Clinical Education Initiative
Support@ceitraining.org

ECHO: DEPRESSION EVALUATION AND MANAGEMENT IN AN HIV PRIMARY CARE SETTING

Max Lichtenstein, MD

1/3/2024

ECHO: Depression Evaluation and Management in an HIV Primary Care Setting
[video transcript]

00:08
So I will turn it over to Dr. Max Lichtenstein.

00:11
Hi, everybody. So yes, I'm gonna talk a little bit about depression evaluation, but also management, so hopefully give you some clinical information to take with you. The depression is extraordinarily common in the primary care setting. And so it's, it's something that sort of comes up over and over again. And so we will talking about, you know, common depressive syndromes and HIV and their demographic characteristics, learning what circumstances to use appropriate screening tools like the PHQ, nine and the ASQ, which is the Ask suicide questions, questionnaire, and to learn and review first line medication treatments for a major depressive disorder. So depression is extraordinarily common and extraordinarily debilitating worldwide. So, depression and HIV are both leading causes of disability and morbidity using that as like daily Adjusted Life Years. Worldwide. Depression is often cited as the leading cause of people of morbidity for people under 60. Worldwide, with HIV, sometimes vying for that top spot. It's estimated that three and a half percent of the world's population is living with depression, including about 5% of adults and over that, for folks are over 65. over the lifespan, about 10% of men and about 20% of women in the United States will suffer from a major depressive episode in their lives. depression affects sis women more common than it does sis men, and transgender and non-binary people more commonly than either cisgender group. severe depression can lead to suicide, which co occurs with major depressive disorder in over half of cases and is one of the leading causes of death of people under 40, both in the United States and worldwide. So it's a major, you know, health and health systems issue. Depression, specifically in HIV infected people is more common than it is in the general population. And there's a lot of disparate data around this. So it's anywhere from two to four times more prevalent than HIV negative people. And in the United States is probably closer to that 2%. A lot of these studies showing even rates as high 16 times higher are done in places where HIV is still very poorly controlled in most folks in that population. Depression is a risk factor for contracting HIV. And chronic central nervous system infections like HIV, also may precipitate depression. So it's this sort of like positive feedback loop. And still, despite that being so common in Asia because HIV positive people depression remains dying under diagnosed and undiagnosed in most people who are displaying depression affects HIV treatment outcomes, including things like medication adherence, quality of life, and just general functionality and may increase risk for other medical comorbidities including things like hypertension, cardiovascular disease, and diabetes and cardiovascular diseases has been studied pretty extensively. For this, and a correlation between depression and lower CD for count and higher viral load has also been established. And this has been a couple of fairly recent studies in the 2010s. So treating depression not only improves the patient's quality of life related

to the depression, but also to their HIV related outcomes. And this is like a nice little Venn diagram kind of showing this. So risk factors for HIV and folks who are depressed include, you know, maladaptive coping skills like unprotected sex, multiple partners, intravenous drug use, and risk factors for developing depression in HIV include both and modifiable risk factors like gender and age, but also things like elevated HIV viral load. And then shared risk factors for both developing HIV and developing depression include things like suicidal ideation, and basically poor self-esteem or poor self-assessment. And these are all things that treatment of depression can help with. So in this one, recent and fairly large, HyperCard study of almost 3000 adults with HIV in the United States, which importantly, was representative of the more national demographics of folks living with HIV, found that At 30% of the people in the study presented with at least one psychiatric illness, and this is measured through the DSM five, and 36% of those folks included depression or major depressive disorder. The next most common was a generalized anxiety disorder and I think 16%. So moving on to like the first case, and these are somewhat like interactive, so if you want to type in, you know, or if any of the panel wants to jump in, please do. So M is a 24 year old, non-binary person who uses they them pronouns that registered male at birth, who presents with a past look at history of HIV, who was diagnosed just a few months ago, so pretend that we're currently in Gen in January, and they were diagnosed over the summer of last year, they have an elevated viral load, and they're presenting at their second visit with you after initial HIV diagnosis about six months ago and initiating treatment at that time, so a significant lapse there at the visit, and reports that they're struggling to take their HIV medications regularly. With adherence of only three of the last seven days, they deny any medication side effects when they do take their medications. And for their interview, they express feeling no point in taking their medications because they are broken, and there's no fix again, they're socially isolating, with low appetite or asleep, waking up early in the morning and being unable to get back to bed with fatigue and struggling to complete normal, normal easy tasks at work with many work absences. They said that they got it that evaluation at work, and they should probably care about it, but they don't. They're wanting to go to sleep and never wake up. But tonight any plan to harm themselves or any active suicidal ideation. So in cases like this, you know, are there anything else you'd want to know about this case? This is a pretty common presentation.

07:23
There is a comment on the chat.

07:28
Oh, is he having any medical symptoms? Yeah, so that's important. So yeah, is there anything else medical going on?

07:37
Man, I would like to wonder more about be curious more about their support system or about their work environment. Also, in terms of this difficulties with concentration, are they I mean, having difficulty completing tasks are this like new or this is something that has been going on, before affecting their ability in school. So I would rather I would like to gather more social history and

08:10
yes, yeah. So not only like, what their support system is like that you can engage but also, like, how has this you know, recent diagnosis affected their support system? You either lost relationships? Are they socially isolating and losing friends? I, I also, I think we just want to get some clarification when they say they're broken. Like, tell me exactly, you know, what does that mean to them? Or just because that can mean many different things. And I just want to sort of see if there's anything specific and then also, if they've ever had any other history of kind of like, what Judy had mentioned, just any sort of previous incidences, this has been an ongoing pattern in the past or anything. Yeah. So sort of this affecting them and what is, you know, what is broken mean to them? You know, this is a change in their self-evaluation. And also, of course, any psychiatric history. So yeah, those are all really important things. To add,

09:11
nothing is even they thought about the, you know, is this, could this some of this be a piece of them not really getting good counseling around HIV around being acquiring HIV, that they understand that, you know, it's treatable, and, you know, they think they're going to die because of HIV. I think that'd be a terrible thing for somebody to think at six months into treatment. But you know, who knows what they were told when they first initially were, were identified as being HIV.

09:40
Yeah, so there's definitely a huge amount of stigma people are often SAR under very stressful situations, not super receptive to information. And this person kind of disappeared for like six months after they the initial diagnosis, which also happens fairly frequently. So yeah, there may have then, you know this like, stigma impacting them as well. So this person probably depressed. But before we get into that, what causes depression? You know, it's still incompletely understood. One thing that we could definitely say is we can throw out that, you know, chemical imbalance theory from the 90s. That was never really a an academic theory that was more of a pharmaceutical company theory that was used to sell medications. But what we do know more, but these days from the neuroscience, a part of psychiatry is that depression involves factors in neuroplasticity. So the ability for the brain to adapt to stress in varying situations. We know that mono Amiens, serotonin, norepinephrine, dopamine are involved in the processes of neuroplasticity. But what that exactly is we're still like not 100% Sure, we can't give like a one

sentence answer to that. But what that does mean, more importantly, is that treatment for depression, like the causes of depression needs to be multifactorial, we need to treat depression from multiple different angles, usually to get it under control. And folks with HIV have a number of other factors in your

11:14
can you spend a little bit more about the imbalance? Because I think that is so common, that sometimes we even explain to patients why they should take the medications. And so elaborate more, what part of that should we continue to be telling our patients are isn't like fully, fully completely out? Or how do we incorporate that into why we would prescribe medications? Yeah,

11:38
so the chemical imbalance theory, I think, sort of the fundamental part of it is that you have basically too little of a neurotransmitter, which is not the case. In fact, folks who are very, very psychiatrically, Ill like in terms of autopsies that have been done on folks who have attempted suicide, in means in ways that preserve their brains, so actually much high elevated levels of serotonin. In those cases, what we think the medications do is that they and this is also true for the newer medic newer like modalities of treatment depression, like psychedelic psychotherapy, or therapy and things like AECT. And TMS is that they stimulate a process called neurogenesis. So neurogenesis isn't producing new neurons, but it allows neurons to form new connections between axons and dendrites, in the limbic system, in the sort of the, the emotion centers of the brain. And so if you can, and the way we, and the brain is super complicated, it's an organ of many organs. It's not something we fully understand. But we do know that there are these things in the brain called circuits, which is sort of basically these electrochemical processes that sort of maintain the brain's function, you have a circuit for breathing, a circuit for consciousness, a circuit for mood, a circuit for speech, and the mood circuits. And these behavior circuits can get like a circuit board stuck in like a positive feedback loop, where the more you use a circuit, the stronger that circuit becomes, and the more difficult it is to change the circuit. This is particularly like a great example of like OCD, like OCD, folks who drink the same sort of behaviors over and over again, and it's very difficult for them to move out of that circuit, antidepressants, CCT, psychotherapy all basically allow the neurons to form new connections more easily. And so I think it's, I usually describe it as a kind of a more simplified version of that, that talk when I talk about antidepressants for patients, in that it sort of allows your brain to talk to itself better. And form these new connections. And while the antidepressants and medications help these new connections, or more easily, things like psychotherapy and changes to lifestyle, or we're going to make those connections stay and be more permanent.

14:12
Thank you. That's very comprehensive. I appreciate it. Thank you.

14:17
Yeah, I wish it was chemical imbalance that would be really easy. Fortunately, that is, it's a little bit more complicated than that, which I think ultimately lets us prescribe a little bit better when we're doing these prescribing. But particularly with HIV positive, folks, not only are you dealing with these socio economic factors like social isolation, lack of support, discrimination, violence, people with HIV coming from more marginalized populations broadly, you're also dealing with chronic central nervous system inflammation, and we know any condition that causes central nervous system inflammation can precipitate depression. This is true of lupus. This is true of Folks who are post-surgical folks with certainly CNS diseases like post stroke or Ms. And so you get this activation of essentially cytokines within the brain. And that can induce depression. And depression can also itself cause inflammation in the brain and cause this sort of sort of positive feedback loop, or you're sort of stuck. And that does reduce serotonergic transmission search, a new transition is still important. But it's more about how so the sustainability of it less about the amount of it. So SSRIs, you know, allow more serotonin to be present in synaptic cleft, which allows more sustained transmission, but not like a higher amount of serotonin. And, and so folks with HIV, and particularly uncontrolled HIV, are significantly more likely just from a biological perspective to develop depression. And when you're thinking about these like, cytokines, TNF alpha, and interleukin one are the ones that are like the big ones that are that are mostly studied in Medicaid, depression, secondary medical illness. So depression demographics, just broadly in the United States include a bimodal distribution. So first gen presence presentation is in their 20s with a second peak in the 50s. Suicide rates also have a bimodal distribution in the United States, with a second peak significantly later in life, so in like the geriatric period, but much lower than in the 20s. The average age of diagnosis for depression, despite beginning in the 20 in their 20s, usually early 20s is around 32. So there's this pretty significant delay in diagnosis. And 35% of people never receive treatment for their depression over the course of their lives. In the United States. Major changes in one's social factors can precipitate depression, and these ones are you know, studied and like the social sciences, things like divorce death of a child, those are like the big ones, but disability and pain which affect a lot of our patients' trauma. History of prior depressive episodes are predictive of future depressive episodes, elevated stress. So this is based on like stress scales, including the financial stress, housing, stress, and also family history. So history of depression and a first degree relative. Always remember in our pregnant patients Peri partum, depression, depression, not only in the postpartum period, but also during pregnancy. And sort of immediately after pregnancy can be the first time someone experiences depression. COVID This is a slide that I added to this presentation over the years COVID has dramatically increased the global prevalence of anxiety, depression, and some studies by up to a quarter with young people being hit the hardest. And this is also you know, folks who are more likely to have lost their jobs are likely to face financial strain or housing stressors are often we live with their parents. And it also really exposed these gaps in care, that have always been there between folks who are well resourced and people who are poorly resourced to access mental

health services, which are already you know, pretty thin on the ground. And for this reason, primary care providers are particularly important. More primary and more primary care providers treat depression than psychiatrists do United States so 60% of treatment for depression is done in a primary care setting. 80% of antidepressants are prescribed by non-psychiatric providers, and people who have people who have died by suicide, almost 40% have visited their health care provider in the last week, and 64% in the last month, so it's most important for like intervention as well. And most of the visits weren't to primary care providers. So there's still a lot of you know, stigma and trepidation in the identification and treatment of depression because part of his people may understand or know that people are depressed but they're not quite sure what to do with that information. Because it's not always a part of regular medical training or fellowship. So what is depression this is just sort of the basics of a major depressive episode as defined in the DSM five ciggy caps is our like USMLE mnemonic you can see on the right there, but essentially it is includes low mood, so low or irritable mood nearly every day Anhedonia which means loss of pleasure like hedonism, so like loss of ability to experience joy, motivation or interest and this can be pervasive across all areas. to life are really you know, very limited to certain areas. And this is where you get maladaptive coping skills like substance use coming in or risky sexual behaviors or frequent sex to essentially try to self soothe this Anhedonia changes to appetite either an increase or a decrease or a change overall changes to sleep with insomnia or hypersomnia, or a change in sleep pattern, sometimes day or day and night twitching psychomotor agitation or retardation. So psychomotor agitation is like the inability to sit still fidgeting, Kathy Asia, and retardation which is sort of just a general slowing so slow speech, so slow thoughts and sort of like the sort of sitting like a lump in a chair, fatigue or loss of energy, difficulty concentrating to their normal levels, so inability to focus on tasks at work or in their personal life, hopelessness, worthlessness or excessive guilt, this gets back to that negative self-evaluation, or feeling like life is not worth living, feeling like up there a burden to others, and suicidal ideation or preoccupation with desks. And we'll talk a little bit more about suicide at the end and sort of what to do in those situations. But it's more than just a reactive change in mood. So it is pervasive, it incorporated happens in all settings in a person's life. So not only confined to work or home or with a specific stimuli, it's enduring. So it lasts longer than two weeks as per the DSM, but usually much longer than that, you know, saw the statistics before, there's often this really big lag to diagnosis where people can have multiple depressive episodes that go untreated. And it causes most importantly, impairment, every DSM diagnosis has impairment as a feature. So impairment in work, interpersonal, family, and health functioning. Classically, in psychiatric disorders work is kind of the last thing to fall in the United States. So they can have major dysfunction in interpersonal relationships, and romantic relationships before you know the work starts getting affected. So because depression is such a major public health issue, the US Preventive Services Task Force and the Joint Commission put out some recommendations. They recommend screening for depression in all medical settings, which is not only a good thing to do broadly, but it's also cost-effective treating depression can help with management of all pretty much other medical conditions, improving outcomes across

the board. You can also these screenings can also be used to track symptoms and effects of pharmacotherapy, which is really important, and I still use them in my practice, especially when folks are having difficulty describing their symptoms, I still use scales. And two screening tools are mainly used in this setting. So one is the patient health questionnaire or the PHQ. And there's a PHQ two, which is two questions and a PHQ. Nine, which is nine questions. And the Ask suicide screening questions or the Ask questionnaire, which I'll talk again, a little bit more about at the end. So this is the PHQ, you may probably have seen it, it basically goes over the sticky caps. That's pretty much what it is. And it kind of allows a patient and this can be filled up by patients that can be sort of assisted with the clinician, from a not at all to nearly every day. Point. And then the higher the points, the more severe the depression on the or the more likely that erection I should say on the scale. So this is sort of the scaling, it's pretty easy to do. So less than 10 is mild to minimal symptoms. Moderate to severe is considered treatment for depression or a further diagnostic assessment. And severe is, you know, consider, you know, a more urgent assessment.

24:09
And this is the PHQ. Two, it's really two questions. And the reason why it's a PHQ. Two is because you need to have one of these in order to meet criteria for major depressive disorder. So if they're both negative, this person probably doesn't have major depressive disorder. But they may still have a number of other issues on that system. And this is the ask which again, I'll go over at the end. So to continue the vignette. You know, luckily standard practice that your office humans are the PHQ nine and M score is a total of 15 which is moderate to severe depression. you administer the Ask the suicide questionnaire and the answer no to all of the suicide questions the day sort of were feeling sad and bleak but not suicidal. So Emma's depressed now what do we do in a primary care setting? That you usually means, first of all making a diagnosis. So, the PHQ is very sensitive, it really figures out whether or not someone is having a major depressive episode. But it's not specific. So it can be difficult to figure out what that major depressive episode is coming from. Most likely, it's major depressive disorder. But there's many other things that you should probably rule out first. So, very important rule out, especially before initiating medication treatment is bipolar disorder. So bipolar disorder involves not only depressive episodes, but also elevated episodes of elevated mood, which can include psychosis. And, most importantly, to add to relate depressive disorder is to ask about history of manic symptoms. So periods of elevated mood, lack of need for sleep, so stay up for days at a time without needing sleep, history of psychotic symptoms, history of you know, multiple impulsive decisions, like moving across the country, taking trips, spending all their money, and acting in ways that are impulsive and out of their normal way of acting like excessive drug use multiple partners, etc. neurocognitive disorders or dementia. So folks who are particularly are over 65, we're thinking about, you know, is this also co-occurring in the context of a dementing illness adjustment disorder. So if something really bad does happen to somebody, like they just lost a child, it's pretty normal to feel to have a positive PHQ screen. And adjustment disorder is

sort of a normal reaction to have a bad situation happening. And if it is so close to this bad situation, and the DSM says three months, then generally is recommended that they, you maybe can pursue psychotherapy, but that they, you know, they wait before initiating at least three months for medication treatment. Screening for substance use disorders also more likely, in HIV positive folks. Substance use disorders can be a way of coping with depression, but they can also induce depression on their own. So particularly things like alcohol, benzodiazepines, stimulant withdrawal, and opioid use disorder, depression due to other medical illness. So this is a broad category in the DSM and includes depression, that's precipitated by anything from HIV, to lupus, to a stroke, to even symptoms. So you can have depression secondary to chronic pain, for instance, but much like things like anemia of chronic disease, there has to be a medical illness causing it they can't just be sort of well controlled and ill. There should be so usually there's an active mental illness or active medical illness. And, and also, then, if you're doing these sort of screening questions, no one to refer to like a higher level of care. So broadly, you know, depression can be managed in an outpatient setting, but certain situations should probably seek a psychiatrist. Things like psychosis, acute suicidality, history of psychiatric hospitalizations, a very complex psychiatric history, like if you throw an OCD and trauma in there, let's say, or a complex psychiatric medication regimen. And for me, that means more than two medications to consider referral, initially. And so I'm going to talk about guidelines for first line treatment and major depressive disorder. And these are pulled from like a couple of different places. And like, it's how probably how I practiced and I and the number one is the star d trial, the star d trial is now old, old old, but it is sort of the standard from which a lot of these antidepressant algorithms grow from the American Psychiatric Association guidelines, the can match, which is the Canadian network of mood and anxiety treatments, which is much more, the APA is pretty good, but pretty slow in updating their terms. And the mods li which is the UK guidelines, the monthly is the one I probably pull from the most because it's usually the most recent and current and updated, you can you can access the 2018 version below the 2021 or 2022 version is the 14th version, which is still stuck to people. But the first thing you also want to assess before getting into treatment is the severity of depression. So this is how the DSM five defines severity. It breaks into mild, moderate and severe. And the reason why you want to do this is because you're going to want to base your treatments around the severity of depression. So mild depression has few if any symptoms and an excess of those required to make the diagnosis. So about five in the central categories. The symptoms are distressing but manageable to the patient, and they result in minor or minimal impairment in their social occupational functioning so the patient is distressed by them, but they're not terribly impaired by them. To moderate dysfunction, number of system intensity increases. And these are where most folks lie in the in the, in the categories, and severe depression is a substantial impairment. Most symptoms are present, if not all, and the intensity of the symptoms is severely distressing, unmanageable to the patient. So they feel that they've lost control of their symptoms, and their markedly interfere with their social and occupational functioning. So loss of job loss of partnership, inability to even make it to medical appointments, you know, HIV, treatment being

uncontrolled as well. And so you kind of build a treatment algorithm based on that. And from mild to moderate, generally, the first step is referral to psychotherapy. You know, having a list of or a community resources is pretty important, I sort of have a list of resources by insurance where I refer folks to for psychotherapy, psychology, today.com, is a great resource for pharma practitioners, where you can put in your insurance and to have folks come up. And for moderate to severe depression, psychotherapy and medications are indicated. And for medications, you know, broad concepts is start low, go slow, start at a low dose of the medication, especially for patients who are medication naive. Again, broadly, these antidepressant medications are have pretty manageable side effects. But you don't want to sort of start someone off with the higher dose and have them have side effects and sort of push it away. Going on psychiatric medications can be stigmatizing in certain communities. And so you also want to, you know, start low at a low dose and sort of ease the patient into taking these medications, which can be a big deal for them, sometimes. I probably follow up two weeks after starting medications, I notice is not always possible in outpatient settings. So sometimes I do four weeks with a check in. So I have the patient either message me in two weeks, or I call them in two weeks, just to see how things are going with the new medications. And I say two weeks usually, because that's enough time for the sort of infection side effects to go away and for things to start moving forward. So if there's no response and no side effects at two weeks, then I increase the dose. And I repeat, follow up every two weeks until we see a response if the patient is having side effects, or is it the full dose of the medication. And again, these are like intolerable side effects, then we generally swap agents. And after I've gone through one or two medications, doing this, that's where you want to think about things like antidepressant augmentation, which usually requires a referral or some advanced knowledge, which I won't have time to get into today. But psychotherapy is extraordinarily effective, it's probably as effective as antidepressants. So they, they work well together. And meta-analysis of close to 3000 patients in 53, studies showed that any type of psychotherapy showed a significant improvement versus a control group. And that's a pretty significant improvement, you know, 50% versus 20% in the control group. And then another meta-analysis showed distinctions in type of psychotherapy for mild and moderate depression over others. So behavioral activation, and this has been true across many, many studies, behavioral activation therapy is really just like getting up getting out doing things and moving around. So not sort of wallowing in depression, you know, trying to work through the

33:46
the low mood and the anhedonia, doing things that are pleasurable talking to people going to the gym. Cognitive Behavioral Therapy, or CBT involves focusing on maladaptive thought processes. psychodynamic supportive counseling is sort of the modern sort of lineage of Freudian counseling, you think about like looking for the root causes of psychological issues, and then the control population had the 43% We're doing what is essentially just supportive talking without any sort of specific treatment. So I think when I'm talking with folks about psychotherapy and finding a therapist, I, you know, unless they really have something in mind, I

think it's really about the connection that you have with a therapist, more so than the type of therapy that that person is practicing because you can learn a great deal related to depression, stress, anxiety, from any of these modalities of therapy, and anti going into medication. So the first thing I'm going to do is sort of remove medications from, you know, consideration. There are a lot of antidepressants out there and you don't have to know all of them. So Oat satella pram flu box Amin and paroxetine are really medications you're never going to have a reason to prescribe. They are either superseded by better medications or they are just full of side effects and there's no reason to use them. They're just get rid of those. And the three medications in the SSRI are selective serotonin reuptake inhibitor category are Lexapro, Zoloft, and Prozac that are commonly used. So, these are medications that work on the certain receptor in the brain. So the serotonin reuptake inhibitor allowing serotonin to be maintained longer in the synaptic cleft, which again encourages this process of neurogenesis and searching for transmission. There are many common side effects of these medications by far the most common one is GI upset diarrhea and nausea. Also sometimes like dyspepsia or stomach pain, headache and dry mouth. Uncommon side effects include things like bruxism, diaphoresis, occasionally worsening of mood or anxiety, sometimes, transiently, sometimes, you know, significantly, and also weight gain. So while many of these medications except for paroxetine are weight neutral, they do impact the hunger centers in the brain and many people do gain weight on them. It's usually not a lot. And many people don't gain weight on them, but it is a side effect that you know, I some of my patients do report. sexual side effects are kind of their own category. These medications are well known for causing sexual side effects in in folks with penises that is difficulty with maintaining an erection in any sex, delayed or absent orgasms or inability to achieve orgasms, and low libido. They can also cause vaginal dryness as well. But that's pretty, it's a more uncommon one. rare side effects, it can increase suicidal ideation, and there is a blackbox warning on all these medications that it can increase suicidal ideation when first being started, so it's something to certainly monitor with your patients. I will say that this is these studies were done in teenagers. So these were not in adult patients. And it also increased suicidal ideation, not suicidal behavior. So again, something to keep an eye on for but don't worry, you're going to participate precipitate suicide in your patients by starting these medications, you're going to much more likely reduce risk for suicide medications. So some special considerations about which ones to choose. So fluoxetine is our longest acting antidepressant, it has a long Half Life 72 hours. It's sort of mildly activating it, you know, generally taken at the beginning of the day, if folks are, you know, feeling kind of sluggish, it does have more drug-drug interactions than our other medications, so keep an eye out for that. Sertraline, or Zoloft is a little bit more mildly sedating. And so Talla prime is sort of the standard one that most people start with because it has very few drug-drug interactions, it has a very, you know, banal side effect profile, but recently there was some concern for prolonging Q TC. So, folks have already like a Long QT syndrome or they have cardiac issues, maybe consider a different antidepressant or doing a routine EKG, I have never ever seen this happen in real life. I know it is a theoretical possibility but I think it is. In this was also done in citalopram, which is

again another medication that you know, generally you don't need to worry about because as the telegram is just better across the board. But it's, it is a concern out there. And another thing of folks have been on these medications for months to years. And this is true across the board with all these medications, but particularly the SSRIs and SNRIs. Think about antidepressant withdrawal. You don't want to stop your patients are happier patients stop these medications suddenly, because they can develop this discontinuation syndrome involves insomnia, anorexia, headache, irritability, malaise, body aches, this sort of feeling really kind of ill. Some people get a syndrome called zaps, which is like an electric and non-painful electric shock like sensation in the head or neck usually, it is quite distressing but when I'm lowering patients or tapering patients off the medications, I always tell them about this because it can be quite distressing. This is not a depressive relapse. This usually will resolve over the course of about a week or two but it is quite uncomfortable to go through. And the shorter halflife medications like Paroxetine and venlafaxine and also the ones that target the net receptor or norepinephrine SEPTA, like SSRIs and TCAS are more likely to cost this. And to treat this withdrawal basically start with a slow taper, you know, going down by, you know, one sort of step and the medications over the course of, you know, I generally say two weeks at a time so kind of a pretty gradual taper until the patient's completely off. If they still are struggling a lot with the taper, you can switch it to fluoxetine, which has a very long half-life, and sort of taper down the fluoxetine which is a much easier medication to come off up. SNRIs include duloxetine, venlafaxine, and DESC venlafaxine. This fella vaccine is still fairly new, I believe it's still under patent. It may have recently come off. But their side effects are pretty much the same as SSRIs are more likely to cause headache. And they still have the same sexual side effects. They can also again very rarely cause a tremor in some folks or exacerbate a tremor in people with like a central tremor. So when should you use an SSRI versus an SSRI? It's kind of the one big indication for SNRIs is folks with chronic pain. Cymbalta in particular has a good response to people with chronic neuropathic pain, which can be from HIV and so you Cymbalta quite frequently in my practice here. And duloxetine and desperately vaccine are SSRIs at all doses of their medication or Effexor is more of an SSRI at lower doses and becomes an SSRI at about 150 milligrams a day. Effects or is that a medication I use terribly often because of its short half-life. But because Pristiq is not always covered, I still do sometimes set. The dopamine, norepinephrine reuptake inhibitors, there's only a single medication in this class and that is Wellbutrin or Bupropion. Generally, you only need to worry about reappropriate and XR, that's the one that's the daily medication, it's generally pretty much good for everybody unless there's no reason not to. It's generally a very good medication has very limited side effects, very, very rare sexual side effects. And it's quite, it's quite activating. So it's really good for folks with neurovegetative symptoms like low energy hypersomnia. And even use it off label for ADHD. So it's very similar to the medications like Strattera or Colbry that are used for the non-stimulant medications for ADHD, and has generally minimal or very mild withdrawal. The two rare side effects you need to worry about with or the one birth side of I'd rather you need to worry about with Wellbutrin is risk for seizure, you should really never pushed this medication over 450 milligrams a day, which is like the FDA Max dose. And you

should never use this medication and folks with a history of seizure or a history of an eating disorder like bulimia, which can have rapid electrolyte shifts and can precipitate a seizure. There are two other agents that you'll see fairly frequently that are not in these categories. Trazodone which is an S AR AI, a serotonin agonist and reuptake inhibitor is certainly to sedating to use as an antidepressant which really need to push the dose over 100 250. But we use it fairly frequently as a non-habit forming sleep aid because of this,

43:45
which has the pain or REM Iran has the sort of novel mechanism of action, it works on the alpha two receptors on the and the presynaptic or, sorry, the postsynaptic ganglion and basically increases serotonergic transmission. That way basically, it causes more serotonin, basically by inhibiting the inhibitory chemicals of the alpha two receptors in advertising is a great medication to use in I think the med psych environment, because while it doesn't have sexual side effects, because it doesn't really affect serotonin directly, which is how those sexual side effects happen. It does increase appetite and can be quite sedating. So it can help with folks who are struggling with low appetite and insomnia, which is a lot of sort of very medically ill people use a lot, for instance of Cancer Institutes. Again, the rare side effects which I've never again, never seen in real life, but is a potential side effect is priapism, and Trazodone. Of course if this happens, you should never use it again with that patient. It restroom does work in a way where it's kind of like anti Sudafed, it can cause the sort of the vascularity and the nose to become dilated and can cause a stuffy nose, particularly people are lying down in bed. So if that happens, you know it's on patient tells you about that that's what's causing it. So my husband is also an anti emetic, and has five he three antagonisms, so it's kind of like a dance Tron and offers minimal bleeding risk. So SSRIs have a sort of theoretical risk for increased bleeding and you shouldn't be using them and like folks with very low platelets or high bleeding risk, but Rema on again, because it doesn't directly affect serotonin doesn't have that. And again, as we said, Trust is rarely used as an antidepressant anymore, but is often used as a sleep aid. So I think just because of time, I'm going to skip the serotonin modulators, these are the newer antidepressants like trental X and vibrant they're essentially the same as SSRIs. But they have fewer sexual side effects. That is like the one sentence on them. And drug interactions of note, you know, as you know, in these outpatient settings, most folks are going to be on other medications in addition to their psychiatric medications. Again, blue box and paroxetine. Another reason to not really use them is they have many drug interactions, particularly low VOCs, which are really only used in OCD treatment these days. Prozac has pretty strong to see nine and 2d Six inhibition and reappropriate has very strong 2d Six inhibition. So keep in mind with that, for three or four inhibitors like Cobicistat, present in Gen boya press kopecks and others. Keep an eye out for us. Lexapro, fluoxetine, venlafaxine Trazodone, which has the pain and the Lazybone are vibrant. Because it can cause increase in side effects by basically boosting the doses of those medications as well. Velocita in particular, has like an indication to not use it with the three a

four inhibitors. And should we do the last vignette Do you think or should we open up to questions? So last one is around suicide and suicide risk?

47:23
I think Do you think there's time to discuss this and include that in the discussion?

47:30
I'm sure I mean, I think we can go over briefly. It's really it's sort of a more of a an appeal to sort of implement things in the clinic level. But this patient J is a 54 year old, domiciled, unemployed partnered sis male with HIV and is broadly well controlled. And as he's had for many years, he's a pastor gastric history of major depressive disorder and Christian crystal methamphetamine use disorder, who presents for a follow up after a seven month lapse in care. At his visit, he's lost weight, he's just shoveled malodorous, and unable to sit still in a chair in your office. After some time, he opens up that the last six months his crystal Matthews has gotten out of control. And his partner of eight years has broken up with him and kicked him out of the house their shared apartment two weeks ago. He's been using crystal meth daily since then sleeping in hotels and with sexual partners who uses with which is rapidly draining his savings. He says that when he runs out of money, that's it for me, I'm not going to burden anyone any. That's a pretty scary patient to have sitting across from you, you know, not in terms of like your personal safety, but it's a patient that I the patient that I worry about, I worry about am I going to see them again. And so what are the questions that you want to ask what are the things that you want to figure out about what to do with someone who is, you know, potentially at a high risk for suicide? So this is where a questionnaire called the ASQ comes in. It's a really simple tool that you can use in just five questions. There is, I think, look, I think this is a lot less than it used to be. But there is some concern I think people have that if I talk with patients about suicide, am I going to, you know, give them an idea about suicide? Or am I going to you know, potentially provoke their suicide. And that's not, that's not true. So, asking about suicide actually relieves suicidal, intent and impulses. So the five questions are in the past few weeks, have you wished you were dead? In the past few weeks? Have you felt that your fellow family would be better off? If you were dead? In the past week? Have you been having thoughts about killing yourself? Which is again, a distinction from wishing one was dead? Watching one was dead can be like, you know, wanting to go to sleep and never waking up again. And Act talks about actively trying to harm yourself and the way I talked about it is like do you want to murder yourself? Do you want to do violence to yourself. Have you ever tried to kill yourself? If yes, how? And when? And are you having thoughts of killing yourself right now? And it's just yes or no? And if they don't answer the question, and this is mostly an issue with teenagers, then that becomes Yes. So if they answer no to all questions, that's a negative screen, you know, just sort of a follow up? If the answer yes, or the patient's reviews to any question, or the patient refuses to answer a question, that's a positive screen. In Question Five is a yes is are you planning on killing yourself right now, that is an acute risk level, and that person needs a stat mental health assessment. So the patient

should not leave be maintained on one to one and the one to one is arm's length. Ideally, the patient should be in a room that doesn't have any windows that doesn't have any, like anything that could they could hurt themselves with. And then staff should notify the physician responsible for the case, the mental health team responsible for the case, if that's available. And that case should be escalated, so that they can receive that mental health evaluation. If question five is a no. But any other questions? Yes, that's also a positive screen. But it's a non acute risk assessment. So a brief mental health assessment should be done like a PHQ nine or just an interview. To assess if a more comprehensive evaluation is needed, the patient should also not be. And again, this is like the ask specifically says the patient should not be permitted to leave that legally, you shouldn't do that you should also never like physically restrain a patient in your office unless you're truly worried that they're going to like actively underlies. But the patient should be encouraged to stay until that's completed. And the patient's care team should be notified. So that patient can receive appropriate referrals as soon as possible. So the question I asked, you know, generally of the audience is, does your place of work have policies in place for these types of patients? Because it happens fairly frequently? You know, it's certainly at our offices. And do you know that escalation pathway who is responsible for calling 911? Who is responsible for being the one to one with the patient? Is it the person interviewing them? Is it somebody else? who performs the mental health assessments? And where does the patient sit? Well, all of that is happening? Do you have a designated place for this person to be? Or where they can stay? That's not the waiting room or not a medical room? But yeah, I'd like to, you know, open it up to questions. I know, this is a really big topic that I tried to kind of condense into, you know, a 40-minute lecture.

52:33
Thank you very much, Max. for that. We do have actually one question here in the chat right now is what meant do you recommend for treating OCD?

52:42
So that's like a bit of a bigger topic. So the first type of treatment for OCD are SSRIs. And I still recommend starting with those three, I recommended Prozac, Lexapro or Zoloft, because they're much more easy to manage. If that fails, then loot box or flu, flu vaccine does separate in clinical trials from the other ones. And so it may be better had better results in OCD, and I do use it occasionally in OCD, I don't, you know, again, I usually don't start there. And then you're thinking about the tri cyclic antidepressants like Clomid for me, which again, if you're moving into that direction, a psychiatrist should probably manage the case. Also, these cases for OCD, especially severe OCD, often need super therapeutic doses. So they really need very high doses of SSRIs. I know sometimes upwards of 40, or 60 milligrams of escitalopram. Thank you for that. Oh, and of course therapy. Yeah. CBT therapy is first line treatment for OCD. And these are all suicide prevention resources. These are things you can give to patients. I have handouts where I you know, especially if I'm sort of in that gray zone where the patient is having some suicidal

thoughts, but isn't like acutely suicidal to give these to folks, so many of our patients are LGBTQ. And then we have a specific one for New York City and white 100. NYC well, and then the national Crisis Text Line and the national suicide prevention hotline, which is the first one in the country resources now.

54:17
Do we have any other questions or comments?

54:25
Max? Sorry, I know we're running out of time here. But just a quick question. I often see because I do the PHQ nine fairly regularly. I also do that the GED seven. And for patients who have sort of score high on both, but they don't want they're concerned about the sexual side effects with any of the SSRIs What do you recommend recommending that situation? Yeah, so essential side effects are fairly common. About 50% of people have them. Most of those are mild, and about anywhere from 20 to three People don't have like sexual side effects that impair their sexual functioning. I still try with SSRIs. First, I really try to encourage people to like, hey, let's you know let's try it if it causes extra side effects, let's wait and see. And then and then I move on to the serotonin modulators the vibrant and Trent elects which have a significantly lower rate of sexual side effects. But oftentimes insurance companies will want you to trial and SSRI before and so that way we can at least say we tried to sexual side effects not going to work and we can get them the PA proved I generally don't go with mirtazapine because it people will gain almost always at least 10 pounds. And it can be really sedating. So that's kind of reserved for folks for that the side effects are going to do us help.

55:57
Max, just real quick, do you have any evidence that improving people's sleep alone will improve this neurogenesis piece? I just wonder if sometimes if you're just fixing people's sleep, will they do better from a depression standpoint? I'm sure they probably will. But like so is it I've got sort of depression symptoms related to just their sleep issues.

56:19
I mean, I don't know. Like specifically like in terms of like neuroscience study, I'd have to like kind of look that up. But we do know that using things like cognitive behavioral therapy for insomnia, sleep hygiene techniques, improves overall mental health, like it reduces you know, when you're giving like people big mental health scales, it reduces like depression, anxiety, trauma symptoms, if you can treat sleep, treating sleep with benzos or Z drugs is a little bit trickier because that can make it reduces sleep latency. It makes people fall asleep and can increase the amount of time they are asleep. But it reduces sleep quality. So it reduces that you know stage three stage four sleep that people need for like rested and restorative sleep.

57:06
Well, thank you so much, Dr. Max Lichtenstein for that great presentation.

[End Transcript]