Geriatric Depression

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The question:

Is depression any different in the elderly than in anyone else?
To Consider

• Epidemiology
• Phenomenology
• Pathophysiology
• Course and Outcome
• Treatment
1. Is the Epidemiology of depression different for geriatric patients than in young people?
Old people are physically fragile. Socially they are outcasts, and this has serious effects upon their mental state. Both their existential situation and their sexual state are favorable to the development of neuroses and psychoses.

Simone de Beauvoir, 1977
Old people are morose, petulant, ill-tempered, and hard to please.

Cato the Elderly, 43 BC
Why so much less?

- Greater difficulty remembering past symptoms
- Less psychologically oriented
- Greater mortality
- Cohort effect
- Sampling/Instrument errors
Age Specific Categories?
2. Are the symptoms any different?
“Masked Depression”
Pseudodementia
SIG: E CAPS

- Sleep
- Interest
- Guilt
- Energy
- Concentration
- Appetite
- Psychomotor retardation
- Suicide

- 5 or more
Common Symptoms in the Elderly

- Depressed or sad mood
- Loss of interest or apathy
- Loss of appetite or weight
- Not sleeping
- Anxiety
- Somatization/physical complaints
- Suicidal or not care if lives
Examples of Medical Disorders which can cause “Depressive” Symptoms

- Anemia
- B-12 deficiency
- Cancer
- CNS metastases
- Diabetes
- Hepatitis
- Hypercalcemia
- Hyponatremia
- Hypoxia
- M.I.
- Pain
- Parkinson’s
- Sleep apnea
- Stroke
- Thyroid abn.
- Uremia
Examples
Example: “Normal” Depression

The Hospital (Simcha, 1972)
Example: Geri Depression

De-Lovely (MGM, 2004)
3. Are there any anatomic or physiological findings that are unique to the elderly?
Physiological Changes in the Elderly

- Decreased acetylcholine, dopamine and norepinephrine.
- Increased Monoamine Oxidase
Physiological Changes in the Elderly

• Neuroendocrine changes: HPA axis
  – Increased Cortisol
  – Increased nonsuppression on DST
Vascular Depression Hypothesis

- Cardiovascular risk factors
- Leukoencephalopathy
Vascular Depression: Clinical Presentation

- Reduced depressive ideation
- Greater psychomotor disturbance
- Apathy
- Executive dysfunction on neuropsychological testing
- Neuroimaging abnormalities in the basal ganglia and white matter
4. Is the course and outcome different?
Dementia and Depression
5. Is The Approach To Treatment Any Different?
Antidepressants in the Elderly

Pharmacokinetic concerns

Specific concerns:

SSRIs - affected by age?
Antidepressants in the Elderly

Pharmacokinetic concerns

Decreased efficacy microoxidase system
Decreased muscle fat ration

result: increase $t_{1/2}$, more side effects
Antidepressants in the Elderly

Pharmacokinetic concerns

Woolcott 2009 (Arch Int Med)

compared 9 med classes for fall risk:

antihypertensives, diuretics, beta blockers, sedative/hypnotics, antipsychotics, antidepressants, benzodiazepines, narcotics, NSAIDs.
SSRI’s: Common Side Effects

- GI
  - Nausea, anorexia, diarrhea
- Tremor
- Insomnia
- Sexual side effects
SSRI’s: Serious Side Effects

- SIADH/hyponatremia
- EPS
- Hypofrontal syndromes
- Bleeding
- Bradycardia
- Increased risk of falls, fractures
- Serotonin Syndrome
Antidepressants in the Elderly

Pharmadynamic concerns

Theoretical concerns:

changes in densities and sensitivities of receptors

? relevance
Antidepressants in the Elderly

Pharmacodynamic concerns

Efficacy?
Antidepressants in the Elderly

• 6 RCT’s
  – Response rates: 35-72%
  – placebo v. drug most sig. in severe dep

• Comparisons?
Antidepressants in the Elderly

Metanalysis of 17 studies (2000 patients)

Antidepressants > placebo

Effect size low

(Wilson et al, Cochrane database, 2009)
Longer term studies

• Nortriptyline
• Paroxetine
• Citalopram

• but NOT sertraline - ???
More unusual drugs in the population

• MAOIs
  – Pre Selegiline: 1 trial of 37 patients.
  – Selegiline transdermal (pooled data)
    • 6-12 mg/24 hrs
    • 198 patients ≥ 65
    • As good as w/ younger.
    • AE’s: rash, insomnia, postural hypotension
    • Dietary restrictions not needed at 6 mg.
More unusual drugs in the population

• Stimulants
  – 1 RCT
  – 13 patients.
The Bottom Line on Antidepressants
Psychotherapy

Old people are no longer educable.
Combined Treatment?

- Drug
- Drug + IPT
- Placebo
- Placebo + IPT

% recurrence
Collaborative Care Models
Collaborative Care Models

• IMPACT study (2002)
  – >1800 elderly depressed patients
  – “Usual care” versus
  – “Depression Care Management”
    • Psychiatrist supervising
    • Education
    • Med Management support
    • Brief Psychotherapy
IMPACT study

% response

- Usual
- DCM
Collaborative Care Models

• PROSPECT study (2004)
  – >200 elderly depressed patients
  – “Usual care” versus
  – “Care Manager”
    • Interpersonal Therapy
The Lesson?

For the depressed elderly “Usual Care” is not enough.
Innovative Approaches
Example
In Conclusion

- Epidemiology
  - Maybe, but not how you think
- Phenomenology
  - Sometimes, but don’t assume
- Pathophysiology
  - Maybe, not always
- Course and Outcome
  - Probably (worse)
- Treatment
  - How we give > what we give
Thanks, and questions?