Q&A

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Based on a neuroscienceCME Live & On Demand webcast held on January 7, 2015

Faculty Response to Questions from the Live Webcast

Remission in MDD: What Does the Future Hold for Clinicians and Patients?

Q: How do you dose aripiprazole for augmentation in MDD? If there is akathesia, does it resolve over time, is it an issue to be aware of at low dose?

A: *Begin with 2.5 mg po qhs. This will be effective for many patients. If there are no side effects, particularly akathesia, increase dose to 5 mg po qhs if needed. Akathesia is usually not an issue at low doses.*[1]

Q: In the audience response question, I did not vote to augment with atypical because I am not sure how to dose them. Can you tell me how you would start to augment with risperidone, and aripiprazole?

A: *See question 1 for dosing of aripiprazole. For risperidone, dosing is largely determined by patients' age and propensity for side effects. I generally begin in young and middle age patients at 0.5 mg po qhs and increase to 1-2 mg if needed. In the elderly, I begin at 0.25 mg and increase slowly to 0.5 mg or higher if needed, and prescribers should vigilant for extrapyramidal side effects.*[2]

Q: Quetiapine has efficacy in depression but is it really efficacy or mostly somnolence in patients with anxiety underlying the MDD?

A: *The clinical trial data that led to approval of quetiapine for bipolar depression revealed significant beneficial effects on the core symptoms of depression independent of beneficial effects on sleep and independent of side effects such as somnolence.*[3]

Q: One of the toughest issues I have when I want to augment with an atypical antipsychotic is that patients are uncomfortable using an antipsychotic. How do you discuss these agents with patients?

A: *This is not an uncommon problem. I explain to patients that many medicines have more than one use and that antipsychotic drugs, at lower doses than generally prescribed, act to increase the effectiveness of antidepressants and I want to work with them to determine the best treatment choice for them.*

Q: What about monoamine oxidase inhibitors (MAOIs) in treatment resistant depression (TRD)? Do these agents work, how do you dose them, and what are the most common side effects?

A: *There is considerable evidence that MAOIs are effective in many patients with TRD, particularly those with atypical depression characterized by symptoms of hypersomnia and extreme lethargy. Tranylcypromine is initiated at a dose of 10 mg po tid*[4] *and phenelzine at 15 mg po tid*[5]*. Doses can be increased as needed up to the FDA approved upper recommended limit. Dietary counseling is mandatory to avoid the so called "cheese reaction."*[6]

Q: All of my primary care colleagues use stimulants with treatment resistant depressive patients, what is the evidence there?

A: *Psychostimulants including amphetamines and methylphenidate can be helpful in depressed patients, particularly those with comorbid medical illness to increase energy and reduce the sedating effects of pain medications. Unfortunately they have failed as augmenting agents in a series of well conducted randomized clinical trials. They are not effective antidepressants as either monotherapy or as augmenting agents.*[7]

Q: You mentioned estrogen replacement therapy in women. Can you address the use of testosterone replacement in men as an adjunctive treatment?

A: *All depressed men should have a serum level of testosterone measured. There is good evidence that depressed men with low testosterone levels often respond well to testosterone replacement alone. Others will require both testosterone and antidepressant treatment.*[8]

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Q: One point about your first poll, we don't have enough information... the resistance to treatment may be non-compliance. Many people with depression don't want to take medications or feel they are cured and don't need to take it once there is some improvement. Please comment.

A: *Non-compliance is, indeed, a major cause of non-response. In most studies, 30% of outpatients are not adherent to their prescribed antidepressant.[9] This is a major reason that it is so important to make sure you talk with your patients about the impact of non-adherence on their overall outcomes, you talk with family members about the importance of adherence and you ask your patient at each visit about their adherence and provide them with tips, tools or mobile apps to help as medication reminders, etc.*

Q: What about cognitive-behavior therapy (CBT) in TRD?

A: *CBT is an important evidence-based treatment modality for TRD. There is considerable evidence that combined CBT-antidepressant treatment is more effective than either treatment alone.[10]*

Q: What about transcranial magnetic stimulation (TMS) and deep-brain stimulation (DBS)?

A: *TMS is approved by the FDA for patients who have failed one (but not more than one) SSRI. Unfortunately, the randomized controlled trial data base on TMS is meager compared to antidepressants. DBS is a novel neurosurgical treatment for depression. Thus far, 2 randomized controlled trials of TRD have not separated active DBS from sham treatment in efficacy. What the best CNS DBS target is remains a matter of debate.[11]*

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