G.P. Review Article

THE TREATMENT OF DEPRESSION IN GENERAL PRACTICE*

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The object of this paper is to present a practical, compact and effective method for the treatment of depression in general practice. The factors which precipitated this study were:

(*a*) The apparently increasing incidence of depression, depressive states or depressive syndrome seen in all branches of medicine today, together with its better diagnosis, and our acceptance of it as a very disrupting illness which can cause considerable domestic upsets and loss of working ability; and also the large number of 'red herrings' by which we may be misled.

(*b*) The advent of very potent antidepressive drugs which have bounced the ball back into the general practitioner's court, where depression is so readily recognized and where it can be so effectively treated at an early stage.

The primary burden of diagnosis and treatment of mental disorders rests with the general practitioner, who, in the battle against illness, is in the 'forward observation post'. His acuity in the early recognition of physical and emotional illnesses may save extensive, fruitless and costly investigations.

The family doctor is, by acquaintance with the families under his care, forearmed to recognize any minor changes in behaviour or personality which will arouse the suspicion of an early serious mental disorder. Early diagnosis and expeditious treatment of psychiatric diseases prevent them from developing into serious problems requiring hospitalization.

Furthermore in psychiatric illnesses there is a tendency to crises or 'panic attacks' when there is an acute exacerbation of symptoms and masked conditions become overt. Patients reluctant to solicit advice for ill-defined or, to them, bizarre and odd symptoms, are more easily persuaded during these crises to consult their family doctor, and present to him, at the right moment, a diagnostic gift.

Finally, minor physical conditions such as influenza or a sore throat may also precipitate an incipient depression and the general practitioner will be the one at hand at this stage. The purpose of this survey is to discuss the treatment of this condition in general practice.

MATERIAL AND METHODS

Fifty mild and moderate cases of depression were investigated. These represented 5% of all cases seen in a busy urban general practice. Cases of severe depression where the danger of suicide hung like a sword of Damocles over the patients' heads were not included, on the contention that they should be hospitalized under specialist psychiatric attention. The investigation included 16 men and 34 women who were under follow-up control for 6 months. Ages of male patients ranged from 26 to 75 years (mean 51) and for female patients from 24 to 62 years (mean 44). The study was limited to:

(*i*) Reactive, exogenous or psychogenic depression.
(*ii*) Endogenous, or physiological, depression.
(*iii*) Endo-reactive, or mixed, depression.

TABLE I. DIAGNOSTIC CATEGORIES

Diagnostic group	*No. of cases*
Reactive depression	28
Endogenous depression	16
Endo-reactive depression	6

When these initial criteria had been met and defined within these limits, a trident approach was adopted.

Physical Treatment

A full clinical examination, with investigations where necessary, was carried out. Where it was clear that depression was secondary, efforts were directed at eradicating or ameliorating the cause.

Psychological Treatment

Patients have frequently done the rounds of 'musical chairs' or 'doctor hopping'; have tried fringe remedies, vitamins, Sanatogen; and have completely lost confidence in themselves, drug therapy and the medical profession. Explanation, suggestion, persuasion and re-education are cardinal. The lay stigma of having emotional or psychiatric illness was avoided by explaining that the condition was both emotional and biochemical. However, the high pressure under which general practice is carried out applies unfortunate limitations to this method of treatment, so that pharmacotherapy of necessity has to be the major approach and psychotherapy the lesser.

Pharmacotherapy

The following drugs are used:

Thymoleptics. Only clomipramine (Anafranil, Geigy) was used in this series, as it was my initial observation of the profound effect of this drug that inspired this clinical survey. It was selected from among the iminodibenzyl derivatives because of the impression gained of its rapid onset of action and high and sustained levels of mood elevation. Dosage varied from 75 to 125 mg. orally per day.

Neuroleptics. Fluphenazine 1 - 2 mg. each morning for a duration of 7 days. This was selected for those cases with marked tension, continued restlessness and inability to relax.

Soporifics. These were Mogadon (1,3-dihydro-7-nitro-5-phenyl-2H-1,4-benzodiazepin-2-one) or Mandrax (methaqualone 250 mg., diphenyldramine HCl 25 mg.) and were given in all cases for 7 - 10 days.

Psychostimulants. Dextroamphetamine 10 mg. long-acting (Desoxyn), one before breakfast for 7 days. This was found to be an important facet of treatment and was employed in 37 cases.

As far as possible, patients were required to continue with their work, provided this was not found to be a

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contributing factor in reactive depression, and where excessive fatigue was not present. Follow-up consultations were on a sliding scale, initially at 3-day intervals—ostensibly to have a vitamin injection because anorexia was frequently of some duration, but in fact to assess drug reaction and to proceed with psychological treatment.

RESULTS

The following rating scale was used to assess progress and results:

Grade 1: Complete and rapid remission of all symptoms, with pronounced drive and a slightly euphoric patient at the 8-week check-up.

Grade 2: Complete amelioration of depressive symptoms, with return to drive but with some minor symptom persisting.

Grade 3: Some improvement but not satisfactory.

Grade 4: No beneficial change.

TABLE II. GRADED RESULTS

	Total	*Endo-genous*	*Reactive*	*Endo-reactive*
	%	%	%	%
Grade 1	50	69	43	33
Grade 2	32	19	39	33
Grade 3	8	6	7	17
Grade 4	10	6	11	17

DISCUSSION

The importance of these results is that they show that an 82% success rate can be achieved entirely with treatment by the general practitioner. These results may be ascribed to three factors:

The Mode of Administration of Drugs

In patients already despondent, the delay between the initiation of clomipramine and its functional shift presented a problematical hiatus. By breeching this with amphetamine for a few days, patients were assured that they would feel an almost immediate improvement in drive, self-confidence and well-being. When this drug was withdrawn the potent effect of the antidepressant had reached therapeutic levels and no or little mood drop occurred. These were used in cases with marked despondency, tiredness and anergia. In the 13 cases in which these were not used, the shift was apparent in 3 - 5 days.

Neuroleptics were given if tension, restlessness, anxiety, etc., were marked. Soporifics were given in all cases, as insomnia was the most consistent initial complaint, and the period of rest enabled the sufferer to face his problems with greater equanimity.

Clomipramine

The improvement in 82% of cases was assumed to be due to the clomipramine and supportive psychotherapy. There was a progressive increase in well-being, and in particular there was a profound improvement in drive. Sleep and appetite improved and diurnal mood swings disappeared. Neurotic symptoms subsided and the patient became alert, attentive and interested. There were amelioration of somatic anxiety and improvement in memory, and in 50% of cases a mild euphoria occurred.

Most patients reached their grading in 2 weeks, but too rapid withdrawal of clomipramine caused a slip-back and patients were thus kept at optimal dosage for 3 - 4 weeks before gradual withdrawal. A follow-up examination at 6 months showed no incidence of exacerbations or relapses.

Side-effects were present to some degree in 80% of cases. They included dryness of the mouth, a metallic taste, sedation, fine tremor, constipation, nausea and sweating. These were transient and did not constitute a real problem, and did not appear to be dose-dependent. However, loss of libido and impotence were frequent and troublesome, and one feels this drug may have some interesting place in the treatment of sexual aberrations.

Interest in the Patient

An interest was taken in these patients with early mental disorder which did not necessitate an increase of time devoted to the patient. They would otherwise have ended on the slagheap, so-called neurotics, hysterics, weaklings and cranks who are regarded as time-consuming and financially ill-rewarding.

SUMMARY

The object of this paper was to demonstrate that depression could be effectively treated in general practice, with very satisfactory results.

This involved taking a sincere interest in the patient and his troubles, by alleviating his immediate symptoms with neuroleptics, soporifics and psychostimulant drugs, and by relieving his depressive state using a potent, rapid-acting and safe antidepressive compound.

ADDENDUM

Since completing this series a further 100 cases have been treated with Anafranil, and the results fully support the initial results and impressions gained with this preparation.