DEPRESSION IN THE ELDERLY

- M.Shiehmorteza

Assistance of professor,Azad University of Tehran

Clinical Pharmacist

Diagnostic Approach to Clinical Depression

S	Sleep disturbance
I	Interest diminished
G	Guilt excessive and inappropriate
E	Energy diminished
C	Concentration impaired
A	Appetite disturbance
P	Psychomotor disturbance
S	Suicidal ideation

Medications causing symptoms of depression

- Anabolic steroids
- Digitalis
- Glucocorticoids
- H2 Blockers
- Metoclopramide
- Opioids
- Some Beta-blockers
- Anti-arrythmics
- Anti-convulsants
- Barbituates
- Benzodiazepenes
- Carbidopa/Levodopa
- Clonidine

Comorbid Conditions with High Risk Depression

- Alcohol dependency/Substance abuse
- Cerebrovascular/neurodegenerative disease
- Cancer
- COPD
- Chronic pain
- CHF/CAD/MI
- DM/electrolyte imbalance
- Head trauma/ Orthostatic hypotension
- Abuse
- Schizophrenia

تشخیص در بیماران مسن تر دشوار است، زیرا آنها...

- اغلب علائم جسمی را گزارش می کنند
- ممکن است بخشی از پیری طبیعی در نظر گرفته شود
- اختلال شناختی ممکن است در تشخیص اختلال ایجاد کندپزشکان ممکن است بیشتر روی علائم فیزیکی تمرکز کنند
- کمتر حالت افسرده، احساس گناه را گزارش می کنند
- « که با نگرانی‌های جسمانی پوشانده شده و maskedممکن است با افسردگی با همپوشانی علائم جسمی و عاطفی پیچیده است، ظاهر شود.

Screening Tools

- Geriatric Depression Scale (GDS; validated) 15 item scale (≥ 5 points or positive responses is diagnostic)
- Cornell Scale for Depression in Dementia (scoring system: >12 means probable depression)
- Center for Epidemiologic Studies of Depression Scale (CES-D)
- Patient Health Questionnaire 9 (9 item self-rating scale)

AMDA Clinical Practice Guideline

درمان:

- هداف درمان:
- بهبود خلق و خو، عملکرد و کیفیت زندگی
- اهداف درمان یک دوره افسردگی حاد، دستیابی به بهبودی و جلوگیری از دوره های بعدی افسردگی است
- نتیجه مورد نظر باید رفع کامل علائم باشد، نه صرفاً کاهش علائم

Treatment

- Acute Phase (reverse current episode)
  - Duration: about 3 months: Goal is complete recovery from signs and sx of acute episode
- Continuation Phase (prevent a relapse)
  - Duration: 4-6 months: Goal is to prevent relapse as sx continue to decline and functionality improves
- Maintenance Phase (prevent future recurrence)
  - Duration: 3 months or longer: Goal is to prevent recurrence of a new depressive episode

TYPES OF THERAPY FOR DEPRESSION

- Psychotherapy
- Pharmacotherapy
- Electroconvulsive therapy (ECT)

PSYCHOTHERAPY

رویکردهای استاندارد

درمان شناختی- رفتاری

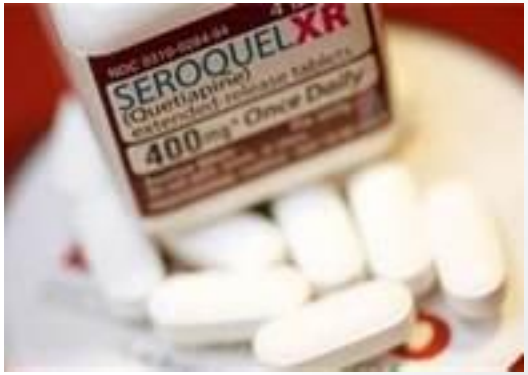
روان درمانی بین فردی

درمان حل مسئله

با یک داروی ضد افسردگی ترکیب شود

PHARMACOTHERAPY

- Individualize choice of drug on basis of:
  - Patient's comorbidities, age
  - Drug's side-effect profile
  - Patient's sensitivity to these effects
  - Drug's potential for interacting with other medications
  - Drug cost
  - Prior med use and response



- • SSRIs – First line – Generally well tolerated – Consider drug-drug interactions with the P450 system
- • SNRIs – Also considered first line, though might be less well tolerated in the very old – May be helpful for comorbid neuropathic pain
- • Bupropion (Wellbutrin) – Dopamine and NE reputake inhibitor
- • Mirtazapine – Helpful for patients with insomnia and decreased appetite
- • TCA – Higher dropout rate than with the above because of tolerability – Cardiac side effects

- • SSRI
- – Citalopram: start 10mg, increase to 20mg dose max
- – Sertraline: start 50mg, increase up to 200mg
- – Paroxetine: avoid
- – Fluoxetine: start 10mg qday, increase up to 60mg
- – Fluvoxamine: avoid
- – Escitalopram: start 5mg, increase to 10mg
- • SNRI
- – Venlafaxine: start 75mg qday, increase to 225mg
- – Duloxetine: start 15mg qday, increase to 60mg
- – Desvenlafaxine: start 50mg qday, increase to 100mg

- • SARI
- – Vilazodone: start 10qd x 7d, then 20qd x7 days; may go to 40qday
- – Nefazodone: start 50mg bid up to 150mg bid
- • Atypical Antidepressants
- – Bupropion: start 75mg qday, up to 300mg
- – Mirtazapine: 7.5mg qHS up to 60mg
- • Atypical Antipsychotics
- – Aripiprazole: 2.5mg to 5.0mg as adjunct
- • TCAs: avoid
- • MAOIs: avoid without referral to psychiatry

SELECTIVE SEROTONIN-REUPTAKE INHIBITORS (SSRIs)

- Side effects:
  - Anxiety, agitation, nausea & diarrhea, sexual effects, pseudoparkinsonism, ↑ warfarin effect, other drug interactions, hyponatremia/SIADH, anorexia

SSRI DOSING

Drug	Recommended Dose
Citalopram	10–40 mg/day
Escitalopram	10–40 mg/day
Fluoxetine	10–40 mg/day
Paroxetine	10–40 mg/day
Sertraline	50–200 mg/day

TRICYCLIC ANTIDEPRESSANTS (TCAs)

- Avoid in the presence of conduction disturbance, heart disease, intolerance to anticholinergic side effects

- Most patients achieve target concentrations at:
  - Nortriptyline**:** 50**–**75 mg per day
  - Desipramine: 100**–**150 mg per day

Treatment : Pharmacotherapy

- Antidepressants
  - SNRI and SSRI
    - Cymbalta (duloxetine) 30-60 mg/day
  - Norepinephrine, $5HT_2$ and $5HT_3$ antagonist
    - Remeron (mirtazapine)
    - Can cause serotonin syndrome when given with other SSRI's

Treatment : Pharmacotherapy

- Antidepressants
  - Stimulants
    - Ritalin (methylphenidate) 20mg BID
    - Provigil (modafinil) 400mg q am
    - Dexedrine (dextroamphetamine) 2.5-5mg 7am and noon

VENLAFAXINE

- Acts as SSRI at low doses; at higher doses SNRI (selective norepinephrine reuptake inhibitor)
- Effective for major depression & generalized anxiety
- Side effects:
  - Nausea
  - Hypertension
  - Sexual dysfunction
- Dose range: 75–225 mg per day

DULOXETINE

- Effective for major depression and FDA- approved for neuropathic pain
- Precautions: drug interactions (CYP450 1A2, 2D6 substrate), chronic liver disease, alcoholism, serum transaminase elevation
- Dose range: 15–60 mg per day

NEFAZODONE

- Has SSRI and 5-HT_2 antagonist properties
- Approved for depression & anxiety
- Not associated with insomnia, sexual dysfunction
- Potent inhibitor of CYP-450 3A4 system—use with caution with other medications
- Dose range for young adults: 300–500 mg per day; older adults may not tolerate same doses due to sedating side effects

MIRTAZAPINE

- Norepinephrine, 5-HT_2 , and 5-HT_3 antagonist
- **Associated with weight gain, increased appetite**
- May be used for nursing-home residents with depression & dementia, nighttime agitation, weight loss
- Dose range: 15-45 mg per day
- May be given as single bedtime dose (sedative side effects); available in sublingual form

METHYLPHENIDATE

- هیچ داده کنترل شده ای وجود ندارد که اثربخشی را برای افسردگی نشان دهد

برای دهه ها برای درمان افسردگی اساسی استفاده می شود

- ممکن است در معکوس کردن بی تفاوتی، کمبود انرژی در بیماران مبتلا به زوال عقل یا ناتوان کردن شرایط پزشکی نقش داشته باشد

- استفاده کوتاه مدت،

Treatment : Pharmacotherapy

- Antidepressants
  - Monoamine Oxidase Inhibitors (MAOIs)
    - Marplan (isocarboxazid) 30 mg/day
    - Nardil (phenelzine) 30–45 mg/day
    - Parnate (tranylcypromine) 30–40 mg/day
  - Orthostatic hypotension, falls
  - Life-threatening hypertensive crisis if taken with tyramine-rich foods, cold remedies (pressor amine)

درمان خط اول برای بیمارانی که در معرض خطر جدی خودکشی قرار دارند

مناسب برای افسردگی روان پریشی(سایکوتیک) در افراد مسن.

نرخ پاسخ ۸۰%

اثرات جانبی:فراموشی

موارد منع مصرف:

وجود مشکلات قلبی عروقی و انفارکتوس

افزایش فشار داخل جمجمه

PHARMACOLOGIC ALGORITHM

Initiate citalopram, escitalopram, or sertraline

If response is inadequate, switch to fluoxetine, OR switch class based on symptom profile

Apathy, retardation	Insomnia, anxiety, anorexia	Pain	Atypical, melancholic, anxious
↓	↓	↓	↓
bupropion	mirtazapine	duloxetine	venlafaxine If inadequate response…
			↓ ↓
			Atypical anxious / Melancholic,
			↓ ↓
			MAOI / TCA

- نظارت بر پاسخ بیمار به درمان
- اهداف احتمالی درمان
- رفع علائم و نشانه ها
- بهبود نمره در ابزار غربالگری
- بهبود حضور و مشارکت در فعالیت های معمول
- بهبود الگوی خواب

Adjuvant Medical Treatment

- Anxiety
- Insomnia
- Constipation
- Shortness of Breath
- FAMILY!!

Nonpharmacologic Treatment

- Physical/Occupational therapy
- Touch – massage
- Increased social interaction
- Support groups if patient is able

SUMMARY

- In older adults, depression is
  - Common (especially “minor” depression)
  - Associated with morbidity
  - Difficult to diagnose because of atypical presentation, more somatic concerns, overlap with symptoms of other illnesses
- Differential diagnosis: medical illnesses, dementia, bereavement

SUMMARY

- *Suicide* is a serious concern in depressed older patients, particularly older

white males

SUMMARY

- Treatment (acute & preventive) should be individualized and may include:
  - Psychotherapy
  - Pharmacotherapy
  - ECT
- Choice of antidepressant should be based on comorbidities, side-effect profiles, patient sensitivity, potential drug interactions