

Depression in Older Adults – Key Information

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Epidemiology

- Community: Incidence of Major Depression (MD) 1% overall F>M. Among ≥ 65 yo, 15% have depressive symptoms without full MD criteria. Case finding identifies 17-37% of older patients seen in primary care offices having significant depressive symptoms.
- Hospital: 11% Major Dep, 25% sig. symptoms LTC: 12% Major Dep, 30% sig symptoms. Recognized biases among patients and physicians suggest that there is persistent under-detection of depression in older adults.

Pathophysiology

- 2° CNS disease: CVA, Parkinson's, etc resulting in a single or accumulation of lesions of the prefrontal system and their modulating pathways. a.k.a. vascular depression. Left hemispheric and basal ganglia lesions are often associated with post-stroke depression.
- 2° Medical illness: SLE, chronic pain, Cushing's disease, hypothyroidism, hyperpara-thyroidism, folate deficiency, B12 deficiency, lymphoma, malnutrition, hepatitis, HIV, cancer

Evaluation:

- Single question: Do you feel you are depressed? Are you sad?
 - Interview: A useful diagnostic tool is the mnemonic *SIG E CAPS*. Guidelines suggests a patient must exhibit 5 out of 9 symptoms (eight symptoms from *SIG E CAPS plus depression itself**). Used often in non-geriatrics populations. The nine symptoms to watch for include:
 - S**—Sleep symptoms such as insomnia
 - C**--lack of Concentration.
 - I**—lack of Interest.
 - A**--lack of Appetite.
 - G**—feelings of Guilt.
 - P**--Psychomotor changes.
 - E**—lack of Energy.
 - S**--thoughts of Suicide.
- * A profoundly *depressed mood* that has been present for 2 weeks or more and permeates daily life.
- Questionnaire instruments: Geriatric Depression Scale, Cornell Depression, Ham D, CES-D. All validated. GDS used in some clinical settings. The GDS elicits the social withdrawal, somatic symptoms, and irritability that are more common than sadness in older patients
 - Suicidal assessment: Ask "Are you thinking about killing yourself?" And "Do you have a plan?" Studies have demonstrated that asking does not precipitate suicide or instill ideas that were not pre-existing.

Management (Three phases: Acute, Continuation, Maintenance and Two Approaches):

Psychological therapy:

Pharmacological

- *Interpersonal*: short focused on

four factors: grief, roles transformation, role disputes, and interpersonal deficits

- *Cognitive-Behavioral:* Techniques based on learning theory to reduce pathological ideas and behaviors associated with depression

- *Tricyclics.* Nortriptyline and desipramine are preferred agents with lower anticholinergic properties than other TCAs. Avoid TCAs in pts with BPH, glaucoma and history of nonadherence with treatment. In patients with pre-existing LBBB or RBBB, 10% may develop 2nd degree heart block.
- *SSRI's.* Less side effects (agitation, anorexia, & hyponatremia). Inhibits the P-450 pathway, so drug-interactions (digoxin & wafarin) are possible. Sertraline, paroxetine and fluoxetine are preferred agents

Atypicals

- Bupropion: well tolerated, may exacerbate existing hypertension.
- Venlafaxine: well tolerated. Nausea common
- Trazodone: reduces anxiety, but limited by hypotension.

References:

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