



Summary of Evidence-Based Recommendations

Practice recommendations discussed in this program are from the following sources:

Institute for Clinical Systems Improvement

Source: Institute for Clinical Systems Improvement. May 2009. Depression, Major, in Adults in Primary Care.

Website: http://www.icsi.org/depression_5/depression__major__in_adults_in_primary_care_3.html

Strength of Evidence: The strength of evidence is indicated following each recommendation. See table below for description of evidence levels.

Recommendation #1: The PHQ-9 has been validated for measuring depression severity. The factor structure of the 9 items is comparable when tested with African Americans, Chinese Americans, Latino and non-Hispanic white patient groups. (C)

Recommendation #2: The PHQ-9 is an effective management tool and should be used routinely for subsequent visits to monitor treatment outcomes and severity. It can help the provider decide if/how to modify the treatment plan. (C)

Recommendation #3: The concept of depression varies across cultures. For example, in many cultures, for depression to become a problem for which a person seeks medical treatment, symptoms may include psychosis, conversion disorders or significant physical ailments. (D)

Recommendation #4: Psychotherapy, especially focused psychotherapy, can significantly reduce symptoms, restore psychosocial and occupational functioning, and prevent relapse in patients with major depression. (M)

Recommendation #5: Because both antidepressants and psychotherapy are effective, careful consideration to patient preference for mode of treatment is appropriate. (A)

Recommendation #10: 10%–75% of patients are non-compliant with medication use, and rates are higher in intercultural settings because of cultural expectations and communication problems. (R)

American College of Physicians

Source: American College of Physicians. Using Second-Generation Antidepressants to Treat Depressive Disorders: A Clinical Practice Guideline from the American College of Physicians *Qaseem A, et al. Ann Intern Med.* 2008;149:725-733.

Website: <http://www.annals.org/content/149/10/725.full>

Strength of Evidence: The strength of evidence is indicated following each recommendation.

Recommendation #6: When choosing pharmacologic therapy to treat acute major depression, select second-generation antidepressants on the basis of adverse effect profiles, cost and patient preferences. (Strong recommendation; moderate-quality evidence)



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Recommendation #7: Assess patient status, therapeutic response and adverse effects of antidepressant therapy on a regular basis beginning within 1–2 weeks of initiation of therapy. (Strong recommendation; moderate-quality evidence)

Recommendation #8: Modify treatment if patient does not have adequate response to pharmacotherapy within 6–8 weeks of initiation of therapy for MDD. (Strong recommendation; moderate-quality evidence)

Recommendation #9: Continue treatment for 4–9 months after satisfactory response in patients with a first episode of MDD. For patients who have had 2 or more episodes of depression, a longer duration of therapy may be beneficial. (Strong recommendation; moderate-quality evidence)

Evidence Grading System

A. Primary Reports of New Data Collection	
Class A:	Randomized, controlled trial
Class B:	Cohort study
Class C:	Non-randomized trial with concurrent or historical controls Case-control study Study of sensitivity and specificity of a diagnostic test Population-based descriptive study
Class D:	Cross-sectional study Case series Case report
B. Reports that Synthesize or Reflect upon Collections of Primary Reports	
Class M:	Meta-analysis Systematic review Decision analysis Cost-effectiveness analysis
Class R:	Consensus statement Consensus report Narrative review
Class X:	Medical opinion
A full explanation of ICSI's Evidence Grading System can be found at http://www.icsi.org .	