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OLD AGE DEPRESSION AND ITS TREATMENT

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SUMMARY

The Numbers of elderly people are gradually increasing in our society, and mood disorders are progressively increasing among older people. Old age depression may also occur after life events: the death of the significant other, economical reasons, health problems (neurological and/or cardiovascular diseases, arthritis, cancer, nutritional deficiency) and can develop into a depressive state.

Old age depression is often mistreated, or undertreated, and also underdiagnosed, and this for several reasons: older people reduce their social relations, depression very often presents as a comorbidity with organic diseases (that cover and mask depressive symptoms); finally,the patient may believe that a depressive state is a normal course of life in older people.

Recovering from depression is really feasible both in young/adults and in old people, but in older people we can find a higher frequency of admission to hospital, or mortality or suicidality.

The depressive symptoms in old age depression is similar to those in adults, however the following aspects require special care, in order to ensure a correct diagnosis despite the presence of comorbidities:

- the mood: in contrast with the young and adult, old people often do not complain about their low mood;

- the psychotic simptoms: hypocondriacal and psychotic, including hallucinatory symptoms are often present.

- the anxiety symptoms: these are often present together with neuro-sensory symptoms;

- the somatic symptoms: the comorbidity with organic diseases can mask and overlap the depressive state;

- reduction of congnitive functioning: in these cases, which are quite frequent, it is essential to make a differential diagnosis from "pseudodementia" and "dementia".

In conclusion, several factors contribute to the onset of depression in old age, so that we can assert that it is a really a multifactorial disease.

Key words: *late-onset depression - anxiety simptoms – pseudodementia - dementia*

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Introduction

Many clinical studies have demonstrated the increase of the prevalence of depression of late onset in the elderly population. Quantitative criteria distinguish this pathology from so called ‘normality’; these include the intensity of symptoms, their duration, and their impact on social functioning and autonomy (Domenico Cucinotta). The first problem to consider in this age group is that of achieving an early and precise diagnosis. Depression in the elderly differs from that in young adults because of the frequency of somatic preoccupations, especially symptoms of pain, easy tiredness, memory difficulties, agitation, frequent insomnia, agitation, frequent insomnia, and frequent suicidal (Katona & Livingston 1997). Furthermore, the presence of co-morbidity, with consequent poly-therapies, and symptoms on intellectual and cognitive deficits make diagnosis more difficult.

A dimentional diagnostic approach, based on evaloation of symptoms, is therefore more useful and effective in these patients than a catagorical approach, based on identifying discrete clinical syndromes (Wellens & Durrer 1974).

The second important issue to be dealt with is the choice of medication in the elderly. This issue is related to the complexity of psychopharmacology in the elderly because of the complex physiology in the elderlyand the complex depressive pathology in the elderly and the interactions with other pharmaceuticals which are being prescribed to deal with the somatic pathologies which are very frequently associated with this age group.

It is therefore inevitable that polytherapy increases the risk of pharmacological interactions which may be both pharmacodynamic and pharmacokinetic.

The SSRIs present a real clinical advantage because of their tolerability, which is clearly much more favourable than the tricyclics and other antidepressants (AD. Menting et al. 1996). Antidepressants are also useful in the elderly in the frequent cases where there is a mixed smmptomatology of both anxiety and depression in which the mood disorder is considered the primary condition. On the other hand, in anxiety disorders when there is only a secondary lowering of mood, the use of a benzodiazepine in monotherapy enables the maintenance of the most beneficial risk-benefit ratio in the elderly patient as compared to other classes of pharmacotherapeutic agents (Roose et al. 1987).

Clinical experience

The clinical experience which I wish to report is an observational study which was carried out within a territorial psychiatric service. It involved 19 patients with a diagnosis of ‘Agitated Depression’ of late onset, which had begun in old age. These patients were observed over the period 2008-2010. Of these

patients,14 were female and 5 were male. The study also includes 23 patients who were hospitalised over the years 2008-2010, of whom 18 were female and 5 were male. The diagnoses of these patients was 'Depressive Syndrome with Behavioural Problems' and comorbidity with 'Vascular Dementia' in 12 cases and 'senile dementia' with comorbidity of 'Major Depression' in 11 cases.

Findings

The administration of tests in these patients was very difficult because of the patients' lack of co-operation. The collection of information was achieved through the very helpful support of the relatives, who were most helpful when taking the history (anamnesis).

The medications used were: SSRIs ed SNRIs, used in conjunction with benzodiazepines with a short half-life; the medications used were: Triazolam (0,125 mg), Bromazepam (1,5-3 mg), Alprazolam (0,25-50 mg). Other medications used were Quetiapine and Sodium Valproate. Using these medications, we observed that over 8-10 weeks there was an improvement in mood, in symptoms of agitation and in somatic symptoms. Resistant cases of insomnia, and agitation and other behavioural disorders and thought disorder in the acute phase was treated with Quetiapine, at a dose of 100mg at night. The patients careful monitoring of their cardiovascular system, their metabolic function, their renal, hepatic and haematological functioning, and their gastrointestinal and endocrine function. The patients experienced a significant subjective improvement in their quality of life, with a reengagement in their social life and their relationships and great relief to their families. Over six months there were no changes in any parameters of their vital functions. Treatment of Insomnia was continued by gradual tailing off of the Quetiapine and substitution with Trazodone in association with a short half life benzodiazepine in the evening.The utility of Quetiapine in patients with anxiety states or agitated depression associated with affective disturbances such as anxious and agitated depression has recently be confirmed in a study of patients who were being treated with SSRIs (Adson & Kushner 2002).

Clinically, patients affected by depression who also suffer from dementia teng to demonstrate a greater propensity for self pity, feeling of abandonment and anhedonia, with psychomotor agitation and continuous shouting, particularly at night, and less neuro-vegitative signs than elderly depressed patients who do not have dementia.

The SSRIs have been our medication of first choice because they do not damage cognitive function, they have little anticholinergic action, they have minimal antihistaminergic and alpha-adrenergic effects, and hence the risk of hypotention and falls is low in comparison to the tricyclic anti-depressants. Unwanted effects, in particular anxiety and agitation are kept under control by using a benzodiazepine with short half-life.Very frequently the use of Quetiapine alone or in association with Valproate has brought about an improvement of symptoms of anxiety, aggressivity, insomnia and behavioural disorders and has enabled us to avoid the use of benzodiazepines with their side effects of tolerance and dependence. Pharmacological interventions have been integrated with rehabilitative activities, creative therapies, psychotherapies, musico-therapy, and group activities. Outcomes have included an initial improvement followed by a long phase of stability with marked improvement in the quality of life.

Conclusion

In conclusion, many factors contribute to the development of depression and anxiety disorders in the elderly; we can in fact afferm that depression at this age is an illness which is multifactorial and multidimentional but it can also be affermed that clinical practice shows that depression is an illness from which one can recover and that our therapeutic instruments have now become exremely effective.Clearly there is much more to do and discover from a scientific point of view, but the multidimentional and multifactorial nature of the problem requires the involvment of everyone, at all levels and all competencies in order to improve the quality of life of human beings to whom science has 'gifted' with a longer lease of life.

References

1. *AD. Menting A, Honig A, Verhey FRJ, Vet HCW, Rozendaal N, van Praag HM. SSRI's in the treatment of depression in the elderly: a meta-analysis. Int Clin Psychoparmacol 1996; 11: 165-176.*
2. *Adson DE.,Kushner MG, Schulz SC: Quetiapine as an adjunctive therapy for persistent anxiety in those patients receiving treatment with an SSRi: an open label pilot study.Biological Psychiatry, 2002, 51, 180S.*
3. *Geragogia.net Comorbilità e depressione nell'anziano-Domenico Cucinotta.*
4. *Katona & Livingston, 1997.*
5. *Roose SP, Glassman AH, Giardina EV, et al. Tricyclic antidepressants in depressed patients with cardiac conduction disease. Arch Gen Psychiatry 1987; 44: 273-275.*
6. *Wellens HJ, Durrer D. Wolf-Parkinson-White syndrome and atrial fibrillation: relation between refractory period of accessory pathway and ventricular rate during atrial fibrillation. Am J Cardiol 1974; 34: 777-782.*

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