“Life is a miserable thing. I have decided to spend my life thinking about it.”

— Irvin D. Yalom, The Schopenhauer Cure
Conflicts of Interests

• No financial conflicts
• Inpatient geriatric psychiatrist
Case of Mr. V

- 69 year old ex-body builder is admitted to a nursing home after a protracted hospitalization post cardiac-valve repair that was complicated by a massive MI, pneumonia, acute renal failure and urinary incontinence. After 5 months of rehab, he is “Foley-free”. He has been actively engaged in PT until 2 days ago when he started refusing to participate in PT. He is noted to be irritable and tearful. On interview, he is “tired” and “sick of it all.” “There seems to be no hope…now I haven’t had a bowel movement for 4 days!” Among his 17 medicines, psychotropics include mirtazapine 30 mg nightly.
Case of Mr. E

- 75-year old male with history of bipolar disorder is admitted to hospice unit for end-stage colon cancer. The tumor pushes on his belly in the front and erodes out of his rectum where it occasionally bursts oozing pus. He refuses to leave his room, shower, or engage in the activities but constantly seeks company of nurses, who are sick of him pressing the call bell without any reason. He reports being hopeless, expresses fear of dying and is afraid that he will be discharged from hospice before his death. He is on therapeutic doses of lithium, risperidone and venlafaxine.
Case of Mrs. W

- 79-year old married woman, a retired accountant, medically described as a “vasculopath”, admitted with a crippling fear of being destitute. She completely stopped eating 3 days ago as she was afraid she will impoverish her family as a result of her eating. She is withdrawn but engages when approached often giving you reasons of why she is becoming poorer. She is dressed in ill-fitting clothes, appears weak and has a blunted affect. She is only oriented to self and her family and repeats herself during the interview. Family reports that she has not been to the senior center for 6 months as she did not like the activities there.
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- 89 year old widowed female, retired business owner, living with her never-married daughter, with history of stable HTN, s/p colectomy for colon cancer 20 years ago, and depression stably treated for at least 10 years on venlafaxine, olanzapine and lorazepam, presents with increasing anxiety, anhedonia, insomnia, low mood, and significant anergia. She says “I am just tired of it all and pray that the Lord take me in my sleep.” She scores a 30 on MMSE, is well groomed, respectful, has a constricted affect and easily engages. She narrates a life of struggle and successes, and expresses her worries for her unmarried daughter’s ability to take over her estate.
Objectives

- To list key epidemiological features of depression in the elderly
- To describe a method to screen for depression in older adults
- To describe at least 2 subtypes of depression among older adults and describe differentiating features of each subtype
- To become aware of the differential diagnoses
- To describe keys aspects of management of depression among the elderly
Epidemiology

• 44 million adults >65 in 2013 (14%; www.census.gov)

• Rates of depression vary based on setting
  • LTC facility dwellers: MDD 10%; minor depression 29% (Seitz et al., 2010)
    • Higher in medically ill

• Suicide risk (www.cdc.gov)

• Increased health-care utilization, morbidity and mortality
Table 2. 12-Month Prevalence Rates of DSM-IV/WMH-CIDI Mood, Anxiety, and Comorbid Disorders in 2575 Adults 55 Years and Older

<table>
<thead>
<tr>
<th>12-mo Disorder</th>
<th>Total, Weighted % (SE)</th>
<th>55-64 y (n = 1114)</th>
<th>65-74 y (n = 813)</th>
<th>75-84 y (n = 526)</th>
<th>≥85 y (n = 122)</th>
<th>Rao-Scott $\chi^2$</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any mood</td>
<td>4.9 (0.4)</td>
<td>7.6 (0.9)</td>
<td>3.6 (0.6)</td>
<td>1.8 (0.6)</td>
<td>2.4 (1.4)</td>
<td>28.2</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Major depressive disorder</td>
<td>4.0 (0.4)</td>
<td>6.2 (0.8)</td>
<td>3.1 (0.6)</td>
<td>1.1 (0.5)</td>
<td>1.8 (1.3)</td>
<td>25.9</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>0.8 (0.3)</td>
<td>1.2 (0.6)</td>
<td>0.5 (0.2)</td>
<td>0.5 (0.3)</td>
<td>0.5 (0.6)</td>
<td>3.4</td>
<td>.34</td>
</tr>
<tr>
<td>Bipolar I or II disorder$^a$</td>
<td>0.9 (0.2)</td>
<td>1.4 (0.4)</td>
<td>0.5 (0.3)</td>
<td>0.7 (0.4)</td>
<td>...</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Any anxiety$^b$</td>
<td>11.6 (0.7)</td>
<td>16.6 (1.2)</td>
<td>8.9 (1.1)</td>
<td>6.0 (0.9)</td>
<td>8.1 (2.5)</td>
<td>52.5</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>1.3 (0.3)</td>
<td>2.0 (0.6)</td>
<td>0.6 (0.3)</td>
<td>1.0 (0.4)</td>
<td>0.5 (0.5)</td>
<td>8.8</td>
<td>.03</td>
</tr>
<tr>
<td>Agoraphobia without panic</td>
<td>0.8 (0.2)</td>
<td>1.4 (0.4)</td>
<td>0.5 (0.3)</td>
<td>0.4 (0.3)</td>
<td>...</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>6.5 (0.5)</td>
<td>8.8 (0.9)</td>
<td>4.9 (0.9)</td>
<td>4.4 (0.9)</td>
<td>5.1 (2.1)</td>
<td>15.5</td>
<td>.001</td>
</tr>
<tr>
<td>Social phobia</td>
<td>3.5 (0.4)</td>
<td>5.1 (0.7)</td>
<td>3.1 (0.6)</td>
<td>1.5 (0.5)</td>
<td>...</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
<td>2.0 (0.3)</td>
<td>3.2 (0.5)</td>
<td>1.4 (0.5)</td>
<td>0.8 (0.3)</td>
<td>1.8 (1.2)</td>
<td>12.7</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Posttraumatic stress disorder$^c$</td>
<td>2.1 (0.4)</td>
<td>4.7 (0.9)</td>
<td>0.6 (0.2)</td>
<td>0.1 (0.1)</td>
<td>0.7 (0.6)</td>
<td>74.8</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Comorbid disorder$^{a,b,d}$</td>
<td>2.8 (0.4)</td>
<td>4.6 (0.8)</td>
<td>1.7 (0.5)</td>
<td>0.9 (0.4)</td>
<td>...</td>
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<td>...</td>
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</tbody>
</table>

Abbreviations: ellipses, data not available to compute weighted estimate/test; NCS-R, National Comorbidity Survey Replication; WMH-CIDI, World Mental Health Survey Initiative version of the Composite International Diagnostic Interview; PTSD, posttraumatic stress disorder.

$^a$Bipolar I and II disorder represents proportion of respondents who endorsed either bipolar I or II disorder or subthreshold bipolar disorder.

$^b$Estimated in the part 1 sample. No adjustment was made for the fact that PTSD was directly assessed in part 2. Sensitivity analyses performed with part 2 showed similar results.

$^c$Analyses conducted using the part 2 sample (PTSD directly assessed), which included all part 1 respondents with lifetime disorder plus a probability subsample of other respondents (n = 1372).

$^d$Comorbid disorder defined as any co-occurring mood-anxiety disorders.
Phenomenology

• Symptom-based diagnosis: DSM-IV TR
  • DSM 5 criteria remain the same; bereavement exclusion was excluded
  • Minor depression

• Geriatric Depression Scale (Sheikh & Yesavage, 1986)
  • Somatic complaints
  • Cognitive impairment
  • Anxiety and agitation
  • Psychotic, melancholic, catatonic

• Note on pathophysiology
  • Vascular depression (Krishnan & McDonald, 1995; Sneed, et al, 2011)
  • Risk of dementia (Diniz, et al., 2013)
Differential Diagnoses

- **Demoralization** (Frank, 1974; Clarke & Kissane, 2002)
  - Hopelessness and overwhelming of the coping systems
  - Loss function; medical disease burden; social stressors

- Thyroid disorders
- Cancers (pancreatic cancer)

- Polypharmacy

- Neurological disorders
  - Parkinson’s disease

- Bereavement
Management

- History
- Functional assessment
- Medication review
- Investigations

- Collaborative care (utilizing mental health specialists in primary care settings; www.uptodate.com)
Management

• Medicines
  • Homeostenosis (www.ouhsc.edu)
  • Start low, go slow, **up to the highest dose** if tolerated.
  • **Selection based on side effect profile** and depressive subtype
    • High placebo rates
    • Comparator trial have higher response rates vs placebo controlled trial

• SSRI* (SIADH)
  • Sertraline, escitalopram, fluoxetine, citalopram
  • **Avoid paroxetine** (highly anticholinergic) and fluvoxamine

• TCAs: start with low dose of NTP or desipramine, close monitoring

• SNRIs and **mirtazapine**
  • Lower tolerability than SSRIs
  • Constipation with mirtazapine

(Unutzer, 2007 for a quick review of medicines)
Management

- Exercise (Bridle, et al., 2012)

- Psychotherapy (Cuijper et al., 2006; IPT, CBT, problem solving)

- ECT (van der Wurff, et al., 2003; catatonic, psychotic, melancholic varieties)

- Antipsychotics
- Stimulants
Summary

- Depression is a common, albeit etiologically heterogeneous, clinical entity prevalent among the elderly
  - Screening is important in all healthcare settings

- Detailed assessment, *including medication review* and functional assessment, is necessary to diagnose and differentiate it from other conditions

- Choose medicines wisely
- ECT should be considered in appropriate cases
- Exercise and psychotherapeutic approaches are helpful in mild to moderate depression
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All right, here's a nickel. What do I get?

Nothing. I just ripped you off.

What?!

That's life!

Hey, oh! ow!