Depression in the Older Adults

Summary

Major depressive disorder (MDD) is the leading cause of disability according to the World Health Organization.

Common clinical conditions and previous research has shown that the worldwide prevalence is approximately 15% in community-dwelling individuals.

Significant depressive symptoms are present in nearly 15% of older adults living in the community, especially in those older adults who have chronic illness and pain.

Depression in later life is associated with greater risk of suicide, ischemic heart disease, heart failure, osteoporosis and poor cognitive and social functioning.

Physiologically it is associated with changes such as hypercortisolemia, visceral adiposity, and higher risk of hypertension and diabetes mellitus.

Key Points

Depression in the older adult

- amplifies disability/pain
- lessens quality of life and increases mortality
- results in increasing office and emergency department visits
- results in more prescription and OTC medication use
- leads to increased alcohol and drug use
- increases length of hospital stay

Eighty percent (80%) of mental health treatment for depressed older adults is delivered in the primary care setting.

It is estimated that 10-15 percent of older adults with intact cognitive functioning have depression. Health care providers should screen all geriatric patients for depression.

Greater than 50% of nursing home residents are depressed.

_Dementia syndrome of depression_ is defined as a cognitive impairment present in an elderly patient with major depression that may have cognitive deficits that develop after the onset of mood symptom.
Risk Factors for depression in older adults

- Female sex
- Previous depressive episode
- Inadequate emotional support
- Impaired memory
- Living alone
- Mild cognitive impairment
- Somatoform disorders

Assessment

Atypical presentation of depression in older adults may include:

- More sleep disturbance,
- Fatigue
- Psychomotor retardation
- Memory impairment
- Slower cognitive perception

Assessment of the older adult suspected of being depressed includes:

- A complete and thorough medical and psychiatric history
  - Presence of suicidal ideation and plan (lethality, intent, and means).
  - Acute suicidal ideation requires urgent psychiatric referral. Unlike the younger population, elderly attempt suicide less often, but are usually more successful.
- Review of system - ask specifically about hopelessness, insomnia, and psychotic symptoms.
- Conduct a complete medication review (prescribed, OTC, and homeopathic) evaluating potential side effects that may cause depression.
  - Assess potential drug-drug interactions with substances such as alcohol, opiates, benzodiazepines, and other CNS depressants.
- Utilize a standardized, reliable and valid geriatric screening tool such as the Geriatric Depression Scale. This scale has a 5, 15 or 30 question scale available for clinicians. See the 5 question scale below:
Use the Geriatric Depression Scale (GDS) to screen for depression (Hoyt et al., 1999):

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you basically satisfied with your life?</td>
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<tr>
<td>Do you often get bored?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Do you often feel helpless?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do you prefer to stay at home, rather than going out and doing new things?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Do you feel pretty worthless the way you are now?</td>
<td>Yes</td>
<td>No</td>
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</tbody>
</table>

Two out of five depressive responses ("no" to question 1 or "yes" to questions 2 through 5) suggests the diagnosis of depression.

**Interventions**

- An interprofessional team approach is important to provide support to your patient and their family.
  - Include family members wherever possible in diagnosis and treatment.
  - Utilize Chaplain Services, Social Work, Psychiatry and Psychology to assist with non-pharmacologic services.
- Psychotherapy and pharmacotherapy may be used as monotherapy or in combination.
  - Elder adults respond well to psychotherapy, although pharmacotherapy or a combination of pharmacotherapy and psychotherapy is recommended for moderate to severe depression.
  - For depressed patients with chronic and or life-threatening illness, use a combination of supportive psychotherapy, cognitive approaches, behavioral techniques, and antidepressant medication.
  - Medicare covers therapy services.
- Exercise may be effective in the treatment of minor or major depression in the elderly.
  - Patients with major depression, however, may be difficult to engage in an exercise program and would likely benefit from concomitant pharmacotherapy or psychotherapy.
- Important pharmacologic treatment considerations in the elderly are:
  - Initial medication dosage should be low and then adjusted for the elder adult; typically starting half the usual starting dose for patients (however, full therapeutic doses are often required to achieve the desired responses).
  - Typically take two to four weeks to show efficacy; in older patients a full antidepressant response may not occur until 6 to 8 weeks of therapy.
  - Life-long treatment may be necessary to prevent recurrence.
  - All patients should be followed up within two weeks of initiating medication to discuss tolerance, assess response, monitor for adverse events and adjust dose as indicated.
  - First line: SSRIs are first-line antidepressants because of safety and tolerability.
  - Second line: venlafaxine, duloxetine, mirtazapine, or bupropion.
- Third line: Consider augmentation of first-or second line antidepressants with aripiprazole or quetiapine, or SSRI with buspirone or bupropion. Alternatively, consider switching to a different classification of medication.
- Older adults should be assessed for relapse.

The table below provides basic information regarding medications for the treatment of depression:

<table>
<thead>
<tr>
<th>Class Medication</th>
<th>Initial Dosage</th>
<th>Usual Dosage</th>
<th>Formulation</th>
<th>Comments</th>
</tr>
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<tbody>
<tr>
<td><strong>SSRIs</strong></td>
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<tr>
<td>Citalopram</td>
<td>10-20 mg po qam</td>
<td>20 mg/day</td>
<td>T: 20,40,60</td>
<td>Class Adverse Events: EPS, hyponatremia, increased risk of upper GI bleeding, suicide (early in treatment), lower BMD and fragility fractures, risk of toxicity if methylene bile or linezolid co administration. Avoid if history of falls or fractures; caution if history of SIADH. 20 mg/day is max dose in age &gt;60; concerns about dose-dependent QT interval prolongation that can lead to arrhythmias.</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>10 mg po qam</td>
<td>10 mg/day</td>
<td>T: 10,20</td>
<td>10 mg/day is max dose in age &gt;60.</td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>5 mg po qam</td>
<td>5-60 mg/day</td>
<td>T: 10 C: 10,20, 40; C SR90 S: 20mg/5ml</td>
<td>Long half-lives of parent and active metabolite; may cause more insomnia than other SSRI</td>
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<tr>
<td>Paroxetine</td>
<td>5 mg po qam</td>
<td>10-40 mg/day</td>
<td>T: 10,20,30,40</td>
<td>Helpful with anxiety symptoms; increased risk for withdrawal symptoms (dizziness); anticholinergic events</td>
</tr>
<tr>
<td>(Paxil)</td>
<td>CR: 12.5mg po qam</td>
<td>CR: 12.5-37.5 mg/day</td>
<td>CR: T: ER 12.5, 25, 37.5 CR: S: 10mg/ml CR: Increase by 12.5 mg no faster than once/week</td>
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<tr>
<td><strong>SNRIs</strong></td>
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<td></td>
<td></td>
<td>Caution with history SIADH. Most common adverse events: nausea, dry mouth, constipation, diarrhea, urinary hesitance;</td>
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<tr>
<td>Drug</td>
<td>Dosage</td>
<td>Dosing</td>
<td>Notes</td>
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<tr>
<td>Duloxetine (Cymbalta)</td>
<td>20 mg po qam, then 20 mg po q12h</td>
<td>40-60 mg q24h or 30 mg q12h</td>
<td>C: 20,30,60 Reduce dosage if CrCl 30-60 ml/min; contraindicated if CrCl &lt; 30 ml/min Useful in patients with depression and neuropathic pain</td>
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<tr>
<td>Venlafaxine (Effexor)</td>
<td>25-50 mg po q12h</td>
<td>75-225 mg/day in divided doses</td>
<td>T: 25, 37.5, 50, 75, 100 XR: 75-225 mg/day XR: 37.5, 75, 150 Low anticholinergic activity; minimal sedation and hypotension; may increase BP and QTC; may be useful when somatic pain present; EPS, withdrawal symptoms, hyponatremia</td>
<td></td>
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<tr>
<td>Desvenlafaxine (Pristiq)</td>
<td>60 mg po qam</td>
<td>50-400 mg/day</td>
<td>SR T: 50,100 Active metabolite of venlafaxine; adjust for CrCl &lt;30ml/min</td>
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<tr>
<td>TCAs</td>
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<td>Caution in the elderly due to significant arrhythmic side effects, anticholinergic effects causing urinary retention, orthostasis, and possible exacerbation of dementia.</td>
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<tr>
<td>Desipramine (Norpramin)</td>
<td>10-25 mg po qhs</td>
<td>50-150 mg/day</td>
<td>T: 10,25,50,75, 100, 125 Therapeutic serum level &gt;115 ng/ml</td>
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<tr>
<td>Nortriptyline</td>
<td>10-25 mg po qhs</td>
<td>75-150 mg/day</td>
<td>C: 10,25,50,75, 100,150 S: 10mg/5ml Therapeutic window 50-150 ng/ml</td>
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<tr>
<td>Additional Options</td>
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<td>Consider for SSRI, TCA nonresponders; safe in HR; may be stimulating; can lower seizure threshold.</td>
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<tr>
<td>Bupropirion (Wellbutrin)</td>
<td>37.5-50 mg po q12h</td>
<td>75-50 mg q12h</td>
<td>T: 75,100</td>
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<tr>
<td>Wellbutrin SR (Zyban)</td>
<td>SR: 100 mg po q12h or q24h</td>
<td>100-150 mg q12h</td>
<td>T: 100,150,200</td>
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<tr>
<td>Wellbutrin XL</td>
<td>150 mg</td>
<td>300</td>
<td>T: 150,300</td>
<td></td>
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<tr>
<td>Drug Name</td>
<td>Dosage</td>
<td>Frequency</td>
<td>T:</td>
<td>ADJECNT</td>
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<td>Methylphenidate (Ritalin)</td>
<td>2.5-5 mg po q7am and q12pm</td>
<td>5-10 mg at 7am and 12p</td>
<td>5,10,20</td>
<td>Short term treatment of depression or apathy in physically ill older adults; avoid if insomnia; used as adjunct</td>
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<tr>
<td>Mirtazapine (Remeron)</td>
<td>15 mg po qhs</td>
<td>15-45 mg/day</td>
<td>15,30,45; ODT (SolTab available)</td>
<td>Useful for patients with insomnia, agitation, restlessness, or anorexia and weight loss; sedating</td>
</tr>
</tbody>
</table>

ECT may be effective for the older patient who is unable to tolerate medications or who is not responding to medications. ECT causes transient memory loss.

**References**


