Depression

(See also *Harrison's Principles of Internal Medicine*, 17th Edition, Chapter 386)

Definition

- A clinical mood disorder associated with depressed mood or loss of interest and other symptoms that prevent a patient from leading a normal life
- Depressive disorders usually begin in early adulthood and recur episodically over a lifetime.
- Major depression
  - Depressed mood on a daily basis for a minimum duration of 2 weeks
- Dysthymic disorder
  - A pattern of chronic (at least 2 years), ongoing, mild depressive symptoms
- Minor depression
  - Experience of at least 2 depressive symptoms for 2 weeks but does not meet the criteria for major depression
- Seasonal affective disorder
  - Seasonal pattern of depression

Epidemiology

- Unipolar depressive disorders
  - Twice as common in women as in men; incidence increases with age in both sexes
  - Major depression
    - Fourth among all diseases in terms of disability-adjusted life years in the Global Burden of Disease Study (conducted by World Health Organization)
      - Projected to rank second by year 2020
      - Approximately 15% of the population experiences a major depressive episode at some point in life.
      - 6–8% of all outpatients in primary care settings satisfy diagnostic criteria for the disorder.
  - Dysthymic disorder
    - Affects ~5% of primary care patients
  - Seasonal affective disorder
    - More common in women
    - Prevalence increases with distance from the equator.
- Depression associated with medical illness
  - Cardiac disorders
    - 20–30% manifest a depressive disorder.
    - A higher percentage experience depressive symptomatology when self-reporting scales are used.
  - Cancer
    - Mean prevalence of depression is 25%.
  - Neurologic disorders
    - Depression occurs frequently in stroke and neurodegenerative diseases.

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    - Diabetes mellitus
        - Prevalence varies from 8–27%.
        - Severity of mood state correlates with the level of hyperglycemia and presence of complications.
    - HIV/AIDS
        - Lifetime prevalence estimated at 22–45%

Risk Factors

- Family history
    - More frequent in families of bipolar individuals
- Female sex
- Medications
    - Antihypertensive drugs; especially ß-adrenergic blockers and calcium-channel blockers
    - Antiarrhythmic agents
    - Glucocorticoids
    - Antimicrobials
    - Systemic analgesics
    - Antiparkinsonian medications
    - Anticonvulsants
- Medical illnesses
- Stressors/negative life events
    - Death of a relative
    - Assault
    - Severe marital or relationship problems
- Alcohol or substance abuse
- Past episodes of depression
    - 50–60% of patients who have a first episode have at least 1 or 2 recurrences.

Etiology

- Genetic factors
    - Monozygotic twins have a higher concordance rate (46%) than dizygotic twins (20%); little evidence for any effect of a shared family environment.
    - May influence the sensitivity of individuals to stressful events
- Neurotransmitter abnormalities
    - Decreased noradrenaline and serotonin levels in the brain
- Possible neuroendocrine abnormalities
    - Increased cortisol and corticotropin-releasing hormone secretion
    - Increase in adrenal size
    - Decreased inhibitory response of glucocorticoids to dexamethasone
    - Blunted response of thyroid-stimulating hormone (TSH) level to infusion of thyroid-releasing hormone
    - Upregulation of proinflammatory cytokines (major depression)
- Defect in regulation of biologic rhythms
    - Diurnal variations in symptom severity
        - Alterations in circadian rhythmicity of neurochemical and neurohumoral factors

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    - Major depression
        - Decrease in rapid eye movement (REM) sleep onset (REM latency), increase in REM density, decrease in stage IV delta slow-wave sleep

Associated Conditions

- Medical illnesses
    - Cardiac disorders
    - Cancer
    - Neurologic disorders, particularly cerebrovascular disorders, Parkinson's disease, dementia, multiple sclerosis, and traumatic brain injury
    - Diabetes mellitus
    - Hypothyroidism/hyperthyroidism
    - HIV/AIDS
    - Hepatitis C
    - Chronic fatigue syndrome
    - Fibromyalgia
- Substance abuse

Symptoms & Signs

- Major depression
    - Five (or more) of the following symptoms are present during most of the day, nearly every day, in the same 2-week period. At least 1 of the symptoms is either depressed mood or loss of interest or pleasure:
        - Depressed mood
        - Sadness, indifference, apathy, or irritability
        - Diminished interest or pleasure in almost all or all activities
        - Significant weight loss or weight gain (e.g., a change of >5% of body weight in a month) or decrease or increase in appetite
        - Insomnia or hypersomnia; early-morning awakening
        - Psychomotor agitation or retardation
        - Fatigue or loss of energy
        - Feelings of worthlessness or excessive or inappropriate guilt (may be delusional)
        - Diminished ability to think or concentrate, or indecisiveness
        - Recurrent thoughts of death (not just fear of dying); recurrent suicidal ideation without specific plan; suicide attempt or specific plan for committing suicide
    - The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
    - The symptoms are not due to the direct physiologic effects of a substance or general medical condition.
- Dysthymic disorder
    - Does not appear to be episodic
    - Not clearly associated with either psychosocial dysfunction or change from usual experience in life
    - Ongoing (at least 2 years) mild depressive symptoms
    - Less severe and less disabling than major depression
    - Major depression vs. dysthymic disorder sometimes difficult to separate
        - Can occur together; "double depression"

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- Minor depression
  - At least 2 depressive symptoms for 2 weeks; does not meet full criteria for major depression
  - Associated with significant morbidity and disability
- Seasonal affective disorder
  - Onset and remission of episodes at predictable times of the year
  - Symptoms
    - Anergy
    - Fatigue
    - Weight gain
    - Hypersomnia
    - Episodic carbohydrate craving
  - Potential improvement by altering light exposure

Differential Diagnosis

- A general medical condition
  - Cancer
    - Extreme cachexia may be misinterpreted as part of the symptoms of depression.
  - Hypothyroidism
    - Features of depression, most commonly depressed mood and memory impairment
    - Subclinical hypothyroidism can also produce symptoms of depression and cognitive difficulty.
    - Symptoms respond to thyroid replacement.
  - Hyperthyroid states
    - May also present with depression especially in geriatric populations
  - Chronic disorders of uncertain etiology
    - Chronic fatigue syndrome and fibromyalgia are strongly associated with depression and anxiety.
- Mood-incongruent delusions or hallucinations
- Direct physiologic effects of a substance (e.g., a drug of abuse, a medication)
  - When feasible, change medication to aid in decision about causal relationship between pharmacologic therapy and mood change.
- Bereavement

Diagnostic Approach

- Major depressive episode suspected
  - Determine if it is unipolar or bipolar depression.
  - Determine if it is secondary to general medical illness or substance abuse (10–15% of cases).
    - Symptoms in cases of associated disease may be due to:
      - Psychological stress of coping with disease
      - Disease process itself
      - Medications used to treat disease
  - Assess the risk of suicide.
    - Approximately 4–5% of all depressed patients will commit suicide; most will have sought help from a physician within 1 month of death.

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        - Use direct questioning; patients are reluctant to verbalize without prompting.
            - Probe in an empathic and hopeful manner.
            - Be sensitive to denial and possible minimization of distress.
        - If patient has specific plans or significant risk factors (e.g., a past history of suicide attempts, profound hopelessness, concurrent medical illness, substance abuse, social isolation), refer to a mental health specialist for immediate care.
        - Presence of anxiety, panic, or agitation significantly increases near-term suicidal risk.
- Validated questionnaires exist to screen patients for mental disorders.
    - Inventories that require only 10 minutes to complete
    - Link patient responses to formal diagnostic criteria of anxiety, mood, somatoform, and eating disorders and to alcohol abuse or dependence
        - Prime MD (and a self-report form, the Patient Health Questionnaire)
        - Symptom-Driven Diagnostic System for Primary Care

Laboratory Tests

- Laboratory tests are generally not helpful in the evaluation or diagnosis of depression.
- TSH level may be useful in determining presence of thyroid disease.

Imaging

- No imaging studies are indicated in the evaluation and treatment of depression.

Diagnostic Procedures

- No diagnostic procedures are indicated in the evaluation and treatment of depression.

Treatment Approach

- Coordinate short-term symptom remission with long-term maintenance strategies to prevent recurrence.
- Most effective intervention is combined medication and psychotherapy.
- If treatment regimen is unsuccessful:
    - Select alternative drug, or
    - Use combinations of antidepressants, and/or adjunctive treatment
    - Consider referral to mental health specialist

Specific Treatments

General approach to medications

- Determine if there is a history of good response in patient or first-degree relative.
    - If not available, evaluate characteristics and match to a drug.
    - Consider:
        - Health status
        - Side effects
        - Convenience
        - Cost
        - Patient preference

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        - Drug interaction risk
        - Suicide potential
        - Medication compliance history
    - Suicidal ideation: Choose a drug with low toxicity if taken in overdose.
        - Selective serotonin reuptake inhibitors (SSRIs) and other newer antidepressant drugs are distinctly safer.
        - Tricyclic antidepressants (TCA): Prescribe only a 10-day supply for patients with suicide risk.
    - 60–70% respond to any drug chosen if given in a sufficient dose for 6–8 weeks
- Begin new medication at one-third to one-half target dose if drug is a TCA, bupropion, venlafaxine, or mirtazapine.
- Initiate full dose as tolerated if an SSRI.
- If patient experiences side effects, evaluate possibility of tolerance.
    - Consider temporary decrease in dose or adjunctive treatment.
- If unacceptable side effects continue:
    - Taper drug over 1 week and initiate new drug
    - Consider potential drug interactions
- Evaluate response after 6 weeks at target dose.
    - If inadequate, increase dose in stepwise fashion as tolerated.
- If inadequate response at maximal dose:
    - Consider tapering and switching to new drug
    - If TCA, obtain plasma level to guide treatment

Antidepressants

- SSRIs
    - Fluoxetine
        - Usual daily dose: 10–80 mg
        - Has very long half-life
    - Sertraline
        - Usual daily dose: 50–200 mg
    - Paroxetine
        - Usual daily dose: 20–60 mg
    - Fluvoxamine
        - Usual daily dose: 100-300 mg
    - Citalopram
        - Usual daily dose: 20–60 mg
        - No inhibitory effects on the P450 system
    - Escitalopram
        - Usual daily dose: 10–30 mg
        - Most specific of currently available SSRIs; appears to have no specific inhibitory effects on the P450 system
    - Duloxetine
        - Usual daily dose: 40–60 mg (may be divided bid)
    - Most with once-daily dosing, usually in a.m.
    - Side effects: headache, nausea and other GI effects, jitteriness, insomnia, sexual dysfunction, akathisia (during the first week of treatment; rare), effect on plasma levels of other medications (except sertraline), angina due to vasospasm (rare)
    - Serotonin syndrome when multiple serotonin medications are combined
        - Myoclonus
        - Agitation
        - Abdominal cramping
        - Hyperpyrexia

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        - Hypertension
        - Potentially death
    - Potential drug interactions
        - Monoamine oxidase inhibitors (MAOIs)
            - Serotonin syndrome—absolute contraindication
        - Serotonergic agonists (e.g., tryptophan, fenfluramine)
            - Potential serotonin syndrome
        - Drugs metabolized by P450 isoenzymes
            - TCAs, other SSRIs, antipsychotics, beta blockers, codeine, terfenadine, astemizole, triazolobenzodiazepines, calcium-channel blockers, 1C antiarrhythmics, carbamazepine
        - Drugs that are bound tightly to plasma proteins (e.g., warfarin)
            - Increased bleeding secondary to displacement
        - Drugs that inhibit the metabolism of SSRIs by P450 isoenzymes (e.g., quinidine)
            - Increased SSRI side effects
- TCAs
    - Amitriptyline
        - Usual daily dose: 150–300 mg
        - Most patients require daily dose of 150–200 mg to achieve therapeutic blood level of 150–300 ng/mL and satisfactory remission.
        - Some patients show a partial effect at lower doses.
    - Nortriptyline
        - Usual daily dose: 50–200 mg
        - Best tolerated, especially by elderly
    - Imipramine
        - Usual daily dose: 150–300 mg
        - Most patients require daily dose of 150–200 mg to achieve a therapeutic blood level of 150–300 ng/mL and satisfactory remission.
        - Some patients show a partial effect at lower doses.
    - Desipramine
        - Usual daily dose: 150–300 mg
        - Greatest risk of lethal overdose
    - Doxepin
        - Usual daily dose: 150-300 mg
    - Clomipramine
        - Usual daily dose: 150–300 mg
    - Once–daily dosing, usually qhs
    - Generic equivalents make TCAs relatively inexpensive.
    - Geriatric patients may require a low starting dose and slow escalation.
    - Side effects: anticholinergic (dry mouth, tachycardia, constipation, urinary retention, blurred vision), sweating, tremor, postural hypotension, cardiac toxicity due to conduction block or arrhythmias (uncommon at therapeutic levels), sedation, weight gain
    - Contraindicated in patients with serious cardiovascular risk factors
    - Blood levels of most TCAs available
        - With several tricyclics (particularly nortriptyline, imipramine, and desipramine), there is a well-defined relationship among dose, plasma level, and therapeutic response.
    - Significant ethnic differences in drug metabolism
        - Hispanic, Asian, and African-American patients generally require lower doses than Caucasians to achieve a comparable blood level.
    - Potentially lethal in overdose (lethal dose = 2 g)

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- Mixed norepinephrine/serotonin reuptake inhibitors
  - Venlafaxine
    - Usual daily dose: 75–375 mg
    - Bid-tid dosing (extended-release available)
    - Side effects: nausea, dizziness, dry mouth, headaches, increased blood pressure, anxiety, insomnia
    - Lower potential for drug interactions than SSRIs
    - Contraindicated with MAOIs
  - Mirtazapine
    - Usual daily dose: 15–45 mg
    - Once-daily dosing
    - Side effects: somnolence, weight gain, neutropenia (rare)
- Mixed-action drugs
  - Bupropion
    - Usual daily dose: 250–450 mg
    - TID dosing; sustained-release also available
      - Exceptionally short half-life, requiring frequent dosing
    - Side effects: jitteriness, flushing, seizures in at-risk patients, anorexia, tachycardia, psychosis
    - Fewer sexual side effects than SSRIs or TCAs
  - Trazodone
    - Usual daily dose: 200–600 mg
    - Side effects: sedation, dry mouth, ventricular irritability, postural hypotension, priapism (rare)
    - Useful in low doses for sleep; sedating effects with no anticholinergic side effects
  - Nefazodone
    - Usual daily dose: 300–600 mg
    - Once-daily dosing; steady state within 4–5 days
    - Side effects: sedation, headache, dry mouth, nausea, constipation
    - No effect on REM sleep, unlike other antidepressants
    - May inhibit one or more cytochrome P450 enzymes
  - Amoxapine
    - Usual daily dose: 200–600 mg
    - Side effects: sexual dysfunction
    - Extrapyramidal symptoms possible
      - Risk of tardive dyskinesia with long-term use
- MAOIs
  - Phenelzine
    - Usual daily dose: 45–90 mg
  - Tranylcypromine
    - Usual daily dose: 20–50 mg
  - Isocarboxazid
    - Usual daily dose: 20-60 mg
  - May be more effective in patients with atypical features or treatment-refractory depression
  - Side effects: insomnia, hypotension, anorgasmia, weight gain, hypertensive crisis, tyramine cheese reaction
  - Lethal reactions with SSRIs
  - Do not use concomitantly with TCA—possible hyperadrenergic effects
  - Hypertensive crisis following intake of tyramine-containing food or sympathomimetic drugs
  - Serious reactions with narcotics

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Management of antidepressant side effects

- Nausea, loss of appetite
  - Usually short lived and dose related
  - Consider temporary dose reduction or administration with food and antacids
- Diarrhea
  - Famotidine 20–40 mg/day
- Constipation
  - Wait for tolerance
  - Diet change
  - Stool softener
  - Exercise
  - Avoid laxatives
- Sexual dysfunction
  - Consider dose reduction; drug holiday
- Anorgasmia/impotence; impaired ejaculation
  - Bethanechol 10–20 mg 2 hours before activity or 25 mg tid, or
  - Buspirone 10 mg tid, or
  - Cyproheptadine 4–8 mg 2 hours before activity, or
  - Bupropion 100 mg bid, or
  - Amantadine 100 mg bid/tid
- Orthostasis
  - Tolerance unlikely
  - Increase fluid intake
  - Use calf exercises/support hose
  - Fludrocortisone 0.025 mg/day
- Anticholinergic
  - Wait for tolerance
- Dry mouth, eyes
  - Maintain good oral hygiene
  - Use artificial tears
  - Sugar-free gum
- Tremor/jitteriness
  - Antiparkinsonian drugs not effective
  - Use dose reduction/slow increase
  - Lorazepam 0.5 mg bid, or
  - Propranolol, 10–20 mg bid
- Insomnia
  - Schedule all doses for the morning
  - Trazodone 50–100 mg qhs
- Sedation
  - Caffeine
  - Schedule all dosing for bedtime
  - Bupropion 75–100 mg in afternoon
- Headache
  - Evaluate diet, stress, other drugs
  - Try dose reduction
  - Amitriptyline 50 mg/day
- Weight gain
  - Decrease carbohydrates
  - Exercise
  - Consider fluoxetine

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- Loss of therapeutic benefit over time
  - Potentially related to tolerance
    - Increase dose or drug holiday
  - Add amantadine 100 mg bid; buspirone 10 mg tid; or pindolol 2.5 mg bid

Other treatments

- Electroconvulsive therapy
  - At least as effective as medication
  - Reserved for treatment-resistant cases and delusional depressions
- Transcranial magnetic stimulation
  - Investigational treatment of depression
  - Shown to have efficacy in several controlled trials
- Cognitive-behavioral and interpersonal therapies
  - Give patients time to describe their experience, outlook, and the impact of depression.
  - Occasional empathic silence may be as helpful for the treatment alliance as verbal reassurance.
  - Effective in improving psychological and social adjustment
- Vagus nerve stimulator
  - Currently investigational

Depression in general medical illness

- Cardiac
  - SSRIs
    - First-line drugs for patients at risk for TCA-related complications
    - Appear not to induce electrocardiogram changes or adverse cardiac events
    - May interfere with hepatic metabolism of anticoagulants causing increased anticoagulation
  - TCAs
    - Contraindicated in bundle branch block
    - TCA-induced tachycardia—a concern in congestive heart failure
- Cancer
  - Antidepressant medication improves quality of life and mood.
  - Psychotherapeutic approaches, particularly group therapy
    - May have some effect on short-term depression, anxiety, and pain symptoms
- Neurologic disorders
  - TCA and SSRI agents, stimulant compounds, and MAOIs are effective against depression.
- Diabetes mellitus
  - Treatment is complicated by effects of antidepressive agents on glycemic control.
    - MAOIs can induce hypoglycemia and weight gain.
    - TCAs can produce hyperglycemia and carbohydrate craving.
    - SSRIs may reduce fasting plasma glucose; easier to use than MAOIs and may improve dietary and medication compliance.
- Hypothyroidism/hyperthyroidism
  - Improvement in mood usually follows normalization of thyroid function.
  - Adjunctive antidepressant medication is sometimes required.
- Chronic fatigue syndrome and fibromyalgia
  - Patients may partially benefit from antidepressant treatment, usually at lower-than-normal dosing.

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Monitoring

- Evaluate response to treatment after ~2 months.
  - Three-quarters of patients show improvement by this time.
  - If remission is inadequate, question patient about compliance.
  - Consider medication dose increase if side effects are not troublesome.
    - If unsuccessful, refer to a mental health specialist.
- Approximately 40% of primary care patients with depression drop out of treatment and discontinue medication if no symptomatic improvement occurs within a month.
  - Additional support is necessary to improve outcome.
  - Increase intensity and frequency of visits during the first 4–6 weeks of treatment.
  - Provide supplemental educational materials about:
    - Depression
    - Benefits and side effects of medications
    - Stress reduction
    - How alcohol may exacerbate depressive symptoms and impair drug response
  - Obtain psychiatric consultation as indicated.
- Refer all patients with serious suicidality and/or severe depression and those refractory to treatment for psychiatric evaluation.

Complications

- In major depression, symptoms may cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Suicide
  - Question patients directly and initiate urgent/emergent referral if patient is suicidal.

Prognosis

- Unipolar depressive disorders
  - Pattern of recurrence and clinical progression in a developing episode is variable.
    - Nature of attacks may be similar over time.
  - Severe depressive episode may progress to a psychotic state in a minority of patients.
  - Dysthymic disorder
    - May respond to antidepressant treatment
  - Minor depression
    - Responds to pharmacologic treatment
  - Remission
    - Continue drug treatment for at least 6–9 months to prevent relapse.
    - After 2 or more episodes of depression, consider indefinite maintenance treatment.

Prevention

- Initial episode of a depressive disorder is not typically preventable.
- Recurrence of depression many times can be prevented by combination of:
  - Medication compliance
  - Balanced diet
  - Regular exercise
  - Maintaining a regular sleep pattern

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- Avoiding drugs and alcohol
- Seeking treatment immediately when symptoms recur

ICD-9-CM

- 311 Depressive disorder, not elsewhere classified

See Also

- Alcoholism
- Anxiety, Including Obsessive-Compulsive Disorder
- Approach to Weight Loss
- Bipolar Disorder
- Chronic Fatigue Syndrome
- Fibromyalgia
- Health Care Screening and Disease Prevention
- Hypothyroidism
- Somatoform Disorders

Internet Sites

- Professionals
  - Health Information
    National Institute of Mental Health
  - Depression
    ClinicalTrials.gov
- Patients
  - Depression
    Natioinal Institute of Mental Health
  - Depression
    MedlinePlus
  - Homepage
    National Mental Health Association

General Bibliography

- Ablon JS, Jones EE: Validity of controlled cinical trials of psychotherapy: findings from the NIMH Treatment of Depression Collaborative Research Program. *Am J Psychiatry* 159:775, 2002 [PMID:11986131]
- Charlson M, Peterson JC: Medical comorbidity and late life depression: what is known and what are the unmet needs? *Biol Psychiatry* 52:226, 2002 [PMID:12182928]
- Farvolden P, Kennedy SH, Lam RW: Recent developments in the psychobiology and pharmacotherapy of depression: optimising existing treatments and novel approaches for the future. *Expert Opin Investig Drugs* 12:65, 2003 [PMID:12517255]
- Hollon SD et al: Psychotherapy and medication in the treatment of adult and geriatric depression: which monotherapy or combined treatment? *J Clin Psychiatry* 66:455, 2005 [PMID:15816788]
- Kessler RC et al: The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). *JAMA* 289:3095, 2003 [PMID:12813115]
- Ko DT et al: Beta-blocker therapy and symptoms of depression, fatigue, and sexual dysfunction. *JAMA* 288:351, 2002 [PMID:12117400]

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- Manji HK et al: Enhancing neuronal plasticity and cellular resilience to develop novel, improved therapeutics for difficult-to-treat depression. *Biol Psychiatry* 53:707, 2003 [PMID:12706957]
- Nease DE, Maloin JM: Depression screening: a practical strategy. *J Fam Pract* 52:118, 2003 [PMID:12585989]
- Williams RS et al: A common mechanism of action for three mood-stabilizing drugs. *Nature* 417:292, 2002 [PMID:12015604]

PEARLS

- Major depression is a common disease and often has a lifelong relapsing course.
- Assessment of suicide by direct questioning is an essential part of the evaluation of depression; if present, emergent referral to a psychiatrist is needed.
- The most effective treatment for depression is medication combined with psychotherapy.
- SSRIs are widely used due to ease of daily administration and relatively low side-effect profile; specific medication choice is tailored to the individual patient.
- Depression is common in general medical illnesses including cardiac, neurologic, and oncologic conditions.

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