Depression in the Elderly:
When Treatment Fails

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Depression is the most common mental health problem in the elderly and is more common in medical settings than in the community.[1]

The majority of seniors with depression are treated at the doctor's office or in a long-term care setting. Approximately two-thirds of people will respond to the first or second antidepressant they are given. However, there is a core of elderly patients who do not respond well to therapy and require a more in-depth assessment to determine how to treat or manage the situation.

How should recurrent depression in th... treat...

...novel antidepressants of antidepressants or even ...oconvulsive therapy to resolve.

Table 1 outlines some commonly accepted combinations to try when a single antidepressant fails. In these patients, the introduction of an augmenting agent (if switching to another class of antidepressant has not worked) is worth considering.

Joe's Problem

- Age: 76
- Joe presents with classic symptoms of depression, such as low mood, lack of energy, early wakening, guilty thoughts about the past and poor appetite.
- Joe had four previous episodes of depression successfu... sertraline and citalopra...
- He is still ...

...health with a ...y of hypertension that is well-controlled with ramipiril, 2.5 mg, once daily.

- Carol presents with a first episode of depression with no obvious stressors to explain it. She admits to poor memory over the past few weeks.
- Mini-mental status exam (MMSE): 25/30
- In light of her MMSE results, a computed tomography scan of her head is ordered. This shows mild cortical atrophy, more pronounced in the Parietal lobes.

How should Carol be managed? For the answer, go to page 56.

Table 1

Accepted drug combinations

If the patient is on a selective serotonin reuptake inhibitor or a serotonin/ norepinephrine reuptake inhibitor:

- Mirtazapine, qhs
- Trazodone, qhs
- Tricyclic nortriptyline
- Atypical antipsychotics (risperidone, olanzapine, quetiapine)

If unsuccessful, consider:

- Buspirone
- Triiodothyronine
- Modafinil 25 mg to 50 mg qam
- Cognitive behaviour therapy
- Lithium (beware of toxicity)

qhs: Every hour of sleep
qam: Every morning

Joe's Depression

- His physical exam and investigations are all normal.
- You decide to switch to venlafaxine (which has both serotonin and norepinephrine actions at 150 mg a day).
- Six weeks later, Joe is somewhat better, but still depressed and not sleeping. You add mirtazapine, 15 mg every hour of sleep (qhs).
- Three weeks after his last visit, Joe is back to his normal self. You maintain him on venlafaxine, 150 mg, and mirtazapine, 15 mg qhs.

Helping Carol

- Treatment of depression with a serotonin reuptake inhibitor leads to resolution of depression and improvement in MMSE (29/30).
- Carol should have a repeat MMSE every 6 to 12 months to watch for possible early dementia.

What else can it be?

- The other group presenting to the family physician's office is the group in which depression is the apparent problem, but in reality the symptoms are secondary to an underlying neurologic disorder.
- It is becoming increasingly evident, for example, that patients with small blood vessel disease (particularly in the subcortical regions of the brain) may present with depressive features that are highly resistant to traditional antidepressant therapy.
- Parkinson's disease and Alzheimer's disease may present with depression, long before the onset of the typical symptoms of these disorders.[2]

Is it depression or apathy?

Families may show concern for a relative having a lack of energy or interest and this may be mistaken for depression. These patients often show restricted affect, but deny feeling depressed.

Obviously, investigating for thyroid disease is worth undertaking. However, a quick assessment of the patient may determine that their mood appears bright and cheerful and they are simply disinterested in engaging in usual activities. Assessment of frontal lobe function may be required and use of a more stimulating antidepressant (*i.e.*, sertraline or bupropion) may improve function, but may cause irritability.

Frontal depressive executive dysfunction syndrome of late life, where patients present with a combination of depressive features and frontal lobe symptoms, is not uncommon and has been recorded in geriatric literature for some time.[3]

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Geriatric patients often require augmentation with agents that work on the dopaminergic/noradrenergic system, rather than the traditional serotonin reuptake inhibitors (*e.g.*, mirtazapine or addition of a stimulant, such as modafinil).

If frontal lobe involvement in early dementia is suspected, use of a cognitive enhancer may be worth trying. Such patients may have either a frontal lobe dementia or frontal lobe features related to other disorders (Alzheimer's, tumour, *etc.*). These patients can be referred to a specialist for further evaluation of depression versus frontal lobe executive dysfunction symptoms.

Can it be a neurologic disorder?

If a careful long-term history is obtained and it is clear that a patient has developed late onset depression denovo and this depression is proving hard to treat, a very high index of suspicion for early neurologic disease should be considered.[4] There is a high risk that they may go on to develop more obvious features of a neurologic disorder of which the most common will prove to be either vascular dementia or senile dementia of the Alzheimer type. Mini mental status examinations at six-month to one-year intervals are recommended.

In the meantime, augmentation of the dopamine/noradrenergic pathways are likely to be the most successful strategies. If it becomes evident that mild dementia is present, addition of a cognitive enhancer (donepezil, galantamine, rivastigmine) may enhance mood.

Can other illnesses present as depression?

Underlying medical illnesses, particularly malignancy and advanced chronic obstructive pulmonary disease of advanced cardiovascular illnesses may present with depression-like symptoms. Treatment is always worth considering, but may not be effective.

If anxiety is not significant, use of psychostimulants (modafinil, 25 mg to 50 mg, or methylphenidate, starting at 5 mg, twice a day, but titrating up to 10 mg, three times

a day, in exceptional cases, (watch for risk of seizures, palpitations or psychosis during the titration phase) can be considered before psychiatric consultation. Higher doses may be used, but are best avoided in the primary-care setting.

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References
1. Schneider LS, Reynolds CF, Lebowitz BD, et al: Diagnosis and treatment of depression and treatment in late life: Summary of the NIH consensus statement. MD Med J 1993; 42(2):192-4.
2. Kales HC, Maxiner DF, Mellow AM: Cerebrovascular disease and late life depression. Am J Geriatr Psychiatry 2005; 13(2):88-95.
3. Vataja R, Pohjasvaara T, Mantyla R, et al: Depression–executive dysfunction syndrome in stroke patients. Am J Geriatr Psychiatry 2005; 13(2):99-107.
4. Sobin C, Sackheim HA: Psychomotor symptoms of depression. Am J Psychiatry 1997; 154(4):4-17.