PROVIDING PSYCHIATRIC CARE VIA PCP

Kasey Strosahl DO
Medical Director Behavioral Health Services, MGMC
Psychiatrist, MGMC
Assistant Clinical Professor, Des Moines University
I have no financial relationships with a commercial entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients.
PSYCHIATRY, IT’S NOT JUST FOR PSYCHIATRISTS ANYMORE...
PSYCHOTROPIC MEDICATIONS

Figure 1
Percentage of U.S. retail psychotropic prescriptions written from August 2006 to July 2007, by type of provider

1 "Datapoints: Psychotropic Drug Prescriptions by Medical Specialty." Psychiatric Services, 60(9), p. 1167
PSYCHIATRY IN THE PRIMARY CARE OFFICE

1/3 of Americans with mental health problems receive treatment for their condition\textsuperscript{2}
- One culprit: Lack of insurance coverage for mental health services

Mental Health Parity and Addiction Equity Act of 2008 addressed mental health coverage issues\textsuperscript{2}
- Still barriers to access for Medicare/Medicaid enrollees
  - Few private mental health care providers willing to accept publicly-funded insurance

Shortage of mental health providers\textsuperscript{2}
- Parity Act may exacerbate problems with provider shortages as demand is increased

PCPs account for nearly 50% of antidepressant related visits\textsuperscript{3}
60+% of first antidepressant scripts\textsuperscript{3}
PSYCHIATRIST SHORTAGE

Employment of psychiatrists, by state, May 2015

Blank areas indicate data not available.
DIFFICULTIES IN PRIMARY CARE

Primary care visits last an average of 13 minutes and include an average of 6 patient problems

Mental health problems compete with acute physical illness, monitoring chronic illness, and preventative health services

Vague somatic complaints without established psychiatric diagnosis

Patient reluctance to acknowledge underlying psychiatric cause

Only 20-30% of patients with mental health issues report them to their primary care provider

- Somatization of psychiatric issues

Median visits to PCP 1.7 versus 7.4 for MH specialty providers in 12 month period

Establishing therapeutic alliance
RATES OF DETECTION OF MOOD AND ANXIETY DISORDERS

People with anxiety disorders 3-5 times more likely than those without anxiety to visit their doctor

Often misdiagnosed or undiagnosed, leading to
  ▪ Self-medication
  ▪ Higher incidence of substance abuse
  ▪ Frequent use of medical services
  ▪ Inappropriate treatment
  ▪ Social isolation
  ▪ Educational and occupational impairment
80% of people with MDD are treated entirely within the primary care setting
- Depression is one of the most prevalent and fastest rising disorders in primary care
- Prevalence in primary care patients is 23-35%

GAD most frequent anxiety disorder in primary care
- 5.8-22.0% in patients complaining of anxiety
- Lifetime prevalence 5.1%
- General medial practice prevalence 2.8-8.5% versus 1.6%-5% in general community

Social anxiety
- 12 month prevalence 7.9%, lifetime 13.3%--most prevalent of any anxiety disorder
- Associated with
  - Higher health care use
  - Psychiatric comorbidity (especially MDD, alcohol use disorder, suicide attempts)
  - Most common psychiatric disorder behind depression and alcohol use disorder
Studies indicate that general practitioners recognize mood disorders at chance levels:

- 50-70% of depressive episodes go undetected by physicians

Detection rate for bipolar disorder is approximately 50%

Social anxiety detected in 0.5%
Patients administered MINI (Mini International Neuropsychiatric Interview) in waiting room of primary care clinic

Medical charts reviewed for evidence of prior diagnosis of a mood or anxiety disorder

n = 840
- MDD 27.2%
- Bipolar disorder 11.4%
- Panic disorder 12.6%
- GAD 31.2%
- Social anxiety disorder 16.5%

Misdiagnosis = diagnosis reached during the MINI but not documented in the patient’s chart
- 65.9% MDD
- 92.7% bipolar disorder
- 85.7% panic disorder
- 71.0% GAD
- 97.8% social anxiety disorder
WHAT DO I NEED TO DO?
COMPLETE PSYCHIATRIC ASSESSMENT

History of present illness and current symptoms
Past psychiatric history
Substance use
Relevant social, occupational, and family history
Physical examination and appropriate diagnostic tests to rule out physical causes for current symptoms
SAFETY EVALUATION

Specific inquiries about suicidal thoughts, plans, intent, means, and behaviors
Psychiatric symptoms or general medical conditions that might increase the likelihood of acting on suicidal ideas
Past and recent suicidal behavior
Potential protective factors that may decrease the odds that the patient will harm him/herself
Family history of suicides/attempts
Self-care including hydration and nutrition
Ability to care for dependents in their custody
MONITORING PROGRESS

Ongoing assessment for
- Adherence to treatment
- Symptom control
- Side effects

Especially important when
- New to medications
- First episode of illness
- High risk for suicide
- Not improving clinically
IT’S NOT WORKING!—CONSIDERATIONS BEFORE CHANGING MEDICATIONS

Verify compliance
Appropriate dosing?
Adequate duration of treatment?
• 4-6 weeks for depression
• Up to 12 weeks for anxiety disorders
Is the diagnosis correct?
Is there an untreated co-morbid condition?
Was it helping then symptoms worsened or new symptoms arose?
ADEQUATE ANTIDEPRESSANT DOSING

Starting dose should be lower
- Titration speed based on tolerability
- Titrate to effectiveness
- Bupropion increased only after 4-5 days secondary to seizure risk

If little response on lower doses, titrate to at least equivalent therapeutic dose to see if the patient demonstrates more response, can titrate to maximal dosing if tolerated
- 4-6 weeks at this dose

Much debate about what dose at which to consider patient a non-responder to that medication

<table>
<thead>
<tr>
<th>Antidepressant</th>
<th>Evidence-based equivalent (mg)</th>
<th>Clinically practical equivalent (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>fluoxetine</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>bupropion</td>
<td>348</td>
<td>300</td>
</tr>
<tr>
<td>paroxetine</td>
<td>34</td>
<td>30</td>
</tr>
<tr>
<td>escitalopram</td>
<td>18</td>
<td>20</td>
</tr>
<tr>
<td>sertraline</td>
<td>98</td>
<td>100</td>
</tr>
<tr>
<td>venlafaxine</td>
<td>149</td>
<td>150</td>
</tr>
<tr>
<td>mirtazapine</td>
<td>51</td>
<td>45</td>
</tr>
</tbody>
</table>

Continuation phase treatment

- Prevent relapse
- Discontinuation of medication during this period of remission will likely result in relapse
- Continue medications for 6-12 months after full remission of symptoms
- Same medication, same dosage

Should discontinuation be trialed?

- Current stressors are at a minimum
- Number of prior episodes of depression
  - 2 or more episodes, at least 3/4 have another episode
  - If side effects tolerable, recommend continuation of medication
Can I just stop the medicine cold turkey?

Fluoxetine = Yes
  - Long half life with active metabolites

Others = No
  - Your patient will thank you
  - Venlafaxine can be especially uncomfortable
    - Decrease dose stepwise every 3-7 days, pending tolerability
    - May need to prescribe to 37.5 mg for 1-2 weeks prior to discontinuation
  - Exception: concern for serotonin syndrome = discontinue abruptly

If switching to an alternate medication that acts on the same receptors
  - Can taper off 1st medication more rapidly
WHEN SHOULD MY PATIENT BE REFERRED TO __________?
Diagnoses
- Major depressive disorder, severe, with psychotic features
- Refractory depression
- Refractory anxiety
- Bipolar disorder
- Schizophrenia

Diagnostic uncertainty

Repeated hospitalizations

Mental health concerns override time for serious medical concerns
... TO A PSYCHOTHERAPIST/COUNSELOR

Depression
- Always
- Build coping skills, gain insight, improve cognitive distortions, etc.

Anxiety disorder
- Always
- Non-pharmacologic methods to deal with anxiety

Bipolar disorder
- Always
- Gain insight, interpersonal and social rhythm therapy, improve cognitive distortions, build coping skills, etc.

Schizophrenia
- Sometimes
- Can be helpful to cope with residual psychotic symptoms, gaining rapport with mental health system
...TO THE EMERGENCY DEPARTMENT FOR POSSIBLE PSYCHIATRIC ADMISSION

Active suicidal ideation
  • Plan, means, intent
  • Not passive death wish or chronic, unchanged suicidal ideation

Severe inability to care for self including malnutrition/dehydration secondary to psychiatric symptoms

Manic
  • Minimal sleep for several days; elevated/expansive/irritable mood; flight of ideas, racing thoughts; poor thought processing; excessive spending; impulsive behaviors; +/- hallucinations, paranoia, or delusional ideas

Psychotic symptoms which pose risk to patient or others’ safety
  • i.e. command hallucinations, believe being poisoned and at risk for malnourishment/dehydration

Homicidal ideation
PSYCHIATRIC INPATIENT CONSULTATION

Suicide attempt
Active suicidal ideation
Concern for mania
Increasing psychotic symptoms
Mental health symptoms impeding medical care
Severe behavioral concerns secondary to delirium
- Non-responsive to treatment of underlying condition
Capacity evaluation based on mental health concerns
- Any physician can perform a capacity evaluation
BIPOLAR DISORDER OR ANXIETY?
**BIPOLAR OR ANXIETY?**

**Mania/hypomania**
- Decreased need for sleep
- Racing thoughts
- Episodic decreased concentration
- Episodic irritability
- Boundless energy
- Restlessness/increased psychomotor activity

**Anxiety**
- Difficulty falling and staying asleep, need for sleep unchanged
- Racing thoughts when worrying
- Sustained decreased concentration
- Sustained irritability
- Fatigue
- Restlessness/increased psychomotor activity
MY PATIENT HAS A MENTAL HEALTH PROVIDER. WHAT DO I NEED TO DO?
COLLABORATION WITH MENTAL HEALTH SERVICES

Communication
- Especially medication changes

Laboratory and metabolic monitoring in those on psychotropic medications
- Should be done by prescriber of the medication, but…

Contraception
LABORATORY MONITORING

Antipsychotics

- BMI/weight
  - Performed baseline, monthly x 3 months, then quarterly
- HbA1c, fasting plasma glucose, fasting lipid panel
  - Performed baseline, after 3 months, and annually
  - If patient develops diabetes mellitus, use ADA guidelines for monitoring

Mood stabilizers

- Lithium—Level, TSH/T3/T4, BMP (electrolytes/renal function)
- Depakote—VPA level (80-120 mcg/mL for mania, timing depends on preparation), LFTs, CBC
- Carbamazepine—Levels (first levels 3-4 weeks apart), LFTs, CBC, UA/electrolytes
MENTAL HEALTH GAP ACTION PROGRAMME

mhGAP Intervention Guide
- for mental, neurological and substance use disorders in non-specialized health settings
- World Health Organization
- Addresses
  - Moderate-Severe Depression
  - Psychosis
  - Bipolar Disorder
  - Epilepsy/Seizures
  - Developmental Disorders
  - Dementia
  - Alcohol Use and Substance Use Disorders
  - Self-harm/Suicide
  - Other Significant Emotional or Medically Unexplained Complaints
Depression

Assessment and Management Guide

1. Does the person have moderate-severe depression?

- For at least 2 weeks, has the person had at least 2 of the following core depression symptoms:
  - Depressed mood (most of the day, almost every day). (for children and adolescents: either irritability or depressed mood)
  - Loss of interest or pleasure in activities that are normally pleasurable
  - Decreased energy or easily fatigued

- During the last 2 weeks has the person had at least 3 other features of depression:
  - Reduced concentration and attention
  - Reduced self-esteem and self-confidence
  - Ideas of guilt and unworthiness
  - Bleak and pessimistic view of the future
  - Ideas or acts of self-harm or suicide
  - Disturbed sleep
  - Diminished appetite

- Does the person have difficulties carrying out usual work, school, domestic, or social activities?

Check for recent bereavement or other major loss in prior 2 months.

YES

If YES to all 3 questions then moderate-severe depression is likely

- Psychoeducation, ➔ DEP 2.1
- Address current psychosocial stressors, ➔ DEP 2.2
- Reactivate social networks, ➔ DEP 2.3
- Consider antidepressants, ➔ DEP 3
- If available, consider interpersonal therapy, behavioural activation or cognitive behavioural therapy, ➔ INT
- If available, consider adjunct treatments: structured physical activity programme ➔ DEP 2.4, relaxation training or problem-solving treatment, ➔ INT
- DO NOT manage the complaint with injections or other ineffective treatments (e.g. vitamins).
- Offer regular follow-up, ➔ DEP 2.5

NO

If NO to some or all of the three questions and if no other priority conditions have been identified on the mhGAP-IG Master Chart

- Exit this module, and assess for Other Significant Emotional or Medically Unexplained Somatic Complaints, ➔ OTH

In case of recent bereavement or other recent major loss

Follow the above advice but DO NOT consider antidepressants or psychotherapy as first line treatment, ➔ Discuss and support culturally appropriate mourning/adjustment.
Depression
Assessment and Management Guide

2. Does the person have bipolar depression?
- Bipolar depression is likely if the person had:
  - 3 or more manic symptoms lasting for at least 1 week OR
  - A previously established diagnosis of bipolar disorder
- Ask about prior episode of manic symptoms such as extremely elevated, expansive or irritable mood, increased activity and extreme talkativeness, flight of ideas, extreme decreased need for sleep, grandiosity, extreme distractibility or reckless behaviour. See Bipolar Disorder Module. »BPD

3. Does the person have depression with psychotic features (delusions, hallucinations, stupor)?
- If YES
  - Augment above treatment for moderate-severe depression with an antipsychotic in consultation with a specialist. »PSY
- (Reconsider risk of suicide/self-harm (see mhGAP Master Chart))
- (Reconsider possible presence of alcohol use disorder or other substance use disorder (see mhGAP Master Chart))
- Look for concurrent medical illness, especially signs/symptoms suggesting hypothyroidism, anaemia, tumours, stroke, hypertension, diabetes, HIV/AIDS, obesity or medication use, that can cause or exacerbate depression (such as steroids)

4. Concurrent conditions
- If a concurrent condition is present
  - Manage both the moderate-severe depression and the concurrent condition.
  - Monitor adherence to treatment for concurrent medical illness, because depression may reduce adherence.

NOTE: People with bipolar depression are at risk of developing mania. Their treatment is different!
5. Person is female of childbearing age

Ask about:
- Current known or possible pregnancy
- Last menstrual period, if pregnant
- Whether person is breastfeeding

If pregnant or breastfeeding

Follow above treatment advice for the management of moderate-severe depression, but
- During pregnancy or breastfeeding antidepressants should be avoided as far as possible.
- If no response to psychosocial treatment, consider using lowest effective dose of antidepressants.
- CONSULT A SPECIALIST.
- If breastfeeding, avoid long-acting medication such as fluoxetine

If younger than 12 years

- DO NOT prescribe antidepressant medication.
- Provide psychoeducation to parents. ➔ DEP 2.1
- Address current psychosocial stressors. ➔ DEP 2.2
- Offer regular follow-up. ➔ DEP 2.5

If 12 years or older

- DO NOT consider antidepressant as first-line treatment.
- Psychoeducation. ➔ DEP 2.1
- Address current psychosocial stressors. ➔ DEP 2.2
- If available, consider interpersonal psychotherapy (IPT) or cognitive behavioural therapy (CBT), behavioural activation. ➔ INT
- If available, consider adjunct treatments: structured physical activity programme ➔ DEP 2.4, relaxation training or problem-solving treatment. ➔ INT
- When psychosocial interventions prove ineffective, consider fluoxetine (but not other SSRIs or TCAs). ➔ DEP 3
- Offer regular follow-up. ➔ DEP 2.5
Depression

Intervention Details

Psychosocial/Non-Pharmacological Treatment and Advice

2.1 Psychoeducation
(for the person and his or her family, as appropriate)

- Depression is a very common problem that can happen to anybody.
- Depressed people tend to have unrealistic negative opinions about themselves, their life and their future.
- Effective treatment is possible. It tends to take at least a few weeks before treatment reduces the depression. Adherence to any prescribed treatment is important.
- The following need to be emphasized:
  - the importance of continuing, as far as possible, activities that used to be interesting or give pleasure, regardless of whether these currently seem interesting or give pleasure;
  - the importance of trying to maintain a regular sleep cycle (e.g., going to bed at the same time every night, trying to sleep the same amount as before, avoiding sleeping too much);
  - the benefit of regular physical activity, as far as possible;
  - the benefit of regular social activity, including participation in communal social activities, as far as possible;
  - recognizing thoughts of self-harm or suicide and coming back for help when these occur;
  - in older people, the importance of continuing to seek help for physical health problems.

2.2 Addressing current psychosocial stressors

- Offer the person an opportunity to talk, preferably in a private space. Ask for the person’s subjective understanding of the causes of his or her symptoms.
- Ask about current psychosocial stressors and, to the extent possible, address pertinent social issues and problem-solve for psychosocial stressors or relationship difficulties with the help of community services/resources.
- Assess and manage any situation of maltreatment, abuse (e.g. domestic violence) and neglect (e.g. of children or older people). Contact legal and community resources, as appropriate.
- Identify supportive family members and involve them as much as possible and appropriate.
- In children and adolescents: 
  - Assess and manage mental, neurological and substance use problems (particularly depression) in parents (see mhGAP-IG Master Chart).
  - Assess parents’ psychosocial stressors and manage them to the extent possible with the help of community services/resources.
  - Assess and manage maltreatment, exclusion or bullying (ask child or adolescent directly about it).
  - If there are school performance problems, discuss with teacher on how to support the student.
  - Provide culture-relevant parent skills training if available. **INT**

2.3 Reactivate social networks

- Identify the person’s prior social activities that, if re-initiated, would have the potential for providing direct or indirect psychosocial support (e.g. family gatherings, outings with friends, visiting neighbours, social activities at work sites, sports, community activities).
- Build on the person’s strengths and abilities and actively encourage to resume prior social activities as far as is possible.

2.4 Structured physical activity programme
(adjunct treatment option for moderate-severe depression)

- Organization of physical activity of moderate duration (e.g. 45 minutes 3 times per week).
- Explore with the person what kind of physical activity is more appealing, and support him or her to gradually increase the amount of physical activity, starting for example with 5 minutes of physical activity.

2.5 Offer regular follow-up

- Follow up regularly (e.g. in person at the clinic, by phone, or through community health worker).
- Re-assess the person for improvement (e.g. after 4 weeks).
Depression

3.1 Initiating antidepressant medication

3.2 Precautions to be observed for antidepressant medication in special populations

- People with ideas, plans or acts of self-harm or suicide
  - SSRIs are first choice.
  - Monitor frequently (e.g. once a week).
  - To avoid overdoses in people at imminent risk of self-harm/suicide, ensure that such people have access to a limited supply of antidepressants only (e.g. dispense for one week at a time). See Self-Harm/Suicide Module.

- Adolescents 12 years and older
  - When psychosocial interventions prove ineffective, consider fluoxetine (but not other SSRIs or TCAs).
  - Where possible, consult mental health specialist when treating adolescents with fluoxetine.
  - Monitor adolescents on fluoxetine frequently (ideally once a week) for emergence of suicidal ideas during the first month of treatment.

- Older people
  - TCAs should be avoided, if possible. SSRIs are first choice.
  - Monitor side-effects carefully, particularly of TCAs.

- People with cardiovascular disease
  - DO NOT prescribe TCAs to people at risk of serious cardiac arrhythmias or with recent myocardial infarction.

3.3 Monitoring people on antidepressant medication

- In all cardiovascular cases, measure blood pressure before prescribing TCAs and observe for orthostatic hypotension once TCAs are started.

- If symptoms of mania emerge during treatment: immediately stop antidepressants and assess for and manage the mania and bipolar disorder.

- If people on SSRIs show marked/prolonged akathisia (inner restlessness or inability to sit still, review use of the medication. Either change to TCAs or consider concomitant use of clonazepam (5–10mg/day) for a brief period (1 week). In case of switching to TCAs, be aware of occasional poorer tolerability compared to SSRIs and the increased risk of cardio-toxicity and toxicity in overdose.

- If poor adherence, identify and try to address reasons for poor adherence (e.g. side-effects, costs, person’s beliefs about the disorder and treatment).

- If inadequate response (symptoms worsen or do not improve after 4–6 weeks) review diagnosis (including co-morbid diagnosis) and check whether medication has been taken regularly and prescribed at maximum dose. Consider increasing the dose. If symptoms persist 4–6 weeks at prescribed maximum dose, then consider switching to another treatment (i.e., psychological treatment \( \text{INT} \), different class of antidepressants \( \text{DEP 3.5} \)). Switch from one antidepressant to another with care, that is stop the first drug; leave a gap of a few days if clinically possible; start the second drug. If switching is from fluoxetine to TCA the gap should be longer, for example one week.
C A S E S
Your patient is a 31 year-old man, married with two young children. He presents with muscle and joint discomfort, heart palpitations, and dizziness of more than one year duration. He complains of being restless and edgy most of the time and believes that he’s “losing it” because he’s constantly apprehensive. His mind races and he “can’t seem to pin them (the thoughts) down”. He has come to see you because he’s concerned that his health is deteriorating to the point that sometimes he has to leave work when the symptoms become intolerable. As well, he has given up many social contacts aside from family and close friends. Shortly after he began feeling this way, he cut back his coffee intake to 1 cup/day. Physical exam: General—alert and oriented. Skin—moist, Color—good, HEENT—unremarkable, Chest—grade II murmur. Abdomen—unremarkable, Extremities—unremarkable. Reflexes—brisk bilaterally.
CASE #1—DIFFERENTIAL DIAGNOSIS

1. Generalized anxiety disorder
2. Hyperthyroidism
3. Major depressive disorder
4. Panic disorder/attack
5. Bipolar disorder
6. Drug/alcohol use disorder
7. Cardiac arrhythmia
# CASE #1—TREATMENT PLAN

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>1. Pharmacotherapy</td>
</tr>
<tr>
<td>20%</td>
<td>2. Therapy</td>
</tr>
<tr>
<td>20%</td>
<td>3. Pharmacotherapy and counseling</td>
</tr>
<tr>
<td>20%</td>
<td>4. Lifestyle changes only</td>
</tr>
<tr>
<td>20%</td>
<td>5. Watchful waiting</td>
</tr>
<tr>
<td>Percentage</td>
<td>Option</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>20%</td>
<td>1. SSRI (i.e. fluoxetine, sertraline)</td>
</tr>
<tr>
<td>20%</td>
<td>2. SNRI (i.e. venlafaxine, duloxetine)</td>
</tr>
<tr>
<td>20%</td>
<td>3. Bupropion</td>
</tr>
<tr>
<td>20%</td>
<td>4. Benzodiazepine (i.e. lorazepam, clonazepam)</td>
</tr>
<tr>
<td>20%</td>
<td>SSRI plus benzodiazepine</td>
</tr>
</tbody>
</table>
## Case #1 — Follow Up

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Suggested Follow-Up Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>1 week or sooner</td>
</tr>
<tr>
<td>20%</td>
<td>1-2 weeks</td>
</tr>
<tr>
<td>20%</td>
<td>3-4 weeks</td>
</tr>
<tr>
<td>20%</td>
<td>4-6 weeks</td>
</tr>
<tr>
<td>20%</td>
<td>2-3 months</td>
</tr>
</tbody>
</table>

[Answer Now]
CASE #2

Your patient is a 42 year-old employed woman, married for 21 years with 2 adult children. She is being seen for a four-week history of fatigue, insomnia, headache and abdominal pain. The pain is generalized over the abdomen, constant in nature. She denies signs and symptoms of an acute infectious process and was in relatively good health before the previous month. She has obtained intermittent relief from headache by using acetaminophen, and takes a multivitamin regularly. She complains, “food just doesn’t taste good anymore”. She has been finding it harder lately to concentrate at work, and to get up the energy to socialize with friends and family. Your patient has reached a point where she wonders if she will ever feel normal again, yet denies any stress or significant problems in her life. She does not smoke, and drinks 2 cups of coffee/day. She denies alcohol intake. Physical exam: General—tired but in no acute distress. Skin—normal, color—good, HEENT—unremarkable. Pelvic exam—normal. Abdomen—generalized tenderness. Extremities—unremarkable.9
### Case #2 – Differential Diagnosis

<table>
<thead>
<tr>
<th>Rank</th>
<th>Diagnosis</th>
<th>Likelihood</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Generalized anxiety disorder</td>
<td>11%</td>
</tr>
<tr>
<td>2</td>
<td>Hyperthyroidism</td>
<td>11%</td>
</tr>
<tr>
<td>3</td>
<td>Major depressive disorder</td>
<td>11%</td>
</tr>
<tr>
<td>4</td>
<td>Irritable bowel syndrome</td>
<td>11%</td>
</tr>
<tr>
<td>5</td>
<td>Anemia</td>
<td>11%</td>
</tr>
<tr>
<td>6</td>
<td>Cancer</td>
<td>11%</td>
</tr>
<tr>
<td>7</td>
<td>Diabetes</td>
<td>11%</td>
</tr>
<tr>
<td>8</td>
<td>Menopause</td>
<td>11%</td>
</tr>
<tr>
<td>9</td>
<td>Somatization disorder</td>
<td>11%</td>
</tr>
</tbody>
</table>

---

**Answer Now**
# Case #2—Treatment Plan

<table>
<thead>
<tr>
<th>20%</th>
<th>1.</th>
<th>Pharmacotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>2.</td>
<td>Therapy</td>
</tr>
<tr>
<td>20%</td>
<td>3.</td>
<td>Pharmacotherapy and counseling</td>
</tr>
<tr>
<td>20%</td>
<td>4.</td>
<td>Lifestyle changes only</td>
</tr>
<tr>
<td>20%</td>
<td></td>
<td>Watchful waiting</td>
</tr>
</tbody>
</table>

[Answer Now]
# Case 2 — Pharmacotherapy

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>14%</td>
<td>1.</td>
<td>SSRI (i.e. fluoxetine, sertraline)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14%</td>
<td>2.</td>
<td>SNRI (i.e. venlafaxine, duloxetine)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14%</td>
<td>3.</td>
<td>Bupropion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14%</td>
<td>4.</td>
<td>Mirtazapine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14%</td>
<td>5.</td>
<td>Tricyclic antidepressant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14%</td>
<td>6.</td>
<td>Benzodiazepine (i.e. lorazepam, clonazepam)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Answer Now**
## CASE #2—FOLLOW UP

<table>
<thead>
<tr>
<th>20%</th>
<th>1. 1 week or sooner</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>2. 1-2 weeks</td>
</tr>
<tr>
<td>20%</td>
<td>3. 3-4 weeks</td>
</tr>
<tr>
<td>20%</td>
<td>4. 4-6 weeks</td>
</tr>
<tr>
<td>20%</td>
<td>2-3 months</td>
</tr>
</tbody>
</table>
REFERENCES

1 "Datapoints: Psychotropic Drug Prescriptions by Medical Specialty." Psychiatric Services, 60(9), p. 1167

2 Cunningham, PJ. Beyond Parity: Primary Care Physicians’ Perspectives On Access to Mental Health Care. Health Affairs. Published online April 14, 2009.


REFERENCES


7 Vermani M, Marcus M, Katzman MA. Rates of Detection of Mood and Anxiety Disorders in Primary Care: A Descriptive, Cross-Sectional Study. The Primary Care Companion to CNS Disorders. 2011;13(2):PCC.10m01013. doi:10.4088/PCC.10m01013.


REFERENCES


QUESTIONS?