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CLINICAL VIGNETTE

A Depressed Patient with Underlying Comorbidities Demonstrates that Counseling Alone is Not Enough

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Case Presentation

The patient is a 45-year-old female presenting for a physical exam. She is a divorced occupational therapist with 2 biological 17-year-old twins and 2 other step-children. She has never smoked and drinks socially in moderation and does not use recreational drugs. Her past medical history is significant for Hypothyroidism, Polycystic Ovarian Syndrome (PCOS), Herpes Simplex Virus Infection, Hypovitaminosis D, Herniated Lumbar Disc, Appendectomy, Breast Surgery, Caesarean Section, and Depression. Currently she is only taking Vitamin D 50,000U and Levothyroxine 50mcg. All her vaccinations are up to date. She is feeling “fine” and has had a recent negative mammogram and her pap is up to date. LMP was 3 weeks prior and regular. She eats healthily and exercises regularly. She last saw a therapist a month ago, but is still feeling depressed and anxious at times. She denies suicidal ideation or homicidal ideation. She reports trouble with decisiveness even when making relatively simple decisions such as grocery shopping. Her physical exam showed a blood pressure of 112/77, pulse 60, temp 36.8, respiratory rate of 18, Height 5’2”, Weight 116lbs, O2sat 100% on Room Air. BMI was 21.2. She was alert, appeared her stated age and was cooperative and pleasant. Physical exam was essentially normal except for mood. She was generally a good historian and showed no memory problems. However her affect was clearly depressed and anxious and at various points during the visit she broke down into tears. A diagnosis of depression with anxiety was made and she was started on Paroxetine 20mg orally daily¹ and a referral with a therapist was made. She returned one month later and reported feeling better with less depression, anxiety, and improved decision making with a better outlook, without following up with a therapist.

Discussion

Primary care physicians have an important role in diagnosing and treating depression.² Depression has a worldwide lifetime prevalence of 12% and in the U.S ranks second among all diseases and injuries as a cause of disability. The general definition of a major depressive episode is a period lasting at least two weeks, with five or more of the following symptoms: depressed mood, anhedonia, insomnia or hypersomnia, appetite or weight changes, psychomotor agitation or retardation, low

energy, poor concentration, thoughts of worthlessness or guilt, and recurrent thoughts of suicide or death. Many studies report that the combination of psychotherapy and pharmacotherapy is more effective than either alone. Additionally pharmacotherapy alone seems more effective than psychotherapy alone, for a number of reasons including general availability and convenience. Among the many choices for pharmacotherapy, SSRI’s are the preferred initial treatment of choice. Tricyclics and MAO inhibitors remain only secondary or tertiary options due to their inferior safety and side effect profiles. Bupropion is useful for those who want to avoid the sexual dysfunction or want treatment for comorbid smoking cessation. Citalopram has fewer drug interactions and mirtazapine may cause weight gain.

As is often times the case in primary care, depression may be treated as an episodic diagnosis, with antidepressants and counseling. Sometimes this results in resolution of the symptoms and “cure” of the depression. However in many instances, the symptoms linger despite appropriate mental health care. One study concluded that most MDD (Major Depressive Disorder) patients have an unfavorable prognosis.³ It contends that the majority of patients with MDD have a chronic disabling disorder. Conceptualizing and treating MDD as an episodic disorder may result in under treatment of the majority of depressed patients. Solomon et al. followed 318 patients with unipolar major depression for 10 years. After recovery from major depression the two year reoccurrence rate was greater than 40%. After a second, episode of depression, the 5 year reoccurrence rate was 75%.⁴ In this case, the disabling and chronic disorder could be related to one of her other many chronic medical problems, including PCOS. Anxiety and depression symptoms are more prevalent in patients with PCOS.⁵ Vitamin D deficiency is also independently associated with depression with or without PCOS.⁶ Regardless of the comorbidities associated with her depression, this patient responded quite well to Paroxetine. Paroxetine is a potent and selective serotonin reuptake inhibitor (SSRI) with currently approved indications for the treatment of depression, obsessive-compulsive disorder, panic disorder and social phobia. It is also used in the treatment of generalized anxiety disorder, post-traumatic stress disorder, premenstrual dysphoric disorder and chronic headache. This should come as no surprise since paroxetine is well tolerated

and effective in the treatment of both depressive and anxiety disorders across all age ranges.

Conclusion

This case showed the importance of treating depression at the point of care at the primary care visit. Even though the patient had seen a therapist before she benefitted from an approach which included medication as well as acknowledging that her depression may not be an isolated diagnosis separate from her other past medical history. In recognizing that multiple factors and organic diagnoses may come in to factor into her depressed state, the patient ultimately benefitted more than counseling alone.

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