Depressive Disorder: Diagnosis and Management in General Practice in Pakistan

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Abstract

Objective: To formulate guidelines for diagnosis and management of depressive illness in general practice in Pakistan.

Methods: Using guidelines developed through research in primary care, this article explains how depressive illness could be diagnosed using diagnostic and statistical manual (DSM) criteria and managed systematically at general practice level in Pakistan.

Results: Diagnosing depression accurately and choosing the right anti-depressant and giving it for adequate length of time are crucial factors in effective management of depression.

Conclusion: Depressive illness can be diagnosed and managed effectively in general practice in Pakistan and only a minority of patients would need to be referred to psychiatrists (JPMA 53:500;2003).

Introduction

A 33 years old housewife, mother of 2, presented to out-patient clinic at the Aga Khan University Hospital with a 2 months history of sleeping poorly, restlessness and numbness in hands and feet. Her mood had been low, especially in the mornings, she cried often, lacked in interests and felt ignored by her family.

This or a similar presentation is quite common in a psychiatry clinic and occurs probably more frequently in general practice. Many family physicians have a reasonably good idea about the diagnosis of such a case. The challenge they face is how to be sure of the diagnosis and how to manage it properly. This paper aims to clarify these issues.

How depressions presents?

It is quite possible that depressed mood may not be a presenting complaint of the patient. More commonly, difficulties in coping with day-to-day life are mentioned as presenting problems. There could be a feeling of tiredness or inability to cope with work and sleep difficulties occur quite frequently. It is only when you explore the details of these complaints that the evidence for depressive illness emerges. In the case of the above mentioned woman, her children were being looked after by her mother-in-law and she felt upset and agitated watching the mother-in-law running her house. This gave rise to feelings of guilt and hopelessness.

Symptoms of depression are well listed in several textbooks and need not be repeated here. The doctor however should be able to translate them into appropriate Urdu or regional language equivalents. Table 1 lists the core features which are necessary for the diagnosis of a major depressive episode. This list can be made much longer if other possible ways of describing these core features are also included. If a doctor is well conversant with it, these features can be elicited in a fairly short interview. But if left to the patient, she will not necessarily talk about these symptoms.

Low mood, sadness or anhedonia are cardinal symptoms of depression. Irritability sometimes accompanies low mood or may in fact be more prominent than the sad mood. Patients lose their capacity to enjoy their usual pleasurable activities. They tend to isolate themselves, stop socializing or pursuing their usual activities. These features could be at depression is difficulty in maintaining sleep resulting in early morning wakening. Atypically, the patient may sleep excessively. In such a case sleep is regarded as a refuge and the patient considers it as her way of getting away from everything.

Thinking changes in a characteristic manner. The patient has rumination of negative themes and thinks selectively of negative outcomes of situations. Similarly, their recall of past is also selective for negative events, losses and failures. All efforts by family to reassure are unhelpful. Shame or unjustified guilt are also common. Frequently such thoughts are only exaggerations of a real situation. At times, in severe depression, such doubts about self and other can reach delusional intensity. These delusions are typically of negative nature, e.g., hopelessness, poverty and nihilism. Suicidal tendency, being preoccupied with thoughts of death or attempting suicide can be easily linked with depressive illness. These features are also suggestive of severe depression.

Psycho-motor retardation is another feature of severe depression. It manifests in slowness of thinking and normal physiological body movements. Everything becomes an effort for the patient, from daily household chores to answering simple questions during a routine assessment in your clinic. Indecisiveness and inattention are also common in such cases, the latter manifesting as difficulties in concentration and memory. This could be particularly true in old age when severe depression resembles features of dementia, also called `depressive pseudodementia'. Sometimes, instead of becoming slow and withdrawn, the patient becomes agitated with motor restlessness and purposeless overactivity. This also tends to be more common in old age depression.

Anxiety symptoms invariably accompany depression. Separating anxiety from depressive syndromes has been an age old debate. Perhaps it had some purpose when the drug management of these syndromes was considered to be different. With the recognition of benzodiazepine dependence syndrome, tricyclic antidepressants are being used increasingly in the management of anxiety disorders. Therefore, it is not really necessary for management purposes to establish the diagnosis clearly between anxiety or depressive disorders.

Several family physicians are very good at diagnosing depressive illness. For those who are not very sure of their diagnostic skills the real question is how to confirm the diagnosis when they have elicited the above mentioned depressive features. This is where the concept of major depressive disorder as given in ICD-10[2] and DSM-IV[3] proves helpful (Table 1). This has been shown to be a reliable method of diagnosing most depressive disorders in general practice setting.[4] If your patient fulfils these criteria, you must go ahead and treat him/her even if there is an apparent cause for the depression.[4,5] This can bring about a great difference in their quality of life within a few weeks. If the treatment is delayed, larger doses of medication would be needed for longer periods of time thus increasing the cost of treatment as well as prolonging patient's suffering.

A word here about so called `masked depression', a term which is both confusing and grossly misleading. It is almost impossible to describe it in operational terms like the diagnostic criteria for major depressive disorder discussed above. Generally, it implies that the patient has all the features of depression except that he does not complain of low mood (sometimes these patients are called `smiling depressed' because they do not show depressed mood and also deny it when questioned). Every family physician can diagnose depressive illness, masked or otherwise, if he/she is systematic in the assessment. It is worthwhile pointing out that a safe diagnosis can be made in the absence of depressed mood as long as other criteria are being fulfilled.

Who is more likely to get depressed?

The literature shows that at any one time 5% of general population is clinically depressed of whom almost half remain undiagnosed.[5] Depressive illness has a life-time risk of 30%. These are very high prevalence figures for any illness, certainly higher than some physical illness, e.g., hypertension and diabetes mellitus, which get much attention from doctors, general public and the media.

Community based prevalence studies for depression in Pakistan give extremely high figures, ranging from 25% to 72% for women and 10% to 44% for men.[7-9] The fact that twice as many women as men suffer from depression in Pakistan is consistent with research findings from several parts of the world.[6] Other hospital based studies of psychiatric illnesses also show that women patients constitute 60% - 70% of the patient population.[10,11]

Who should treat depression?

This question has been studied well in the UK and this research provides useful guidelines for us in Pakistan. Of all consultations in general practice, 5% have a major depressive disorder, another 5% have a minor depressive disorder while 10% show some depressive features.[5] The implication is that an average GP should expect to see at least two depressed patients in a day. Only about 10% of these patients are referred to a psychiatrist, 90% being treated successfully by the GP.[5]

How to treat depression?

The algorithm in Figure answers this question. Starting with the common presentations, it outlines subsequent steps of management and the clinical information required to implement each of these steps.

If the DSM-IV criteria for major depressive episodes are established in a patient and there are no contra-ndications to use of tricyclic anti-depressive (TCAs) (Table 2), he/she should be started on a TCA. This group of antidepressants remain the treatment of choice in major depressive disorders.[12] The starting dose of 25-50 mg is increased by 25mg every 3-5 days to reach an average dose of 150-175mg, given as a single night time dose, in 2 weeks.

All these drugs are more or less equal in terms of their therapeutic benefits. They however differ in their side-effects profile and price, which are the usual parameters to choose a particular drug in any clinical practice. Table 3 lists their common side effects some of which, e.g., excessive sedation could be used to patient's advantage. Patients develop tolerance to side effects after a week or two of using these medicines. In case of severe anticholinergic side-effects leading to intolerance of medication, another TCA could be tried. Otherwise there is no point in changing from one TCA to another. Giving TCAs in a combination is even more unreasonable.

Table 1. DSM-IV criteria for major depressive episode.

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

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

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (eg, feels sad or empty) or observations made by others (e.g., appears tearful).

   Note: In children and adolescents, can be irritable mood.

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).

3. Significant weight loss when not dieting or weight gain (e.g. change of more than 50% of body weight in a month), or decrease or increase in appetite nearly every day.

   Note: In children, consider failure to make expected weight gain.

4. Insomnia or hypersomnia nearly every day.

150mg or more for at least 6 weeks. It has been noted repeatedly that patients referred to psychiatry clinics for having failed to respond to medication have in fact never been given therapeutic doses of antidepressants. It is also necessary to ensure compliance of medication, which depends vitally on how much the patient has been counselled about the nature of antidepressant medication.

SSRIs are indicated in cases of contra-indications to, intolerance of side effects of or failure to respond to TCAs. In terms of therapeutic benefits these compounds are not superior to TCAs but are equally good. The cost difference, considering the time that a patient needs to continue the antidepressant medication, can be significant. The local manufacturing has brought down the costs of some SSRIs, though even then they remain out of reach of poorer sections of the population.

SSRIs could be started in their average daily dose from the first day of treatment. This has the advantage of saving about a fortnight which it takes for TCAs to reach their therapeutic dose. The preparations available in Pakistan, their average doses, side effects and contra-indications are also given in tables 2 and 3. An uncommon idiosyncratic effect is exacerbation of anxiety features, which tends to occur early in treatment and resembles a panic attack.

Benzodiazepines are frequently used in the management of depressive disorders. Several manufacturers of benzodiazepines encourage such practices and in fact every new compound in this group has been studied for its antidepressive potential. Several such research reports have failed to prove the presumed antidepressive action. These medicines may succeed in alleviating sleeping difficulties, agitation and some anxiety features but may actually go on to worsen the mood features of a depressive illness. The need for prolonged medication of depressive illness and the risk of benzodiazepine dependence make them highly unsuitable as a choice for medication. If they have to be used, benzodiazepines should be used in the least possible dose and for as short a time as possible.

The role of supportive therapy

The role of supportive therapy as an adjunct to antidepressant medications in the treatment of depression cannot be overemphasized. This is frequently overlooked or not given as much emphasis as the prescription of medications. Depressed patients need frequent reassurance and encouragement. It is therefore imperative that at every visit, the doctor listens to the patients' symptoms and complaints attentively, gives advise on the management of these symptoms as well as side-effects, reassures and encourages the patient. Advice regarding diet, exercise and developing good sleeping habits should be given at every clinical encounter. A healthy doctor-patient interaction improves patients' compliance with medications as well.

When to refer to a psychiatrist?

Given the prevalence figures for depressive illness, there is no health care system in the world, which could rely solely on the psychiatrists to treat all the depressed patients. This is even more true for Pakistan which has barely one trained psychiatrist for a million people. It is, therefore, inevitable that the family physicians must be trained in recognising and treating depression effectively. There certainly is a place for referral to a psychiatrist. To make it cost effective, it has to be done at proper time in the management of a patient. Table 4 lists suitable scenarios where such a referral would be appropriate.

Acknowledgements

We are grateful to the following people for their invaluable suggestions and help: Drs. Annie Fatima and Syed Abdul Quadir Ahmer for reviewing earlier drafts of this paper and Dr. Ahmar Iqbal and Mr. Parvaiz Patel for developing the algorithm.

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