



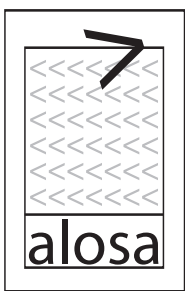
The pursuit of happiness... and the management of misery

Practical recommendations for the diagnosis and treatment of depression in the elderly

Depression in the elderly is one of the most common and challenging conditions facing the primary care physician. Symptoms of depression may be incorrectly attributed to “just getting old,” or may present with, or be masked by somatic complaints. Failing to make the correct diagnosis can mean losing an opportunity to make a significant improvement in a patient’s life, or even saving it. Identifying who does and does not need treatment can limit exposures to unnecessary medications, their side effects, and costs.

Accurate diagnosis and appropriate treatment of depression are essential

- Major depression is present in up to one in twenty older patients, with dramatically increased rates in those with other illnesses and functional limitations,¹ causing substantial disability.²
- Older people are 33% more likely to commit suicide than the general population.³
- Up to 75% of those who committed suicide had seen their health care providers within the month before their death.⁴



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Balanced data about medications



Figure 1. Major Depressive Episode (DSM-IV TR).

Either 1 or 2 of the following must be present:

- ✓ **depressed mood** most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful)
- ✓ **markedly diminished interest or pleasure** in all or almost all activities, most of the day, nearly every day (as indicated by either subjective account or observation made by others; also called “anhedonia”)

Plus other symptoms to make a total of 5:

- ✓ **significant weight gain or loss (when not dieting)**, more than 5% of body weight in a month, or decrease or increase in appetite nearly every day
- ✓ **insomnia or hypersomnia** nearly every day
- ✓ **psychomotor agitation or retardation** nearly every day, observable by others, not merely subjective feelings of restlessness or being slowed down
- ✓ **fatigue or loss of energy** nearly every day
- ✓ **feelings of worthlessness or excessive or inappropriate guilt**, may be delusional, occurring nearly every day (i.e., not merely self-reproach or guilt about being sick)
- ✓ **indecisiveness or diminished ability to think or concentrate** nearly every day (either by subjective account or as observed by others)
- ✓ **recurrent thoughts of death** (not just fear of dying), **recurrent suicidal ideation** even without a specific plan, **or a suicide attempt or a specific plan** for committing suicide

In addition, the symptoms must:

- ✓ **cause clinically significant distress or impairment** in social, occupational, or other important areas of functioning

Not be due to:

- ✓ the direct physiological effects of a substance (e.g., a drug of abuse, a medication)
- ✓ a general medical condition (e.g., hypothyroidism)
- ✓ bereavement (after the loss of a loved one, major depression may be present if symptoms persist for longer than 2 months, or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation)

Derived from Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV).⁵



Making the diagnosis

In a busy practice, it can seem daunting to identify and diagnose depression correctly, especially in a patient with multiple chronic illnesses or life-crises such as bereavement.

Simple, practical screening tools can help. One well-validated instrument compresses the initial depression screening to just two questions.⁶ These can be provided to the patient to answer in the waiting room:

- “During the past month, have you been bothered by feeling down, depressed or hopeless?”
- “During the past month, have you been bothered by little interest or pleasure in doing things?”

In all patients with symptoms of depression, a careful history and physical should seek other treatable problems such as hypothyroidism, dementia or parkinsonism, which must be considered before labeling the patient as “depressed.”

Patients who screen positive on a depression screen should be queried using the DSM-IV criteria⁵ (see previous page) to establish the diagnosis.

For mild depression

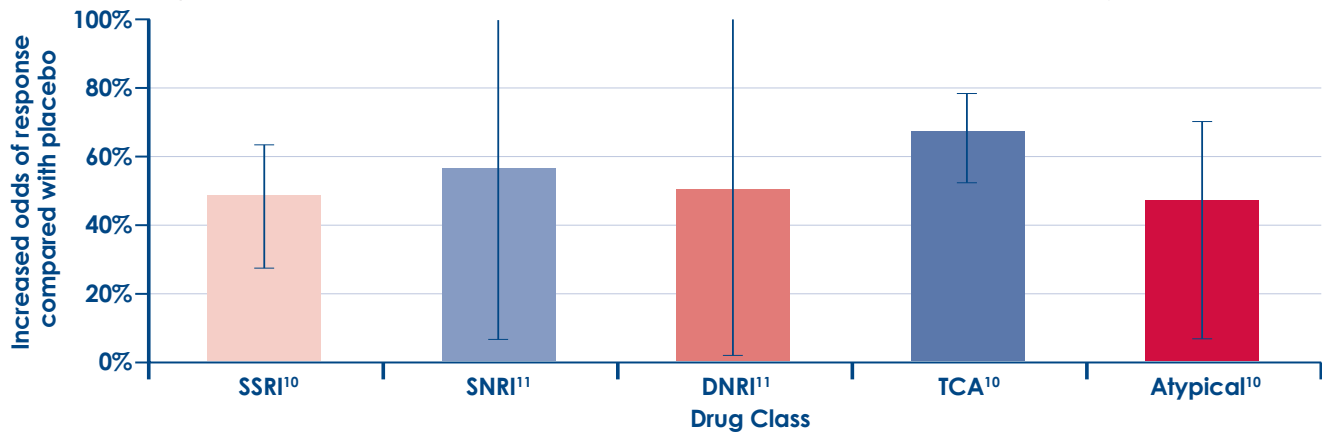
A recent comprehensive review of the clinical trials literature, including studies with negative results that were not published, found that for patients with only mild depression, there is no clear benefit of drug treatment over placebo.⁷ For these patients, drug treatment may bring the risk of side effects without the promise of symptomatic improvement. Other treatment modalities, such as cognitive behavioral therapy, interpersonal therapy, or even careful monitoring without treatment may be appropriate for these patients.



If depression is moderate to severe...

...this constitutes a major medical problem that can cause substantial morbidity and mortality if untreated. In these patients, it is important to rule out a treatable organic condition or medication side effect. Once this is done, antidepressants can be an important component of treatment. Although the trials comparing individual antidepressants to placebo or to each other have methodological limitations, these trials have generally found that all of the commonly used agents are equally effective.⁸⁻¹⁰

Figure 2. Response to different antidepressant classes is similar in major depression.



The top of each colored bar represents the increased odds of responding for that class of agents compared to placebo. The thin error bars represent the 95% confidence intervals for the odds of responding. Atypical antidepressants include mirtazapine, minaprine and medifoxamine, the last two of which are not approved for use in the U.S. The data presented are from Nelson et al.¹¹ and Wilson et al.¹⁰

Older tricyclic antidepressants have been largely replaced by the SSRIs because of differences in their side effect profiles, and because SSRIs present a much lower suicide risk, since an overdose of a tricyclic antidepressant carries a high risk of death.

Initiating drug treatment

Before initiating therapy, patients should always be evaluated for conditions that would require psychiatric referral, including:

- suicidality
- severe features such as psychosis, minimal verbal interaction, or severely restricted food intake
- manic symptoms

Based on their effectiveness and side effect profiles, most older patients requiring an antidepressant can be started on citalopram 10-20 mg/day or sertraline 25-50 mg/day.



Figure 3. Summary of comparative efficacy, safety and cost of antidepressants.

Class	Drug	Efficacy	Safety							Cost*	Overall
			Anticholinergic effects	Drowsiness	Insomnia and agitation	GI	Headache	Withdrawal effects	Drug-drug interactions		
SSRI	citalopram (Celexa)					N					
	sertraline (Zoloft)					N					
	paroxetine (Paxil)					N					
	escitalopram (Lexapro)					N					
	fluoxetine (Prozac)					N					
SNRI	venlafaxine (Effexor) [†]		+			N					
	duloxetine (Cymbalta)					N					
TCA	amitriptyline (Elavil)					C					
	imipramine (Tofranil)					C					
	nortriptyline (Pamelor)		++			C					
	desipramine (Norpramin)		++			C					
Other	bupropion (Wellbutrin)										
	mirtazapine (Remeron)		+								

N = nausea/vomiting; **C** = constipation

■ Best outcome

■ Intermediate

■ Problem

* Based on generic formulation.

+ Anticholinergic-like effects likely attributable to adrenergic activation.

++ These agents may have less anticholinergic effects than other TCAs but they are still associated with a high degree of side effects in the elderly.

† Venlafaxine lost patent protection in June 2008. Prices for Effexor and Effexor XR are expected to drop substantially over the next year.

Patients should be given the following information with the first prescription:

- **Improvement in symptoms may not occur for 4 to 6 weeks.** Patients who are not informed about the time required to see a benefit are more likely to abandon therapy if they experience only side effects during this period.
- **These drugs may increase feelings of suicidality in the initial weeks of treatment.** Patients should be warned about this and told to contact their physician if this occurs. Patients should be carefully reassessed during this period.



Continuation and monitoring of therapy

Patients should be reassessed after 4 to 6 weeks. A 50% reduction in the original symptoms represents an adequate response, and can be identified with the question:

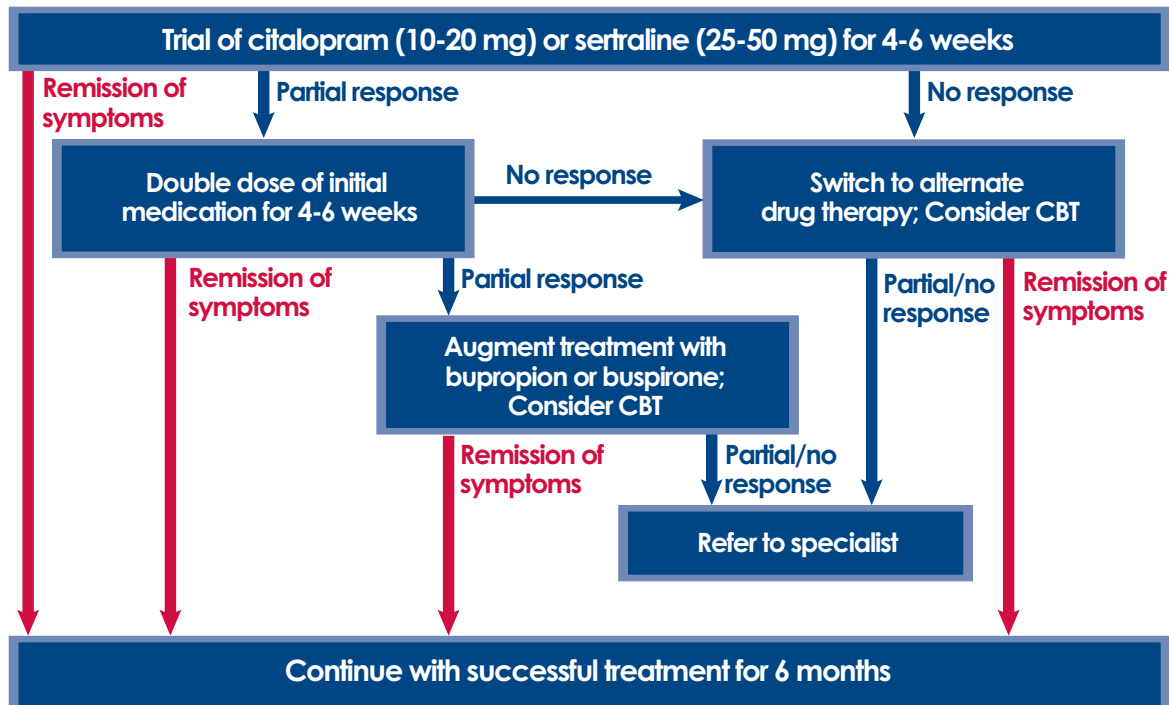
- “How depressed are you compared to when we first met?”

Research has shown that patients who say they are “much better” are having an adequate response to treatment.¹² If a patient is not having an adequate response, the physician should consider augmenting or changing the initial treatment.

Intensifying therapy

The federally funded STAR*D trial evaluated 4,000 patients with moderate to severe depression, testing several regimens in order to determine the best treatment approach for those who do not respond adequately to citalopram.¹³ This important study provided valuable evidence on the efficacy of several alternative next-step strategies.¹⁴ A management approach based on the STAR*D results is shown below.

Figure 4. Management of depression in the elderly.



CBT: cognitive behavioral therapy.



Adjunct therapies

Although medications have become the most common treatments for depression, other forms of management can play an important role for patients with moderate to severe depression, and will actually work as well as drugs in patients with mild depression. Cognitive behavioral therapy and interpersonal psychotherapy are two modalities that have been extensively studied and consistently show a beneficial effect, even for patients with more severe depression.^{10,15}

Rarely, depression can present emergently in an older patient whose symptoms are so severe that they lead to total withdrawal and cessation of food and fluid intake. In these patients, or in carefully selected patients with refractory severe depression, electroconvulsive therapy (ECT) can be strikingly effective and even life-saving.

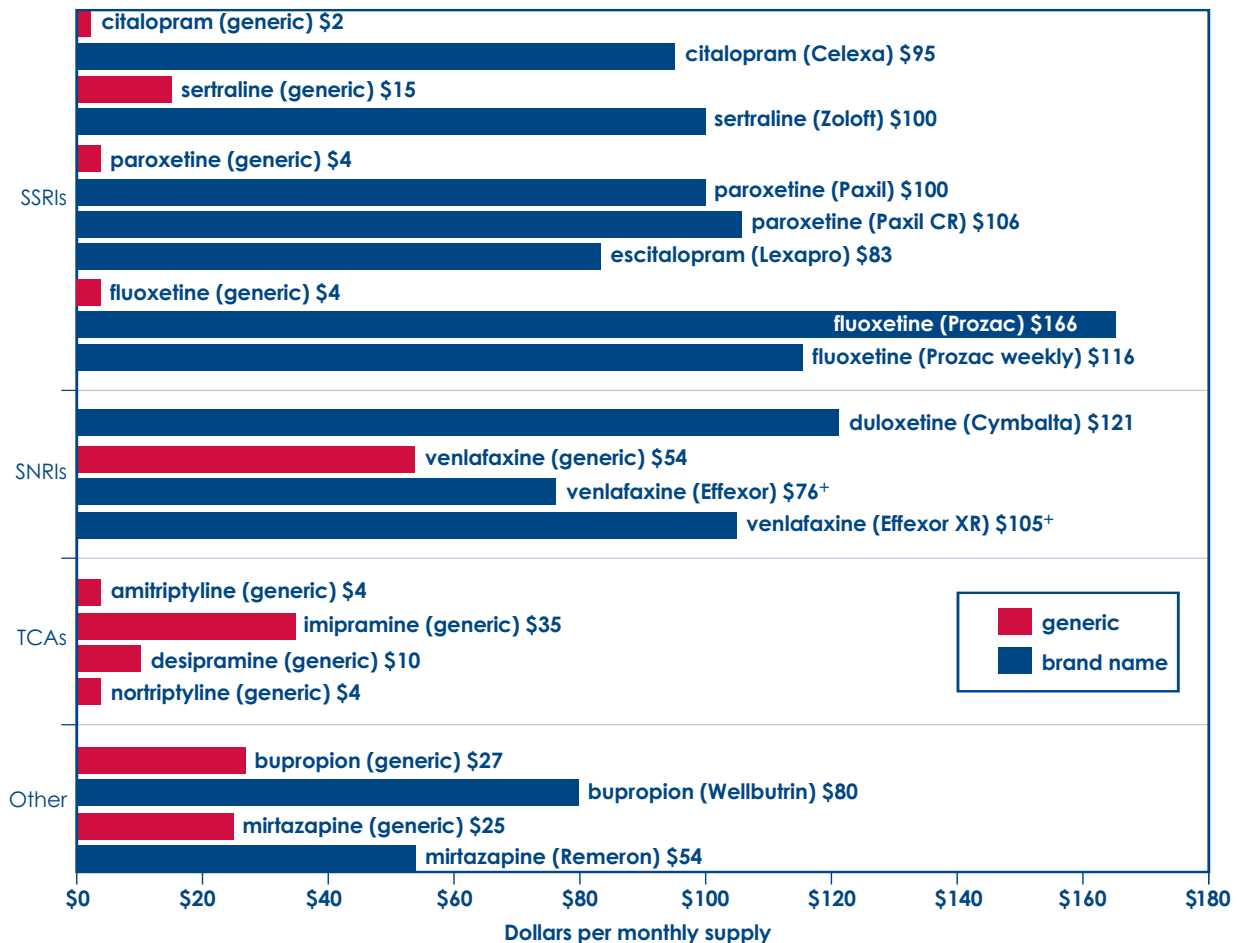
Referral to a psychiatrist

Although primary care doctors manage most depression in the elderly, for some patients help from a psychiatrist is needed. Patients should be screened for suicidal ideation both initially and at follow-up visits, and evidence of suicidality should result in immediate referral. Patients with atypical features of depression suggesting schizophrenia or bipolar disease, or those not responding to treatment should also be referred for psychiatric consultation.

Medication costs vary widely

Even though the effectiveness of most commonly used antidepressants is nearly identical, the costs of drug regimens can differ dramatically, an important consideration for patients with limited or no health insurance, as well as for those taking multiple drugs who must bear the burden of many co-payments. Unaffordable prescriptions reduce adherence, which can doom the effectiveness of even the most carefully constructed regimen.

Figure 5. Monthly costs of antidepressants.*



* Monthly price is for lowest recommended starting doses in the elderly. Figure includes the lowest prices obtained 5/9/08 from drugstore.com and walmart.com. Many generics are available for \$4 per 30-day supply or \$10 per 90-day supply.

+ Venlafaxine lost patent protection in June 2008. Prices for Effexor and Effexor XR are expected to drop substantially over the next year.

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Additional references documenting these recommendations are provided in the evidence document accompanying this material.

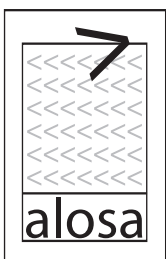
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This material was developed by the Alosa Foundation, a nonprofit organization that is not affiliated in any way with any pharmaceutical company.

It is provided through the Independent Drug Information Service and supported by the PACE Program of the Department of Aging of the Commonwealth of Pennsylvania.

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These are general recommendations only; specific clinical decisions should be made by the treating physician based on an individual patient's clinical condition.



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