

RECOGNISING AND TREATING DEPRESSION IN THE ELDERLY

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SUMMARY

Introduction: Depression is a major contributor to healthcare costs and is projected to be the leading cause of disease burden in middle and higher income countries by the year 2030. Depression in later life is associated with disability, increased mortality, and poorer outcomes from physical illness. Its prevalence remains high throughout lifetime, with almost 14% of older adults living in the community estimated to have clinically relevant symptoms of depression worldwide.

Diagnosis: Recognizing depression in the elderly is not always easy. Medical illnesses are a common trigger for depression.

Treatment: Most depressed people welcome care, concern and support, but they may be frightened and may resist help. The treatment of depression demands patience and perseverance for the patient and physician. Sometimes several different treatments must be tried before full recovery. Each person has individual biological and psychological characteristics that require individualized care.

Prognosis: The prognosis for recovery is equal in young and old patients, although remission may take longer to achieve in older patients.

Further Care: Depression is a highly treatable medical condition and is not a normal part of growing older. Therefore, it is crucial to understand and recognize the symptoms of the illness in the primary care.

Key words: depression - elderly

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INTRODUCTION

Depression is one of the major contributors to healthcare budget and is projected to be the leading cost burden in Western countries in coming years. Depression in later life, traditionally defined as age older than 65, is associated with disability, increased mortality, and poorer outcomes from physical illness. The condition often is under-diagnosed and hence not properly treated, particularly in the primary care settings (Depression in older adults 2011).

According to World Alzheimer's report 2014, the prevalence of depression remains high throughout lifetime, with almost 14% of older adults living in the community estimated to have clinically relevant symptoms of depression. Major depressive disorder was ranked as the 11th leading contributor to the global burden of disease (GBD), but with some relevant geographical variations. For instance, it was ranked as high as third or fourth in Latin America, North Africa and the Middle East, Western Europe and Australasia.

As per UK national records, in 2011, within UK, there were 12.7 suicides per 100,000 population in males aged 60 to 74, and this rate has not changed significantly since 2001. This is relatively low compared with males aged 30 to 59. The suicide rate in older men (those aged 75 and over) has shown the opposite trend to middle aged men, as the rate declined significantly between 2004 and 2011 (Office for National Statistics).

ETIOLOGY

In many cases, there are no identifiable causes of depression. The risk factor for developing elderly de-

pression can be categorised as biological, psychological and social factors. Biological includes multiple acute and chronic physical health causes, pain, cardiovascular, dementia and comorbidities. Psychological includes retirement, loss of purpose, bereavement, guilt and being widowed. Social causes are lack of social role, social isolation and loss of occupation.

DIAGNOSIS

Recognizing depression in the elderly is not always easy. It often is difficult for the depressed elderly to describe how he or she is feeling. A proper detailed history, collateral information, and detailed mental state examination is vital to establish the diagnosis.

It is vital that a full physical examination, blood tests (including full blood count, Liver function tests, Urea/Electrolytes, Thyroid function tests, Vitamin B12, Folate levels), Urine analysis, and ECG are carried out to rule out any physical health issues with elderly presenting as depressed. Certain scales are commonly used to confirm the presence of depression and response to treatment.

The severity is often assessed by DSM-IV and ICD-10 criteria. DSM-IV and ICD-10, have virtually the same diagnostic features for a 'clinically important' severity of depression (termed a major depressive episode in DSM-IV or a depressive episode in ICD-10). Nevertheless their thresholds differ, with DSM-IV requiring a minimum of five out of nine symptoms (which must include depressed mood and/or anhedonia) and ICD-10 requiring four out of ten symptoms (including at least two of depressed mood, anhedonia and loss of energy. The others are reduced concentration and attention, reduced self-esteem and self-confidence,

ideas of guilt and unworthiness, bleak and pessimistic views of the future, ideas or acts of self-harm or suicide, disturbed sleep and diminished appetite.). This may mean that more people may be identified as depressed using ICD–10 criteria compared with DSM–IV or at least that somewhat different populations are identified related to the need for only one of two key symptoms for DSM–IV but two out of three for ICD–10.

Elderly depression can present differently. Agitated depression is more common. The biological symptoms may not manifest that often.

The most common symptoms of late-life depression include persistent low mood (lasting two weeks or more), low energy, excessive worries about finances and health problems, frequent tearfulness, feeling worthless or helpless, weight changes, pacing and fidgeting, difficulty sleeping, difficulty concentrating, physical symptoms such as pain or gastrointestinal problems.

One important sign of depression is when people withdraw from their regular social activities. Rather than explaining their symptoms as a medical illness often depressed persons will give different explanations (Geriatric Mental Health Foundation).

The cognitive and functional impairment and anxiety are more common in older than in younger adults with depression.

In the older population, medical illnesses are a common trigger for depression, and often depression will worsen the symptoms of other illnesses. The illnesses that are common causes of late-life depression include cancer, Parkinson's disease, heart disease and stroke.

Medical illnesses may hide the symptoms of depression. When a depressed person is preoccupied with physical symptoms resulting from a stroke, gastrointestinal problems, heart disease, arthritis or any chronic physical condition, he or she may attribute the depressive symptoms to an existing physical illness, or may ignore the symptoms. As a result, he or she may not report the depressive symptoms to the doctor.

SCALES

The Geriatric Depression Scale has been the best validated among the elderly; however, it may not be useful in the moderately to severely cognitively impaired elderly, and there has been little research in its ability to detect symptom changes over time in the context of clinical trials. The scale was designed as a self-administered test, although it has been used in observer-administered formats as well.

The HAM-D was developed as a measure of treatment outcome rather than a screening or diagnostic tool for depression. It is commonly used as a screening scale, particularly in the context of clinical trials to try to identify participants with depressive disorders. The HAM-D is a 21-item rating scaled used to systematize clinical observations of features related to depression. The SDS was initially developed as a self-rating scale. It

has been used widely in epidemiological studies and consists of 20 items.

The MADRS is particularly sensitive to measuring change in symptoms with treatment over time. The MADRS is an observer-rated scale that is based on a clinical interview that moves from broad questions to more detailed ones. There are 10 questions, but each question has 6 possible ratings and covers core symptoms of depression.

The Cornell Scale for Depression in Dementia (CSDD) is suitable for patients with dementia.

DEPRESSION AND DEMENTIA

World Alzheimer Report 2014 states the latest published studies seem consistent with earlier work, and accordingly strengthen the evidence that depression may increase dementia risk. While the analysis clarifies the strength of the association between depression and the subsequent onset of dementia, it still does not distinguish clearly between the two most plausible explanations for this association – that is, whether depression is a prodrome of dementia, or an independent causal risk factor.

Differentiating Depression, Delirium, and Dementia

It is very important to distinguish depression from delirium and dementia as they all can have similar presentation. Generally speaking, an acute behavioural or mood change is suggestive of delirium. Once medical contributors have been ruled out, depression, characterized by a more pervasive or chronic low-mood state with or without cognitive impairment should be considered. Patients with dementia are less likely to self-report their cognitive problems than are patients with depression (Table 1).

TREATMENT

Many elderly depressed patients welcome the support, but they may resist help. The first step is to make sure he or she gets a complete physical check-up, as the depression may be a side effect of a medication or due to pre-existing medical condition or. If the depressed older adult is confused or withdrawn, it is helpful for a family members and friends to accompany the person to the doctor and provide vital collateral information. After a thorough evaluation, GP (General Practitioner) will determine the treatment best suited for a person's depression. The treatment of depression needs to be individualised (by looking into individual biological and psychological characteristics of the patient) and needs perseverance for the patient and family.

There are differences in the way elderly depression is being treated.

Treatments include psychotherapy, medications and social support.

Table 1. Differentiating Depression, Delirium, and Dementia

	Depression	Delirium	Dementia
Onset	Weeks to months	Hours to days	Months to years
Mood	Low/apathetic	Fluctuates	Fluctuates
Course	Chronic; responds to treatment.	Acute; responds to treatment	Chronic, with deterioration over time
Self-Awareness	Likely to be concerned about memory impairment	May be aware of changes in cognition; fluctuates	Likely to hide or be unaware of cognitive deficits
Activities of Daily Living (ADLs)	May neglect basic self-care	May be intact or impaired	May be intact early, impaired as disease progresses
Instrumental Activities of Daily Living (IADLs)	May be intact or impaired	May be intact or impaired	May be intact early, impaired before ADLs as disease progresses

There is no ideal antidepressant as all have side effects. The antidepressant is started at low dose and increased slowly. Tricyclic antidepressants are generally avoided due to risks of postural hypotension. SSRIs are generally better tolerated than TCAs. They are, however associated with increase risk of gastrointestinal bleeding, particularly in the elderly and those with established history of bleed or treatment with NSAID, steroids or warfarin. The elderly are also prone to hyponatremia from SSRIs. The ultimate choice is determined by clinical severity, comorbid conditions and concomitant medications. Mirtazapine can be a preferred choice for insomnia in depression, and Venlafaxine for co-morbid anxiety (Maudsley).

A frequent reason some people do not respond is because they do not take the medication regularly. Missing doses or taking more than the prescribed amount can compromise with the effect of the medication. Similarly, stopping the medication too soon often results in a relapse of depression. In fact, most patients who stop taking their medication before four to six months after recovery will experience a relapse of depression.

Antidepressant medication should be taken for at least six months to a year. It takes four to 12 weeks to begin seeing results from antidepressant medication. If after this period of time the depression does not subside, the patient should consult the doctor. Antidepressant drugs are not habit-forming or addictive.

There is a role of Lithium and mood stabilising drugs like sodium valproate in severe depression and depression in bipolar affective disorder. The side effects particularly need to be taken in account in the elderly when these are considered.

Electroconvulsive therapy (ECT) is fast-acting and effective treatments for severe depression. It can be life saving. ECT often is the best choice for the person who has a life-threatening depression that is not responding to antidepressant medication or for the person who cannot tolerate the medication.

Psychotherapy can play an important role in the treatment of depression with, or without, medication. This type of treatment is most often used alone in mild to moderate depression. There are many forms of short-term therapy (e.g. CBT for 10-20 weeks) that have proven to be effective. It is important that the depressed

person find a therapist with whom he or she feels comfortable and who has experience with older patients.

A proper social care package with involvement of family and friends, day centre, social clubs, and enrolment to relevant courses can provide the framework to treat and prevent depression in the elderly.

Importantly, dysphoria or mild depressive symptoms that can substantially affect older patients' lives are common and psychosocial management may be effective to prevent further deterioration.

PROGNOSIS

Older adults with depression are at increased risk of suicide and are more likely than younger adults to complete suicide. Each attempt at suicide needs to be taken as a failed attempt. Comorbid history of substance misuse escalates the risks.

The prognosis for recovery is equal in young and old patients, although remission may take longer to achieve in older patients. In patients with psychotic depression, recovery rates are reduced by one half, and relapse and disability rates are twice those in patients with non-psychotic depression. Regular follow-ups and review of side effects are important when prescribing antidepressants because a high percentage of patients stop using medications within first few weeks.

FURTHER CARE

Depression is a treatable medical condition and is not a normal part of ageing. It is important to understand and recognize the symptoms of the illness. The GP (General Practitioner) may refer the older adult to secondary mental health services under an old age psychiatrist.

Some indications for secondary mental health services include presence of suicidal ideations, Bipolar affective disorder, presence of psychotic symptoms, unresponsiveness or intolerance to adequate trial of first line treatment, uncertainty over diagnosis, severe depression where patient is not eating or drinking. If the risks of suicide or self-harm are high and the patient is refusing treatment, then the use of Mental Health Act assessment to assess and treat him/her should be considered.

If the patient is showing reluctance, he or she may need assurance that an assessment is necessary to determine if treatment is needed to reduce their symptoms and sufferings and hence, improve their quality of life.

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