J. MICHAEL BOSTWICK: My name is J. Michael Bostwick. I'm a professor of psychiatry here at Mayo Clinic. The title of the article is "A Generalist Guide to Treating Patients With Depression With an Emphasis on Using Side Effects to Tailor Antidepressant Therapy," and it will be in the June 2010 issue of *Mayo Clinic Proceeding.*

We know that in the US at this point, more than 75% of antidepressant prescriptions are actually written by primary care physicians, which would include internists, family practitioners, and presumably sub specialists in this field. We also know that there are a couple of dozen choices to make among all the antidepressants, and this presents a challenge for primary care doctors, particularly when they don't have ready access to a psychiatrist to help to clarify what they should do. That's the premise under which this article was prepared and written in hopes of offering some guidelines for helping primary care physicians pick among a welter of options.

One of the major problems with depression is a tendency to rush to treat it with medication. There are a number of different conditions where a person appears depressed, but in order to make the diagnosis, a patient has to have a number of symptoms plus the presence of these symptoms for at least two weeks. The first option for them would be watchful waiting. If the person tells you that they've been depressed for only a few days, often in conjunction with an event in their life, then you might think about counseling them a bit and seeing them back in a week or so to see if the depression symptoms have established themselves more firmly have gone away.

A second option would be to use antidepressants when you've established the diagnosis of major depression. For mild to moderate depression, medication, the second option, or psychotherapy, the third option, have been shown to be equally effective. The fourth option is combined medication and psychotherapy. And particularly for severe depressions, this may really be the way to go because the medications will perhaps prepare the patient to be able to benefit from this psychotherapy more than they would without the medication. Medication alone may also not help patient deal with whatever issues are driving the depression in their personal lives.

There are a number of circumstances under which a primary care doctor might wish to or really should refer to a psychiatrist. These include if the patient fails to respond to initial antidepressant trial. Some would argue that the patient is requiring more than one antidepressant in more than one class of medication, so it might be time to get a psychiatrist involved.

Another would be when a patient experiences only adverse effects from the medications that have been tried or when the patient has a strong family history for psychiatric illness, particularly bipolar illness, where the depression may actually be a manifestation of the more complex illness. If a patient tells you that nothing is ever helped, there's a good chance that nothing has ever helped, and you might want to get an opinion from a psychiatrist at that point about whether there's some other modality of treatment that might be relevant or whether the patient, perhaps, has a personality disorder that's not amenable to therapy, or finally, whether the depression diagnosis is actually a misdiagnosis and there's something else going on that requires an expert opinion.

I think it's also helpful to think about referral if the patient has complex medical co-morbidities because then the choice of antidepressants may become more complex based on what other medications the patient is taking or what treatment they're having. For example, corticosteroids can cause all kinds of mood symptoms, and at least initially, one probably wouldn't jump to psych antidepressants to treat those. Likewise, one of the things to keep in mind with medically ill patients is then they look depressed, but it's actually masquerading for any number of other conditions that are associated with the primary medical condition.

Finally, if there are psychotic symptoms or active suicidality or evidence for mania, those are times when you really might like to get a psychiatrist involved. If you determine that you feel comfortable prescribing antidepressants, then the message of this article is to work with the side effect profiles of the medication to try to make those side effects work for you. All antidepressants have some side effects, and the three that seem to be most concerning for patients and for doctors are side effects related to sleep, side effects related to sexual function, and side effects related to weight gain.

I actually pulled a number of my colleagues in medicine and surgery to come up with those three, which were the most prominent concerns they were hearing from their patients. I'd suggest you take a look at the article to get some tips on which classes of antidepressants are likely to be more appropriate for your patient. I also must emphasize that one man's curse is another man's blessing. The example that's often given is with the SSRIs, which are known to cause changes in sexual function.

Often we refer to sexual dysfunction, but for some men in particular, a delayed orgasm is actually a good thing. The evidence for this will be that urologist are using low-dose SSRIs to treat premature ejaculation. My point is that depending on the way your patient is presenting, what we're calling a side effect may actually be of benefit. Sedation from an antidepressant for somebody who can't sleep could be a good thing.

Activation from an depressant for someone who's dragged out and tired could also be a good thing. So as you take a look at the article, you'll see that I try to address these three classes of side effects-- sexual function, sleep issues, and weight gain-- in recommending certain choices among the many possibilities there are of antidepressants that you can choose.

Well, the reality these days is that it's very hard to get a psychiatric referral in many parts of the country. And in some parts of the country, there are no psychiatrists at all. My hope is that an article like this will give primary care providers a way to think about antidepressants that's new and they allowed them to have better compliance from their patients. I'm also quite intrigued by the idea that we can use side effects to our benefit, and I think the article is fairly transparent about how to think about doing that.

In this respect then, if you're only going to use one antidepressant on your patient, hopefully, it will help you to pick the right one for your patient and maybe make it easier to prescribe rather than be frustrate yourself and have a frustrated patient. The takeaway message is that all antidepressants work essentially the same in terms of having benefit. There are complex neurotransmitter explanations underlying them, but they basically all work. The issue then becomes picking the right one based on side effects for your patient so that you get, hopefully, compliance as well as an effective treatment for the depression.

My final thought, of course, is that I do try to emphasize that you should be very clear that you are actually treating depression before you start a medication for it. So often I find patients who were never really depressed who were started on medications that then didn't work when what they really needed was someone to talk to or someone to help them sort out life difficulties.