MEDICAL MEMO

Kevin Leehey, M.D. Child, Adolescent and Adult Psychiatry; Board Certified

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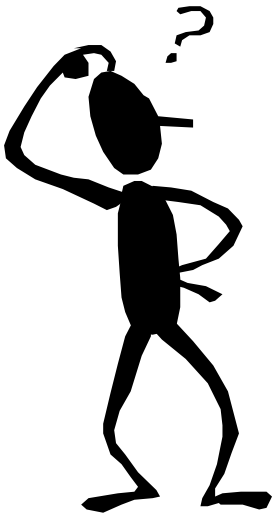
More On Depression



Please also refer to prior Medical Memo articles on Bipolar Disorder (Summer '99), Seasonal Affective Disorder (Fall '99), and the Winter 2000 article "What Is Depression?"

What Is Major Depression?

Major Depression is the most severe form of depression. Major Depression is almost always a biologically based disorder of the brain just as asthma is based in the lungs and diabetes is based in the pancreas. The more "biological" signs of depression that are present the more likely medication treatment will be advisable and helpful. These biological signs are the criteria listed below. Other health problems may worsen or cause depression. Depression also worsens the prognosis of some other health problems. In order to give the diagnosis of Major Depression at least 5 of the following criteria (signs and symptoms) must be present for at least 2 weeks and cause substantial impairment in functioning:

• Depressed mood most of the day, almost every day
• Marked loss of interest or pleasure in usual activities (anhedonia) often including libido
• Fatigue or loss of energy nearly every day
• Feelings of worthlessness, hopelessness, and unreasonable feelings of guilt
• Significant weight loss when not dieting or weight gain (appetite changes)
• Insomnia or excessive sleep nearly every day
• Agitation or pronounced slowing of body movements
• Significant decreased ability to think, concentrate, or make decisions
• Recurrent thoughts of death or suicide

What Is Dysthymic Disorder?

Dysthymia is a more moderate to mild but persistent form of depression in which less than 5, but at least 2, of the above criteria of Major Depression are present for at least 2 years in adults and at least 1 year in youth under 18 years old. In the past this condition was often called Depressive Personality or Depressive Neurosis. Until the last decade psychotherapy was thought to be the only treatment for the condition. Now we know people with Dysthymia also often respond to antidepressants, especially the newer ones.

What is Depression NOS?

The NOS stands for Not Otherwise Specified and includes all the varying kinds of depression that are not severe enough to fit Major and not long lasting enough to fit Dysthymic Disorder. Treatment advice and need for treatment depends on the unique situation.

Can Health Problems Cause Depression?

Yes! Certain medications, infections, hormone imbalances, immune system disorders, neurologic conditions, a couple of vitamin deficiencies, and some cancers can cause either depression or something that looks a lot like depression.

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Newer Medications

The following medications are either new, relatively new, coming soon, or there is new important information about an older medicine. The brand name is listed first and the generic or chemical name follows in parenthesis. Several of these are further described in the Medication Charts available on my website.

Sonata (*zaleplon*)

This is a new quick onset short duration non-benzodiazepine sleeping pill, much like Ambien. Sonata and Ambien are good for those seeking help with getting to sleep but not needing or wanting a medicine that will keep them asleep. This lessens greatly the risk of morning grogginess caused by the medication. These options also avoid the low risk of habit forming potential the benzodiazepines have (Halcion, Restoril, Dalmane, Ativan, etc.). Like many prescription sleeping pills the benefit usually wears off if taken more than 5 to 7 nights in a row.

Celexa (*citalopram*)

This is the newest addition to the SRI (Serotonin Reuptake Inhibitor) class which already includes Prozac, Zoloft, Paxil, and Luvox. Celexa came out in the US 9/98 after about 8 years use in Europe and Canada. Thus, more is known about it than you might otherwise expect. Where it fits into the group of SRIs is still unsettled but it appears to be a good option with lower chances of excess energy (see Summer '99 Medical Memo article "What Are Behavioral Side Effects?") or excess sedation with maybe less chance of sexual dysfunction. All the SRIs appear equally effective although one person may respond best to one or two of the group.

Seroquel (*quetiapine*)

Seroquel is the newest of the "atypical" antipsychotic medications which also includes Risperdal, Zyprexa, and Clozaril. These newer options have a lower risk of certain side effects than the older antipsychotics which the new group is largely replacing. See the Spring '99 Medical Memo article "What Is Tardive Dyskinesia?". Seroquel often is less sedating and less likely to promote weight gain than the other "atypicals". This can be a plus for those who don't want these 2 effects. Seroquel may not be quite as broadly effective as the other atypicals but appears to have almost no risk of either tardive dyskinesia (TD) or a muscle rigidity side effect that can look like but isn't parkinson's disease. Clozaril probably works best but has by far the most side effects; so much so that I avoid it. Zyprexa and Risperdal both show very good benefit and similar side effects. Zyprexa is probably lower than Risperdal in TD risk, parkinson's disease-like symptoms, and increasing prolactin (at times leading to breast engorgement and even a milk like discharge) while Zyprexa is probably higher in weight gain and sedation.

By the way, Zyprexa has recently been approved by the FDA as a mood stabilizer for Bipolar Disorder. This confirms what many psychiatrists had already found to be true. In fact, this is likely true for all the atypical antipsychotics although only Zyprexa has so far done the studies to earn the FDA approval.

Wellbutrin (*buproprion*)

The news here is that there is now a generic form of Wellbutrin available - Buproprion. This is, of course, a substantial cost savings. It probably works just as well as the brand but I've heard a few complaints about its taste. Buproprion generic is only available in the Immediate Release (IR) version. The Slow Release (Wellbutrin SR) version is still only in brand form. The SR and IR forms probably work equally well but the SR may be easier to tolerate for most people and is usually more convenient. Remember, Zyban (marketed to help people stop smoking) is exactly the same thing as Wellbutrin SR 150 mg tablets.

Adderall (*dextroamphetamine* and *amphetamine* combined)

This combination medicine for ADHD (Attention Deficit Hyperactivity Disorder) has, with time in use clinically and in several recent studies, confirmed itself to have a valuable place in the stimulant medicine options for ADHD. I still usually use Ritalin (methylphenidate) first, especially with younger children, because of its longer track record, its relative gentleness, and safety; but Adderall is a close second. In fact, in several situations Adderall is better. It is stronger, longer lasting, related to Ritalin and yet different enough to help some people Ritalin does not help. Adderall comes in convenient scored tablets of several different doses. It only occasionally lasts long enough to cover a whole school day with only one dose in the morning; but 2 doses will usually reliably cover the whole

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day, both in and after school. See my ADHD medicine chart for more information on this group of medicines.

Cylert (*pemoline*)

I almost never prescribe this medicine anymore due to the rare (1 in roughly 20,000 to 40,000) but serious potential for life threatening liver damage. Cylert, nonetheless, has certain key advantages for ADHD. It lasts all day with one dose, is not abusable, and is refillable by phone (convenience).

Methylin (*methylphenidate*)

So far, I am not aware of any advantage of this form of methylphenidate over Ritalin or plain generic methylphenidate other than for folks who might prefer its slightly smaller pill size, no pill color, and pill size that varies with dose.

Metadate ER (*methylphenidate* extended release)

This new version of slow release Ritalin (Ritalin is the original brand name for the generic methylphenidate) brings the potential advantage of a 10 mg size of slow release, which they call extended release (ER). Ritalin SR only comes in 20 mg. It remains to be seen if Metadate is more reliable than Ritalin SR. It seems to some of us clinicians that Ritalin SR is less reliable than plain Ritalin and the SR (spansule) version of Dexedrine.

Vestril (*reboxetine*)

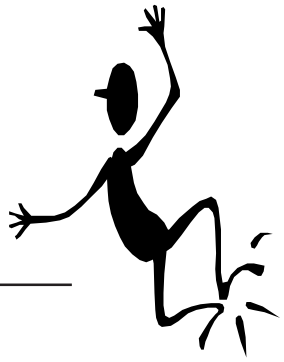
This potentially valuable addition to the current sizable group of antidepressants is still not fully approved by the FDA and thus not yet available. Vestril will be the only pure Norepinephrine Reuptake Inhibitor (NRI) so far available. This makes it most similar to Wellbutrin and desipramine (generic) but focused only on NRI and thus unique. It is quite different in its action from the SRIs. Wellbutrin is already a new generation low side effect option while desipramine has broader actions that also cause more side effects. Effexor has NRI action at higher doses, on top of its SRI action at all doses. The hype, with some research evidence to support the notion, is that the NRI effect of Vestril will give it more motivation boost to those with depression than the other more serotonin enhancing medicines do. Some people will probably respond better to NRI action and Vestril should give a more direct way to get that effect. Serotonin effect seems to be most important for people with anxiety or anxiety and depression. Vestril may be used alone or as a booster or as a second antidepressant for people who have a partial response to another antidepressant.

Internet Update

Partnership For A Drug Free America (drugfreeamerica.org) has a very good website full of information for our kids and great tips for parents looking for ways to talk to and help their kids resist drugs and alcohol.

Tucson Charter and Private School lists and information is available for reading and printing out from my website.

These and other helpful websites can be reached by links from my website at leeheymd.com



More On Depression

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Although these are uncommon causes of depression, this a good reason to see your family physician, internist, or pediatrician as part of seeking help when depression is suspected.

What is Unipolar Depression?

Unipolar depression means the person only experiences depression and not the mania or hypomania that automatically changes the diagnosis to Bipolar Disorder (formerly called Manic Depression).

What Causes Depression?

Typically, there is an inherited tendency toward depression which is brought on by stressful life events, losses, or may occur for no clear reason.

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What Is Melancholic Depression?

Melancholia is an older term which refers to most people's notion of severe depression. This type of major depression is marked by weight loss, extremely low energy or agitation, marked feelings of worthlessness, extreme even irrational guilt, severe loss of pleasure in virtually all areas of life, very early morning awakening, consistent severely depressed mood, and increased risk for suicide. Medication treatment is thought to be particularly important for this condition.

What Is Atypical Depression?

Generally, this refers to the non-melancholic depression patterns such as increased eating, increased sleeping, and personality problems such as "rejection sensitivity". In the past, MAOI'S (Monoamine Oxidase Inhibitor medications) were found to be more helpful than the Tricyclic antidepressants for this subtype of depression. Now, we usually use the SRI's (Prozac, Paxil, Zoloft, etc.) first.

What Is Psychotic Depression?

This is another very severe form of Major Depression identified by the additional presence of hallucinations and delusions. Sometimes the depression (or mania) may co-exist with signs of schizophrenia and is then referred to as Schizoaffective Disorder. This condition often requires both antidepressant and antipsychotic medications.

What Is Post Partum Depression?

Post Partum means after delivery. The dramatic drops and rebalancing of hormones that comes with childbirth can throw some women into a potentially severe depression. Time and treatment help. Treatment is especially key when the depression is severe as there can be risk to the baby as well as to the mother. Repeat episodes of depression with or without future pregnancies are not uncommon. Women with a personal history or family history of depression are at higher risk. A milder form, known as post partum "blues" is less dangerous but can be a warning sign and can also impact the early parenting relationship.

What Is Co-morbidity?

Co-morbid means than one or more other conditions occur at the same time. The conditions may be related or not. For example, anxiety often occurs along with (is co-morbid with) depression. This is also not unusual for substance abuse, ADHD, personality disorders, eating disorders, Alzheimer's, heart disease, etc. When other disorders occur along with depression this often makes the depression (or both) more difficult to treat or chronic. Both or all conditions often benefit from simultaneous or sequential (one after the other, addressing the underlying condition first) treatment.

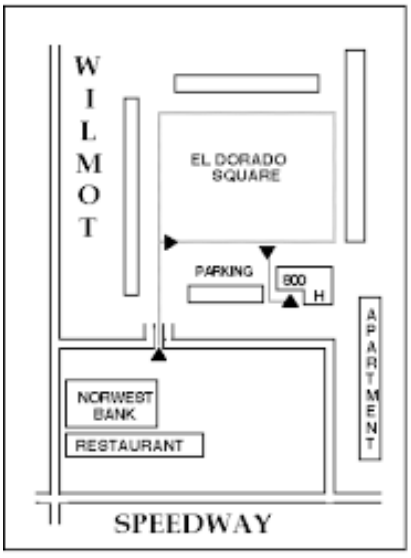
If I had a Major Depression, will my child have it someday?

Probably not, but the chances are somewhere between 15% and 25% your child will someday have an episode of Major or other depression. This compares to the risk for the general population which is about 2%.

If I had a Major Depression, will I have another one?

Probably not but your risk is higher, too. If you have had 3, and maybe 2, episodes of major depression in 5 years your risk of recurrence is so high we often advise staying on a maintenance dose of antidepressant to lessen the chance of more episodes and lessen their severity.

If you know you have a tendency to depression it is helpful to make lifestyle adjustments just like you should if you had a tendency to diabetes, seizures, high blood pressure, heart disease, or asthma, etc. Learn to recognize warning signs, risk factors for you, and especially at difficult times lessen your stress with rest, exercise, good nutrition, supportive people and activities, spirituality, and treatment services when appropriate.



Kevin Leehey, M.D.
1200 North El Dorado Pl.
H-800
Tucson, AZ 85715

Phone: (520) 296-4280
FAX: (520) 296-3835
www.leeheymd.com