Objectives

1. Discuss risk factors and signs/symptoms for depression in geriatric patients
2. Identify different screening tools that are able to be utilized effectively in the geriatric populations
3. Select appropriate treatment options available to treat depression in geriatric patients that includes both pharmacological and non-pharmacological modalities.
4. Distinguish risk factors for suicide in geriatric patients.
Depression in Geriatrics

✧ Depression may be seen in up to 35% of residents in long term care facilities
✧ Underreported and undertreated
✧ Causes of underdiagnosing include:
  ◦ Atypical presentation in elderly
  ◦ Focus on medical illness rather than mental health
  ◦ View sadness or depressed mood is a normal sign of aging
  ◦ Symptoms of depression mimic chronic medical conditions

Case Study

✧ 77-year-old widowed white male
✧ PMH – Stroke
✧ Living in NH for 6 months
✧ Children live a couple hours away
✧ Now he is isolative, withdrawn over the past several weeks. Lacks motivation. Poor appetite, with increased sleep
Risk Factors for Depression in Elderly

- Alcohol or substance abuse
- Medication use that is associated with depression
- Hearing or vision impairment
- History of suicide attempts
- History of psychiatric hospital admission
- Diagnosis associated with depression prevalence
- New changes in environment
- Stressful losses (not just death but also of function, etc.)
- History of depression or mood disorder

Medications associated with depression

- Anti-arrhythmic
- Anticonvulsants
- Benzodiazepines
- Carbidopa/Levodopa
- Beta Blockers

- Clonidine
- Digoxin
- Glucocorticoids
- H2 blockers
- Opioids
Diagnoses associated with Depression

- Alcohol use
- CVA
- Chronic pain
- Neurodegenerative disorders
- Cancer
- COPD
- CAD or open chest procedure
- Heart failure
- Diabetes
- MI
- Abuse
- Schizophrenia

Signs and Symptoms

- Depressed mood
- Thoughts of suicide
- Difficulty making decisions
- Helplessness
- Worthlessness
- Hopelessness
- Guilt
- Psychomotor agitation or retardation
- Social withdrawal
- Change in appetite
- Difficulty concentrating
- Failure to thrive
- Fatigue
- Insomnia or hypersomnia
- Pain
- Weight loss
Case Study

- Look at specific symptoms with duration
- Collaborate with caregivers
- Ask about self harm
- PHQ-9 = 10

Screening

- Recommended upon admission and if a change occurs in functional or medical condition
- Tools include:
  - Geriatric Depression Scale
  - Cornell Scale for Depression in Dementia (CSDD)
  - PHQ-9
  - PHQ-9OV
Geriatric Depression Scale

- Most well studied
- Best sensitivity and specificity among the other screening tools listed
- Patients need to be cognitively intact
- 15 questions
  - Provider form has yes/no answers bolded. Patient receives 1 point for each bold answer
  - >5 is suggestive of depression and should have work up
  - >10 almost always indicates depression

CSDD

- Validated for residents with dementia and frailty
- Information is provided by caregiver as well as discussion and observation of patient
- Information is obtained from the week prior to administration of the scale
- Score is given from 0-3 or unable to evaluate
- Score >10 indicates probable depression
- Score > 18 indicates definite depression
- [https://cgatoolkit.ca/Uploads/ContentDocuments/cornell_scale_depression.pdf](https://cgatoolkit.ca/Uploads/ContentDocuments/cornell_scale_depression.pdf)
PHQ-9 and PHQ-9 OV

- PHQ-9 OV is recommended by Medicare and Medicaid for residents who are not able to communicate for themselves
- PHQ-9 OV includes a symptom of irritability not seen on the PHQ-9

Case Study

- TSH = 2.01
- Recent UTI
- Vitamin B12 = 427
- Folate = 8.2
Diagnostics to Consider

- Electrolytes
- Kidney function
- CBC
- TSH, free T4
- Vit B-12 and folate

Major Depression Diagnosis

- Criteria includes depressed mood in addition to 4 symptoms for 2 weeks
- OR loss of pleasure in addition to 4 symptoms for 2 weeks
- Symptoms
  - Change in appetite
  - Change in sleep patterns
  - Change in psychomotor activity
  - Decreased energy
  - Feelings of worthlessness or guilt
  - Difficulty concentrating
  - Thoughts of suicide
Case Study

- Try to increase activities
  - Focus on those he enjoys
  - Pastoral visits
  - Family visits (With COVID)
  - Outings from the nursing home
- Escitalopram 5 mg started
- Close follow-up recommended

Treatment

- Consider pharmacologic and non-pharmacologic treatment
- Cognitive behavioral therapy
- Interpersonal therapy
- Exercise
- Light therapy
- Psychoeducation
- Participation in social activities
Treatment

- SSRIs
- TCAs, consider avoiding in older adults
- Bupropion, usually used 2nd line
- SNRIs
- Trazodone, minimal effect for depression unless high dose
- Mirtazapine

SSRIs

- SSRIs for use in elderly
  - Citalopram
  - Escitalopram
  - Sertraline
  - Fluoxetine for OCD

- Side effects may include hyponatremia, nausea or diarrhea
- Need to watch for QT prolongation with use of Citalopram
- Need to reduce dose in elderly for Citalopram and Escitalopram
SNRIs

- SNRIs for use in elderly
  - Venlafaxine XR may increase the blood pressure
  - Long taper needed if stopping or changing

- Skipping a dose by more than 2 hours may cause a flu like feeling in patient

TCAs

- TCAs for use in elderly
  - Desipramine
  - Nortriptyline

- Side effects - Watch Anticholinergic side effects
  - Blurred vision
  - Urinary retention
  - Constipation
  - Dry mouth
  - Postural hypotension
Bupropion

- May be a more stimulating medication
  - May cause jitteriness and insomnia
  - Good for use with daytime sedation, lethargy, or fatigue
- May lower seizure threshold
- Start with a lower dose and titrate up if needed

Trazodone

- May cause sedation
  - Given frequently at low dose for sleep
- Maximum dose for the elderly is 300-400mg/day
- Usually well tolerated by elderly patients
- Does not have the anticholinergic effects of the TCAs
Mirtazapine

- Multi-receptor anti-depressant
- Alternative for failed SSRI treatment or to augment pharmacological management
- May cause sedation at lower doses
- May cause increase in appetite

Non-responders

- Reconsider diagnosis
- Ensure adequate dosing
  - Most geriatric patients are undertreated
- Change classes of medication
- Augment with another agent
- Consider geriatric psychiatrist
Case Study Conclusion

✧ Escitalopram increased to 10 mg
✧ Resident doing well at next visit
✧ He has been participating in activities
✧ Sleeping less

Case Study for SI

✧ “I no good anymore, no sense for me to be around”
✧ No concerns for planting idea of suicide if asking about suicide
✧ Goal is to stretch out the time in suicide risk
✧ Hierarchy
  ✧ Ideation: troublesome no need to jump to conclusions
  ✧ Intent: more problematic explore interventions
  ✧ Plan/Means: Lethality, access to means of carrying out highest risk
Risk Factors

- Adolescent, geriatric
- White male
- Single and widowed
- Military service
- Perturbation (emotional distress) plus Lethality of plan
- Previous attempt: most strongly linked
- Substance use
- Depression
- Crisis
- Schizophrenia

- Anorexia Nervosa
- Panic Disorder
- Family history of suicide
- Social isolation
- Recent Loss
- Anniversary of a loss
- Access the lethal means
- Unable to communicate
- Personality Disorder
  - Borderline, antisocial
  - Homosexuality, experiencing harassment

Assessing for SI

- Use of Geriatric Depression Scale has questions that indicate risk for suicide
  - Do you feel happy most of the time?
  - Do you feel that your life is empty?
  - Do you think it is wonderful to be alive?
  - Do you feel pretty worthless the way you are now?
  - Do you feel that your situation is hopeless?
Assessing for SI

- Important questions to ask:
  - Are you suicidal?
    - Avoid asking if they want to harm self. Better to ask do you wish to be dead? Do you want to kill yourself?
  - Do you have a plan? If so, what is it?
  - What other plans do you have or have thought about?
  - Do you have access to the mechanism in plan?
  - How have you prepared?
  - Have you rehearsed?
  - What prevents you from acting?

Assessing for SI

- Be aware of passive SI as well as active SI
  - Active SI- more aggressive forms of suicide- weapons, poisoning, hanging
    - Tend to be seen in younger patients
  - Passive SI- not eating, not drinking, not taking medications, not seeking help for emergency situations
    - Tend to be seen in older patients
Suicide Prevention Programs

- Collaborative team approach: primary healthcare provider, nurses, social work, psychiatrist, therapist
- Education about treatment options for depression and mental health disorders
- Brief Psychotherapy
- Close monitoring of depression symptoms and medication side effects
- Close follow up

Questions?
Reference