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Personalized Care: Tailoring Treatment Plans for Residual Symptoms in MDD

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

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

Welcome, Manpreet.

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

Dr. Goldberg:
So we're going to dive into a difficult topic in a short space of time, which is how do you tailor treatment plans for patients with residual symptoms of major depression? Would you like to take a crack at this?

Dr. Singh:
You know, personalized medicine has become somewhat of a household name for psychiatry. It's a very exciting time where we can actually imagine doing more selective treatment matching. We used to think about our drugs as broad spectrum, and that's done a service to a lot of conditions that we've had in psychiatry. But unfortunately, only about 1/3 of people seem to get better with the currently available treatments, with 1/3 doing about the same, and 1/3 even getting worse. We have to do better.

And so personalizing care by doing a better job of matching the treatments that patients need for a certain subset of symptoms is on us, upon us as clinicians to do a good job doing a great diagnostic formulation and appropriately matching patients with their treatment. And because we have more tools coming online, I'm very excited about being able to implement more measurement-based and personalized care for patients.

How about you, Joe?

Dr. Goldberg:
So if you spent any time with me, you know that I like to talk about the notion of what are called moderators or treatment outcome. That is, what are the baseline characteristics of a given patient that have some predictive value in the likelihood that a certain treatment's going to work? So rather than just saying, here's a patient with major depression, how should we treat them, or how should we tailor treatments, we might instead say, here's somebody with persistent depressive disorder that began in adolescence, who's had more than 3 or 4 distinct episodes with or without psychosis, with or without anxiety, with or without suicide attempts or chronic suicidal ideation, with or without – pick your favorite comorbidities.

And really, you know how your medical students, that first sentence, this is a 34-year-old, that first sentence tells the whole story? We

kind of, I think, want to do that here in tailoring our treatments so that you really paint a picture of who the patient is, not just here's somebody with depression, but are they young? Are they old? Have they been through many treatments before or not? Have they had a lot of side effect tolerability issues? What are their comorbidities? Any medical problems? So that you really paint a picture in your mind. Has there been variation in the types of medicines that have been used? Or has somebody has been going through every SSRI [selective serotonin reuptake inhibitors] and nothing else without, for instance, trying augmentations with a second-generation antipsychotic, the kinds that we know can be valuable and mindful of tolerability of those medicines? Has there been consideration of subtypes of symptoms like melancholia versus atypical depression versus anxious depression, anhedonic depression? Makes us think about the roles of, well, if you're like a neuroscience kind of person, would a dopamine agonist-type medicine have value for motivation and drive or for cognition? Would a serotonergic drug have particular value if there's a lot of anxiety? If someone's having a lot of agitation, are you sure there's no psychosis or overvalued ideas and you're not missing some residual psychotic symptoms? Maybe last, but not least, metabolic pathways, which I keep giving you a 2D6 substrate and you're not getting better, I mean, I might do pharmacogenetic testing to affirm are you sure you're not a poor metabolizer? Or I might just say, you know, let's pick a drug that doesn't go through that metabolic pathway and see what happens.

So I think personalized medicine means forming some summary of the collective features that describe the patient, recognizing what's gotten better and what's not gotten better, both in the current treatment as well as any prior treatment so you can really pinpoint, target symptoms. More than once or twice, I've had residual insomnia that only turns out to be sleep apnea or restless legs syndrome or a comorbidity that's best managed in a sleep medicine center, or someone that's got some endocrine undiagnosed comorbidity. So we really try to, what colleagues of ours call, deep phenotype the patient, and from there, decide how to proceed.

And you may not solve everything. Document what you do. You may be the one who passes this on to someone else, and they'll benefit from the time you put in. Because, oftentimes, these are works in progress, but challenges that are manageable.

So unfortunately, we're out of time. This has been a great short discussion. Thank you, Manpreet, for joining. Thank you all for joining us today.

Dr. Singh:
Thank you.

Announcer:
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