Managing Refractory Depression to Improve Outcomes;

Attention Deficit Disorder: Diagnosis & Management, Esp. in Substance Users

Christopher Schneck, M.D.
Associate Professor of Psychiatry
Medical Director, CU Depression Center
Mental Health Director, UCH ID/HIV Clinic

February 9th, 2019

DISCLOSURE:

FUNDING SOURCES

Research Funding:

- National Institute for Mental Health

Salary Support:

- Ryan White HIV/AIDS Funding

Speakers Bureau:

- None

Consulting:

- None

Consulting Fees:

- None

Stock Holdings (>$10,000)

- None

OBJECTIVES

- Understand evidenced-based treatments for Treatment Resistant Depression:
  - Pushing dose
  - Switching
  - Augmentation
  - combination strategies
- Understand diagnosis & Management strategies in Adult ADHD patients
  - Epidemiology
  - Utility & selection of Different formulations
  - Considerations when treating ADHD patients who are also substance users

REFRACTORY DEPRESSION

CASE

38 YEAR OLD WOMAN, NO SIGNIFICANT MEDICAL PROBLEMS, WHO PRESENTS WITH DEPRESSION. SHE HAS HAD 2 PRIOR EPISODES OF DEPRESSION WHICH RESPONDED REASONABLY WELL TO FLUOXETINE.

DURING THIS EPISODE, HOWEVER, SHE REMAINS DEPRESSED. FOR THIS EPISODE, SHE HAS HAD REASONABLE TRIALS OF:

- FLUOXETINE, UP TO 40 MG
- SERTRALINE, UP TO 150 MG
- VENLAFAXINE, UP TO 150 MG

What to do next?

ANTIDEPRESSANTS

SSRI

- Fluoxetine
- Paroxetine
- Sertraline
- Citalopram
- Escitalopram
- Fluvoxamine
- Vilazodone*

SNRI

- Venlafaxine
- Desvenlafaxine
- Duloxetine
- Levomilnaciprin

TCA

- Amitriptyline
- Nortriptyline
- Desipramine
- Imipramine
- Doxepin
- Trimipramine
- Protriptyline
- Amoxapine

Other

- Mirtazapine
- Buproprion
- Trazodone
- Vortioxetine
- (Nefazodone)

MAOI

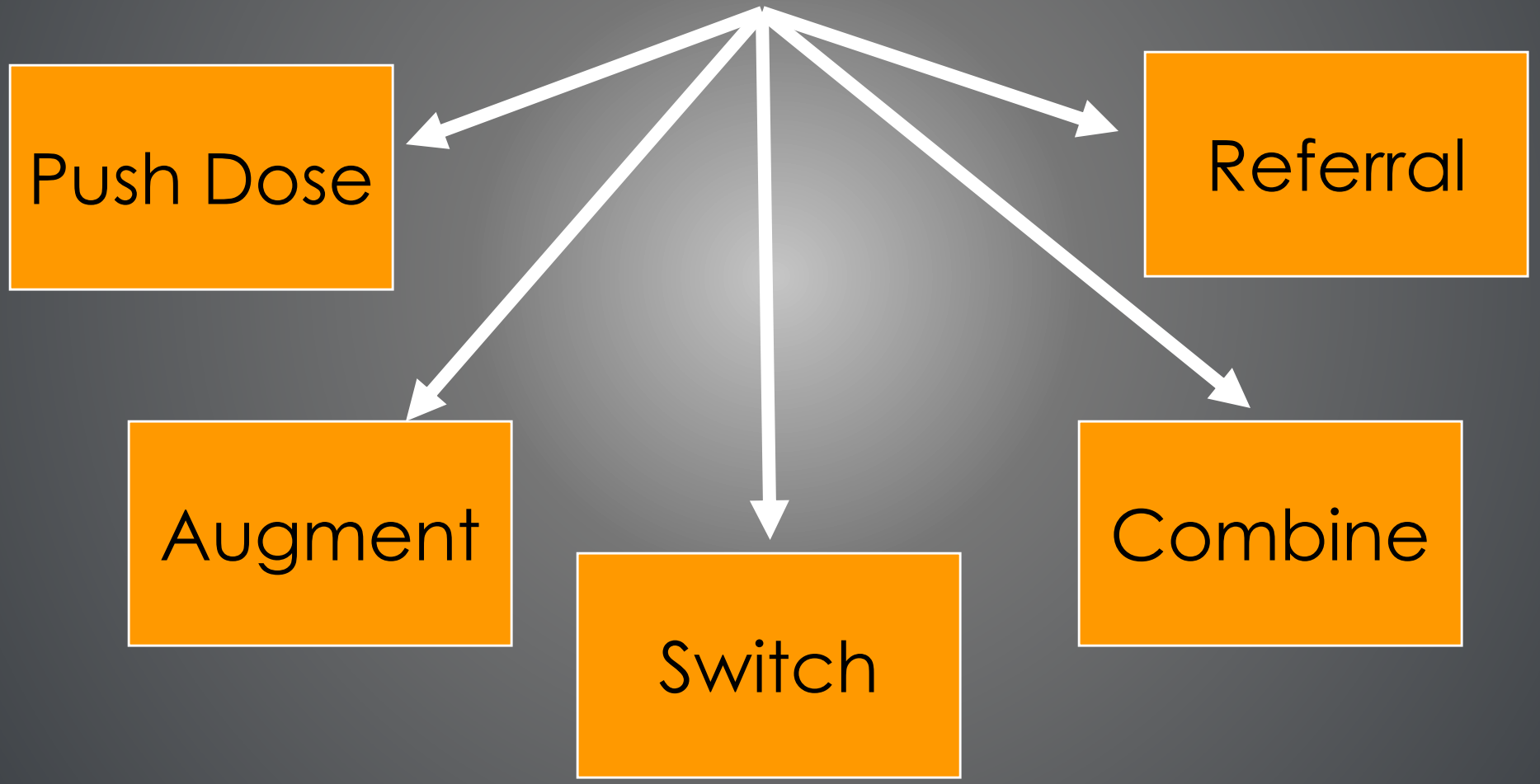
- Phenelzine
- Selegeline (transdermal)
- Tranylcypromine
- Isocarboxazide

ANTIDEPRESSANT *EFFICACY*

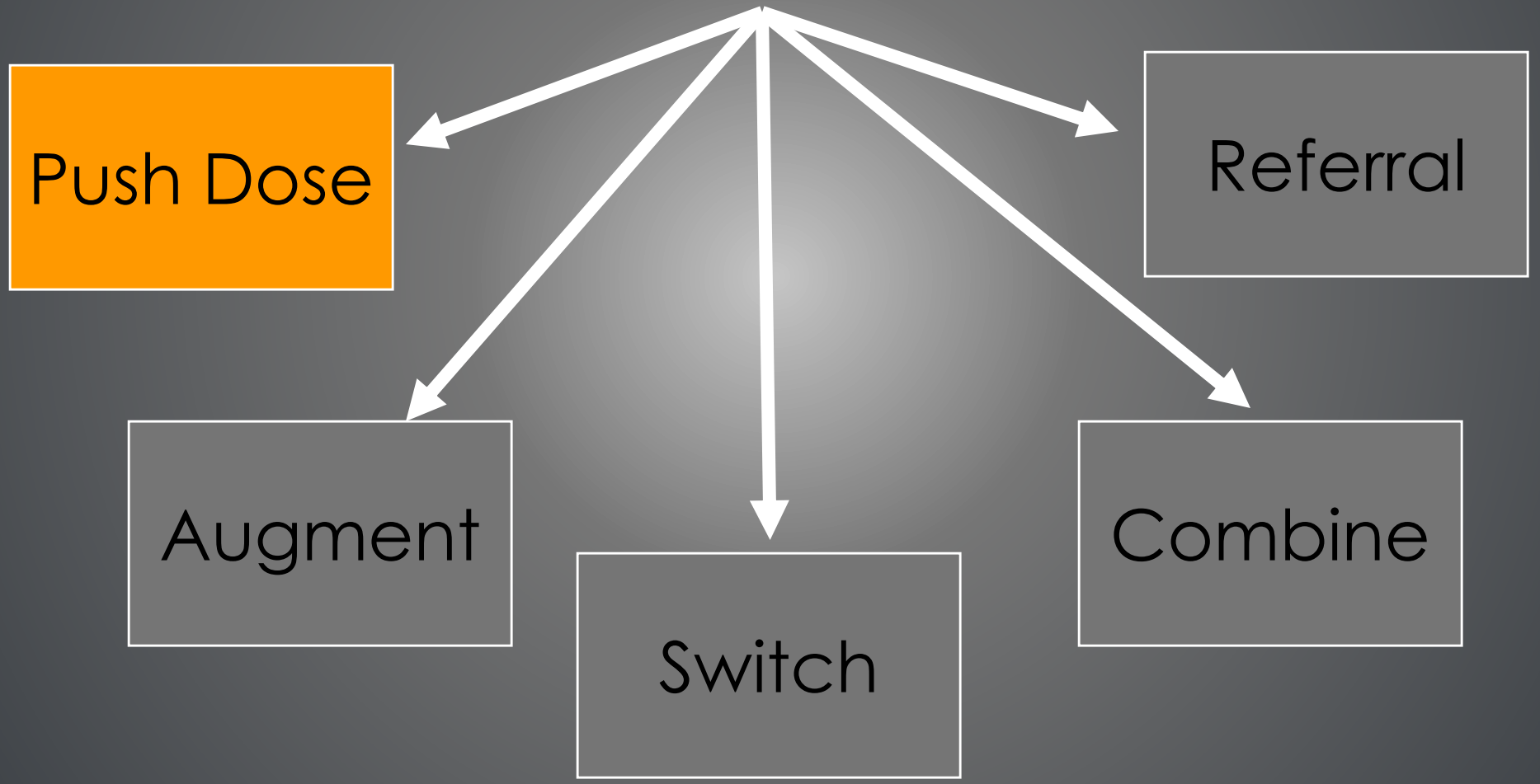
Depression Guideline Pane. AHCPR Publication 93-0550. 1993
Thase ME J Clin Psychiatry. 1999;60 (suppl 4) 23

Slide courtesy M. Thase

OPTIONS WHEN ANTIDEPRESSANT TREATMENTS FAIL OR ARE INADEQUATE



OPTIONS WHEN ANTIDEPRESSANT TREATMENTS FAIL OR ARE INADEQUATE



HOW HIGH CAN YOU PUSH?

SSRI

Fluoxetine: 80-100 mg

Paroxetine: 60-80 mg

Sertraline: 300 mg

Escitalopram: 40 mg

SNRI

Venlafaxine: 450 mg*

Duloxetine: 120 mg

Other

Mirtazapine: 60 mg

*Watch for diastolic HTN at doses > 225 mg

DON'T PUSH

Bupropion → Seizure

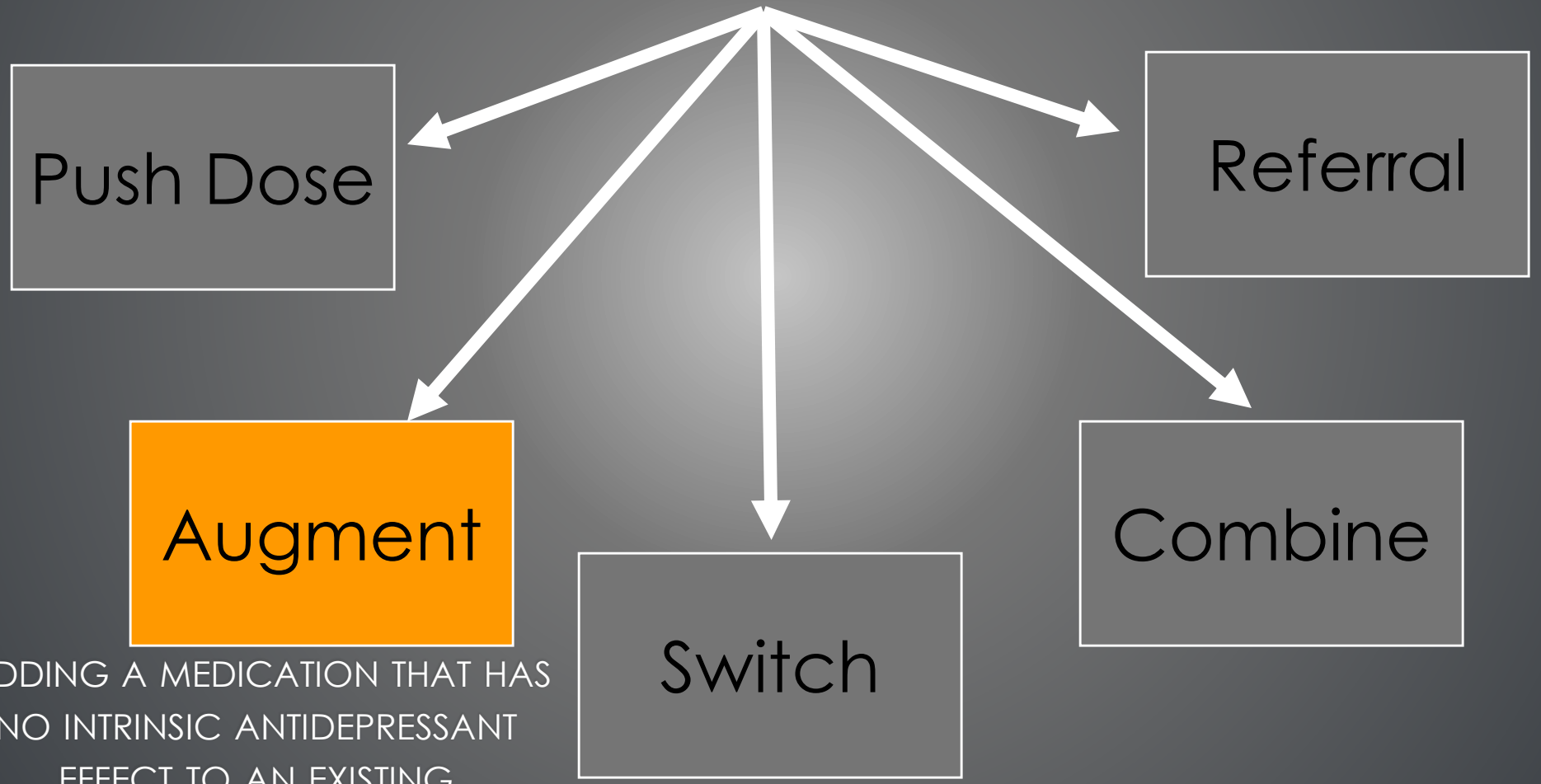
Tricyclics → Toxicity
(check levels)

Citalopram → Conduction Disturbances
(Prolonged QT, Torsades)
Max 40 mg; 20 mg in patients > 60

WHEN TO PUSH A DOSE?

Rothberg B & Schneck CD. Anxiety and Depression. In *Textbook of Family Medicine, 9th Edition,* Chapter 47. 2015.

OPTIONS WHEN ANTIDEPRESSANT TREATMENTS FAIL OR ARE INADEQUATE



ADDING A MEDICATION THAT HAS NO INTRINSIC ANTIDEPRESSANT EFFECT TO AN EXISTING ANTIDEPRESSANT.

- Thase ME et al. CNS Spectrum 12:12 (supple 22), 2007

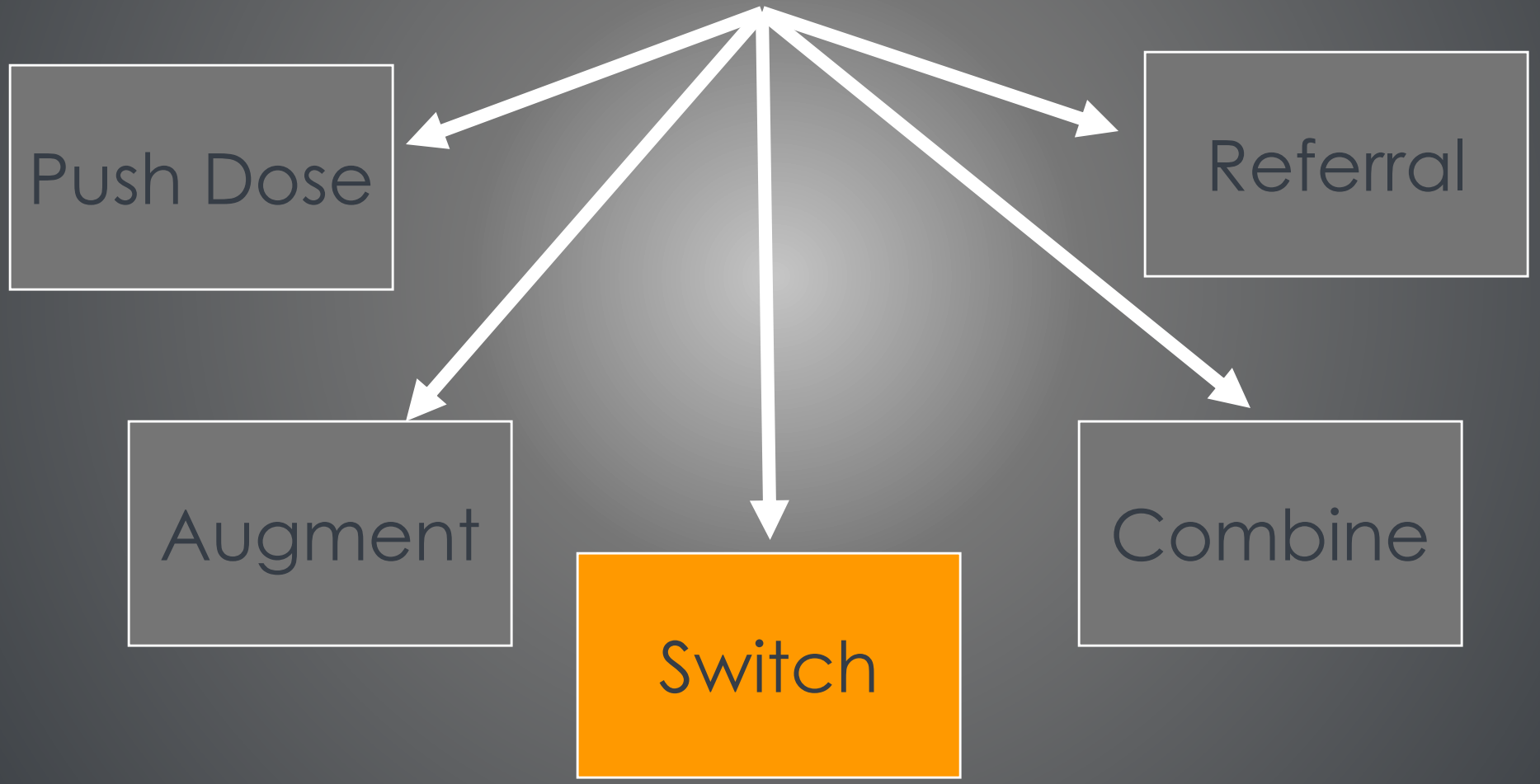
AUGMENTATION IN THE PRIMARY CARE SETTING

Rothberg B & Schneck CD. Anxiety and Depression. In *Textbook of Family Medicine, 9th Edition,* Chapter 47. 2015.

TESTOSTERONE SUPPLEMENTATION FOR DEPRESSIVE SYMPTOMS

From Shaffer JA et al. Psychosomatic Med, 2014

OPTIONS WHEN ANTIDEPRESSANT TREATMENTS FAIL OR ARE INADEQUATE



WHEN TO SWITCH?

PARTIAL RESPONSE

(AUGMENT)

VS.

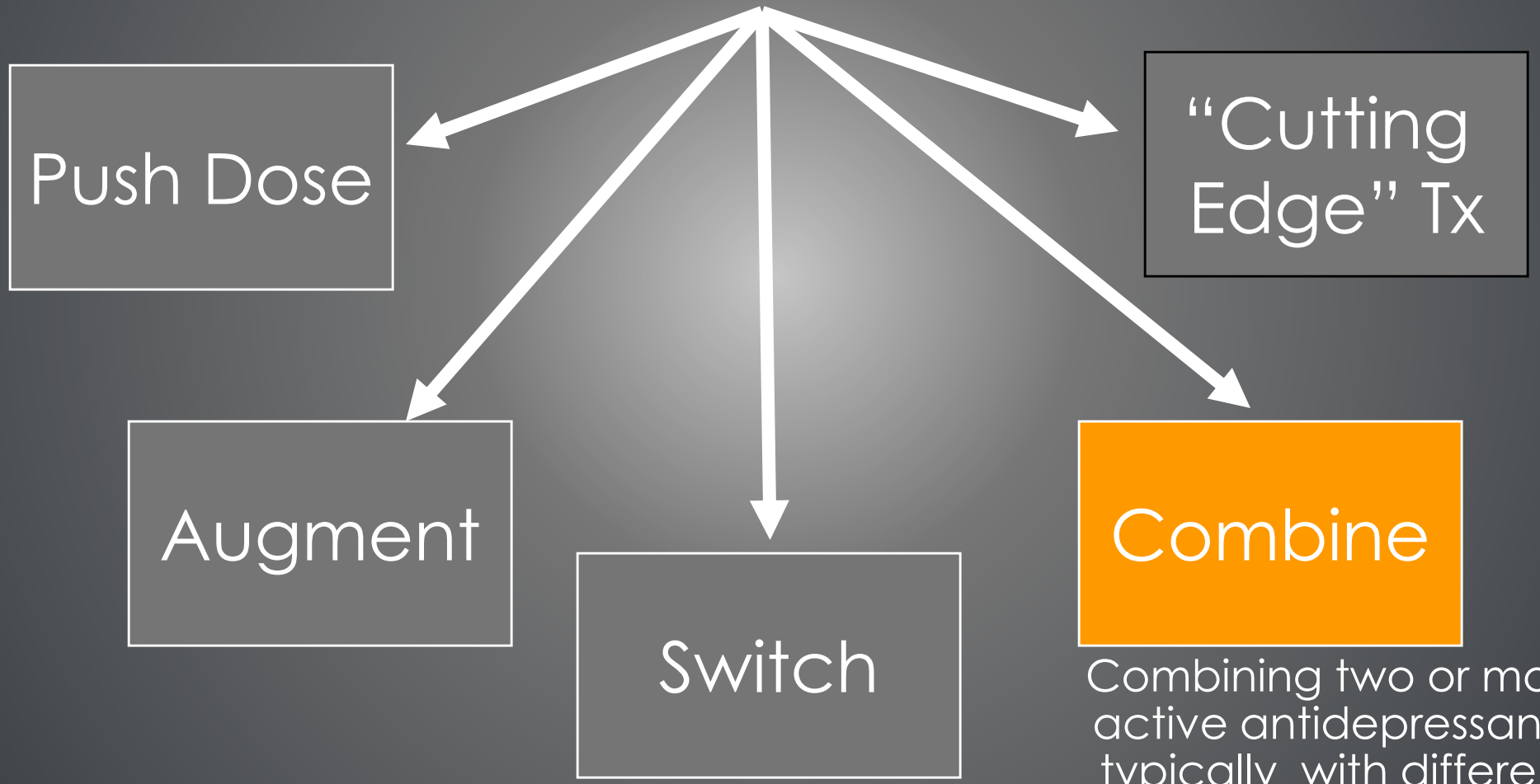
NO RESPONSE

(SWITCH)

ACROSS CLASS OR WITHIN CLASS SWITCHES

- Rothberg B & Schneck CD. Anxiety and Depression. In *Textbook of Family Medicine, 9th Edition,* Chapter 47. 2015.

OPTIONS WHEN ANTIDEPRESSANT TREATMENTS FAIL OR ARE INADEQUATE



Combining two or more active antidepressants, typically with different mechanisms of action.

COMMON COMBINATIONS

- Rothberg B & Schneck CD. Anxiety and Depression. In *Textbook of Family Medicine, 9th Edition,* Chapter 47. 2015.

REMISSION & RESPONSE RATES IN CO-MED

- Rush AJ et al.Am J Psych 2011;168:689-701

REMISSION & RESPONSE RATES IN CO-MED

- Rush AJ et al.Am J Psych 2011;168:689-701

SO HOW MUCH BENEFIT ARE THESE STRATEGIES?

STAR*D REMISSION RATES:

- THASE ME ET AL. AM J PSYCHIATRY 2007;164(5)

Trivedi MH et al. Am J Psychiatry 2006;163(1) 28-40

STAR*D REMISSION RATES: SWITCHES

Thase ME et al. Am J Psychiatry 2007;164(5)

Trivedi MH et al. Am J Psychiatry 2006;163(1) 28-40

STAR*D REMISSION RATES: AUGMENTATION

Thase ME et al. Am J Psychiatry 2007;164(5)

Trivedi MH et al. Am J Psychiatry 2006;163(1) 28-40

STAR*D REMISSION RATES: COMBINATION

Thase ME et al. Am J Psychiatry 2007;164(5)

Trivedi MH et al. Am J Psychiatry 2006;163(1) 28-40

REFERENCES

Burns, DD. Feeling Good—the new mood therapy. 2008

- Canadian Network for Mood And Anxiety Treatments (CANMAT) Guidelines (www.canmat.org/canmatpub.html)
  - Psychological Treatments
  - Pharmacological Treatments
  - Neurostimulation Treatments
  - Complementary and Alternative Treatments
  - Special Populations (Youth, Women, Elderly)
- Rakel & Rakel
  - Rothberg B & Schneck CD. Anxiety and Depression. In *Textbook of Family Medicine, 9TH Edition,* Chapter 47. 2015.

ATTENTION DEFICIT HYPERACTIVITY DISORDER

CASE

25 y/o male presents for evaluation and treatment of self-reported ADHD. He says he was diagnosed in grade school and treated for a number of years with Ritalin. He stopped taking Ritalin after leaving high school. He says he "got through" college with average grades, went to graduate school and received a masters degree.

He also has used marijuana daily for years and enjoys the "relaxed, mellow feeling" he gets from it.

He has a new job and is falling behind in work. He feels he can get "about 5 minutes worth of work done" before he daydreams or is distracted. He is asking to go back on stimulants.

Should you treat his ADHD? What with?

ADULT ATTENTION HYPERACTIVITY DISORDER

Kessler RC et al. Am J Psych 2006

TRUE LATE-ONSET ADULT ADHD?

Sibley MH et al. Am J Psych 2017

FREQUENCY OF SYMPTOM SUBTYPE AMONG 536 ADULT PATIENTS WITH ADHD

Michelson D et al. Biol Psych 2003; 53:112-120

Adult presentations of ADHD

- Difficulty with concentration/staying focused
- Hyper-focus (focus in interesting, unimportant tasks)
- Disorganization (procrastination, time-management)
- Hyperactivity
- Impulsivity
- Emotional difficulties

THESE SYMPTOMS LEAD TO…

Wilens, T.E., Faraone, S.V., & Biederman, J. (2004). Attention-deficit/hyperactivity disorder in adults. *JAMA*, 292,619–623.

PSYCHIATRIC CONDITIONS COMMONLY COMORBID WITH ADULT ADHD

Treat most severe disorder first

Baron DA. JCP Visuals vol 6, No. 3 June, 2004; Katzman MA. BMC Psychiatry 2017

SCREENS FOR ADULT ADHD

- NOT STAND-ALONE AGENTS FOR DIAGNOSIS
- COLLATERAL INFORMATION HELPFUL.
- RECALL OF CHILDHOOD SYMPTOMS MAY BE INACCURATE.
- CHECKLISTS DO NOT DETERMINE IF OTHER DIAGNOSES MAY BE THE CAUSE OF ADHD SYMPTOMS.

ADHD RATING SCALES USED FOR ADULTS

Name	Informant	Rating Criteria
Connors' Adult ADHD Rating Scales	Self and/or observer	DSM-IV
Wender Utah Rating Scale	Self	Items from *Minimal Brain Dysfunction in Children*
Brown ADD Rating Scale for Adults	Self	Series of sx descriptors reported by HS & college students with non hyper-active ADD
Adult ADHD Self-report Scale-v1.1 Symptom Checklist for Adults	Self	DSM-IV-TR

PLEASE SEE SLIDE AT PRESENTATION

TREATMENT AND MONITORING

* Black box warning re suicidality † not FDA-approved for treatment of ADHD

Santosh PJ et al. CNS Drugs, 2011;25:737-63

ADHD AND PATIENTS WITH SUBSTANCE USE DISORDERS

Carpentier PJ & Levin FR. Harvard Review of Psych. 2017 (25): 50-64

ADHD AND PATIENTS WITH SUBSTANCE USE DISORDERS: RECOMMENDATIONS

Carpentier PJ & Levin FR. Harvard Review of Psych. 2017 (25): 50-64

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Carpentier PJ & Levin FR. Harvard Review of Psych. 2017 (25): 50-64

ADHD AND PSYCHOTHERAPY

Carpentier PJ & Levin FR. Harvard Review of Psych. 2017 (25): 50-64

KEY ARTICLES

- Katzman MA et al. Adult ADHD and comorbid disorders: clinical implications of a dimensional approach. *BMC Psychiatry*(2017) 17:302
- Weiss MD et al. A guide to the treatment of adults with ADHD. *J Clin Psych*.2004; 65(suppl 3): 27-37
- Carpentier PJ & Levin FR. Pharmacological Treatment of ADHD in addicted patients: What does the literature tell us? *Harvard Review of Psychiatry*. Vol 25, no. 2, 2017.
- Gautem M & Prabhakar D. Stimulant formulations for the treatment of ADHD. *Prim Care Companion CNS Disord*. 2018;20(6):18r02345.


Thank you!