



DEPRESSION IN THE ELDERLY

CCSMH NATIONAL GUIDELINES- INFORMED INTERACTIVE CASE-BASED TUTORIAL

BASED ON TEACHING MODULE BY: DR. M. BOSMA

MODIFIED BY: DRS. KL. CASSIDY, C. MURPHY, M. BOSMA, C. HICKEY, & M. RITCHIE (RN)

INTRODUCTION



- Guidelines have been developed by the Canadian Coalition for Seniors Mental Health for the diagnosis and management of depression in the elderly
- Please refer to the handout you have been given to work through the following case example

CASE: REFERRAL



You have been asked to see Mrs. D. Pressed. She is a 78 year old woman whose husband died suddenly of a heart attack one month ago.

Her family doctor reports that since the death, she has appeared sad-looking, with low energy and trouble falling asleep. She has spoken of “feeling his presence” and hearing his voice call her name. She is accompanied by one of her daughters.

NICE DEPRESSION TOOL



You recently received a tool on depression assessment for older adults from NICE, or National Institute for the Care of the Elderly. After reviewing it, you decide to take it with you as it may be helpful in assessing Mrs. Pressed.



What else would you like to know?

1. Past psychiatric history
2. Past medical history
3. Medications and substances
4. Family history
5. Personal history

See CCSMH Depression Guidelines p 22



What do you think is going on?

1. Bereavement
2. Adjustment Disorder with depressed mood
3. Major Depression (?with psychotic features)

See CCSMH Depression Guidelines pp 23-26



What else would you like to know?

1. Estimate of severity: presence of catatonic or psychotic symptoms
2. Suicide risk assessment
3. Level of functioning or disability
4. Review DSM Criteria for depression

See CCSMH Depression Guidelines p 22

CRITERIA FOR DEPRESSION



SIGECAPS

Sleep disturbance

Loss of Interest

Inappropriate or excessive feelings of Guilt

Decreased Energy and increased fatigue

Diminished ability to think or Concentrate

Appetite change

Psychomotor agitation or retardation

Suicidal ideation

See CCSMH Depression Guidelines p 10, 19, and 22
NICE Brochure

CASE: HISTORY OF PRESENT ILLNESS



Mrs. Pressed reports the following information:

She feels “down” with poor sleep and energy, and hasn’t been enjoying usual activities like knitting or playing bridge with friends. Her appetite and concentration are normal, and she denies hopelessness or suicidal ideation.

She sometimes hears her husband’s voice calling her name, but knows he has died. She does not report symptoms of anxiety or psychosis. She has not been drinking alcohol. There is no impairment in cognition or functioning.

CASE: PAST PSYCHIATRIC HISTORY



She had a postpartum depression after the birth of her youngest child. She was treated successfully for two years with Amitriptyline 150 mg OD.

CASE: PAST MEDICAL HISTORY



- Hypertension
- Osteoarthritis
- 2003 – fracture right wrist from fall
- 1955 – appendectomy

CASE: MEDICATIONS



- Hydrochlorothiazide 25 mg OD
- Tylenol plain daily for arthritis pain
- Gravol 1-2x/week to help sleep

CASE: FAMILY HISTORY



Mrs. PRESSED is the middle child of a sibship of 7. Her mother had “bad nerves”. Two of her brothers had alcohol problems.

CASE: PERSONAL HISTORY



Mrs. Pressed was born in Windsor, NS. Her childhood was unremarkable. She finished Grade 10 and then worked as a waitress. She married at age 18 and moved to Halifax with her husband. She stayed at home to raise their three daughters, and then worked as the church secretary for 15 years until she retired at age 60. Her husband retired from his job at the bank at age 65. They moved into a seniors' apartment five years ago, and usually spend the winter in Florida. Only one of her daughters still lives in Halifax.



What is the most likely diagnosis?
Bereavement



What is bereavement?

- Reaction to the death/loss of a loved one
- May present with symptoms characteristic of major depression
- Typically seen as “normal”

See CCSMH Depression Guidelines pp 20-21



When is bereavement “abnormal”?

- If it is prolonged
 - DSM-IV suggests 2 months as cutoff
- If symptoms are severe
 - Certain abnormal characteristics suggest major depression

See CCSMH Depression Guidelines pp 20-21



What symptoms suggest “abnormal” grief?

- Guilt about things other than actions taken or not taken at the time of the death
- Thoughts of death other than feeling that he/she should have died with the deceased
- Intense worthlessness
- Marked psychomotor retardation
- Marked and prolonged functional impairment
- Hallucinatory experiences other than transiently hearing or seeing the deceased person

See CCSMH Depression Guidelines pp 20-21



What is your management plan?

You agree to see her in one month for a follow up appointment. You refer her to an upcoming grief group. You ask her daughter to “keep an eye on her”.

See CCSMH Depression Guidelines pp 20-21

CASE: MRS. PRESSED



Mrs. PRESSED does not attend her follow-up appointment. Two months later you see her in the emergency department after she has taken an overdose of Gravol. She has significantly deteriorated and rarely gets out of bed. She stopped eating and drinking one week ago and has lost 20 pounds. She rarely bathes, and doesn't clean the house. She is very quiet, but often speaks of having headaches. She believes this is from "brain cancer", and that she is dying. She wishes she had died from the overdose.

CASE: MENTAL STATUS EXAMINATION



The previous information is confirmed by **MSE including assessment for cognitive function.**

Mrs. Pressed does not appear to have insight into her condition. On MMSE she scores 18/30, often answering “I don’t know”.

See CCSMH Depression Guidelines pp 10 and 22



What is your diagnosis?

Major depression,

Severe,

With psychotic features

CASE: MRS. PRESSED



Mrs. Pressed's daughter is shocked that her mother attempted suicide. She didn't think that "old people killed themselves".



Is suicide common in the elderly?

- Older men
 - 5x greater in white men >65
- 60% of completers are men
 - Hanging and firearms most common
- 75% of attempters are women
 - Drug overdose, hanging, cutting most common

See CCSMH Suicide Guidelines p 14

See CCSMH Depression Guidelines p 21



Screening for Suicide in the Elderly

In those with risk factors assess for:

- Suicidal ideation and death ideation
- Presence of suicidal intent
- Presence of a suicide plan
- Review current or past suicidal behaviour
- Be vigilant: ask about it regularly, get collateral
- Consider hospitalization for severe suicidal ideation or plan

See CCSMH Suicide Guidelines p 15



What can we do?

- Patients with suicidal thoughts are often suffering an unrecognized 1st episode of depression
- **Depression is treatable!**
- Most communicate suicidal thoughts first
- 75% see GP in month before
 - For general medical or somatic complaints



What are non-modifiable risk factors of suicide in the elderly?

- Old age
- Male gender
- Caucasian
- Widowed/ Divorced
- Previous attempt
- Losses
- Personality factors: rigid, non-adaptive

See CCSMH Suicide Guidelines pp 16-17

See CCSMH Depression Guidelines p 21

See NICE Brochure



What are some potentially modifiable risk factors of suicide in the elderly?

- Medical illness: present or perceived, including chronic painful conditions
- Social isolation
- Substance abuse/misuse
- Presence and severity of depression
- Presence of hopelessness
- Access to means (especially firearms)

See CCSMH Suicide Guidelines pp 16-17
See CCSMH Depression Guidelines p 21
See NICE Brochure



What are protective factors for suicide in the elderly?

- Sense of meaning and purpose
- Enhanced social support and interpersonal activities
- Good physical health

See CCSMH Suicide Guidelines p 17



What is your management plan and why?

Admission to acute care

Medical investigations

Treatment

CASE: MEDICAL INVESTIGATIONS



What test will you order?

1. CBC
2. Electrolytes
3. BUN/creatinine
4. ALT/AST/GGT
5. Glucose
6. TSH
7. B12/Folate
8. Urinalysis
9. CT Head (**WHY?**)

See CCSMH Depression Guidelines p 10



Test Results

1. Na 146
 2. BUN 10.5
- } dehydration
3. CT Head – Age-associated atrophy
- **Other results normal**
 - **What do Na and BUN results suggest?**

CASE: MRS. PRESSED



Mrs. PRESSED is admitted to an acute care ward for treatment of psychotic depression. You meet with her daughter to discuss treatment options. Before discussing treatment, her daughter requests education on depression in the elderly. She asks, “Isn’t it normal to be sad when you’re old? Why does she need treatment?”



Is depression a normal response to the aging process?

NO

How common is depression in the elderly compared to a younger cohort?

See CCSMH Depression Guidelines p 16



Prevalence over 65

- 1.4% ♀
- 0.4% ♂
- **1% overall**
- 2% dysthymia
- 4% adjustment disorder with depressed mood
- 15% depressive symptoms
- Higher in institutional setting: Up to 25-40% in a general hospital setting and in long term care

See CCSMH Depression Guidelines p 16

Serby et al 2003

Konstantinos et al 2003



Depression is under-reported: WHY?

- Communication issues (eg. hearing impairment)
- Presence of dementia
 - Symptom overlap
- Stigma of aging
 - Depression is “normal”
- Symptoms “masked” by co-morbid illness
- Cohort effect
 - Older persons less likely to report depression

THEREFORE YOU MUST SCREEN IN THOSE AT HIGHER RISK!

See CCSMH Depression Guidelines p 16



What are risk factors for depression in the elderly?

- Recently bereaved
- Female gender
- Single/widowed (recently)
- Stressful life events (eg. prolonged hospitalization, recent move to nursing home)
- Social isolation
- Persistent complaints of memory difficulties, diagnosis of dementia
- Chronic disabling illness or recent major physical illness (eg. Parkinson's disease, stroke)
- Chronic sleep problems or anxiety

See CCSMH Depression Guidelines pp 9 and 22



Does depression look different in the elderly?

- “Depressed mood” may be less prominent
- More anxiety
- More likely to express somatic complaints
 - 65% have hypochondriacal symptoms
- Less likely to report guilt feelings
- Cognitive impairment more common
- Psychosis more common
 - Typical delusions – more common
 - Somatic, persecution, nihilism, poverty

See CCSMH Depression Guidelines p 19



Late-onset depression may differ from early onset depression:

- More likely to have
 - Cognitive impairment
 - Cerebral atrophy
 - Deep white matter changes
 - Medical comorbidity
- Higher mortality
- Less likely to have family history of depression

See CCSMH Depression Guidelines, Special Populations p 45



“Vascular Depression” Subtype

- Marked apathy
- Lack of insight into depression
- Less depressed ideation
- Executive dysfunction
- Cortical and subcortical white matter changes
- Treatment resistance (controversial)

See CCSMH Depression Guidelines, Special Populations p 45



What are your treatment options?

Medication

ECT

Psychotherapy

WHICH ONE WILL YOU CHOOSE?

See CCSMH Depression Guidelines p 24-26



Why choose ECT?

- Elderly are more sensitive to side effects of psychotropic medications
- Psychotic features are more common
- **Vulnerable to physical and functional complications**
 - Dehydration
 - Malnutrition
 - Sustained inactivity

See CCSMH Depression Guidelines p 26

ECT CONSIDERATIONS IN THE ELDERLY



- Average number of treatments is 6 – 12
- Cognitive deficits are not permanent
- Patients with co-morbid dementia or other neurological disorders are more likely to be confused

CASE: MRS. PRESSED



After 12 treatments with ECT Mrs. Pressed is free of depressive and psychotic symptoms.

What is the next step of her treatment?



What are the treatment options for this patient?

Antidepressant

Maintenance ECT

Psychotherapy

Combination

Which will you choose?

TRY TO AVOID THE USE OF BENZODIAZEPINES

See CCSMH Depression Guidelines pp 34 and 40



What are the classes of antidepressants?

Tricyclics (TCA's)

SSRI's

“Others”

How will you choose?

See CCSMH Depression Guidelines pp 33 and 34

NICE Brochure



Guidelines on choosing an antidepressant:

- 1) Previous response to treatment
- 2) Type of depression
- 3) Other medical problems
- 4) Other medications*
- 5) Potential for risk of overdose

*Caution: Wellbutrin (bupropion) could increase anxiety

See CCSMH Depression Guidelines p 34



Monitoring for Side Effects

- Drug – drug interactions are common
- S/E's are more likely to occur, even for SSRI's
- S/E's have more serious consequences- avoid anticholinergic medications
- Hip fractures are more frequent with **ALL** antidepressants

See CCSMH Depression Guidelines p 36



What are side effects of TCA's?

- Anticholinergic
- Orthostatic hypotension
- Sedation
- Cardiotoxicity

Which TCA's might you use in the elderly?

- Nortriptyline (least alpha-adrenergic blockade)
- Desipramine (least anticholinergic)

See CCSMH Depression Guidelines Table 5.1 p 33



Anticholinergic side effects of TCA's

- Dry mouth
- Urinary retention
- Constipation
- Blurred vision
- Confusion

See CCSMH Depression Guidelines Table 5.1 p 33, and p 34

ANTICHOLINERGIC SIDE-EFFECTS



- Hot as a hare (Hyperthermia)
- Dry as a bone (Dry mouth, urinary retention)
- Red as a beet (Flushed)
- Blind as bat (Blurred vision)
- Mad as a hatter (Delirium/confusion)



What are the SSRI's?

- Paroxetine (Paxil) - most anticholinergic, short half-life
- Sertraline (Zoloft)
- Citalopram (Celexa) and Escitalopram (Cipralex)
- Fluvoxamine (Luvox)
- **Avoid Fluoxetine (Prozac) in seniors**
 - long half-life

See CCSMH Depression Guidelines Table 5.1 p 33, and p 38



What are the SSRI's side effects?

- **H**eadache
- **A**gitation
- **A**norexia
- **N**ausea
- **D**iarrhea
- **S**exual dysfunction
- **S**leep loss (Insomnia)
- **H**yponatremia (SIADH)*
- **E**PSE*

*more common in the elderly

See CCSMH Depression Guidelines Table 5.1 p 33, and p 34



Side effects of “other” antidepressants:

- Venlafaxine
 - Elevated blood pressure
- Bupropion
 - Seizures
 - Anxiety
 - Least sexual dysfunction
- Mirtazapine
 - Sedation
 - Weight gain

See CCSMH Depression Guidelines Table 5.1 p 33



Guidelines for Starting Antidepressants:

“Start low, go slow”

- Start at half the dose of younger people
- Aim to reach an average dose at one month

See CCSMH Depression Guidelines p 36

CASE: MRS. PRESSED



You start Mrs. Pressed on Citalopram 5 mg, in one week increasing the dose to 10 mg. By one month she is taking 20 mg OD and starting to feel better. Her daughter calls 2 weeks later to say her mother seems very confused and disoriented. You suggest she sees the family doctor to check for hyponatremia, which is found on blood work.

Citalopram is reduced to 10 mg, the hyponatremia resolves, but her mood deteriorates on the lower dose. After 6 weeks with normal blood work, you suggest she increase the dose back to 20 mg, and you monitor electrolytes closely.

CASE: MRS. PRESSED



In 2 months she is feeling 70% better, but is still not enjoying her previous hobbies, such as knitting or playing bridge. She still misses her husband terribly. She is also worried about taking any more medication.

WHAT SHOULD YOU DO NOW?



Guidelines for Switching Antidepressants:

Change if:

- No improvement in symptoms after at least 4 weeks at maximum tolerated or recommended dose
- Insufficient improvement after 8 weeks at maximum tolerated or recommended dose

When recovery is incomplete after an adequate trial, consider:

- Further 4 weeks of treatment, with or without augmentation (meds or psychotherapy)
- Switching to another antidepressant
 - When switching, it is safe to reduce the first medication while starting the alternate (cross-over titration)
 - Consider specific interaction profiles

See CCSMH Depression Guidelines pp 36-37

CASE: MRS. PRESSED



Given Mrs. PRESSED's concern about increasing the dose of medication, you decide together to pursue a non-pharmacological augmentation treatment. She attends a grief group at the hospital day program for 10 weeks. When seen three months later, she is doing well.



PSYCHOTHERAPIES

- CBT
- IPT
- Brief Dynamic
- Supportive therapy

- **Instillation of hope is important**
 - **Protects against suicide**

See CCSMH Depression Guidelines pp 27-31

CASE: MRS. PRESSED



Mrs. PRESSED's daughter asks if there is a chance her mother may become depressed again.

What is the prognosis?

How long should treatment continue?



PROGNOSIS?

- Reasons to be optimistic
- Similar response rates to younger patients

See CCSMH Depression Guidelines p 34



Long-term Treatment Guidelines:

- After 1st episode continue to treat for at least a year
- Monitor for recurrence up to 2 years
- Medication discontinuation should be slow (over months)
- Patients with partial resolution of symptoms, more than 2 episodes, severe or difficult to treat depression, or treatment requiring ECT, should receive indefinite treatment
- Treatment response in nursing home patients should be evaluated monthly after initial improvement, and at quarterly care conferences and annual assessment once remission is achieved
- Consider tolerance of treatment versus risks of discontinuation

See CCSMH Depression Guidelines p 40

CONCLUSION



You continue to follow up with Mrs. Pressed for another 2 years and she does very well. With your expert skills (and some luck) she does not have a relapse. Hopefully your involvement in this case has helped you become more familiar with the Depression & Suicide National Guidelines of the CCSMH.

KEYPOINTS FOR SENIORS



- Depression is not normal in seniors
- Seniors are at higher risk for depression
 - Especially after bereavement
 - Seniors are more vulnerable
- Monitoring needs to be more aggressive so that seniors don't fall through the cracks
- Consider Anticholinergic reactions

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