Complete Summary

GUIDELINE TITLE

Pharmacotherapy companion to the depression.

BIBLIOGRAPHIC SOURCE(S)

American Medical Directors Association (AMDA). Pharmacotherapy companion to the depression clinical practice guideline. Columbia (MD): American Medical Directors Association (AMDA); 2005. 24 p. [12 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Pharmacotherapy companion to the depression clinical practice guideline. Columbia (MD): American Medical Directors Association; 1998. 26 p.

**** REGULATORY ALERT ****

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- October 24, 2007, Provigil (modafinil): Cephalon has agreed to include additional labeling revisions to the WARNINGS, CLINICAL PHARMACOLOGY, PRECAUTIONS, and PATIENT PACKAGE INSERT sections.
- May 2, 2007, Antidepressant drugs: Update to the existing black box warning on the prescribing information on all antidepressant medications to include warnings about the increased risks of suicidal thinking and behavior in young adults ages 18 to 24 years old during the first one to two months of treatment.
- October 25, 2006, Effexor (venlafaxine HCl): Published retrospective studies report that venlafaxine overdosage may be associated with an increased risk of fatal outcome.
- August 21, 2006, Dexedrine (dextroamphetamine sulfate): Changes to the BOXED WARNING, WARNINGS and PRECAUTIONS sections of the prescribing information.
- May 12, 2006. Paxil (paroxetine) and Paxil CR: changes to the Clinical Worsening and Suicide Risk subsection of the WARNINGS section in the prescribing Information related to adult patients, particularly those who are younger adults.

- December 8, 2005, Paxil (paroxetine): pregnancy category changed from C to D and new data and recommendations added to the WARNINGS section of prescribing information.
- September 27, 2005, Paxil (paroxetine) and Paxil CR: changes to the Pregnancy/PRECAUTIONS section of the Prescribing Information to describe the results of a retrospective epidemiologic study of major congenital malformations in infants born to women taking antidepressants during the first trimester of pregnancy.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Depression

GUIDELINE CATEGORY

Treatment

CLINICAL SPECIALTY

Geriatrics
Psychiatry

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Nurses
Pharmacists
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Social Workers

GUIDELINE OBJECTIVE(S)

- To promote effective treatment of depression in the long-term care facility by helping practitioners select the most appropriate antidepressant for each patient and to eliminate inappropriate pharmacotherapy
- To outline a process that facilitates optimal prescribing of pharmacotherapy for depression
- To provide information to all members of the care team concerning the rationale for and choice of antidepressant medications
- To assist practitioners and other members of the interdisciplinary team in applying the concept of pharmacoeconomics to evaluation of the outcomes of depression pharmacotherapy
- To differentiate between remission and response when evaluating the clinical outcomes of depression pharmacotherapy
- To discuss adverse drug events related to antidepressant pharmacotherapy, including drug-drug and drug-disease interactions

TARGET POPULATION

Elderly individuals and/or residents of long-term care facilities who have, or are suspected of having, depression

INTERVENTIONS AND PRACTICES CONSIDERED

1. Determining if pharmacotherapy is indicated
2. Consideration of absolute and relative contraindications to specific antidepressants
3. Selection of antidepressant, including appropriate starting dose and titration schedule
    - Tricyclics (desipramine, nortriptyline) Note: Tertiary amine tricyclics (e.g., amitriptyline, doxepin, imipramine) are not recommended to treat depression in elderly long-term care patients
    - Selective serotonin reuptake inhibitors (SSRIs) (citalopram, escitalopram, fluoxetine, paroxetine, sertraline)
    - Dual-acting agents (duloxetine, venlafaxine)
    - Psychostimulants (dextroamphetamine, methylphenidate, modafinil, atomoxetine)
    - Other (bupropion, mirtazapine, nefazodone, trazodone, monoamine oxidase inhibitors)
4. Establishing treatment goals, assessing response, and monitoring for relapse
5. Consideration of pharmacoeconomics
6. Psychiatric evaluation, if indicated

MAJOR OUTCOMES CONSIDERED

- Resolution or improvement of signs and symptoms of depression
- Functional status
- Side-effects associated with antidepressants
- Quality of life

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The guideline was developed by an interdisciplinary workgroup, using a process that combined evidence- and consensus-based approaches. The workgroup included practitioners and others involved in patient care in long-term care facilities. Beginning with a general guideline developed by an agency, association, or organization such as the Agency for Healthcare Research and Quality (AHRQ), pertinent articles and information, and a draft outline, each group worked to make a concise, usable guideline tailored to the long-term care setting. Because scientific research in the long-term care population is limited, many recommendations were based on the expert opinion of practitioners in the field.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Guideline revisions were completed under the direction of the Clinical Practice Guideline Steering Committee. The committee incorporated information published in peer-reviewed journals after the original guidelines appeared, as well as comments and recommendations not only from experts in the field addressed by the guideline but also from "hands-on" long-term care practitioners and staff.

All AMDA clinical practice guidelines undergo external review. The draft guideline is sent to approximately 175+ reviewers. These reviewers include AMDA physician members and independent physicians, specialists, and organizations that are knowledgeable of the guideline topic and the long-term care setting.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The algorithm Pharmacotherapy Companion to the Depression Clinical Practice Guideline is to be used in conjunction with the clinical practice guideline. The numbers next to the different components of the algorithm correspond with the steps in the text. Refer to the "Guideline Availability" field for information on obtaining the full text guideline.

CLINICAL ALGORITHM(S)

A clinical algorithm is provided for Pharmacotherapy Companion to the Depression Clinical Practice Guideline.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

The guideline was developed by an interdisciplinary workgroup, using a process that combined evidence- and consensus-based approaches. Because scientific research in the long-term care population is limited, many recommendations were based on the expert opinion of practitioners in the field.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Treatment for depression is effective, even in the frail elderly.
- Early recognition and diagnosis, along with careful caring treatment, offers long-term care patients with depression a better quality of life, while preventing suffering and preserving function.

POTENTIAL HARMS

- Table 1 of the original guideline document lists possible clinical consequences of certain properties of antidepressant medications. Table 2 of the original guideline lists examples of metabolic drug interactions for selected antidepressant agents.
- The potential side effects of selective serotonin reuptake inhibitors (SSRIs) include anorexia, nausea, loose stools, anxiety, agitation, insomnia, tremor, sexual dysfunction, and syndrome of inappropriate secretion of antidiuretic hormone, leading to symptomatic hyponatremia.
- Much of the side-effect profile of tricyclic antidepressants arises from their binding to histamine-1, acetylcholine, and alpha-1 adrenergic receptors, leading to both autonomic and central anticholinergic effects, such as sedation, orthostatic hypotension, weight gain, a lowered seizure threshold, and cardiotoxicity.
- Compared with the tricyclic antidepressants, trazodone has fewer anticholinergic effects but can be quite sedating. Both trazodone and nefazodone may be associated with orthostatic hypotension.
- The Serzone brand of nefazodone has been removed from the market because of concerns about its hepatic toxicity. Generic versions of the drug continue to be available and carry a black-box warning on their labels.
- Seizures have been reported in patients without a prior history of them when the bupropion dose was increased rapidly.
- Duloxetine and venlafaxine may elevate blood pressure and heart rate.
- Because mirtazapine may increase appetite and promote weight gain in some patients, some practitioners choose it for patients with depression who exhibit significant symptoms of weight loss and anorexia. Mirtazapine has been associated with orthostatic hypotension and should be used with caution in patients with cardiovascular or cerebrovascular disease. In addition, this agent can increase hepatic enzymes and should be used with caution in patients who have liver disease.

CONTRAINDICATIONS

CONTRAINDICATIONS

- Appendix 2 of the original guideline document lists a number of cautions with regard to the use of certain antidepressants in patients who have specific medical conditions and may be a useful starting point for practitioners considering the initial choice of an antidepressant.
- Tertiary amine tricyclics (e.g., amitriptyline, doxepin, imipramine) should ***not*** be used to treat depression in elderly long-term care patients because of the

unacceptable side effects associated with their strong binding to norepinephrine and serotonin.

- Contraindications that are particularly pertinent in the long-term care setting include the following:
  - ***Absolute contraindications***:
    - Allergy to the antidepressant
    - Nefazodone in combination with cisapride
    - Bupropion for a patient with seizures
  - ***Relative contraindications***:
    - Tricyclic antidepressant for a patient with symptomatic benign prostatic hyperplasia, troublesome constipation, symptomatic or unstable ischemic heart disease, or orthostatic hypotension
    - Trazodone for a patient with orthostatic hypotension
    - Selective serotonin reuptake inhibitor (SSRI) for a patient with anorexia and significant weight loss

QUALIFYING STATEMENTS

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- This clinical practice guideline is provided for discussion and educational purposes only and should not be used or in any way relied upon without consultation with and supervision of a qualified physician based on the case history and medical condition of a particular patient. The American Medical Directors Association, its heirs, executors, administrators, successors, and assigns hereby disclaim any and all liability for damages of whatever kind resulting from the use, negligent or otherwise, of this clinical practice guideline.
- The utilization of the American Medical Directors Association's Clinical Practice Guideline does not preclude compliance with State and Federal regulation as well as facility policies and procedures. They are not substitutes for the experience and judgment of clinicians and caregivers. The Clinical Practice Guidelines are not to be considered as standards of care but are developed to enhance the clinician's ability to practice.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The implementation of this clinical practice guideline (CPG) is outlined in four phases. Each phase presents a series of steps, which should be carried out in the process of implementing the practices presented in this guideline. Each phase is summarized below.

I. **Recognition**

- Define the area of improvement and determine if there is a CPG available for the defined area. Then evaluate the pertinence and feasibility of implementing the CPG

II. **Assessment**

- Define the functions necessary for implementation and then educate and train staff. Assess and document performance and outcome indicators and then develop a system to measure outcomes

III. **Implementation**

- Identify and document how each step of the CPG will be carried out and develop an implementation timetable
- Identify individual responsible for each step of the CPG
- Identify support systems that impact the direct care
- Educate and train appropriate individuals in specific CPG implementation and then implement the CPG

IV. **Monitoring**

- Evaluate performance based on relevant indicators and identify areas for improvement
- Evaluate the predefined performance measures and obtain and provide feedback

IMPLEMENTATION TOOLS

Clinical Algorithm
Tool Kits

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1998 (revised 2005)

GUIDELINE DEVELOPER(S)

American Medical Directors Association - Professional Association

GUIDELINE DEVELOPER COMMENT

Organizational participants included:

- American Association of Homes and Services for the Aging
- American College of Health Care Administrators
- American Geriatrics Society
- American Health Care Association
- American Society of Consultant Pharmacists
- National Association of Directors of Nursing Administration in Long-Term Care
- National Association of Geriatric Nursing Assistants
- National Conference of Gerontological Nurse Practitioners

SOURCE(S) OF FUNDING

Funding was provided by educational grants through Bayer Pharmaceuticals, Eisai, Inc./Pfizer, Eli Lilly & Company, Merck & Company, Novartis Pharmaceuticals, Parke-Davis, and Wyeth-Ayerst Laboratories.

GUIDELINE COMMITTEE

Steering Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Members: Marjorie Berleth, MSHA, RNC, FADONA; Susan M. Levy, MD, CMD; Lisa Cantrell, RN, C; Harlan Martin, RPh, CCP, FASCP; Charles Cefalu, MD, MS; Evvie F. Munley; Sandra Fitzler, RN; Jonathan Musher, MD, CMD; Joseph Gruber, RPh, FASCP, CGP; Mary Tellis-Nayak RN, MSN; Larry Lawhorne, MD, CMD; Barbara Resnick, PhD, CRNP; Steven Levenson, MD, CMD; William Simonson, PharmD, FASCP, CGP

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

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GUIDELINE AVAILABILITY

Electronic copies: None available

Print copies: Available from the American Medical Directors Association, 10480 Little Patuxent Pkwy, Suite 760, Columbia, MD 21044. Telephone: (800) 876-2632 or (410) 740-9743; Fax (410) 740-4572. Web site: www.amda.com.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on September 24, 1999. The information was verified by the American Medical Directors Association as of September 27, 1999. This NGC summary was updated by ECRI on August 26, 2005. This summary was updated by ECRI on May 31, 2006 following the U.S. Food and Drug Administration advisory on Paxil (paroxetine hydrochloride). This summary was updated by ECRI on September 7, 2006 following the updated U.S. Food and Drug Administration advisory on Dexedrine. This summary was updated by ECRI on November 22, 2006, following the FDA advisory on Effexor (venlafaxine HCl). This summary was updated by ECRI Institute on November 6, 2007, following the U.S. Food and Drug Administration advisory on Provigil (modafinil) Tablets. This summary was updated by ECRI Institute on November 9, 2007, following the U.S. Food and Drug Administration advisory on Antidepressant drugs.

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