

Depression in Older Adults

Paul Boulware, MD

Arizona Neurological Institute

April 22, 2012

What is it?

- Major depressive disorder is a syndrome, a collection of symptoms
- Presentation is variable among individuals

SIG E CAPS

- Sleep
- Interest
- Guilt
- Energy
- Concentration
- Appetite
- Psychomotor changes
- Suicide

DSM-IV

- Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, 2000 (DSM-IV-TR)
- DSM-IV diagnosis of depression requires that a certain number of symptoms be present during a 2-week period, represent a change from previous functioning, and either depressed mood or loss of interest or pleasure must be present

What does DSM-IV miss?

- Two of the *most important* indicators of depression, at any age, are
 - Self attitude change
 - Change in vital sense

DSM-IV

- Major problem with DSM-IV is that it resembles a field guide – check off symptoms on a list and arrive at, or exclude, a diagnosis

Depression in Older Adults

- As many as 10% adults > 65 seen in primary care settings have clinically significant depression
- Particularly common in women, in patients with chronic medical disorders, and in patients who have experienced stressful life events (e.g., loss of a spouse), functional decline, or social isolation

Depression in Older Adults

- What's different?
 - Older adults are less likely to present complaining of depressed mood
 - Older adults are more likely to present with physical complaints (GI, neurological, vague somatic symptoms)

Case of Mary D.

- 82 yo WF presents to the ED c/o stomach pain, anorexia (20 lb weight loss), low energy, and isolative behavior
- Extensive medical workup excludes medical illness
- Admitted to psychiatry for depression for failure to thrive/not eating
- Patient gets treated with ECT for depression, stomach pain resolves, but she at no point admits to feeling depressed

Co-morbidity

- Grief and loss contribute to depression
- Nearly 60% of depressed patients have co-morbid anxiety
- Up to 40% of anxious patients have co-morbid depression related to their medical illnesses (heart disease, renal failure, cancer, endocrine, infections) and neurological illnesses (stroke, Parkinson's disease, cerebral neoplasm, MS)

Co-morbidity

- About 30% of patients with dementia also have major depression (treating depression often helps with psychotic symptoms)
- Patients with stroke, Parkinson's disease, or MS are also vulnerable to depression

Suicide

- Common in the elderly
- Peak among women 50-65 and men 80-90
- 1/9 suicide attempts in the elderly results in death
- Risk of suicide in adults > 65 is TWICE that of U.S. population at large

Suicide

- Predictors of risk:
 - Advanced age
 - Male
 - Being separated, isolated, or divorced
 - Debilitating illness
 - Alcohol abuse
 - Highest incidence among older, white men

Suicide

- Recognizing and treating depression and reducing access to firearms may be the most important things primary care providers can do to reduce the risk of suicide

Suicide

- Suicide rate for white men > 65 is five times greater than for the general population

Drugs and Depressive Symptoms

- Narcotics, NSAIDs
- Antihypertensives
- Antipsychotics
- Anxiolytics (alcohol, benzodiazepines)
- Chemotherapy (antineoplastics)
- Sedative-hypnotics
- Steroids
- Thiazide diuretics
- H2 blockers
- Interferon (HCV)-20-30%

Case of Jim T.

- 86 yo AAM w/ chronic pain from diabetic neuropathy, chronic renal failure, and rheumatoid arthritis c/o low energy, hopelessness, suicidal thoughts
- Medications include oxycontin, oxycodone
- Daughter states patient often falls asleep standing, leaning on the wall or doorway

Case of Jim T.

- Patient has been taking increasing doses of opiates for pain
- Major depression is diagnosed, along with chronic pain disorder
- Treatment with an antidepressant is instituted and opiates are slowly reduced

Treatment

- Polypharmacy is common in the elderly
- Review all medications for contraindications and possible causes of symptoms
- Start low and go slow
- But, if suicide or psychosis is present treat aggressively (hospitalize, ECT)

Treatment

- First-line usually SSRI (sertraline, escitalopram, citalopram, paroxetine, fluoxetine)
- Choice influenced by symptoms (e.g., patient with insomnia and anorexia may benefit from mirtazapine)

Treatment

- SSRIs commonly cause GI upset, headache, sexual dysfunction (healthy adults of all ages may be sexually active)
- Less commonly cause apathy, hyponatremia, GI bleeding (5-HT receptors on platelets, some think complementary in coronary artery disease)

Treatment

- Mirtazapine

- often a great choice in older adults--increases appetite, quick reduction of anxiety and insomnia; available in ODT (catatonia, nausea, noncompliance)
- rarely causes leukopenia; often causes weight gain, RLS not uncommon

SNRIs

- Venlafaxine (Effexor), desvenlafaxine (Pristiq), and duloxetine (Cymbalta)
- May be helpful in patients with comorbid chronic pain
- Venlafaxine may elevate blood pressure-
monitor (usually systolic)

Tricyclics

- Nortriptyline, amitriptyline, clomipramine, imipramine
- Side effects troubling, especially in older adults
 - -orthostatic hypotension (peripheral alpha-1 blockade)
 - Constipation, dry mouth, blurred vision, urinary retention
 - Cardiac side effects (prolong QT; avoid in LBBB or bifascicular block)
 - Overdose of even 1-week supply may be lethal

Antipsychotics (neuroleptics)

- Conventional and newer (SDAs) neuroleptics effective for positive symptoms of psychosis in depression (hallucinations, delusions, paranoia)
- Conventional drugs (haloperidol, chlorpromazine) high risk of EPS

Antipsychotics (neuroleptics)

- newer agents, SDAs, atypical neuroleptics, quetiapine, olanzapine, ziprasidone, clozapine, aripiprazole, risperidone probably better for negative symptoms--anhedonia, isolative behavior
- and probably better in the elderly, BUT
 - increased risk of sudden death in patients with dementia (recent study shows elevated risk with conventionals as well)

Atypical neuroleptics (SDAs)

- Consider weight gain with clozapine > olanzapine > quetiapine > risperidone (metabolic effects)
- Less likely with ziprasidone, aripiprazole
- May cause orthostatic hypotension (quetiapine)
- Quetiapine often useful in insomnia, very low incidence of EPS (but it can happen)

And...

- MAOIs--very good in treatment resistant depression but must be used carefully (dietary restrictions, medication interactions--hypertensive crisis)
- Lithium--very good for augmentation, can use lower doses, but trickier in the elderly (reduced sCr, dehydration) and dangerous in overdose
- Thyroid hormone, even if euthyroid

Stimulants

- Stimulants, such as methylphenidate, dextroamphetamine, or modafanil, may be used safely in depressed older adults with apathy or very low energy
- Avoid in heart disease (arrhythmia, uncontrolled HTN) and with low appetite/weight loss

Undertreatment

- Stigma
- Common belief that depression is a normal part of aging—it is NOT
- Depression is normally associated with loss of a loved one, but if symptoms of major depression persist for more than 2 months after a loss, treat

Maintenance

- Antidepressant treatment should be continued at full doses for 12 months after patients are in remission at least 6- (recurrence rates otherwise are up to 70%)
- In absence of contraindication, antidepressants should probably be continued indefinitely

When to refer

- In patients who prefer nonpharmacologic treatments (psychotherapy) or who have persistent depression after one or more trials of antidepressants (8-12 weeks)
- Psychosis
- History of mania or emergence of manic symptoms during treatment
- Suicide
- Hospitalization/ECT

References

- Reynolds CF et al. Maintenance Treatment of Major Depression in Old Age. *N Eng J Med* 2006; 354: 1130-1138.
- Stern TA, Herman JB. *Geriatric Psychiatry in Massachusetts General Hospital Psychiatry Update and Board Preparation*. McGraw-Hill, 2004: 471-477.
- Unutzer J. Late-life Depression. *N Eng J Med* 2007; 357: 2269-2276.

Dementia

- Dementia is not an illness but a clinical condition or syndrome of a progressive decline in cognitive function so severe that it impairs daily activities

Dementia

- Dementia Alzheimer's type about 70% cases of dementia
- Remaining include vascular dementia, dementia with Lewy bodies, frontotemporal dementia

Dementia

- Diagnosis of dementia Alzheimer's type requires memory impairment plus one or more of the following
 - Apraxia
 - Aphasia
 - Agnosia
 - Or disturbance in executive function

Stanley W.

- 57 yo WM internal medicine physician first noticed problems concentrating at work
- Started to demonstrate behavioral changes at home — not caring about hygiene, ignoring wife and grandchildren
- NO prominent memory loss
- Denies feeling depressed or anxious, no past psychiatric history

Frontotemporal Dementia

- Eventually had to retire
- Would spend hours sitting on couch or pacing
- Neuropsychological testing done suggested diagnosis of frontotemporal dementia
- Very little insight; apathy

Interesting case

- Mellissa A. is a 47 yo WF who was sent to me by her neurologist for pseudoseizures
- When I met with her she had an odd lisp with a British accent (she's from Arizona)
- She admitted to depression and a long history of sexual and physical abuse

Interesting case

- On our third visit, she started to talk about her past abuse. As we were walking out of the office, she fell to the floor and started convulsing (non-symmetric, typical of pseudoseizure—i.e., non-epileptic seizure)
- She started speaking in a language like Chinese, while she was still convulsing

Interesting case

- 911 was called; I received a call from the ED stating she was fine and was being released from the hospital
- She came in for follow-up the next week, and she was speaking in an American accent, stating she's not sure why she sometimes speaks in a British accent

Interesting case

- Her anxiety and depression are now well-controlled but she reports that she continues to have “seizures” at home and that she frequently speaks “in tongues” and frequently reverts to a British accent
- Conversion disorder