Depression in Older Adults

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Melancholia

Depression in Older Adults

- Phenomenology
- Evaluation Strategy
- Treatment
- Interaction with Dementia

Depression in Older Adults

- Common
- Disability
- Morbidity and mortality
- Costs
  - Healthcare utilization
  - Medication use

Depressive Symptoms in the Elderly

- Major Depression
- Bipolar Disorder, depressed
- Dysthymia
- Mood Disorder Due to a Medical Condition
- Substance-induced Mood Disorder
- Adjustment Disorder with Depressed Mood
- Other:
  - Minor depression
    Mixed anxiety-depressive disorder
    Bereavement
    Loss
    Personality

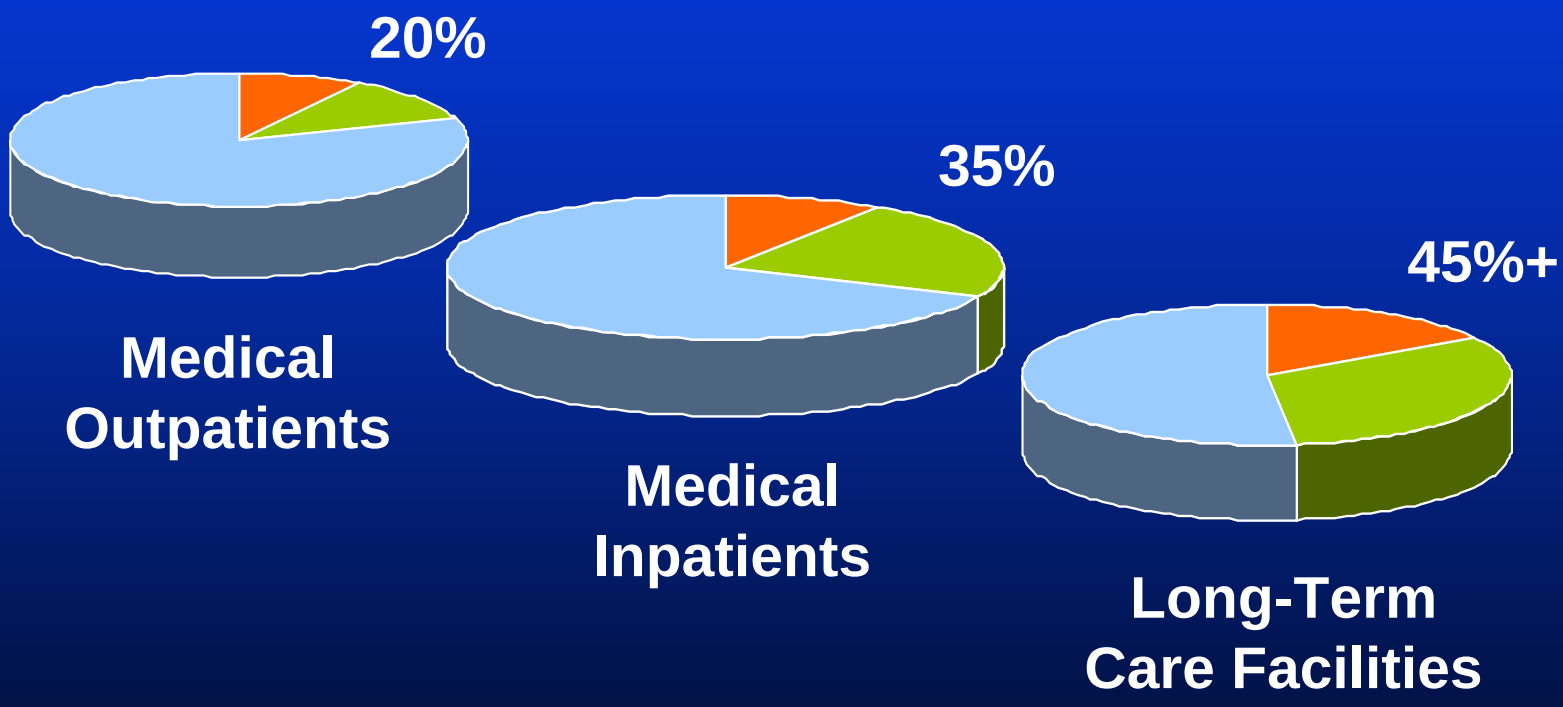
Major Depressive Episode – DSM-IV

- At least 5 symptoms for 2 weeks:
  - Depressed mood
  - Reduced interest or pleasure
  - Appetite change
  - Sleep change
  - Psychomotor retardation or agitation
  - Fatigue or loss of energy
  - Worthlessness or guilt
  - Poor concentration
  - Thoughts of death
- Clinically significant distress or impairment in social/occupational functioning
- Not due to the direct physiological effect of drug or medical condition
- Not bereavement

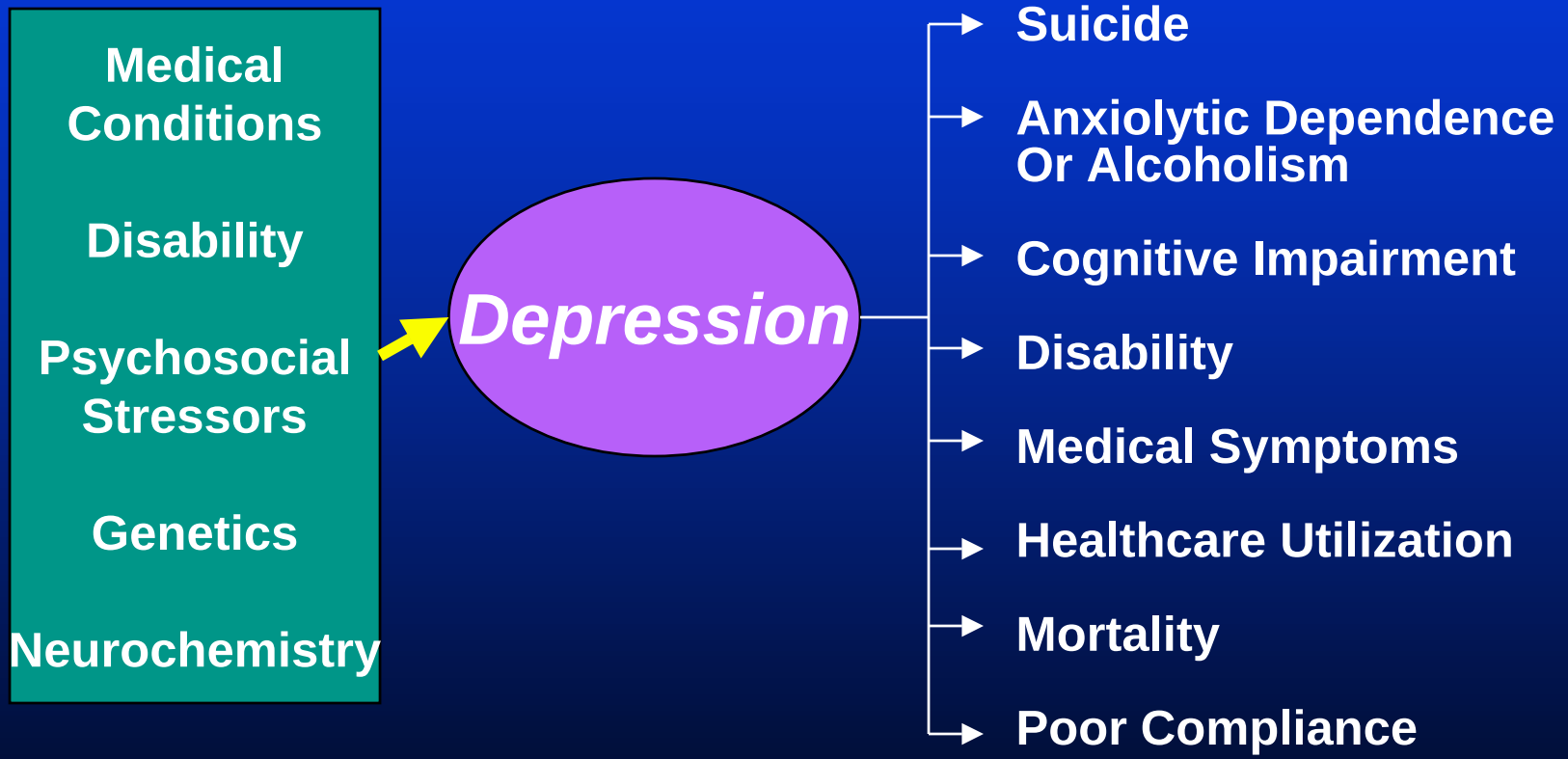
Epidemiology
Depression in Older Adults

- Major Depression
  - Women 1 - 4%
  - Men 0.5 - 2%
- Dysthymic Disorder 2%
- Adjustment Disorder, Depressed 4%
- Other ~10%

Special Populations
Depression in Older Adults

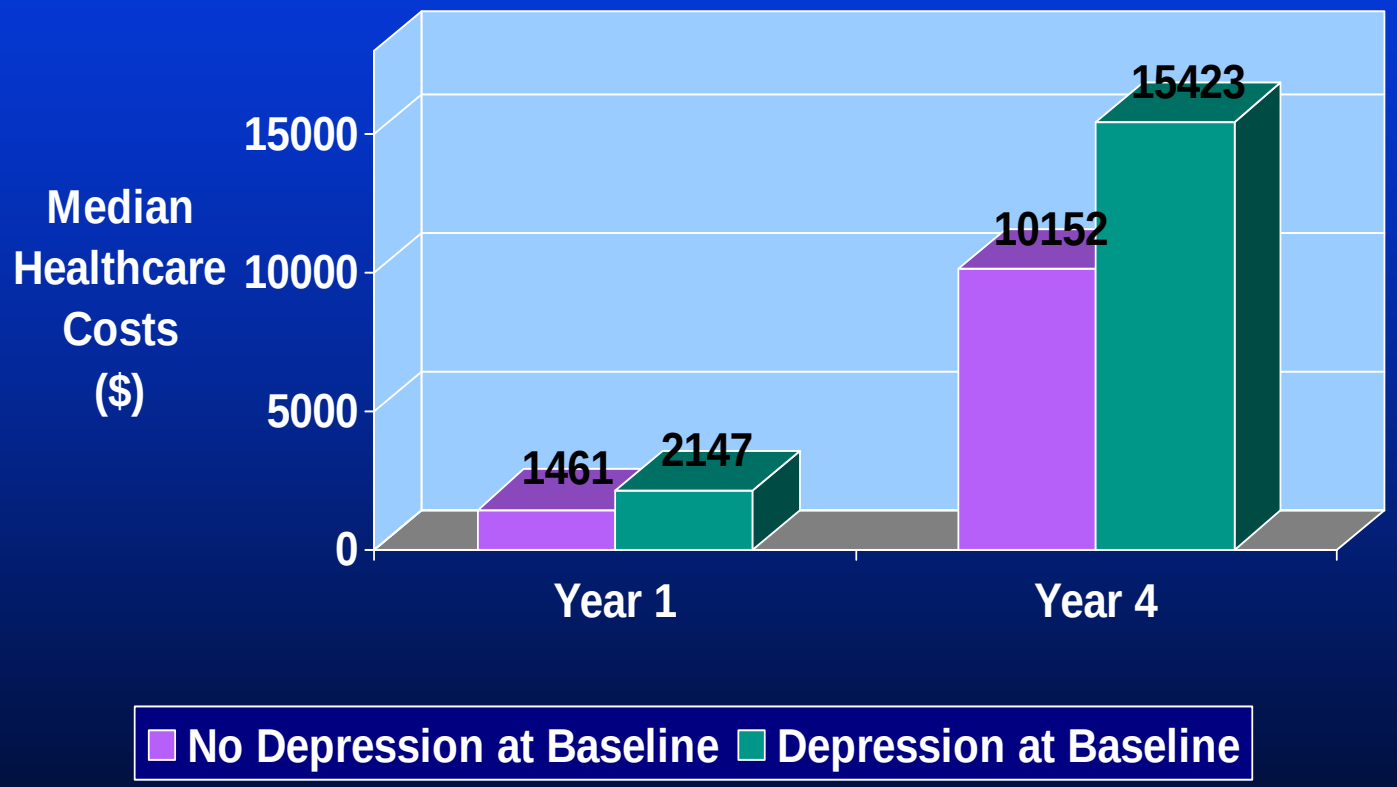


Late-Life Depression
Causes and Effects



Adapted from Geriatric Psychiatry Alliance

Health Care Costs Associated With Depression



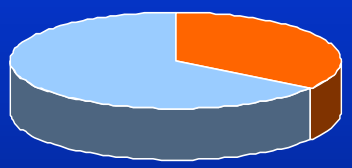
Unutzer et al. 1997

Suicide
Depression in the Older Adults

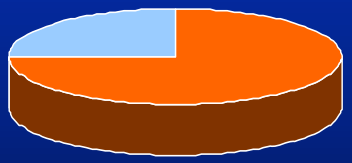
- 2X frequency of general population
- Attempts: women, OD or laceration
- Completers: men, white, guns or hanging
- Physical illness, loss, late-onset depression, first episode
- Greater association with depression in elderly

Late-Life Suicide

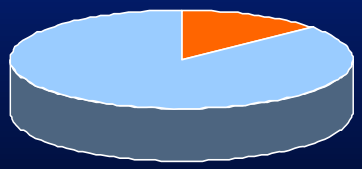
Recent contact with physician



35% → **Visited primary care physician within 7 days**



75% → **Visited primary care physician within 30 days**



14% → **Received psychiatric care within 15 years**

Late-Onset Depression
vs. Early-Onset, Now Older

- Fewer with family history
- Suicide risk
- Similar rate of treatment response
- More often with residual symptoms and recurrence
- Cognitive impairment

High-Risk Medical Conditions
Depression in the Elderly

- Alcohol abuse
- Stroke
- Parkinson's disease
- Alzheimer's disease
- Vascular dementia
- Delirium

- Other medical conditions:
  - Cardiac disease
  - Pancreatic cancer
  - Hypothyroidism
- Medications
  - Steroids
  - Cardiac/antihypertensive
  - Benzodiazepines
  - Opioids
  - Others

Depression in Older Adults

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Is Late-Life Depression Recognized and Treated?
Primary Care Settings

< 50%	of those with a depressive syndrome are identified
< 50%	of those identified receive any treatment
50%	of those treated receive treatment for an adequate period of time

Also, many with early dose reduction or discontinuation

Mulsant

Distinctive Diagnostic Features
Depression in the Elderly

- Look for -
  - Somatic concerns or chronic pain
  - Anxiety
  - Memory impairment: forgetful, aware
  - Motor slowing
  - Excessive functional disability
  - Men: anger, apathy, anhedonia without sadness
  - Women: somatic symptoms, sadness
- Remember -
  - Depression associated with medical illness is not only due to disability

Depression vs. Medical Illness
Physical Symptoms

- When depression is prominent, physical symptoms aren't well-explained by medical illness or treatment
- Less likely to be depression, when:
  - Looks forward to some things, e.g. family
  - Responds to affection
  - Some interests are present
  - Participates in therapy and engaged in the treatment process
  - Acknowledges specific links to medical illness

Screening & Rating Scales

- A question:

  Are you feeling down, depressed, or hopeless over the past couple weeks?

- Followup:

  What do you enjoy?

  What do you look forward to?

- Rating Scales

  Geriatric Depression Scale

  Beck Depression Inventory

  PHQ-9

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Therapeutic Options
Depression in Older Adults

- Eliminate causal factors
- Education
- Psychotherapy
- Pharmacotherapy
- ECT

Education
Depression in Older Adults

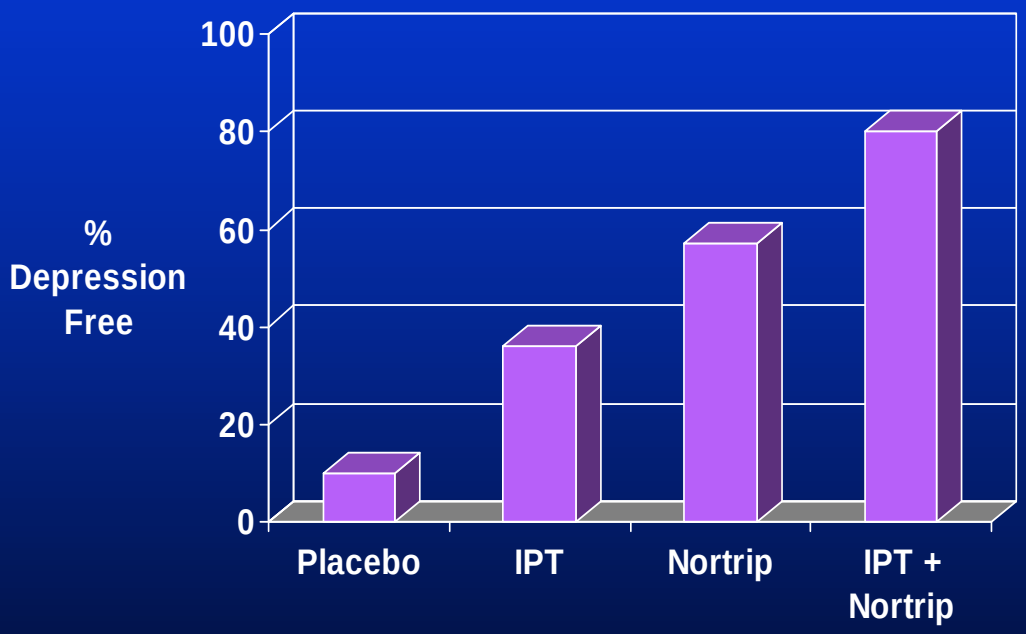
- Not a character defect
- Treatment works
- Treatment takes awhile to work
- Treatment plan is long-term: remission and staying well
- Beware recurrence

Psychotherapy

- Supportive relationship
- Cognitive – behavioral therapy
- Problem-solving therapy
- Interpersonal therapy
- Consider when:
  - Patient preference
  - Diagnosis other than major depression
  - Medication sensitivity
  - Combined treatment model

Psychotherapy + Medication

Maintenance Treatment for Depression



- Acute and continuation rx → stable
- Maintenance rx x 3 years
- IPT ≅ nortrip at 1 year
- Older age more vulnerable to recurrence in all groups, except combined rx

Reynolds 1999

Antidepressant Treatment Principles

- Identify specific target symptoms
- Choose a medication based on
  - Previous response
  - Target symptoms
  - Side effect profile
  - Likely adherence
- $START_{low}$, GO_{slow}
- Underdosing is common in primary care settings
- Education

SRIs

		Usual starting dose	Usual dose*
Citalopram	Celexa	10mg/day	20-40 mg/day
Escitalopram	Lexapro	5-10mg/day	10-20mg/day
Sertraline	Zoloft	25mg/day	50-200 mg/day
Paroxetine	Paxil	10mg/day	10-30 mg/day
Fluoxetine	Prozac	10mg/day	10-30 mg/day (long T½)

Notable side effects: nausea, diarrhea, anorexia, insomnia, fatigue, anxiety, sexual dysfunction, hyponatremia, drug interactions

* Usual doses are reduced by about 25% in those with multiple medical illnesses

Other Antidepressants

	Initial dose	Usual dose	Comments
Bupropion Wellbutrin IR, SR, XL	100 mg/day	150-300 mg/day	Anxiety, insomnia; seizure risk at high dose BID if SR>150mg
Mirtazepine Remeron	15 mg/day	15-30 mg/day	Sedation, weight gain?
Venlafaxine Effexor XR	37.5 mg/day	75-225 mg/day	Nausea, dizziness, ↑ BP (rare) Higher doses, if rx resistant
Duloxetine Cymbalta	20 mg/day	30-60 mg/day	Can rx BID, ↑ BP (rare) GI effects, hyponatremia
Phenelzine Nardil	15 mg/day	15-45 mg/day (BID or TID)	MAO inhibitor – rarely recommended Hypotension, sedation, Food and drug interactions

Tricyclic Antidepressants

	Usual dosage
Nortriptyline	50-100 mg/day (start 10-25 mg/day) Titration required Plasma level 50-100ng/ml

Notable side effects: Anticholinergic (constipation, tachycardia, urinary retention, dry mouth, cognitive impairment), cardiac conduction, hypotension, sedation
Contraindicated if bundle branch block

Time Course of Clinical Response

- 2 weeks – Initial response
- 4 weeks – Substantial response
- 8-12 weeks – Maximal benefit

- Maintenance

  9-12 months minimum treatment

  Full dosage

  Relapse risk up to 70% if early discontinuation

Insufficient Treatment Response

- Adherence?
- ↑ time, ↑ dose
- Change meds
- Augment
- ECT

] *NIMH STAR*D*

Brain Stimulation Treatments

- Electroconvulsive therapy (ECT)
- Vagus nerve stimulation (VNS)
- Repetitive transcranial magnetic stimulation (rTMS)

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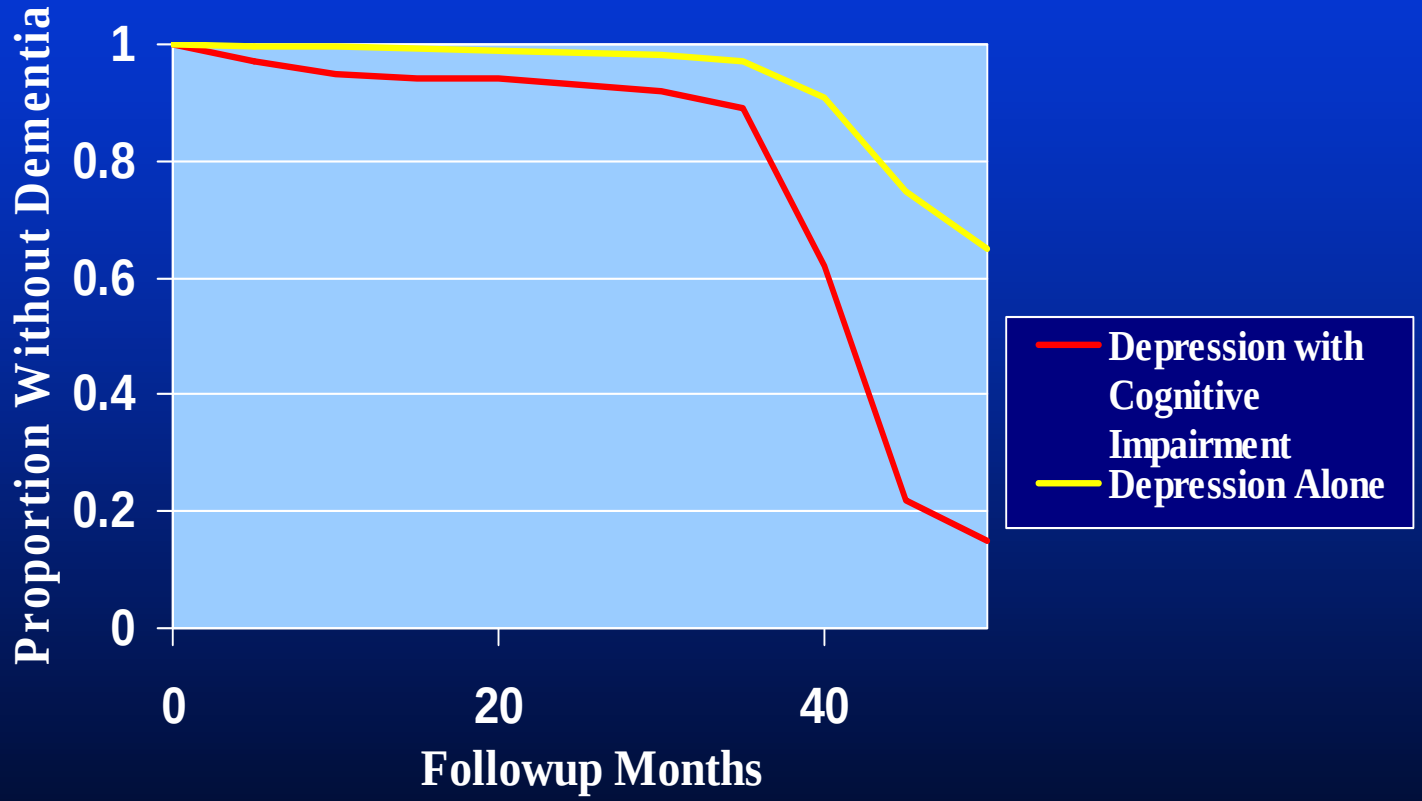
Many older patients with major depression have reversible cognitive deficits

Typical features -

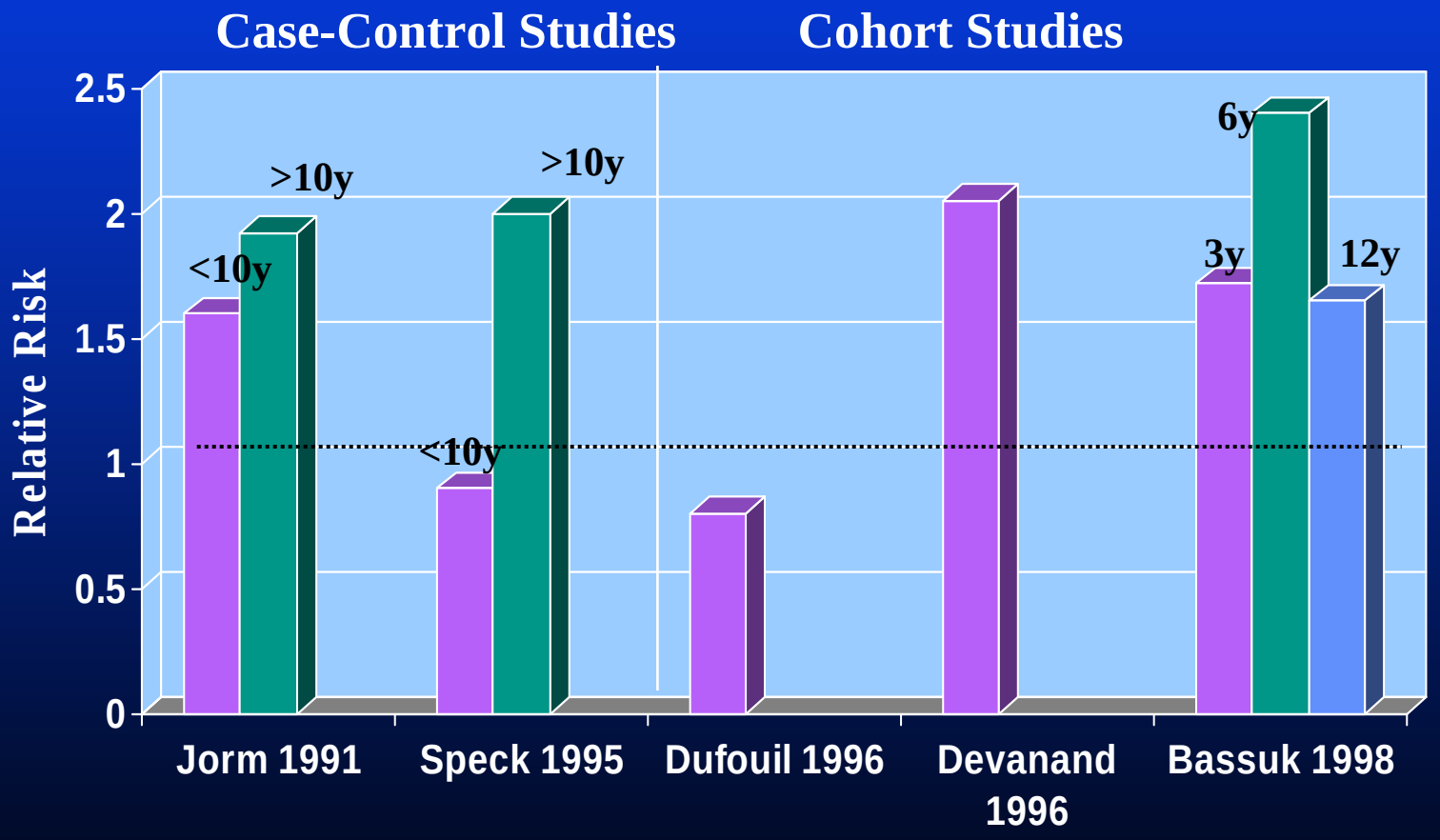
- Memory complaints
- Poor concentration
- Forgetful
- Poor executive skills (may predict poorer outcome)
- Effort-dependent performance

Major Depression with Cognitive Deficits
- *Outcome* -

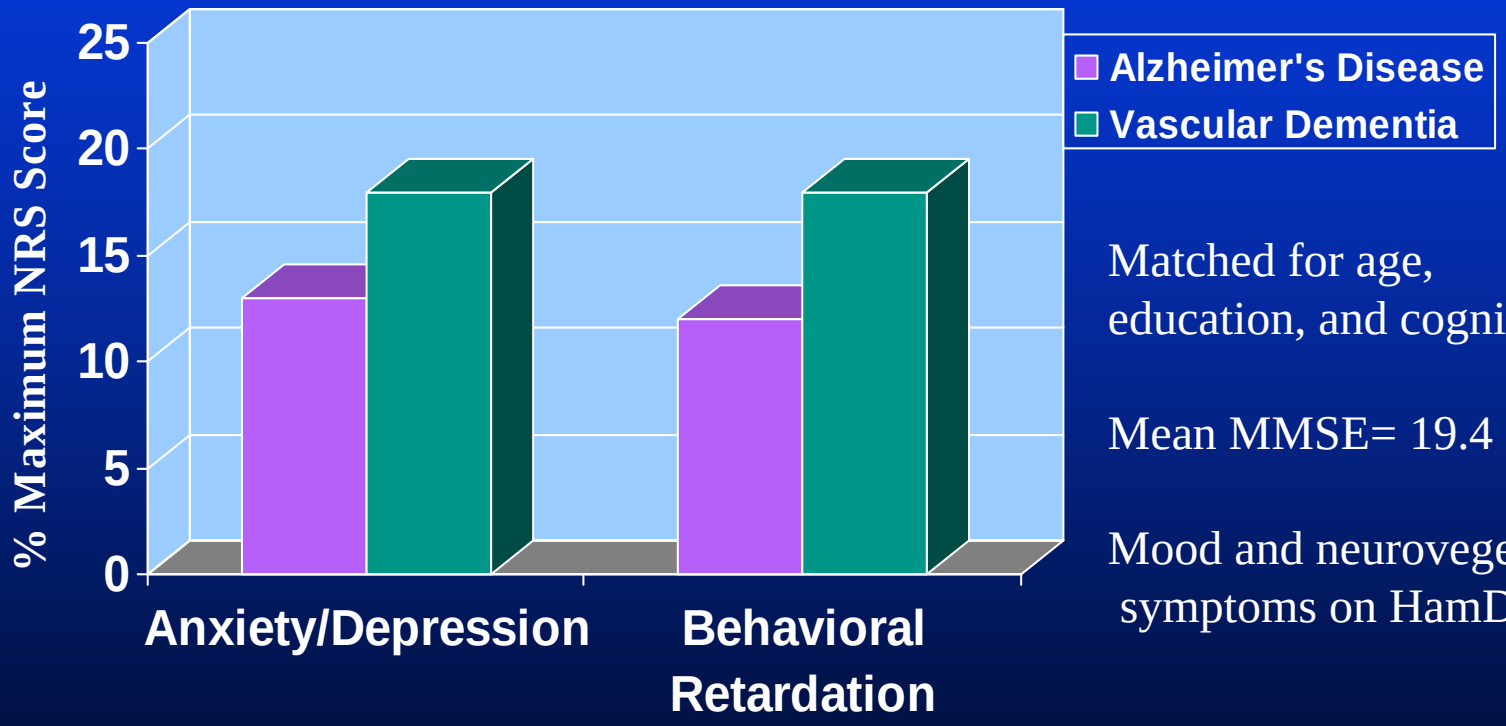


Alexopoulos et al. 1993

Risk for Subsequent Cognitive Decline in Patients with Depression



Depression in Alzheimer's Disease vs. Vascular Dementia



Matched for age, education, and cognition

Mean MMSE= 19.4

Mood and neurovegetative symptoms on HamD

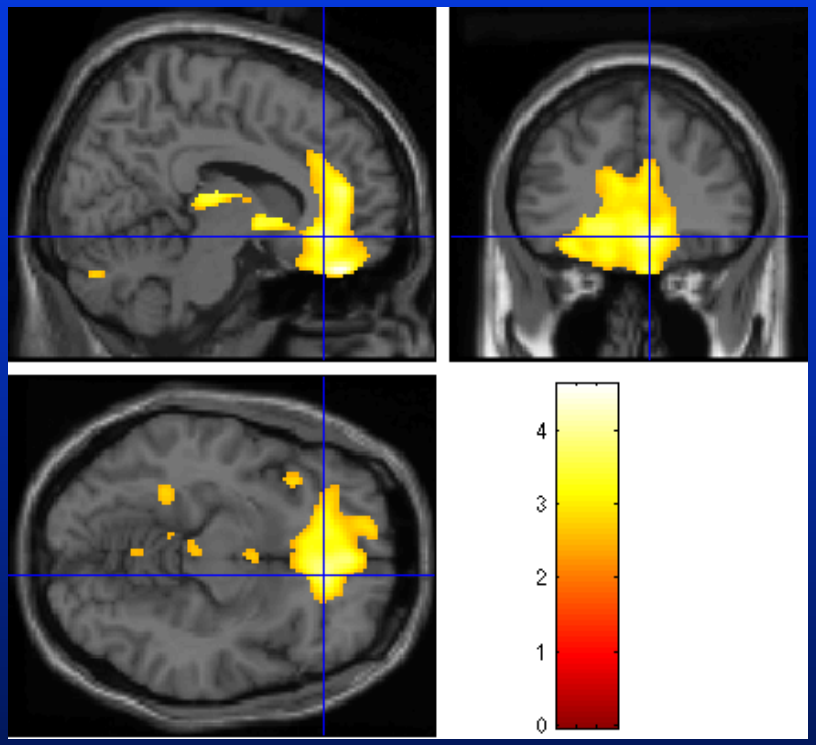
Sultzer et al. 1993

Diagnostic Challenges
Mood Symptoms in Dementia

Who cares about apathy?

- A fundamental aspect of Alzheimer's disease
- Occurs early in AD
- Not strongly associated with dysphoria
- May respond to cholinesterase inhibitor treatment

Apathy in AD



Apathy is associated with low metabolic rate, adjusted for MMSE effects

Marshall et al. 2007

Depression in Older Adults

- Common, not universal
- Variable symptoms
- Linked to medical and social morbidity
- Treatment works
- Long-term monitoring is important
- Cognitive deficits occur in depressive disorders
- Mood symptoms occur in cognitive disorders