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No Symptom Left Behind: Utilizing Standardized Tools to Detect and Manage Residual Depression Symptoms

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

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Dr. Goldberg:
Hello everyone. This is CME on ReachMD. I'm Dr. Joe Goldberg, and with me today is my colleague and friend, Dr. Manpreet Kaur Singh.

Welcome, Manpreet.

Dr. Singh:
Thank you so much, Joe. Glad to be here.

Dr. Goldberg:
As am I. So we're going to tackle the question of standardized tools that we can use to detect and manage residual depressive symptoms. Say what comes to mind when you think about that, Manpreet.

Dr. Singh:
Well, standardized, validated, you know, we have our diagnostic and statistical manual. We have our criteria that help us understand what a depressive episode actually is defined by. And I think that that has to be kind of at our basement foundation, our starting point.

Certainly, if we're screening for depression in a clinical setting, so say in a primary care setting or even in a patient that's coming really with the first episode, maybe we'd want to do a screener or two, like a PHQ-9 or something like that, to just sort of get a sense of whether this is even a phenomenon for our patient and how seriously to take it. Certainly, because you have suicide questions, the imminence of screening for depressive episodes and tracking depressive symptoms over time becomes even more important.

But I will tell you that nothing beats, at the end of the day, a semi-structured classic interview that helps you get at DSM criteria. You have to make sure that in order to meet criteria for a depressive episode, that you have at least 2 weeks, or 50% of the time every day or more of, you know, low mood or lack of motivation and additional SIGECAPS [Sleep disturbance, Interest (diminished), Guilt or feeling worthless, Energy (loss), Concentration difficulties or indecisiveness, Appetite abnormality or weight change, Psychomotor retardation or agitation, and Suicide or death (acts or thoughts of)] symptoms that relate to sleep dysfunction, relate to interest, guilt, energy, concentration, appetite, psychomotor dysfunction, and suicide. These question**s** become really important because they help us define what flavor of depression a patient might be experiencing, whether you can make a treatment that's based on the predominating symptoms and what are likely to be more responsive. And then you can get a chance to really go for a more nuanced treatment planning session with patients to really help them guide their treatment together.

Dr. Goldberg:

You know, I'd say measurement-based care, as it's known, really ought to be your best friend. Did you know that just going through a systematic survey of questions with patients actually has some therapeutic value? Not just because it's sort of lending some coherence to what's going on, and because it gives you a metric for being able to say, wow, this is better and this is not, and by how much so the patient has that shared experience with you, the clinician, in terms of gauging, “Am I better? Am I not better? What's better? What's not better?” But also because

it really is the definitive way of knowing whether or not your interventions are having some impact and being able to track the things that matter the most. So, you know, we like to see – there's a few benchmarks that I like to point out. After a couple of weeks of starting a treatment, we'd like to see at least a 20% improvement from when you started out. That's been shown pretty robustly in mood disorders in general and not just in mood disorders.

So pick your favorite scale. You mentioned the PHQ-9. I like the PHQ-9. If I'm wearing my researcher hat, it might be more of a clinician-administered scale. You know, the Montgomery-Asberg scale. There's the Hamilton scale. There's lots of scales. My measurement-based care colleagues are fond of saying, pick whatever scale you like that you think you're going to use. And that could even be a 0 to 10 analog scale for the patient, because you're comparing them to themself. And that's really important. You compared to you. You began here, and now you're here. Are you 20% better by 2 weeks, and then by the end of, what, 4 to 6 weeks, we'd like to see 50% improvement. That's response. Remission is where you're like somewhere in the single digits. And if you're not seeing that, then you can start to delineate what exactly are the residual symptoms that you're noticing.

And then you may go down a particular pathway. You really seem anhedonic. Maybe we'll do a scale like the SHAPS [Snaith-Hamilton Pleasure Scale] on you, or you're having a lot of lethargy and sleepiness, maybe we'll do an Epworth Sleepiness Scale on you. So we could bring in more. Or maybe about a lot of low self-worth, self-esteem, maybe we'll do a Beck scale on you. So the scales that we might want to use very much can depend on who the patient is and what kinds of symptoms they're having.

So this has been a micro minute sound bite discussion of, I think, a very important topic. That's all our time for now. So thanks for listening.

Announcer:
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