NICE](#)
- [Depression in adults - Symptoms, diagnosis and treatment | BMJ Best Practice](#)
- [Overview - Clinical depression - NHS \(www.nhs.uk\)](#)

