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Psychotherapeutic Medication: Treatment Resistant Depression

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Psychotherapeutic Medication: Treatment Resistant Depression

Abstract

Disciplines
Pharmacy and Pharmaceutical Sciences

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Currents in Psychiatric Pharmacotherapy

Treatment Resistant Depression

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Meet KO...

Discussion of Treatment–Resistant Depression (TRD)

Discuss and share general approaches to patient information (based on most current evidence)

Discuss medication adverse effects, intolerances and safety implications (based on most current evidence)

Make a therapeutic suggestion for KO looking at the factors that make her a unique individual

Facilitate and direct Question–AND–Answer session
KO is a 34 year old female with a history of major depressive disorder (recurrent, severe). She reports that while she is feeling more “able to do things” she is not feeling any less depressed, especially in the evenings when she is home alone and trying to unwind. She denies any suicidal thoughts but reports that she will often just cry in front of the television. She was titrated to bupropion 200 mg PO daily while using sertraline 150 mg PO QAM. This combination has been used for 4 weeks. She wants to know if anything else can help her to manage her depression and reduce symptoms.
What would you like to know about KO?
Approaching Treatment Resistant Depression

- Medication History
- Treatment duration and dose optimization
- Allergies and intolerances
- Other medical or psychiatric conditions
- Prior suicide attempts
Approaching Treatment Resistant Depression

- Medication History
  - Past medication trials
  - Adherence history
  - Intolerances
  - Reasons for discontinuation
  - Health-belief models
Approaching Treatment Resistant Depression

- Treatment duration and dose optimization
  - Time frame for gauging efficacy
  - Dose titration
  - Optimal response time
  - Placebo effect
  - “Switching”
  - Combinations
Approaching Treatment Resistant Depression

A Note on Combinations

- Use of 2 antidepressants – Possible Complications
  - Drug – drug interactions
  - Serotonin syndrome
  - Neuroleptic malignant syndrome (dopamine effects with serotonergic effects)

- Adding non-antidepressant to antidepressant
  - Buspirone
  - Atomoxetine
  - Lithium
  - Liothyronine
  - Lamotrigine
  - Atypical antipsychotics
Approaching Treatment Resistant Depression

- **Allergies**
  - Anaphylactic reactions
  - Generally rare with psychiatric medications

- **Intolerances**
  - Sedation
  - Weight gain
  - Movement disorders
  - Anxiogenesis
  - Sexual dysfunction
  - Other negative experiences
Other medical and psychiatric conditions
  ◦ Bipolar I and II
  ◦ Anxiety disorders
  ◦ Insomnia and sleep disorders
  ◦ Psychosis / schizophrenia
  ◦ Hypertension and cardiac disease
  ◦ Chronic metabolic disorders
  ◦ Immune–suppression
  ◦ Age considerations
Antidepressant Medication History: FLUV, PHEN, FLUOX, PAROX, CITAL, ESCIT, AMIT, TRAZ and MIRT

- Each medication was used at least 12 weeks

- Partial response to symptoms included:
  - Reduced suicidal thoughts and ideation
  - Increased energy
  - Improved sleep patterns
  - Improved appetite patterns

- Nagging feelings of guilt, anhedonia, and inner rumination persist
More Information about KO!

- Treatment duration / Dose optimization
  - All titrated until target dose or side effect

  - All medications were used at therapeutic doses

  - Judicious titration methods

  - Constant follow-up

  - Adherent to appointments and treatment regimens
Allergies/Intolerances

- No Allergies
- Sexual dysfunction with FLUV, FLUOX, PAROX, CITAL, ESCIT
- Palpitations with AMIT
- Weight gain with TRAZ and MIRT
Other Medical/Psychiatric Conditions and Stress Factors
- Hypertension – most recent 148/94 mm Hg and 88 beats/minute
- Insomnia – difficulty getting to sleep
- Anxiety – general and secondary to lack of sleep – worries about losing job
- Body dysmorphic disorder – worries about appearance and cosmetic impact of drug therapy (history of bulimia and anorexia – currently not vomiting or starving)
- Recurring stressors: twin sister died in car accident (she was the driver and both had been drinking) and her work schedule did not allow her to attend the funeral
- Currently “successful” – but cannot bring herself to enjoy anything since the event
More Information about KO!

Current Medication Regimen:
- Lisinopril 20 mg PO BID
- Amlodipine 10 mg PO daily
- ASA (OTC) 81 mg PO daily
- Alli (OTC) 1–2 capsules before each fattening meal
- Sertraline 150 mg PO QAM
- Bupropion 200 mg PO QAM
- Diphenhydramine 50 mg PO QHS as needed
Prior overdose with OTC medications (ASA, APAP) and BENZOS

- She has access to OTC medications such as ASA, Ibuprofen, APAP and antihistamines
- She has no chronic problems with pain but has ASA on a daily basis
- Takes Ibuprofen and/or APAP for pain related to exercise episodes (current form of “purging” calories)
Augmentation Options…

- Patient currently on optimal target doses: already using combination of SSRI and dopamine reuptake inhibitor

- Combinations to avoid:
  - VENLA + SSRI / MIRT (bleeding)
  - VENLA + FLUOX (serotonin syndrome risk)

- Options to “add-on”:
  - Buspirone
  - Already on bupropion
  - Aripiprazole, Risperidone, Ziprasidone, Quetiapine (immediate/extended release)
  - Comeback of Symbyax?
  - Lamotrigine, liothyronine / levothyroxine
  - Others: modafanil, atomoxetine, and methylphenidate
Plan of Action?

- Plan A: Add nothing after determining that she needs to continue this combination at least another 4 weeks?

- Plan B: Increase the dose of either the sertraline or the bupropion?

- Plan C: Recommend psychotherapy or ECT when added to the current regimen?

- Plan D?
Looking Ahead

If selecting Plan A, what if it is now 2 months later and her problems persist?

- Stopping current regimen?
- Buspirone?
- Lithium? Lamotrigine?
- Liothyronine / levothyroxine?
- Antipsychotic?
- Stimulant?
If selecting Plan B, which medication increase would most benefit KO?

- Sertraline?
  - Current dose
  - Maximum dose
  - Exceeding maximum dose

- Bupropion?
  - Current and maximum dose
  - Adherence issues and pill burden
  - New formulations!
Looking Ahead

- If Plan C, what are the treatment implications?
  - Psychotherapy for the busy professional
    - Schedule
    - Type of therapy
    - Personality
  - The role of ECT in treatment resistant depression
    - Medication usage
    - Chronic use of ECT
    - Complications
## Patient–Specific Implications for Safety with Add–On Agents

<table>
<thead>
<tr>
<th>Medication added to antidepressant</th>
<th>Implications on safety and monitoring for KO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buspirone</td>
<td>☑️ May help with anxiety ☹️ May cause DDI</td>
</tr>
<tr>
<td>Lamotrigine</td>
<td>☑️ May help with mood stability ☹️ Slow titration</td>
</tr>
<tr>
<td>Lithium</td>
<td>☑️ May help with mood stability ☹️ Chronic side effects and reactions / monitoring</td>
</tr>
<tr>
<td>Thyroid therapy</td>
<td>☑️ Different mechanism (norepinephrine addition) ☹️ Monitoring and Cardiovascular effects</td>
</tr>
<tr>
<td>Antipsychotic</td>
<td>☑️ Atypical may provide some benefit for SX ☹️ Chronic cardio–metabolic disorders and monitoring</td>
</tr>
<tr>
<td>Stimulant therapy</td>
<td>☑️ May help with target SX ☹️ May cause DDI / Increase agitation or insomnia</td>
</tr>
</tbody>
</table>
What about your Plan...Plan D

- Time for questions!
- It has been my pleasure to be here with you.
- Thank you!