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An Overview of Depression in Primary Care

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Introduction

A 45-year-old hypothyroid patient who has been receiving a stable dose of levothyroxine presents to her primary care doctor with a sad mood, self-doubt, lack of energy, bad sleep, low appetite, and trouble concentrating. Several months ago, following a disagreement with her spouse, she first noticed these symptoms. She has been able to carry on with her career and obligations, but she struggles with melancholy on a daily basis and occasionally considers taking her own life.

Description

Depression is a growing and clinically important public health problem. The third most common cause of disability worldwide was depressive disorders. The estimated lifetime risk of a severe depressive episode is now close to 30% in the United States. The 10th greatest cause of death in the United States is suicide, which is on the rise [1]. Suicide is more frequently related with a diagnosis of depression than not (more than 50% of the time). The majority of people with major depressive disorder first show symptoms in their twenties, and a second peak appears in their fifties. Depression is twice as common in women as it is in men. Being divorced or separated, having experienced depression before, experiencing high levels of stress, having experienced trauma, and having first-degree relatives with the condition are additional risk factors for the development of major depressive disorder [2].

Patients with major depressive disorder who also have anxiety, psychotic symptoms, substance misuse, or borderline personality disorder have a worse prognosis, as well as episodes that last longer and have more severe symptoms. The relationship between depression and anxiety is particularly well-established; more than 50% of depressed patients express clinically severe anxiety and are more resistant to traditional therapies than depressed individuals without anxiety [3]. Primary care physicians are crucial in identifying and treating depression. Approximately 60% of mental health services are provided in primary care settings, and 79% of antidepressant prescriptions are written by medical professionals who do not specialise in mental health treatment. According to one study, 64% of people who tried suicide visited a doctor within the last four weeks before the attempt, and 38% did so in the week prior. The majority of these patients went to a primary care office. Stigma continues to be a major obstacle to diagnosing and treating mental illness, despite attempts to educate individuals, communities, and medical professionals [4].

In the initial evaluation of patients who present with any psychiatric symptoms, potential contributory or causal medical illnesses are a key factor. Up to one-third of patients who enter with depression symptoms in a general hospital setting may have an underlying medical problem. For instance, the symptoms of dementia and delirium, such as the loss of social relationships, melancholy mood states, and cognitive failure, may resemble those of major depressive disorder [5]. Anemia, hypothyroidism, seizures, Parkinson's disease, sleep apnea, vitamin deficiencies like those in B12 and folate, and infectious diseases like human immunodeficiency virus (HIV) infection, syphilis, and Lyme disease are just a few of the other medical conditions that have been linked to depressive symptoms. Treatment for these underlying issues may occasionally lessen or even get rid of depression symptoms. The patient history should assess the use of medications like beta-blockers, barbiturates, anabolic steroids and glucocorticoids, statins, hormones (like oral contraceptives), levodopa and methyldopa, opioids, and some antibiotics because both legal and illegal substances can cause depressive symptoms (e.g., fluoroquinolones, mefloquine, and metronidazole). Depressive symptoms can also result from the illicit use of marijuana, sedatives or hypnotics, opioids, cocaine, or stimulants, as well as withdrawal symptoms from these substances [6].

Conclusion

The patient in the vignette has a significant depressive episode, according to the diagnostic criteria. Although she does not have entirely incapacitating depression symptoms, she is experiencing significant distress that interferes with her ability to perform, which points to a moderately severe episode. In order to rule out any potential causes or contributions to her depression symptoms, we would check her medical history, medications, and ask about substance usage. Since the treatment for bipolar depression would be different from that for major depressive illness, a comprehensive history is also required to identify any indications of mania or hypomania. She should be assessed for suspected suicidality right away to make sure she doesn't have any active plans to harm herself and to make sure she agrees to get emergency care if such feelings arise.

There are viable treatment options for mild depression, including medication, psychotherapy, or both. Given that the patient's symptoms have been persistent for a number of months, we would advise a mix of first-line medication and psychotherapy. Sertraline, which is cost-effective and typically has a manageable side-effect profile, would be started at a starting dose of 50 mg per day and increased by 50 mg every two weeks to a maximum dose of 200 mg, all the while being watched for effectiveness and negative side effects. We would talk about efficient psychotherapy strategies, but interpersonal treatment would be preferred so that the patient could start addressing the issues in her relationship with her partner. We would advise her to continue taking the medication for at least 6 months after her symptoms have fully subsided before thinking about stopping.

Acknowledgement

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Conflict of Interest

None.

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