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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

MDD Treatment: Decisions With Switching, Augmenting, or Staying the Course

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Vanacore:
Welcome to this presentation. I am Denise Vanacore, a Board-Certified Nurse Practitioner in Psych Mental Health and Family Practice. I am the Associate Dean and Professor of Nursing at Eastern University. It's a pleasure to talk to you today about when to switch, augment, or stay the course when treating patients with major depressive disorder.

As we look at this slide, we see the options for treatment after the initial antidepressant has been started. The 2016 CANMAT guidelines list SSRIs, SNRIs, bupropion, mirtazapine, vortioxetine all as first-line psychopharmacology agents. Regardless of the intervention used, a substantial portion of patients do not adequately respond or achieve remission after initial antidepressant treatment. For example, about 40% of patients treated with second-generation antidepressants do not respond, and approximately 70% do not achieve remission. Remission rates continue to decline with each additional line of treatment that providers try. When patients respond poorly to an antidepressant medication or exhibit intolerable side effects, then switching to another antidepressant might be indicated. Clinician should be familiar with the pharmacology of each drug, such as the antidepressant classes, as well as potentials for drug-drug interactions, as well as discontinuation symptoms, and the time to onset of effectiveness of each new medication that they try.

If a patient has a partial response, about 25 to 49%, reduction in symptoms based on scores, or no response, reduction in symptom scores, then the initial treatment might not be working, and it might be time to ensure that optimization is completed. And if that's not happening, then either it might be time to switch or augment.

There is substantial evidence that many patients receive subtherapeutic dosing and/or inadequate duration of treatment or poor adherence. Remission rates for adults with MDD are low, with 36.8% of patients achieving remission with first-line agents.

So how long do we wait before we see whether or not we've gotten remission? Early improvement should show 20 to 30% reduction in the baseline from your measurement-based care. However, there are also evidence that shows switching at 2 to 4 weeks for non-responders to their initial antidepressant might be helpful. Inadequate responses to antidepressants can also prompt non-adherence. If a patient is not feeling better on their antidepressant, they might not continue. So it's also important that we use psychoeducation to remind patients to stay on their medications and discuss it with us before stopping. Antidepressants have an initial dose that can be incrementally increased, depending on the patient's response, as well as tolerability. Partial responses to antidepressants can be addressed by first increasing the doses somewhere around 2 to 4 weeks as the patient is tolerating the medication.

So when do we switch? The 2009 CANMAT guidelines summarized evidence showing that switching non-responders to another antidepressant results in a good response, as well as good remission rates. Studies with newer antidepressants also support this finding. However, the value of switching in class versus out of class is still very controversial.

So what options do we have for switching? Well, we can begin what we call a direct switch, stop the first and a depressant and then abruptly begin a new antidepressant. We can do a taper, and switch immediately. So gradually taper the first antidepressant and then once off, consider adding the new one, or we can taper and switch after a washout. And we can do cross tapering. A wonderful resource that you can use for switching is called SwitchRx.com, and it's a website that has lots of useful information on how to switch patients.

And adjunctive strategy refers to the addition of a second medication to an initial medication. The term adjunctive is preferred over terms such as augment. If the first antidepressant has a 25 to 30% response rate, then it might be time to consider adjunctive treatments. What are these? These can be anything from a second antidepressant to another outside course. So you can use either something from a different medication class to consider adding medication that might target different symptoms.

The last is when to stay the course. So as we've looked at this, we need to make sure that that we look at whether or not we've had adequate time on the current dose and whether we've had adherence. So sometimes it's better to do tincture of time and wait the extra time for further improvement.

In summary, in this presentation, we discussed evidence-based strategies on whether to switch, augment, or stay the course. Thank you for participating in this activity.

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