Objectives

- Identify the DSM-V criteria for diagnosing mood disorders
- Review clinical features which may help providers to distinguish between diagnoses in their patients
- Describe an evidence based management approach to treating patients with depression or anxiety disorders

Diagnostic and Management Pearls for Anxiety and Depression

46th Annual Winter Refresher Course
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Treatment of Mood Disorders is somewhat simple...
- Medications
- Psychotherapy
- Both Medications and Psychotherapy
- Too many disorders to cover all criteria
- Clinically it is not important to distinguish (i.e. does the patient have social anxiety disorder or generalized anxiety disorder)—except for a few disorders where approach to treatment is different

Depressive Disorders in DSM 5
- NEW Disruptive Mood Dysregulation Disorder (Out of proportion developmentally inappropriate temper tantrums 3+ times per week age of onset 6-18 years)
- Major Depressive Disorder (unchanged need 5 symptoms that persist for at least 2 weeks)
- Persistent Depressive Disorder (Dysthymia) (2 or more symptoms for at least 2 years)
- Premenstrual Dysphoric Disorder
- Substance/Medication Induced Depressive Disorder
- Depressive Disorder due to General Medical Condition
- *DON'T FORGET MAJOR DEPRESSIVE EPISODES OCCUR IN BIPOLAR DISORDER

Depressive Disorder Details
- Major Depressive Disorder SIGECAPS Sleep, Interest, Guilt, Energy, Concentration, Appetite, Psychomotor Agitation/Retardation and Suicide *there is a better way to ask
- Persistent Depressive Disorder (Dysthymia) use medication but get these glass half empty patients into psychotherapy
- Substance/Medication Induced Depressive Disorder—stop drinking 1L of vodka per day
- Depressive Disorder due to General Medical Condition—treat that patient’s pancreatic cancer
- Bipolar Disorder patient with depression—need to be on a mood stabilizer but this disorder has become way over diagnosed

How to Pick Which Antidepressant Drug
Antidepressants work 2/3 of time, in some studies barely separate from placebo
These medications take 4-6 weeks to work so most important factor is patient has to be willing to stay on it
- What worked for a family member (placebo)
- Cost/insurance formulary
- By Side Effect Profile/tolerability
- Ease of titration: generally medications will work for depression at lower doses than what is required for anxiety. Fewer steps better in patients who are going to read package insert from pharmacist and get all side effects.
Pharmacotherapy Favorites

<table>
<thead>
<tr>
<th>Medication</th>
<th>Indications</th>
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<tbody>
<tr>
<td>Fluoxetine (SSRI)</td>
<td>Sleepy, Nonadherent or overweight patients on few other medications</td>
</tr>
<tr>
<td>Sertraline (SSRI)</td>
<td>Constipated patients</td>
</tr>
<tr>
<td>(Es)Citalopram (SSRI)</td>
<td>Need easy titration=escitalopram</td>
</tr>
<tr>
<td>(Des)Venlafaxine (SNRI)</td>
<td>Failed SSRI, not good in patients w gerd or hypertension or nonadherence</td>
</tr>
<tr>
<td>Duloxetine (SNRI)</td>
<td>Failed SSRI, Patients with pain</td>
</tr>
<tr>
<td>Tricyclics (nortriptyline)</td>
<td>Patients with pain, somatic disorders</td>
</tr>
<tr>
<td>Mirtazapine</td>
<td>Pts w insomnia, nausea/anorexia or on linezolid or worried about sex fxn</td>
</tr>
<tr>
<td>Bupropion</td>
<td>Worried about sex fxn, sleepy pts who need energy but don’t have seizures/EDOs</td>
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Psychotherapy

- The side effect free treatment for mood disorders
- Cognitive behavioral therapy has the most evidence in terms of RCTs showing efficacy
- Just like medications won’t work if the patient won’t take them, psychotherapy won’t work if the patient doesn’t go
- MCW psychiatry residents have sliding scale clinic at Columbia St Mary’s but patients with substance use disorders not accepted

How do I Find a Therapist

http://www.psychologytoday.com
- Find a therapist by zip code
- Red Check Mark “verified by psychology today” Wisconsin license valid without disciplinary action
- Areas of expertise
- Age ranges
- Treatment orientation: CBT number 1 or 2
- Payment options

Case 1 Depression in Medically Ill

46 y/o F with iron deficiency anemia but no psych hx admitted for “failure to thrive.” She had a weight loss over past 1-2 years from highest weight of 130 pounds, to admission weight of 59 pounds. Psych consult called to assess for depression or eating disorder.

On Exam: She endorsed low energy, sleeping all the time, no appetite, spending less time doing previously enjoyed activities and had impaired concentration on formal testing. She denied eating disorder symptoms stating she knew she was too thin and was hoping to get her appetite back so she could restore weight.

How to Distinguish SAD from SICK

- Patient met criteria for major depression (low energy, increased sleep, no appetite, loss of interest and had impaired concentration )
- However these symptoms were due to being starved due to her undiagnosed gastric adenocarcinoma preventing gastric emptying
- When assessing for 5 symptoms not sleeping due to pain, not doing previous activities because you are now paralyzed, having no energy with a Hgb of 5, having chemo brain don’t count
- Inappropriate Guilty feelings, Anhedonia, Hopelessness, Suicidality, Psychomotor agitation/retardation

Case 2 “Bipolar Depression”

51 y/o Female diagnosed two months earlier with locally advanced pancreatic cancer, undergoing chemotherapy in hopes of becoming candidate for Whipple admitted with nausea & vomiting. Psych consult was requested for depression. Sleep problems, weight loss, guilty feelings, low energy, thoughts of death (passive death wish)like quitting treatment, impaired concentration.

On disability for bipolar disorder which was diagnosed 8 years earlier during a hospitalization after her teenage son died of asthma attack
She had been seen by two other consult attendings in previous 2 months.
Why I Believed her “Bipolar was Bogus”

- Mania Must be Met – poor sleep at night after son died of asthma attack at 2am
- Mood Reactivity vs. sustained mood episodes: Set curtains on fire as adolescent
- Many Meds/Marginal benefits: using depakote prn to avoid yelling at kids
- Unstable relationships: 6 kids by 4 dads (none still in contact) and only the 1 out of 3 kids still living at home talk to her (28 y/o daughter offered to help care for 13 year old baby sister only if made paid caregiver)

Bipolar Disorder vs. Cluster B

- Prevalence 1-2% for Bipolar Type I
- Cannot reliably diagnose if patient has an active substance use disorder
- Bipolars generally do not have criminal behavior outside of major mood episode
- A “rapid cycling” bipolar by definition has 4 mood episodes per YEAR

DSM 5 Criteria for Manic Episode

- A. Distinct period of persistently elevated, expansive or irritable mood lasts at least one week or hospitalized
- C. Mood disturbance is severe enough to impair occupational functioning, social activities/relationships, requires hospitalization for safety or involves psychotic features
- D. Symptoms are not related to substance use or general medical condition

Manic Episode Symptoms

- B. 3 symptoms during period, 4 if irritable:
  1. Inflated self esteem/grandiosity
  2. Decreased need for sleep
  3. More talkative, pressured to keep talking
  4. Flight of ideas or racing thoughts
  5. Distractibility
  6. Increase goal directed activity/psychomotor agitation
  7. Excessive pleasurable activities with high potential for painful consequences

DSM 5 Cluster B Personality Disorders

- Antisocial
  1. Impulsivity
  2. Irritability
  3. Reckless disregard for safety
  4. Consistent irresponsibility
- Borderline
  1. Unstable relationships
  2. Impulsivity
  3. Recurrent suicidal behavior
  4. Affective instability i.e. irritability

Treatment for Bipolar Depression

- Antidepressants- risk of switching led to bupropion preference
- Fluoxetine/olanzapine
- Lithium
- Lamotrigine
- Antipsychotics Quetiapine
- Valproic Acid
- ECT
Suicide in Bipolar Disorder – Why besides Rx changes can’t miss

- 20 fold increase risk compared to general population
- Lithium reduces suicide risk. Clozaril also used
- A significant minority of completed suicides occur when the patient is NOT depressed. Males & patients with psychotic symptoms at increased risk

Why Anxiety Disorders Matter

- Prevalence is 19.5% in primary care
- Untreated in 41%
- Up to 35.6% of patients with untreated anxiety self-medicate with drugs/alcohol
- Treatment was easy in the CALM trial medications + Cognitive Behavioral Therapy

Anxiety Disorder Diagnostic Pearls

- Acute stress disorder is 3 day to one month post traumatic event = post traumatic stress disorder
- Don’t confuse obsessive compulsive disorder with obsessive compulsive personality disorder
- Generalized Anxiety Disorder need to be a persistent worrier for at least 6 months
- PANIC DISORDER is the one disorder I always benzodiazepine “bridge” however similar to bipolar the self diagnosis has led to over diagnosis

Case #1 (Psych Consult for Anxiety)

HPI: 28y/o F found down next to deceased boyfriend admitted w compartment syndrome, rhabdo, AKI, hyperkalemia, UDS +opiates, THC, cocaine.
Past Hx: Bipolar 2, Depression, Anxiety, ADHD, PTSD, hepatitis C, substance use disorder
Medications: alprazolam 1mg TID, trazodone 200mg qhs, quetiapine 100mg TID, venlafaxine 37.5mg qd, gabapentin 200mg TID, amphetamine/dextroamphetamine 30mg daily (snorting)
Social Hx: Mother was legal guardian of 8 yo daughter, homeless and unemployed, 2 brothers refused contact from hospital

DSM 5 Anxiety Disorders

- Substance Induced Anxiety Disorder
- Anxiety due to medical condition
- Panic Disorder +/- Agoraphobia
- Generalized Anxiety Disorder
- Social phobia/social anxiety disorder
- Specific phobia
- Separation Anxiety Disorder

OBSESSIVE COMPULSIVE AND RELATED DISORDERS

- Obsessive-Compulsive Disorder
- Trichotillomania
- Excoriation (skin picking) added to DSM-5

TRAUMA RELATED DISORDERS

- Posttraumatic Stress Disorder
- Acute Stress Disorder
- Adjustment disorder with anxiety
### Psychiatry Consult: Interview Highlights

- **Pt:** "I wanted to see you for anxiety. You can either increase my Xanax to 2mg three times a day or increase the frequency to 1mg every 4 hours, whichever you think is best."
- **Me:** "Are there any other medications you take or have taken in the past 15 years that have helped your anxiety?"
- **Pt:** "No. Well maybe oxycodone."
- **Me:** "Have you tried paroxetine, citalopram, fluoxetine, duloxetine, buspirone, hydroxyzine… ?"
- Patient responded "Yes and it didn’t help" to every drug listed, sometimes before I finished saying the drug name, including the drug "pseudocalmopine."

### Case #1 Diagnoses

- Bipolar Disorder Type 2
- Depression
- Anxiety
- ADHD
- PTSD
- Substance Use Disorder (illicit and prescription drugs) with substance induced mood disorder

### Alprazolam - The Evidence

- **GOOD** safe and effective for most patients, provide quick relief of target symptoms like anxiety
- **BAD** sedation, incoordination
- **UGLY** potentially lethal in overdose, risk of abuse, drug diversion, withdrawal syndromes
  - *Effective for anxiety but sedation, withdrawal and abuse are common according to the evidence*
  - **According to my colleague "Xanax starts and ends with an X because it should never be used."**

### Benzodiazepine Bloopers

- Lack of an appropriate diagnosis
- No documentation of intolerable side effects or residual symptoms with first line treatment
- Ignoring warning signs of inappropriate use
- Unclear documentation of benefit
- No assessment of suicidality

### Steps for Safer Use

1. Diagnose a condition for which a benzodiazepine is indicated
   - Panic disorder
   - Primary insomnia
   - Obsessive Compulsive Disorder
   - Seizures
   - Muscle spasms
   - Generalized Anxiety Disorder
   - Post traumatic stress disorder
   - Social Anxiety Disorder / Social Phobia

2. Document failure of first line therapy either due to residual symptoms or intolerable side effects
   - Selective Serotonin Reuptake Inhibitor (SSRI) or SNRI venlafaxine (Effexor)
   - Functional impairment due to anxiety that warrants temporary benzodiazepine use while SSRI is titrated
   - Psychotherapy
   - Sleep hygiene
Steps for Safer Use
3. Conduct and document a risk-benefit discussion with patient
   • Consider history of addiction
   • Document patient's alcohol use
   • Warn patient about risk of driving
   • Identify target symptoms
   • List specific potential benefits that can be evaluated for and recorded

Steps for Safer Use
4. Select the appropriate benzodiazepine
   • FDA approved indication
   • Short vs. long half life
   • Active metabolites
   • Drug interactions

Steps for Safer Use
5. Dispense the appropriate number of pills
   • Intended for chronic or temporary use
   • Do not write for multiple months supply if follow up is in weeks
   • If it is appropriate to dispense a significant quantity, document an assessment of suicidality

Steps for Safer Use
6. Follow Up
   • Document side effects
   • Document benefits
   • Monitor for signs of misuse lost prescriptions, early refills, rapid dose escalation, urine drug screen, pill count
   • Enact a discontinuation plan when appropriate to ensure safe taper

Inpatient Vs. Outpatient Setting
• Use of benzodiazepines is often appropriate in an acute care hospital – why wait a month for the medication to help. However, this may not be appropriate in patients (like our case) where you do not wish to continue benzodiazepines upon discharge
• If you are using PRN, and do not intend to prescribe to patient on discharge CHECK the MAR. Some patients with prolonged course or ICU stay may need to have a scheduled taper

Treatment Strategies Specific to type of Anxiety Disorder
• Substance induced anxiety- stop it
• Anxiety due to medical condition- treat it
• Specific phobia- exposure therapy even more helpful than CRT in some cases
• Panic disorder patients with frequent attacks deserve a benzodiazepine bridge to prevent agoraphobia which is actually what leads to the disability
**Panic Disorder**
- Prevalence is 2-3%
- Recurrent, unexpected panic attacks
- FOR at least ONE month AFTER: EITHER Worry about having another attack or its consequences, OR maladaptive change in behavior due to attack
- Not due to substance or medical condition
- With or without agoraphobia
- Panic attack: a discrete period of intense fear with 4 or more symptoms with abrupt onset that peaks in minutes

**Panic Attack Symptoms**
- Palpitations, heart racing/pounding
- Sweating
- Trembling/shaking
- Shortness of breath/smothering
- Feeling of choking
- Chest pain or discomfort
- Nausea or abdominal distress
- Dizzy, lightheaded, faint, unsteady
- Derealization or depersonalization (being detached from oneself)
- Fear of losing control or going crazy
- Fear of dying
- Paresthesias (numbness or tingling)
- Chills or heat sensations

**Is It Panic Disorder?**
- Most panic disorder patients have had at least one unprovoked attack
- Panic attacks don’t last for hours, peak is within minutes
- Most patients will have positive family history of panic or alcoholism
- Most patients will be able to describe 4+ symptoms without you giving them the list
- "Tell me about the first time you ever had a panic attack." (psych consult in 54 y/o w lymphoma)

**First Line Anxiety Rx**
- Selective Serotonin Reuptake Inhibitors
  - Sertraline (OCD, Panic, PTSD, Social Anxiety)
  - Escitalopram (GAD)
  - Fluoxetine (OCD, Panic Disorder)
  - Fluvoxamine (OCD, Social Anxiety)
  - Paroxetine (Social Anxiety, Panic, GAD, PTSD)
- Citalopram
- Selective Serotonin Norepinephrine Reuptake Inhibitors
  - Venlafaxine (GAD, social anxiety, Panic)
- Desvenlafaxine
- Duloxetine

**Second Line Anxiety Rx-Options**
- Mirtazapine
- Tricyclic Antidepressants TCA's
  - Mostly norepinephrine: desipramine, nortriptyline
  - Mostly serotonin: Clomipramine (OCD)
- Consider Augmentation Strategies if Partial Response
  - Anticonvulsants: gabapentin, pregabalin quicker onset
  - Serotonin Agonist: buspirone
  - Beta blockers: pindolol, propranolol good for panic
  - Antihistamine: hydroxyzine for patients who need a prn but you are reluctant to give benzodiazepine

**Third Line Anxiety Rx Options- time to call psychiatry for help**
- MAOIs
- Augmentation with a low dose atypical antipsychotics olanzapine, quetiapine, risperidone (all have risk of metabolic syndrome)
- Augmentation with a low dose of haloperidol
- HERBALS
  - chamomile at least has some data (one small RCT in GAD), Kava poor evidence
  - Valerian poor evidence
  - St John’s Wort poor evidence
Summary: Take Home Points

- Don’t memorize criteria for everything because the treatment of the majority of mood disorders is the same (learn manic episode, panic attack)
- Consider if a "depressed" patients can be directly attributable to medical illness
- Bipolar disorder is often confused with Cluster B Personality disorders, so consider this when screening depressed patients for history of manic episodes using an open ended question
- Benzodiazepines work great, but use them wisely

Bibliography in addition to DSM V