Managing Depression and Anxiety in a Geriatric Patient

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Question 1

- You have been treating a 75 year old female over the past 3 months for depression with 100 mg of sertraline daily. It was the patient's first episode. Currently the patient reports a resolution of all her symptoms and she feels “back to herself”. She is complaining of some mild morning nausea that she attributes to the medication, and she would like to discontinue the sertraline. What do you recommend?
Question 1

1) Patient is now free of depressive symptoms and through the acute phase of the depressive episode and may now stop the medication.

2) Patient must continue treatment for 6 months to prevent relapse of the depressive episode.

3) Patient must continue treatment for 6 months to prevent relapse but she may cut the dose in half to minimize side effects.

4) Patient must continue treatment for a minimum of 2 years to prevent a subsequent depressive episode.
Question 2

A 70 year old patient presents to your office complaining of severe nervousness, constant worry, and palpitations. After a full medical workup you attribute her symptoms to anxiety and a clinical depression. You begin treating her with an antidepressant medication. Several days later you receive a call that her anxiety is no better and she requests additional help. In the short term, you decide to prescribe a benzodiazepine. Which of the following agents is the most appropriate choice?
Question 2

1) chlordiazepoxide
2) diazepam
3) oxazepam
4) chlorazepate
Question 3

Which of the following is NOT a major risk factor for completed suicide?

1) Male gender
2) Medical comorbidity with frequent visits to PCP
3) Poor adherence to medical treatment
4) Widowed or divorced status
5) Poor concentration, anhedonia, and insomnia
Demographic Transition

- By 2045, average life expectancy in the US will be 80 years

- By 2030, almost 20% of Americans will be 65+

- By 2030, proportion of older Hispanics will nearly double from 5.6% to 10.9%
Geriatric specialty shortages

- Without significant national changes, older Americans will lack access to affordable, quality healthcare (Institute of Medicine Report 2008)

- 1 geriatric psychiatrist for every 10,000 Americans older than 75 (estimated need is 5000, only 1600 board-certified specialists)

- Only 65% of psychiatrists currently accept Medicare
Prevalence of Geriatric Mental Illness

- Older adults more likely to seek MH care in primary care settings
- Depression and cognitive disorders most commonly seen
Geriatric Depression

- Increased rates of depressive symptoms (10-37%) but decreased rates of DSM-criteria (2-4%)

- 17-35% in Primary Care Settings

- 25% of Hospitalized patients (11% Major Depression)

- 24-47% of Nursing Home residents
Geriatric Depression

Primary care physicians often have difficulty recognizing severe depression (Passik, et al. J Clin Oncol, 1998)

Somatic presentation are often most prominent
Reasons for Under-recognition of Geriatric Depression

- Symptoms attributed to chronic medical conditions
- Often do not complain of depressed mood or crying spells, only anhedonia
- Depression as “normal” part of aging
- Psychosocial and physical losses divert attention from consideration of depression diagnosis
- Stigma
Minority disparities

- Ethnic and racial minorities are less likely than Caucasian elderly to seek specialty MH care

- More likely to express psychological distress through somatic symptoms

- Barriers: language, stigma, lack of transportation, costs, waits for appointments, cultural distance with provider, mistrust

- Use of complimentary and/or alternative medicine
Diagnostic Criteria for Major Depressive Disorder

DSM-IV criteria include 5 or more of the following symptoms are present for 2 or more weeks:

Must have:

1) Depressed mood or
2) Anhedonia
Criteria for Major Depressive Disorder

3) Change in weight or appetite
4) Insomnia or hypersomnia
5) Psychomotor agitation or retardation
6) Low energy
7) Feelings of worthlessness or guilt
8) Poor concentration
9) Recurrent suicidal thoughts or attempt
Consequences of Untreated Depression

- Worldwide, depression is second leading cause of disability adjusted life years
- Poorer adherence
- Increased health services utilization
- Greater mortality due to concurring cardiovascular disease
- Increased risk for suicide
Suicide

40% of elderly suicide completers saw their primary care physician during the week prior

Elderly white men are disproportionately most likely to complete suicide
Risk Factors for Suicide

(Based on the SAD PERSONS Scale)

Male
Age >45
Depression with predominantly poor concentration, insomnia, complete anhedonia, irrational thoughts/psychosis
Severe anxiety
Risk Factors for Suicide

Alcohol or drug use
Organized Plan
Previous attempt
Lack of social support
Separated, divorced or widowed
Multiple comorbid medical illnesses with frequent PCP visits
Comorbid Anxiety

- Often the most prominent presenting symptom along with insomnia
- Decreased response rate to antidepressants
- Longer time to response and remission
Comorbid Anxiety

Generalized anxiety and panic symptoms may accompany depression in the elderly

The somatic focus of anxiety may be mistakenly ascribed to medical diagnoses
Treatment of Geriatric Depression: The Acute Phase

- Goal is remission of illness
- Lasts about 12 weeks/3 months
- Treatment regimen must be carefully monitored
- First line antidepressant treatment is SSRI’S for both efficacy and safety
- Start at ½ usual adult dosage
Treatment of Geriatric Depression: The Acute Phase

- Close monitoring on a weekly basis is required at this phase of treatment for the following:
  - Side effects/adverse reactions
  - Deteriorating clinical condition
  - Suicide risk
  - Medical co-morbidity
  - Support system
  - Adherence to treatment
Treatment of Geriatric Depression: The Acute Phase

Referral to a psychiatrist should be considered with the following:

Suicidal ideation
Complex medical co-morbidity
Severe depression with psychotic features
Neglect/lack of social support
Alcohol and drug abuse
Treatment resistance
Treatment of Anxiety in Geriatric Patients

Antidepressants such as SSRI’s and SNRI’s are the safest.
Sedative hypnotics such as benzodiazepines can be very efficacious in the short term, but must be used with extreme caution in the elderly. They may contribute to worsening depression, cognitive changes, and higher rates of falls/injuries.
Should choose short acting agents with nonactive metabolites (lorazepam, oxazepam, temazepam).
Treatment of Geriatric Depression: The Continuation Phase

- Goal is to continue the preservation of remission of the illness
- Lasts about 6 months
- Continuation of antidepressant treatment at the full dose that resulted in remission is essential
Treatment of Geriatric Depression: The Maintenance Phase

- Goal is to maintain treatment to prevent recurrence of another depressive episode

- The more episodes of depression, the higher the likelihood of recurrence

- In adults, the chance of recurrence is $> 90\%$ after 3 or more episodes
Treatment of Geriatric Depression: The Maintenance Phase

- Depression tends to reoccur in the elderly
- Rates of recurrence of 50-90 percent over a period of 2-3 years
- Studies indicate that preventing the recurrence of depression in geriatric patients require continued treatment with antidepressants for at least 2 years (Reynolds, et al, NEJM, 2006)
- Continuous Maintenance treatment for at least 2 years is recommended in over 65 patients, despite the number of previous episodes.
Depression and Collaborative Care

- Collaborative Care
  - embedded MH providers
  - structured collaboration b/PC and MH
  - disease self-management
  - monitor antidepressant adherence
  - time-limited psychotherapy
  - standardized tools for screening