Case

A 53-year-old man presents to his PCP with a chief complaint of "not sleeping enough, having increased back pain, and feeling run down." For the last 4 months, he has been waking up too early in the morning and cannot get back to sleep. During the day he is exhausted and is having trouble focusing when he's at work. His chronic back pain has increased, so he has been staying at home and has stopped exercising. He has tried everything he can think of to "break out of this rut," but feels like it is pointless and is ready to give up.

The PCP administered a PHQ-9 (the patient scored 18) and then asked the patient about suicidality. After discussing the symptoms on the PHQ-9, the patient said that he never thought of himself as depressed before. The PCP conducted a safety assessment to follow up on the patient's thoughts of giving up. The patient revealed he has thought about jumping off a local bridge but he feels he does not have the courage to go through with it. The patient had never told anyone this, but felt relieved that his PCP knows about this, so they could start to address this

At the initial visit the PCP conducted additional screening for anxiety, which revealed that the patient's GAD-7 score was 6. The patient's review of systems was notable for exacerbation of his chronic back pain. He reported minimal alcohol use on the AUDIT-C and does not have any other relevant health issues. The PCP expressed confidence to the patient that he would be able to improve and introduced the patient to the Care Manager for further evaluation and treatment.

The Care Manager conducted a comprehensive assessment of the patient and learned that he has been more irritable at home with his wife and children for the past six months. He has also stopped going out with friends. In the last two weeks he has been late to work four times because he can't get himself to get started in the morning. Additional history revealed he had a similar episode in the past when he was about 20 years old when he was having trouble with his coursework at college

To manage his stress recently, the patient reports he has started smoking cigarettes again after having quit four years ago. The PCP conveyed the patient's thoughts of suicide to the Care Manager who addressed patient safety as part of the comprehensive assessment. With the patient's permission, the Care Manager contacted the patient's wife in his presence. Together they discussed his passive suicidality, which she stated she had not known about and responded appropriately with concern. The patient expressed he felt reassured that everyone was on the same page.

As part of the Care Manager's initial comprehensive assessment, the Care Manager administered screening instruments for PTSD (PCL-C), and bipolar disorder (CIDI-3), both of which were negative. The Care Manager screened for substance use with the DAST-10 which was negative, and confirmed that the patient did not have a prior history of drug or alcohol problems. The Care Manager and patient discussed the provisional diagnosis of major depression and its treatment, as well as the connections between depression and chronic pain.

Initiate Treatment

The Care Manager and Psychiatric Consultant discussed the patient's presentation. The PCP had asked whether fluoxetine would be appropriate for the patient. The Psychiatric Consultant suggested considering bupropion as an initial antidepressant given its efficacy in supporting smoking cessation. A titration schedule was provided to escalate the dose to the therapeutic range and monitor response with a PHQ-9 over four to six weeks.

The Psychiatric Consultant and Care Manager determined that the Care Manager would offer Problem Solving Treatment (PST) to the patient and help support the antidepressant management. Problem Solving Treatment was described and the patient agreed to this concrete approach. In the first PST meeting, the Care Manager explained the rationale behind PST and what to expect from treatment. The patient agreed to this approach. The Care Manager then explained that PST teaches and empowers patients to solve the here-and-now problems contributing to their depression and helps them feel less overwhelmed.

Working together the patient identified his recent lack of activity as the problem to work on and they brainstormed solutions which he then prioritized for action. In discussing the various activities he had stopped doing, the patient indicated he felt he wanted to do two things: extending his walks with his dog beyond what he was already doing and inviting a friend along with him on these walks. The Care Manager checked with his PCP if this was appropriate, given his chronic back pain, and also consulted with the Psychiatric Consultant regarding the pain relieving effects his antidepressant might confer to assist in gradual increase in physical activity.

Following the Care Manager's recommendation, the patient scheduled a follow-up visit with his PCP. The Care Manager updated the PCP about the treatment plan and the Psychiatric Consultant's recommendations for antidepressant medication. The PCP prescribed bupropion SR 150mg daily. The PCP arranged follow-up with the patient, reinforced the role of the Care Manager in coordinating care and also expressed support for the value of PST in treating depression.

Active Treatment to Target

After four weeks in treatment, the patient's sleep was improving and his energy improved, but his PHQ-9 score remained elevated at 14. The Care Manager notified the PCP and the patient's bupropion SR dose was increased to 150mg twice daily (morning and afternoon) as suggested by the Psychiatric Consultant. By week eight, the patient reported his concentration was improving at work, his back pain had improved, and his PHQ-9 score was down to 8. The patient continued on bupropion 150mg twice daily and ongoing follow-up with the Care Manager for PST. The Care Manager taught the patient ways to prioritize and solve his problems around increasing his activity.

At week 12, the patient's PHQ-9 dropped to a 4 and he reported that his pain was more manageable. The patient indicated that he had added to his walking routine with his dog and twice-weekly aquarobics class at his local community center. He reported feeling better connected socially, and while he occasionally had bad pain days, he felt he had a plan to manage them well. The patient also reported a decrease in irritability, which resulted in better relationships with his family.

The Care Manager recommended that the follow-up meetings be reduced to every other month. After an additional four months, the patient's PHQ-9 score dropped to a 1 and he reported continued success in social engagement and exercise, even when his back bothered him. The patient and Care Manager began to discuss relapse prevention plans. He understood the need to remain on his antidepressant medication for a minimum of six months even though he was feeling better, but that he might consider a longer course given his prior history of a depressive episode.

Relapse Prevention

At the final meeting, the Care Manager and patient developed a detailed relapse prevention plan that included continuation of his medication for another year, and a plan to continue his pleasant activities (walking, swimming, socializing with family and friends, volunteering at the local church on Sundays). Also that he would employ the problem solving skills he had leant if other issues should arise.

The plan also included the patient continuing to track his symptoms on his own as well as a plan to monitor his "hot" symptoms-depression symptoms he felt are an indication he may need to check in with his doctor. The plan specified that if his PHQ-9 was above 5 for two weeks, experienced unremitting pain for one week, or began to drop his activities, he would contact his PCP for follow-up.