Late life depression

This review article looks at identifying late-life depression, which is a common presentation in primary care, and to identify hidden signs and symptoms. It also reviews pharmacological and non pharmacological approaches in treating depressive illness in the elderly population.

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Depression is common, disabling and frequently under diagnosed and sub-optimally treated in older people.[1] It is the second most common reason for people older than 70 years to visit their GP.[2] The risk of developing depression increases when a patient has other illnesses or has a limited ability to function.[3] But, depression is not a normal part of ageing. Emotional experiences of sadness, grief, response to loss, and temporary "blue" moods are normal, but persistent depression that interferes significantly with ability to function is not. Depression is also associated with high risk of completed suicide. Subsyndromal depression ("mild depression") is especially common among older persons and is associated with an increased risk of developing major depression.[4] In comparison with younger people, older people under report depressive symptoms and may not acknowledge being sad, down or depressed.[5] Whether this is due to age itself or a reflection of the generation in which they were raised—where stoicism was a virtue—is unknown.

The loss of loved ones and the physical limitations that are associated with later life can contribute significantly to late-life depression.[5] The Global Burden of Disease study showed that depression will be the single leading cause of Disability Adjusted Life Years by 2020 in the developing world for all age groups.[6]

Prevalence

Between 10% and 15% of older people have depressive symptoms,[7] although major depression is relatively rare in older adults. The overall prevalence of major depression ranges from 0.9% to 9.4% in people living in the community, and from 14% to 42% in institutional living. Among older people, it ranges from 1% to 16% in those living in the community or institutional care.[7] Additionally, the incidence of clinically relevant depressive symptom "cases" (patients who do not meet the complete criteria for a major depressive disorder) in similar settings varies between 7.2% and 49%.[7]

The main predictors of depressive disorders and depressive symptom cases in older patients are: female gender, somatic illness, cognitive impairment, functional impairment, lack or loss of close social contacts, and a history of depression.[8]

Diagnosis

Generally the pattern of depressive symptoms is similar to symptoms exhibited by younger adults. However some symptoms are more striking in elderly. Post[9] reported that approximately a third of depressed older people will have a severe degree of retardation (ie, slowing down of thoughts or movements) and agitation. Cognitive impairment is also common and is found in up to 70% of elderly patients with a depressive disorder.[10] Some symptoms will be more common in older patients, and these are: physical symptoms (eg, "aches and pains"), anxiety, forgetfulness and confusion that can sometimes present as pseudo dementia, and somatic symptoms.

To reach an accurate diagnosis, a good clinical history must be taken. This history should include a review of physical health issues, social history,

Box 1: Relevant types of depression according to DSM-4

Melancholic depression: loss of pleasure in most or all activities; a failure of reactivity to pleasurable stimuli; a quality of depressed mood more pronounced than that of grief or loss; a worsening of symptoms in the morning hours or early morning upon waking; psychomotor retardation; excessive weight loss (not to be confused with anorexia nervosa); or excessive guilt

Atypical depression: mood reactivity (paradoxical anhedonia) and positivity, significant weight gain or increased appetite (comfort eating), excessive sleep or sleepiness (hypersomnia), a sensation of heaviness in limbs known as leaden paralysis, and significant social impairment as a consequence of hypersensitivity to perceived interpersonal rejection

Catatonic depression: rare and severe form of major depression involving disturbances of motor behavior and other symptoms

Seasonal affective disorder (SAD): form of depression in which depressive episodes come on in the autumn or winter, and resolve in spring. The diagnosis is made if at least two episodes have occurred in colder months with none at other times, over a two-year period or longer.

interpersonal relationships, pre-morbid personality, psychosocial circumstances, and a mental state examination with special emphasis on cognition should also be done. The treating physician should also speak to the patient's family members or carers (if available) as they can provide valuable information.

Depression tends to last longer in elderly adults than it does in younger patients.[9] It doubles their risk of cardiac diseases and increases their risk of death from illness. It also reduces an elderly person's ability to rehabilitate. Studies of nursing home patients with physical illnesses have shown that the presence of depression substantially increases the likelihood of death from those illnesses.[11] Depression also has been associated with an increased risk of death following a heart attack.[11,12] Therefore, it is important all patients with suspected depression are carefully assessed even if the depression is mild. Physical conditions like stroke, hypertension, atrial fibrillation, diabetes, cancer, dementia, and chronic pain further increase the risk of depression.[11]

Classification system

The current classification systems are DSM-4 and ICD-10. This criteria requires a fundamental disturbance in mood, usually depressed mood or loss of interest or pleasure.[13] However a major depressive episode is characterised by the presence of a severely depressed mood that persists for at least two weeks. Episodes may be isolated or recurrent and are categorised as mild (few symptoms in excess of minimum criteria), moderate, or severe (marked impact on social or occupational functioning). An episode with psychotic features—commonly referred to as psychotic depression—is automatically rated as severe. If the patient has had an episode of mania or markedly elevated mood, a diagnosis of bipolar disorder is made instead. DSM-4 further subdivides major depression into five categories: melancholic, atypical, catatonic, postnatal, and seasonal affective disorder (Box 1).[14]

In addition to the DSM-4 and the ICD-10 criteria, there is also the Beck Depression Inventory and (specifically for older patients) the Geriatric Depression Scale.[15] However when making a diagnosis of depression, other medical causes should be ruled out through laboratory tests (such as a general blood chemistry screen, urinalysis, and electrocardiogram, etc) first. There are factors that influence how depressive disorders present in older people. These factors are: overlap of physical and somatic psychiatric symptoms, minimal expression of sadness, pseudo dementia, depression superimposed upon dementia, and behavioural disorders.[15]

Suicide

Suicide is more common in older people than in any other age group.[16] In fact, white men aged over age 80 years are six times more likely to commit suicide than the general population, constituting the largest risk group. Suicide attempts or severe thoughts or wishes by older adults must always be taken seriously. It

is appropriate and important to ask a depressed person:

- If they feel as though life is no longer an option for them
- If they have they had thoughts about harming themselves
- If they are they planning to commit suicide
- If there is a collection of pills or other methods of self harm in the house
- If they are often alone.

Most depressed people welcome care, concern and support, but they are often frightened and may resist help. In the case of a potentially suicidal older person, friends and family members need to do more than show concern and "understanding." They need to actively take steps to ensure the person cannot commit suicide, such as removing pills and other methods of self harm from the home. If the patient requires medication, family members or carers should supervise them to ensure they take the right dose at the right time. Family members or carers should also alert the patient's GP or a mental health professional. If necessary, if the danger is imminent, they should contact the police.

Causes

Some of the causes for depression in elderly people are listed in box 2, and these causes should be taken into account and addressed appropriately. These factors can act as precipitating and perpetuating factors. Predisposing factors, such as genetic susceptibility, neurobiological risk factors, vascular factors, physical ill health etc, should be taken into account as well. Central acting drugs that may cause depression are: antihypertensives (β-blockers, methyldopa, clonidine, nifedipine); antiparkinson treatment (levodopa, amantadine); psychiatric drugs (neuroleptics, and benzodiazepines); and analgesics.[9,17]

Management

A comprehensive history both from the patient and their carer is very helpful. A full drug and alcohol history should be obtained. If the patient has had previous episodes of depression, the treatments used and the response to them is also very useful information.

A full mental state examination is helpful, and particular attention should be paid to any risk factors for depression and these should be documented appropriately. Evidence of cognitive impairment should also be carefully documented so that comparisons can be made after recovery (ie. to see if the impairment improves with the mood). Routine neuropsychiatric testing is not usually warranted unless dementia is suspected. However it is useful to incorporate a simple screening measure such as the Mini-Mental State Examination (MMSE). A full physical examination is a must and cannot be overlooked as many drugs and medical conditions can precipitate depression. If these causes are implicated, then the term "organic depressive episode" is used in ICD-10. Full lab investigations, including vitamin B12 and folate levels, should also be done. It does not take long for under nutrition to develop in severe depression and the folate levels may be correspondingly low. Thyroid function should be performed because of well known association of depression with hypothyroidism.[18]

Box 2: Causes of depression

- Social isolation and lack of social support
- Poverty, poor housing and physical disability
- Medication side effects
- Early/late onset alcohol abuse
- Major life event
- Poor health
- Financial worries
- Loss of independence

Antidepressants

A number of age-related factors, including changes in pharmacokinetics and pharmacodynamics, medical comorbidity and an increased risk of drug–drug interaction, can complicate the pharmacologic management of depression in late life. Nevertheless, over 80% of elderly depressed patients will eventually respond to vigorous treatment and, when treated over two years, up to 75% of those will not have a relapse or recurrence of depression.[15]

The first-line treatment for depressive episode or disorder are Selective Serotonin Reuptake Inhibitors (SSRIs), eg. fluoxetine, citalopram, sertraline. If the first-line treatment is not effective or not tolerated, try a different SSRI, a tricyclic antidepressant (TCA) or different antidepressant. Use appropriate therapeutic doses for older people (refer to the British National Formulary; BNF) and

consider drug interactions and side effects. Use an appropriate dose for a minimum of six weeks before deciding it is ineffective. If partial response within this period, treatment should be continued for a further six weeks. If stopping antidepressants, reduce gradually over a four-week period; some people may require longer periods. Taper dose over six months in patients on long-term maintenance treatment.[19] Fluoxetine can usually be stopped over a shorter period.

For severe withdrawal symptoms, consider reintroducing original antidepressant at the effective dose (or another antidepressant from the same class with a longer half-life) and reduce gradually—monitor symptoms. Fluoxetine and citalopram are generally associated with fewer withdrawal symptoms. Paroxetine is associated with greater frequency of withdrawal reactions. Time the course of treatment—antidepressants should be continued for at least six months after initial improvement. Some people may require longer treatment or maintenance therapy.[19]

Common side effects

The acute side effects of SSRIs occur early in treatment and for the most part, tend to disappear over time.[19] Acute side effects of SSRIs include stomach upset, nausea, fatigue, headache, fatigue, tremor, nervousness and dry mouth. Some of the more persistent, or chronic, side effects are daytime fatigue, insomnia, sexual problems (especially problems experiencing an orgasm) and weight gain. Side effects of TCAs include dry mouth, postural blood pressure changes (drop in blood pressure when getting up quickly, resulting in dizziness), constipation, difficulty urinating, blurred vision, weight gain and drowsiness. With monoamine oxidase inhibitors (MAOIs), the major problem is the risk of dangerously high blood pressure if certain foods (eg, cheese) or medications are consumed alongside the treatment with the MAOI.[19]

Electroconvulsive therapy

Electroconvulsive therapy (ECT) remains the most effective treatment for depression, with recovery rate of approximately 80% in acute phase treatment.[20,] It is effective in older people and also is well tolerated in "old old" (eg, patients aged 90 years or older). ECT is the treatment of choice for patients whose lives are threatened by food and/or fluid refusal, profound retardation, or suicidal behaviour and also is highly effective for psychotic depression.[20]

Resistant depression

Many patients with depression will fail to respond to monotherapy at the therapeutic dose.[9,15] Treatment resistance is best dealt with augmentation strategies (ie, the addition of another medication to the antidepressant) and ECT. Prior to introducing augmentation strategies, you may need to revisit the diagnosis. Treatment adequacy, compliance with treatment and side effects should be all evaluated. Thirty percent of elderly patients do not respond to an initial adequate trial of antidepressant medication and require additional or alternative treatment.[21] The adjunctive agent may be a second antidepressant (eg, adding a TCA to an SSRI) or a medication that is not primarily an antidepressant (eg. lithium, triiodothyronine, methylphenidate, buspirone or valproate). The advantage of augmentation is that it does not require discontinuation of the original antidepressant. Therefore, patients who partially responded to treatment are not put at risk of returning to their baseline severity of depression.

Other support

Most depressed people find that support from family and friends, involvement in self-help and support groups, and psychotherapy are helpful. Psychotherapy is especially beneficial for those who prefer not to take medicine.[22,23] It also is helpful for people who cannot take drugs because of side effects, interactions with other medicines, or other medical illnesses. Psychotherapy in older adults can address a broad range of functional and social consequences of depression. Many doctors recommend the use of psychotherapy in combination with antidepressant medicines.[23,24]

When the depression is related to loss (including bereavement, demoralisation and those associated with loss of health and functional capacity), the main focus of management will usually be psychosocial. Grief-work, cognitive behaviour therapy, interpersonal therapy, group therapy or counselling may be indicated.[24] Stress and sorrow may be long-lasting, even though initial emotional responses may be regarded as adjustment disorders. Much depends on personality and whether patients can adapt and

move beyond their depressive reactions. Vulnerability and insecurity, which may become more pronounced in some people as they age, interfere with adaptation.[15] This may be especially difficult for elderly migrants.[25]

Prevention

Lifestyle changes in midlife may be the key to the prevention of depression in old age. As mentioned earlier, there is mounting evidence that cerebrovascular disease may cause depression for the first time in old age, so controlling the known risk factors for vascular disease may prevent depression.[26]

Conclusion

In summary, the balance of evidence appears to support the notion that depression in the elderly is equally responsive to initial treatment but has a more adverse longitudinal trajectory than depression in middle age. However, this effect is probably accounted for by factors such as previous episodes and medical comorbidity. Men are more likely than women to experience a chronically impaired course.[27] A poor prognosis is more likely with a co-existing anxiety, dysthymic or substance abuse disorder.

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