Key Concepts in Assessment & Treatment in Depression in Late Life

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Definition

A syndrome complex characterized by mood disturbance plus variety of cognitive, psychological, and vegetative disturbances
Depression

• Physical symptoms are often the chief complaint in depressed patients in primary care
• In a New England Journal of medicine study, 69% of diagnosed depressed patients reported unexplained physical symptoms as their chief complaint

Depression in the Elderly

- Not a normal part of aging
- 2 million Americans over age 65 are diagnosed with Depression
- Sub-syndromal depression increases the risk of developing depression
- Often co-occurs with other serious illnesses
- Under-diagnosed and under-treated
- Suicide rates in the elderly are the highest of any age group
Facts

- Only 11 percent in the community receive adequate antidepressant treatment
- The direct and indirect costs - $43 billion each year
- Late life depression is especially costly because of the excess disability that it causes and its deleterious interaction with physical health
If Depression is left untreated...

- Increases the likelihood of death from physical illnesses
- Interferes with a patient’s ability to follow the necessary treatment regimen
- Increased healthcare costs – 50% higher than those of non-depressed seniors
- Lasts longer in the elderly
Depression in the Elderly

- Difficult to accurately diagnose
- Low/depressed mood need not be present
- Anhedonia must be present
- Patients reject diagnosis of depression
- Masked depression or depression without sadness – mainly somatic complaints
Depression in the Elderly

• Symptoms of minor depression
• Somatic complaints
• Agitation, anxiety
• Memory problems
• Difficulty concentrating
• Social withdrawal

• A high degree of suspicion and specific inquiry is essential for its detection and treatment
SIGECAPS

- **Sleep** disturbance
- Loss of **Interest**
- Inappropriate or excessive feelings of **Guilt**
- Decreased **Energy** and increased fatigue
- Diminished ability to think or **Concentrate**
- **Appetite** change
- **Psychomotor** retardation or agitation
- **Suicidal** ideation

- From CCSMH Depression Guidelines, pages 10, 19, &22 NICE Brochure
Precipitants

- Conflict with friends and family
- Rejection
- Abandonment
- Death or major illness of loved one
- Loss of pet
- Anniversary of a negative event
- Major medical illness or age-related deterioration
- Stressful event at work
- Medication noncompliance
- Substance use
Differential Diagnosis

• Bereavement
  • Time-limited resolves within a few months
  • 14% develop depression within 2 years of loss
  • Look for functional impairment
Differential Diagnosis

• Differentiation from medical illness
  • Dementia
  • Parkinson’s Disease
  • Pancreatic Cancer
  • Hyperthyroidism
Minor Depression

- Also known as
  - Subsyndomal depression
  - Subclinical depression
  - Mild depression
Dysthymia

- More chronic, low intensity mood disorder
- Symptoms must be present for greater than 2 consecutive years
- Characterized by anhedonia, low self-esteem, & low energy
- It tends to respond equally to treatment and psychotherapy
- Long-term psychotherapy is beneficial in bringing about lasting change
Minor Depression

- 2-4 times more common than major depression
- Associated with subsequent major depression
- Greater use of health services
- Reduced physical, social functioning
- Loss of quality of life
- Responds to same treatments
Depression in Structural Brain Disease

- Alzheimer’s Disease;
  20% of subjects with early AD have depression
- Cerebrovascular Disease/Vascular Depression
  - Anhedonia
  - Late age of onset
  - Risk factors for vascular disease
  - Prefrontal or subcortical white matter hyperintensities on T2 weighted MRI
Pseudo-Dementia

- A syndrome of cognitive impairment that mimics dementia but actually is depression
- Poor attention and concentration
- Symptoms resolve as the depression is treated effectively
- If considerable cognitive impairment remains, suspect underlying dementia
- Even “completely recovered” patients have higher rates of dementia (20% /year of f/u)
- This is 2.5 to 6 times higher than population risk
## Demographics for Elderly Depression

<table>
<thead>
<tr>
<th>Gender</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Men</td>
<td>5-12</td>
</tr>
<tr>
<td>Women</td>
<td>10-25</td>
</tr>
</tbody>
</table>

Prevalence 1-2% in elderly

<table>
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<tr>
<th>Setting</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Primary Care</td>
<td>6-10</td>
</tr>
<tr>
<td>Nursing Home</td>
<td>2-20</td>
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<tr>
<td>Inpatient</td>
<td>11-45</td>
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<tr>
<td>Outpatient Psychiatry /Inpatient</td>
<td>&gt;40</td>
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<tr>
<td>Psychiatry Clinic</td>
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Demographics of Elderly Depression

- Peak age of onset – 3rd decade
- Late-life depression: secondary to vascular etiology
Patho-physiology

• Cerebro-vascular disease
• Increased stress levels
• Decreased levels or activity of norepinephrine and/or serotonin
• Deep white matter hyperintensity
• Decreased latency to 1st rapid eye movement sleep phase and hypofusion of the frontal lobes
Etiology

- Biological
- Psychological
- Social
Biological Factors

- Vascular changes in the brain
- Chronic or severe pain
- Previous history of depression
- Substance abuse
Social Factors

- Loneliness
- Bereavement
- Lack of meaningful social connections
- Decreased mobility
  - Due to illness or loss of driving privileges
Psychological Factors

- Damage to body image
- Fear of death
- Frustration with memory loss
- Role transitions
- Traumatic experiences
Medical Illness

• Parkinson’s
• Alzheimer’s Disease
• Cancer
• Diabetes
• Stroke
# Psychotic Symptoms

<table>
<thead>
<tr>
<th>Impaired reality</th>
<th>Differential diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Auditory or visual hallucinations or</td>
<td></td>
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<tr>
<td>• Delusions</td>
<td>• Dementia (all types)</td>
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<td>• Not all delusions are psychotic</td>
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</table>
Biological Factors

- Genetic
  - High prevalence in first degree relatives
  - High concordance with monozygotic twins
  - Short allele of serotonin transported gene
Psychotherapies

- CBT
- IPT
- Supportive Therapy
- Brief Dynamic

- Most curative factor is the installation of hope
Non-Medical Interventions

- Stress management
- Family support
- Social support
- Exercise
- Doing something that you are passionate about
- Balanced diet
- Pet therapy
Medical Interventions

• Medication Treatment
• Psychotherapy
• Electro-convulsive therapy
• Combination therapy
Medications

• Serotonergic
  • SSRIs: Citalopram, Escitalopram, Sertraline, Paroxetine, Fluoxetine
  • Noradrenergic
    TCAs
Medications

- Sertotonergic
  - SSRIs: *Citalopram, Escitalopram, Sertraline, Paroxetine, Fluoxetine*
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  - TCAs
  - Dopaminergic
    - *Bupropion*
Medications

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Dual mechanism
  *Venlafaxine*, *Mirtazapine*, *Duloxetine*, *SSRIs* plus *Bupropion*
Treatment selection

- Serotonergic
  - Agitated, hostile, and anxious
  - Hypochondriacal

Noradrenergic
Avoid use seniors

Dopaminergic
  - Psychomotor retardation, blunted, apathetic

Dual mechanism
  - Melancholic, atypical, treatment resistant
Special Considerations in the Elderly

- “Start low and go slow”
- Dose adjustment based on renal clearance: 30% reduction of mirtazapine clearance with creatinine clearance: 11-15
- SSRIs are used at the same dose as adults
- Response time is longer in elderly >6-12 weeks
- Because of higher risk of relapse in elderly, continue antidepressants for >2 years after remission of major depressive disorder
Special Considerations

- All antidepressants are equally efficacious
- SSRIs are better tolerated than TCAs
- Escitalopram, citalopram, sertraline, venlaaxine and mirtazapine may have fewer drug interactions
- SSRI related side effects seen in elderly
  - Extrapyramidal side effects
  - Apathy
  - Anorexia
  - SIADH
  - Upper GI bleeding
Benefits of psychotherapy

- Fewer relapses
- Efficacious in mild to moderate depression
- CBT is equally effective as antidepressants
- IPT
  - More effective than antidepressants in treating mood suicidal ideations and lack of interest, whereas antidepressants are more effective for appetite and sleep disturbances
ECT

Indicated when:

- Antidepressants have failed
- Depression is severe
- There are psychotic features, catatonia, or high suicide risk
Key Point

• Depression is not a normal response to the aging process
Bereavement

• A normal reaction to the death of a loved one

• It may look like Major Depression

• CCSMH Depression Guidelines, pages 20 & 21
Protective Factors for Suicide

• Good physical health
• Sense of purpose
• Sense of meaning
• Meaningful social connections and support
Suicide risk in the elderly

- Important to assess
- Ask about firearms
- 20% of elderly who commit suicide do so shortly after they have visited their primary care provider (same day)
- 40% within one week
- Elderly make up 12% of the population, and 20% of all suicides
Risk factors for Suicide in the Elderly

- Male
- Age
- Depression
- Prior attempts
- Substance use
- Impaired reality testing
- Lack of social support
- A plan for suicide
- No partner
- Poor physical health
Most at risk for suicide when:

- Showing signs of responding to treatment
- Improved somatic symptoms
- Improved sleep, appetite, and energy
- Slowly improving in the areas of self-esteem, guilt, and suicidal thoughts
References

• Katona C, Bindman DC, Katona CP. Antidepressants for older people: what can we learn from the current evidence base? Maturitas. 2014, Jun 2, pii.
• Unutzer J, Park M. Older adults with severe treatment-resistant depression. JAMA 2012; 308: 909-918.
References