MANAGING REFRACTORY DEPRESSION TO IMPROVE OUTCOMES;

ATTENTION DEFICIT DISORDER: DIAGNOSIS & MANAGEMENT, ESP. IN SUBSTANCE USERS

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• 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

<table>
<thead>
<tr>
<th>SSRI</th>
<th>SNRI</th>
<th>TCA</th>
<th>Other</th>
<th>MAOI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoxetine</td>
<td>Venlafaxine</td>
<td>Amitriptyline</td>
<td>Mirtazapine</td>
<td>Phenelzine</td>
</tr>
<tr>
<td>Paroxetine</td>
<td>Desvenlafaxine</td>
<td>Nortriptyline</td>
<td>Bupropion</td>
<td>Selegeline (transdermal)</td>
</tr>
<tr>
<td>Sertraline</td>
<td>Duloxetine</td>
<td>Desipramine</td>
<td>Trazodone</td>
<td>Tranylcypromine</td>
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<tr>
<td>Citalopram</td>
<td>Levomilnaciprin</td>
<td>Imipramine</td>
<td>Vortioxetine</td>
<td>Isoxcarboxazide</td>
</tr>
<tr>
<td>Escitalopram</td>
<td></td>
<td>Doxepin</td>
<td>(Nefazodone)</td>
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<tr>
<td>Fluvoxamine</td>
<td></td>
<td>Trimipramine</td>
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<td></td>
</tr>
<tr>
<td>Vilazodone*</td>
<td></td>
<td>Protriptyline</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Amoxapine</td>
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</tbody>
</table>
OPTIONS WHEN ANTIDEPRESSANT TREATMENTS FAIL OR ARE INADEQUATE

- Push Dose
- Augment
- Referral
- Combine
- Switch
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**How High Can You Push?**

<table>
<thead>
<tr>
<th>SSRI</th>
<th>SNRI</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fluoxetine:</strong> 80-100 mg</td>
<td><strong>Venlafaxine:</strong> 450 mg*</td>
<td><strong>Mirtazapine:</strong> 60 mg</td>
</tr>
<tr>
<td><strong>Paroxetine:</strong> 60-80 mg</td>
<td><strong>Duloxetine:</strong> 120 mg</td>
<td></td>
</tr>
<tr>
<td><strong>Sertraline:</strong> 300 mg</td>
<td></td>
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</tr>
<tr>
<td><strong>Escitalopram:</strong> 40 mg</td>
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</tr>
</tbody>
</table>

*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?

OPTIONS WHEN ANTIDEPRESSANT TREATMENTS FAIL OR ARE INADEQUATE

Push Dose

Augment

Switch

Add a medication that has no intrinsic antidepressant effect to an existing antidepressant.

Referral

Combine
• Thase ME et al. CNS Spectrum 12:12 (supple 22), 2007
AUGMENTATION IN THE PRIMARY CARE SETTING

TESTOSTERONE SUPPLEMENTATION FOR DEPRESSIVE SYMPTOMS

From Shaffer JA et al. Psychosomatic Med, 2014
OPTIONS WHEN ANTIDEPRESSANT TREATMENTS FAIL OR ARE INADEQUATE

- Push Dose
- Augment
- Combine
- Referral
WHEN TO SWITCH?

PARTIAL RESPONSE (AUGMENT) Vs. NO RESPONSE (SWITCH)
ACROSS CLASS OR WITHIN CLASS SWITCHES

OPTIONS WHEN ANTIDEPRESSANT TREATMENTS FAIL OR ARE INADEQUATE

- **Push Dose**
- **Augment**
- **Switch**
- **Combine**

"Cutting Edge" Tx

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

REMISSION & RESPONSE RATES IN CO-MED

REMISSION & RESPONSE RATES IN CO-MED

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

TRUE LATE-ONSET ADULT ADHD?

Sibley MH et al. Am J Psych 2017
FREQUENCY OF SYMPTOM SUBTYPE AMONG 536 ADULT PATIENTS WITH ADHD

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...

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Informant</th>
<th>Rating Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connors’ Adult ADHD Rating Scales</td>
<td>Self and/or observer</td>
<td>DSM-IV</td>
</tr>
<tr>
<td>Wender Utah Rating Scale</td>
<td>Self</td>
<td>Items from <em>Minimal Brain Dysfunction in Children</em></td>
</tr>
<tr>
<td>Brown ADD Rating Scale for Adults</td>
<td>Self</td>
<td>Series of sx descriptors reported by HS &amp; college students with non hyperactive ADD</td>
</tr>
<tr>
<td>Adult ADHD Self-report Scale-v1.1 Symptom</td>
<td>Self</td>
<td>DSM-IV-TR</td>
</tr>
<tr>
<td>Checklist for Adults</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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

ADHD AND PATIENTS WITH SUBSTANCE USE DISORDERS: RECOMMENDATIONS

ADHD AND PATIENTS WITH SUBSTANCE USE DISORDERS: RECOMMENDATIONS

ADHD AND PATIENTS WITH SUBSTANCE USE DISORDERS: RECOMMENDATIONS

KEY ARTICLES


Thank you!