

OLD AND SAD — DEPRESSION IN LATER LIFE

Depression is an illness that has been commanding increasing attention worldwide.



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HOW COMMON IS DEPRESSION IN THE ELDERLY?

When the World Health Organisation published statistics predicting overall disability figures for the year 2020, many were surprised to see depression ranking as one of its leading causes. In fact, depression ranked second only to cardiovascular disease. Researchers have also highlighted the economic costs of such widespread disability. Yet, depression remains under-diagnosed and inadequately treated for the majority of sufferers. Unfortunately, less than one-third of people with clinical depression actually seek treatment for their illness. These figures are even more pronounced when depressive illness occurs in previously neglected groups, such as children and the elderly. Through the lifecycle, depression tends to occur more frequently in the adult and elderly population.

In the developed world, demographic trends for 2020 predict an increase in the number of elderly people; hence it is no surprise that the prevalence rates of depression will increase too. South Africa faces a similar increase in the number of elderly citizens as the AIDS epidemic plateaus. Increased life expectancy will be due to improved health and social conditions. Hence clinicians need to be aware of the distinguishing features of depression.

Figures for the rates of depressive illness are best known for the USA, where two major epidemiological surveys have been conducted since the early 1980s. These two reference studies are the Epidemiological Catchment Area (ECA) programme¹ and the National Comorbidity Study (NCS).²

The ECA study reported that the 1-year prevalence rate of mood disorders in adults is approximately 10%. The NCS, conducted 10 years later, revealed a higher 1-year prevalence rate of depression for 11.3% of adult respondents.

When one analyses data for those aged above 65 years, prevalence rates for mood disorders equal about 20%. Depression in its many forms affects more than 6.5 million of the 35 million Americans who are 65 years or older. About 2 million have a depressive illness (major depressive disorder, dysthymic disorder, or bipolar disorder). Just under 5 million may have 'subsyndromal depression', or depressive symptoms that do not meet the full diagnostic criteria for a disorder.^{1,3} Subsyndromal depression is especially common among the elderly and is associated with an increased risk of developing major depression.⁴

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This article serves to highlight the importance of recognition, diagnosis and treatment of depression in the elderly. Common myths around depression in the elderly will be critically examined. The risk of suicide will also be explored.

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IS DEPRESSION A NORMAL PART OF GROWING OLD?

Many people believe that depressed mood is a normal part of ageing. However, it is quite clear that this is false. Most elderly people with depression have been suffering from episodes of the illness during much of their lives. In other words, a chronic depressive condition may extend into later life. For others, depression has a first onset later on — even for those in their eighth or ninth decade. Depression in older persons is closely associated with dependency and disability, and causes great suffering for

the individual and the family. In contrast to the normal emotional experiences of sadness, loss, or transient mood states, major depression tends to be persistent and to interfere significantly with an individual's ability to function, thus markedly diminishing quality of life.

From a psychosocial point of view, the elderly constitute an 'at risk' group. As people age, they may need to contend with many new stressors and losses. These include failing physical health, loss of mobility and chronic illness or pain.

Socially, losses may include death of a spouse, increasing isolation, and diminished family contact. Cognitively, the elderly person may become frustrated with memory loss and have difficulty adapting to this. Other changes associated with ageing include retirement, diminished income and the loss of one's home. In many cases, the overall outcome for an elderly person is a diminished status.

While these losses may cause a normal grief or mourning reaction, the symptoms of clinical depression are quite different. A classic grief reaction is usually temporary. If grief or bereavement becomes pervasive, one may be dealing with a 'complicated' reaction which causes significant morbidity. The duration of a major depressive episode is usually months, rather than weeks.

IDENTIFYING DEPRESSION IN THE ELDERLY PATIENT

Many clinicians are comfortable with the recognition of depression in adults. However, it is incorrect to assume that the elderly depressive presents in an identical way. Lack of familiarity with the symptomatology in the elderly may lead to the diagnosis being missed.

There are some distinguishing features which the clinician should be aware of in order to make an accurate diagnosis.⁵ These include the following: marked memory problems, mental confusion, social withdrawal, loss of

appetite, inability to sleep, irritability, and, in some cases, delusions and hallucinations.

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To explore the presentation in more detail: the overwhelming presenting feature of depression in an adult is subjective experience of low mood. While the elderly individual may have marked feelings of sadness, these feelings are frequently not acknowledged or openly shown. Psychiatrists refer to this state as 'masked depression'. 'Depression without sadness' is a paradoxical presentation that may impede its recognition. Some general clues that someone may be suffering from depression in such cases are persistent and vague complaints, excessive concern about bodily aches and pains, help-seeking, as well as demanding behaviour. Anxiety is also a common presentation.

For the clinician diagnosing depression, *change in function* of the elderly patient is the most important issue. Specifically, one needs to ask about a change in mood, activity level, speech, and sleep. Questions to focus on are: does the patient admit to depression or tearfulness, is there anhedonia (no enjoyment of activities that previously brought pleasure)? Other changes may be in the rate or volume of speech. Is the patient still singing or humming? Activity levels may also have changed in that the patients complain of lacking energy; they may also be overactive (an agitated depression). Changes in other neurovegetative functions such as sleep (early morning waking, or other sleep pattern change) and appetite (loss) are essential parts of the history taking.

Cognitive changes and memory loss may be so marked as to mimic a primary dementing process. This

reversible memory loss is termed a 'pseudodementia'. Once the depression is adequately treated, memory returns. Pseudodementia and an underlying depressive illness should always be considered when assessing an elderly patient for dementia.

Finally, the elderly frequently present with somatic features such as lethargy, headaches, palpitations, dizziness, dyspnoea, gastrointestinal complaints, and chronic pain. Frequently, these physical complaints are persistent and do not respond to treatment.

SUICIDE

As we have noted, older persons with depression rarely seek treatment for the illness. Even if they approach a primary health practitioner, the condition is frequently missed. Unrecognised and untreated depression has fatal consequences in terms of both suicide and non-suicide mortality. The two greatest risk factors for suicide are old age and male gender. In the US, the highest rate of suicide is among older white men. In the group aged 80 - 84 years, the suicide rates are more than twice those of the general population.⁶

Despite all the advances in antidepressant medications, suicide rates have remained fairly constant in the last 20 years. Depression is the single most significant risk factor for suicide in the elderly population. Tragically, many of those people who go on to commit suicide have reached out for help. Studies have found that up to 75% of older adults who die by suicide have visited a primary care physician within a month of their suicide.⁷ Twenty percent see a doctor the day they die, 40% the week they die, and 70% in the month they die. Yet depression is frequently missed.

Older adults with depression are more likely to commit suicide than are younger people with depression. Individuals aged 65 and older, who comprise only 13% of the population, account for 19% of all deaths by suicide.

RISK FACTORS FOR DEPRESSION

Several factors increase the risk of depression in the elderly. These include, among others, female gender, single status (especially if widowed), recent stressful life events (such as bereavement), and lack of a supportive social network. Studies have shown an increased co-morbidity of depression with several medical conditions common in the elderly. Stroke, hypertension, Parkinson's disease, diabetes, carcinoma, chronic pain and dementia all further increase the risk.^{8,9} Patients with cardiovascular illness, diabetes mellitus, or cancer can have severe depression rates as high as 20%. While depression may be an effect of certain medical illnesses, it can also increase susceptibility to other illnesses, including depleted immunity and infectious illness.

From the psychiatric history, further risk factors may be identified including a previous history of depression, a family history, past suicide attempt and substance abuse.

SAFE AND EFFECTIVE TREATMENT

Antidepressant medications, short-term psychotherapies and electroconvulsant therapy are all effective treatments for late-life depression.¹⁰

For many years, tricyclic antidepressants were one of the few options to treat depressive disorders. While these are effective in alleviating symptoms in up to 70% of patients, tricyclics have several undesirable side-effects, particularly in the elderly. Nortriptyline and desipramine are the most frequently used tricyclics. Their proarrhythmic effects, especially in patients with cardiovascular disease, often limit their use.

Side-effects of tricyclics include antihistaminergic effects, causing sedation and possible falls, as well as orthostatic hypotension and cardiotoxicity. Anticholinergic effects are also widespread, and one outcome is the damp-

ening down of an already compromised cholinergic system, with adverse effects on memory and cognition. Tricyclics are also lethal in overdose.

Monoamine oxidase inhibitors (MAOIs) are rarely used because of the need for a tyramine-free diet, which may affect compliance.

The newer antidepressants, namely the selective serotonin reuptake inhibitors (SSRIs), are generally chosen as first-line medication. They have efficacy rates similar to the tricyclics, but their adverse effects are milder.¹¹ Fluoxetine, fluvoxamine, paroxetine, citalopram, sertraline, and escitalopram appear to be well tolerated and effective in treating geriatric depression. There is some evidence that side-effects occur less often in the elderly. They include nausea, agitation, insomnia, and sexual dysfunction.

Citalopram, sertraline, and escitalopram have fewer drug-drug interactions. This is a crucial issue as the elderly often have several co-morbid chronic medical conditions and receive several drugs simultaneously. In addition, elderly patients often have reduced drug clearance due to diminished renal and hepatic clearance. For this reason, drugs with a shorter half-life are preferred.

Serotonin reuptake inhibitors that also have a noradrenergic action, such as mirtazapine and venlafaxine, are also effective options.

DOSING GUIDELINES

To minimise side-effects, low initial doses should be used with slow upward titration. There is some evidence that the therapeutic effect may take longer to manifest in the geriatric population, so antidepressant therapy should continue for at least 3 months before considering treatment failure. Length of treatment may need to be extended in geriatric depression due to the high degree of degenerative changes in the ageing brain. Depressive illness tends to be chronic. After a first episode of depression in

later life, treatment should extend to a year after remission. For those with a history of more than two previous episodes, treatment should extend up to 2 years post remission. Where there have been more than three recurrent episodes, treatment may be life-long.

COMPLIANCE

Medication compliance is always important, but it can present a particular problem among older patients. It has been estimated that 70% of these patients fail to take 25 - 50% of their

medication. Supervision of medication dosing is essential.

Electroconvulsive therapy (ECT) may be indicated in the severely depressed if other measures are unsuccessful. The clinician needs to weigh up the adverse effects of short-term memory loss associated with ECT as well as assess the anaesthetic risk. While ECT is generally a safe and effective treatment option, there are unfortunately no long-term benefits. The acute episode is treated and the patient then needs long-term prophylactic antidepressant treatment.

CONCLUSION

Depression in the elderly is often missed or undertreated. It is not simply a consequence of the ageing process. It is a life-threatening illness that markedly affects quality of life. Suicide rates have not diminished in this population, despite all the advances in pharmacotherapy. Fortunately, safe and effective treatments are available and the diagnosis should be made to alleviate suffering wherever possible.

References available on request.

IN A NUTSHELL

Depression is a common illness that is under-recognised and undertreated in the elderly population.

Major depression is not simply a natural outcome of ageing.

Elderly depressed patients present with a typical clinical picture.

Memory loss, mental confusion, social withdrawal, and neurovegetative symptoms are common.

The elderly patient may not admit to depressed mood but will have numerous somatic complaints.

Suicide is commonest in elderly white men.

SSRIs are preferred over older antidepressants because of milder side-effects, safety in overdose and limited drug-drug interactions.

Nausea, agitation, insomnia, and sexual dysfunction are the commonest side effects of SSRIs.

Doses should initially be low, with slow upward titration and a treatment trial duration of 9 weeks.

ECT and psychotherapy are alternative treatment options.

SINGLE SUTURE

LETHAL TOP BOOTS!

Between 1894 and 1900 a cluster of deaths were reported as being caused by footwear. This sounds rather implausible. However, a theory proposed in a recent issue of the *Journal of the Royal Society of Medicine* might have the answer. It appears that the tight knee-length boots worn by men in the cavalry and men-about-town may have caused pressure trauma to saccular popliteal aneurysms, causing their sudden rupture. The aneurysms were apparently commonly caused by repeated flexion and extension of the knee while riding.

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