



Treating Depression In the Older Adult

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Seventy-six year-old Mrs. M comes to your office for a routine visit for hypertension and arthritis. She appears much younger than her age. She is an avid golfer, volunteers at her church and cares for her two grandchildren during the week. She is on atenolol, calcium with vitamin D and occasional acetaminophen for pain. Her husband of 46 years died a year ago. When you ask her how she is doing, she says "fine." However, she admits she's lost about 10 lbs, hasn't golfed in a year, and no longer volunteers. She still enjoys watching her grandchildren and talks about them with pride, but seems to have lost the spark that made her so vibrant.

BACKGROUND

The prevalence of major depression in older adults is 1-2%. When including minor depression, the prevalence is higher. As expected, it is lower in community settings (8-15%), but doubles in long term care settings (30%).¹

Most cases are treated in the primary care physician's office. Although depression in older adults is as responsive to treatment as in younger patients, depression can present atypically, as with many other illnesses, and is more difficult to treat due to co-morbid illnesses, drug-drug interactions and adverse drug reactions.

The etiology of depression in late life is usually multi-factorial. Medical disorders can contribute to the development of depression (e.g., diabetes, dementia, cerebrovascular disease). Social factors play into the development as well, seemingly more so in men.¹ Lack of social support, loss of spouse, isolation, and loss of independence are common factors. Common precipitating factors include medical illness, financial stress, anniversary of a sad event, and death or major illness of a loved one.¹

Older adults are less apt to present with symptoms meeting criteria for major depression. They are more likely to present with sub-syndromal or minor depressive symptoms.² However, whether major or minor, the same treatment options can help patients. Recognition and treatment are important, since depression is often under recognized in the elderly population. It can often coexist with medical illness and affect functional status. Most importantly, suicide rates in the elderly population are higher than in any other age group. Untreated patients are at high risk for suicide, especially older men. Suicide attempts in older adults are more often successful than those in younger adults. It is absolutely critical to assess every patient in whom depression is suspected for suicidal ideation, organized plan, means, and prior attempts. An estimated 70% of patients who commit-

ted suicide visited primary care physicians within four weeks of the attempt.¹

Diagnosis is more difficult. Patients are less likely to report depressed mood than their younger counterparts, and are more likely to present with somatic complaints. Loss of interest and discontinuation of previously enjoyable activities are almost always present. Other common presenting complaints include cognitive difficulties, impaired concentration, anxiety, social withdrawal, and at times, paranoia and psychotic symptoms.

Medical illness masquerading as psychiatric illness must always be ruled out. Common conditions include thyroid disorders, Parkinson's disease, and dementia. However, these illnesses also predispose to depression, so they often co-exist. Assessment involves a thorough history and physical exam, laboratory evaluation, cognitive assessment and assessment of symptoms. A commonly used tool to screen for depression in the older adult is the Geriatric Depression Scale (see Resources). If this screening test is positive, then further testing and evaluation using the DSM-IV criteria are pursued.

Is Mrs. M depressed?

You discuss your suspicion that Mrs. M might be depressed. She is rather surprised, but admits to being less interested in her previously loved hobbies, and she does think about her husband a great deal, often with tearful spells. In addition, the anniversary of his death just passed a few weeks ago, and she has felt much worse since then. She describes poor appetite and difficulty falling asleep at night due to memories of him. In addition, she reports feeling much more troubled by her arthritis pain and a general feeling of malaise. She denies a prior history of similar symptoms, or of treatment for depression. You administer the Geriatric Depression Scale; out of 15 questions, she scores 9 positive, indicating likelihood of depression. A complete physical and laboratory evaluation reveals no evidence of medical illness. She asks you what you would recommend to help her.

TREATMENT

Treatment in the older adult begins with non-pharmacologic measures, mainly psychotherapy. It is effective in older adults, and provides a useful adjunct to medications and seems to have a lower relapse rate than pharmacotherapy alone. Referral to a therapist or counselor is appropriate, and can help while pharmacotherapy is being instituted. However, other interventions like increasing social activity, exercise, pet therapy, and art therapy also have been found to be helpful.

The course of depression in older adults is more likely to be prolonged and relapsing. Older adults are much less likely to be successfully weaned off medications after short periods of six months or a year.² Most experts recommend continuing therapy for up to two years before attempting a weaning trial, and some propose lifelong therapy. Asking about prior episodes of depression and successful treatment can be helpful. Older adults with a history of prior episodes of depression are less likely to be helped by non-pharmacologic measures alone.

When choosing an agent, the **selective serotonin reuptake inhibitors (SSRIs)** are first line. Citalopram and sertraline have the largest evidence base of effectiveness in older adults.² They are proven to be well tolerated and have the lowest frequency of drug-drug interactions among the SSRIs. However, other SSRIs, such as escitalopram, are also considered safe. The only SSRIs to be cautious about are paroxetine and fluoxetine. These have higher rates of drug-drug interactions, primarily by their inhibition of hepatic metabolism and thus accumulation of other medications. Additionally, paroxetine can have anticholinergic effects in some patients and can cause confusion. Fluoxetine can worsen insomnia in older adults; its longer half life is troublesome if adverse reactions or drug-drug interactions occur. In the older adult, slow titration of dose over several weeks is recommended to avoid adverse drug reactions. Dose increases should be made no more often than weekly for the first three to four weeks.² The most common side effect is gastrointestinal distress with nausea, vomiting and diarrhea. Other side effects include hyponatremia (from SIADH), sexual dysfunction and extrapyramidal effects. Response to medications can be slower in older adults; most experts advise continuing to monitor on an agent for up to 12 weeks before changing medication.

Other options include mirtazepine, a norepinephrine antagonist. This is a popular choice as adjunctive therapy for older adults with depression and weight/appetite loss.² In lower doses (7.5 mg daily or 15 mg daily), mirtazepine has side effects of increased appetite and somnolence. It can be helpful in older adults with dementia (either with or without depression) who have trouble sleeping and weight loss. As a single agent for depression, it must be used in higher doses to be effective, and at those doses the appetite and sleep effects diminish.

Tricyclic antidepressants may cause QT prolongation, and are therefore contraindicated in the presence of ischemic heart disease. These agents, however, have the largest body of evidence for efficacy in older patients, and the least sedating and least anticholinergic agents (nortriptyline and desipramine) are effective in older patients. Orthostatic hypotension can usually be avoided by starting with low doses and increasing slowly, but toxicity in the setting of overdose is a major concern. Venlafaxine is a dual agent, acting on both the serotonin and norepinephrine systems. In lower doses, it acts primarily as an SSRI, but in higher doses, it also inhibits norepinephrine reuptake. It is usually well tolerated, and is useful in patients with concomitant anxiety disorders. Hypertension can develop at the higher doses, and blood pressure should be monitored carefully with dose titration. This agent requires tapering when discontinuing to prevent a flu-like syndrome.

Other dual agents include bupropion (dopamine and norepinephrine) and duloxetine (serotonin and norepinephrine). Bupropion is the least likely to cause sexual side effects and is well tolerated. The major caution is its lowering of the seizure threshold, making it contraindicated in patients with a history of seizures or in patients with other risk factors for a lower seizure threshold. Duloxetine is considered useful in patients with chronic pain, especially of a neuropathic etiology.

Electroconvulsive therapy (ECT) is a consideration in older adults who fail to respond to medication therapy, who cannot tolerate or risk side effects of drugs, or who have very severe depression. It is the most effective treatment in older adults and is safe, although gains must be maintained with follow-up medication. The main contraindications include recent stroke, intracranial mass or elevated pressure, or active, severe cardiac disease. Response rates for ECT are as high as 70 to 90%. ECT should be considered in the older adult with a high risk for drug-drug interactions, failed medical therapy, or catatonic or psychotic features.

What should we recommend to Mrs. M?

You prescribe sertraline 25 mg daily for one week, followed by 50 mg daily, and ask her to return to the office in 3 weeks. You also spend time discussing other treatment options. In addition, as spring has arrived, you recommend she gradually increase her outdoor activities and physical activity. You ask her direct questions about suicidal thoughts or intent, which she very adamantly denies. She feels safe and hopeful after identifying the problem and having accepted a clearly defined treatment plan. You give her the office's social worker as a contact, and ask her to call at any time should she feel worse.

Mrs. M returns for her 3-week follow up visit; she feels better, and reports adherence to medication and behavioral recommendations. She still thinks about her husband often, and has tearful moments, but is more positive about her overall outlook. The daily exercise has helped her sleep better at night and eased her arthritis pain, and the increased physical activity has increased her appetite. She has gained back 4 pounds. She tolerated the sertraline with only mild nausea that stopped after the first few days. She plans on getting back to her golf games once the weather is warmer, is going to continue the sertraline and has started seeing a psychotherapist every few weeks. She thanks you for recognizing her symptoms and helping her regain her positive outlook and enjoyment of life.

Indications for Referral

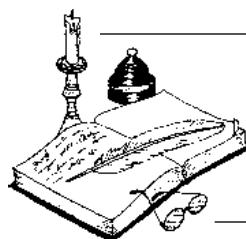
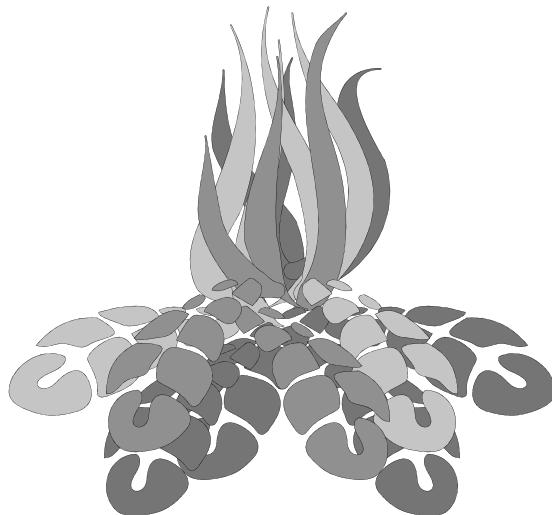
If Mrs. M had not improved, or showed increased functional loss, worsened weight loss, or suicidal ideation, then escalation in care would be necessary. Potential resources include psychiatry, geriatric psychiatry, and inpatient psychiatric care. Referral to psychiatry or geriatric psychiatry should be implemented for patients who are high risk at presentation, have failed treatment trials, or are candidates for ECT.

RESOURCES

Geriatric Depression Scale available on-line at: <http://www.stanford.edu/~yesavage/GDS.english.short.score.html>

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Physician's Lexicon

Those Viable Words

Verdi's opera, La Traviata, was first performed at La Fenice in Venice on March 6, 1853. The title, La Traviata, literally translated as 'The Woman Led Astray', contains the Latin root, *via*, meaning 'the way'. An astonishing number of English words incorporate this root.

Consider the word, trivial, first meaning 'that which belongs at the junction of three roads'; but colloquially, something that is commonplace, vulgar – or, in a word, trivial. The word appears in its original form, *trivium*, meaning the three paths or ways, and is the name given to the entering curriculum in medieval universities. The three courses, or scholarly paths, were grammar, logic [or dialectic] and rhetoric. This was followed by the *quadrivium*, the four ways, embracing arithmetic, geometry, music and astronomy. Only then was the university

student prepared to engage in the study of medicine. The pathway to the contemporary study of medicine in the West is equally formidable, but in different ways.

The word, *via*, appears in words such as deviate [to depart from the path]; obviate [to make unnecessary, literally to keep from the path]; obvious [clear, manifest, literally, lying in the way]; and previous [literally, coming before, leading the way].

The root, *via*, is clearly apparent in words such as viaduct [a bridge carrying a path], viatic [pertaining to a road], viameter [an instrument for measuring distances on roads] and viaticum [monies set aside for travel.] The word, voyage is derived from the Latin, *viaticus* [pertaining to the road] but has been altered in spelling in its passage through Vulgate Latin and later, French. The English

words, envoy and convey, are also derived from the Latin, *via*.

English words such as violet, viola and violin are similarly descended from the Latin, *vitulare*, meaning an aliveness, an exultation. Violate, on the other hand, stems from the Latin, *violare*, meaning related to strength or force.

Medically oriented words such as viable or viability, capable of living or growing and a looser, more current meaning of feasibility, are based rather, on the Latin word, *vita*, meaning life. The word, vial, a small container usually of glass to hold some liquid, and sometimes spelled phial, is from an Old English word, *fiale*.

Finally, the word, viand, an article of food and by inference a culinary delicacy, comes from the Latin, *vivere*, meaning to live.

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