DEPRESSION

AGS Geriatrics Evaluation and Management Tools (Geriatrics E&M Tools) support clinicians and systems that are caring for older adults with common geriatric conditions.

From the AMERICAN GERIATRICS SOCIETY

Geriatrics Evaluation & Management Tools

EPIDEMIOLOGY

- Minor depression (aka subclinical or subsyndromal depression: 8% to >40% of older adults in outpatient settings; associated with disability and poor health outcomes including higher mortality
- Major depression: 6%–10% of older adults in primary care clinics; 12%–20% of nursing home residents; 11%–45% of hospitalized older adults

SCREENING

- Screening for depressive disorders is ineffective without a protocol for treatment initiation and response assessment or referral for mental health services.
- 9-item Patient Health Questionnaire (PHQ-9) (https://bit.ly/1ljT50l)
  - 9 items cover diagnostic criteria for major depression.
  - Initial 2 questions can be used for screening.
  - Serial administrations may assess response to treatment.
- Geriatric Depression Scale (www.stanford.edu/~yesavage/GDS.html)
  - Yes/No format
  - Lacks suicidal ideation query
  - Not useful for assessing treatment response
- **Suicide**
  - Approximately 85% of suicides in older adults occur among men.
  - The highest suicide rates among older people occur among white non-Hispanic men ≥85 years old.
  - Firearms are the leading means of suicide among older adults in both men and women.

DIFFERENTIAL DIAGNOSIS

- **Medical illness:** conditions or medications that promote apathy, diminished appetite, disturbed sleep
- **Dementia:** has overlapping symptoms (see AGS Geriatrics Evaluation & Management: Dementia)
- **Delirium:** may have overlapping symptoms (see AGS Geriatrics Evaluation & Management: Delirium)
- **Bereavement:** most disturbing symptoms resolve in 2 months; no marked functional impairment
- **Bipolar disorder:** refer to *DSM-5* criteria for details
- **Substance abuse**
- **Minor depression:** presence of depressed mood with 2–3 additional symptoms of major depressive disorder
- **Psychotic depression:** sustained irrational beliefs (delusions) in association with depressed mood; irrational belief may focus on somatic symptoms or fears of a serious physical condition when no medical evidence can be identified to support the belief (eg, belief that one's bowels are "blocked with cancer").

HISTORY OF PRESENT ILLNESS

- Inquire about *DSM-5* diagnostic criteria for major and minor depression (refer to PHQ-9)

NONPHARMACOLOGIC MANAGEMENT

- **Psychotherapy**
  - Behavioral activation therapy has proved effective for depression in the context of multimorbidity and is the cornerstone of cognitive-behavioral therapy.
  - Studies have demonstrated efficacy of problem-solving therapy, cognitive-behavioral therapy, and interpersonal psychotherapy for older adults with major and minor depression.
  - Psychotherapy with antidepressant is associated with a longer period of remission after recovery from the acute episode of depression.
- **Aerobic exercise**
  - Treatment for mild to moderate depression in older adults
  - Exercise with antidepressants can yield faster, more lasting results than either alone
- **Light therapy**
  - Treatment for seasonal depression
- **Electroconvulsive therapy (ECT)**
  - First-line treatment for patients at serious risk of suicide, life-threatening poor intake due to major depressive disorder, or delusional depression

MANAGEMENT PRINCIPLES

- **Acute phase:** Patient begins taking antidepressants to achieve remission of depressive symptoms.
- **Continuation phase:** Once remission of symptoms is achieved, patient remains on antidepressants at therapeutic doses for an additional 6 months (at least) to maintain symptom-free state (prevent relapse).
- **Maintenance phase:** Patient remains on antidepressants at therapeutic doses to prevent future recurrence of depression. The duration of maintenance therapy should be based on the frequency and severity of previous depressive episodes and may need to be lifelong if complicated by psychosis or suicidal ideation.

PHARMACOLOGIC MANAGEMENT

Indications to Start Antidepressant Therapy Based on Patient Health Questionnaire-9

PHQ-9 Score	Depression Severity	Clinician Response
1–4	None	None
5–9	Mild to moderate	If not currently treated, rescreen in 2 weeks. If currently treated, optimize antidepressant and rescreen in 2 weeks.
10–14	Major depressive disorder	Start antidepressant therapy
≥15	Major depressive disorder	Start antidepressant therapy; obtain psychiatric consultation if suicidality or psychosis suspected

Generic Name Initial/Final Dose (mg)	Precautions and Comments
Selective Serotonin Reuptake Inhibitors (SSRIs)	
Citalopram 10 qam / 20 qam	■ Risk of QT_c prolongation in doses >20 mg, nausea, tremor, hyponatremia, serotonin syndrome, reduce dosage in renal insufficiency ■ Fewer drug interactions, oral solution available
Escitalopram 10 qam / 10–20 qam	■ Risk of QT_c prolongation in doses >20 mg, nausea, tremor, hyponatremia, serotonin syndrome, reduce dosage in renal insufficiency ■ Also FDA-approved for GAD; oral solution available
Sertraline 25 qam / 100–200 qam	■ Nausea, tremor, insomnia, serotonin syndrome, hyponatremia, diarrhea ■ Fewer drug interactions; also FDA-approved for OCD, PTSD, social anxiety disorder
Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)	
Duloxetine 20–30 qam / 60 qam	■ Drug interactions (CYP1A2, -2D6 substrate); chronic liver disease, alcoholism, increased serum transaminase; reduce dosage in renal insufficiency or choose other agent; rare cases of liver toxicity; narrow dosage range ■ Also FDA-approved for neuropathic pain, GAD
Venlafaxine XR 37.5–75 qam / 75–225 qam	■ Blood pressure elevation, headache, nausea, vomiting; do not stop abruptly; reduce dosage in renal insufficiency ■ Fewer drug interactions; specify XR for once-daily dosing
Stimulants	
Methylphenidate[OL] 2.5 qam / 20 qam	■ Anorexia, insomnia, blood pressure elevation, risk of psychotic symptoms such as delusions; daytime use only; avoid use with buproprion because it also has stimulant effects ■ Quick results; for the frail and apathetic
Tricyclic Antidepressants (TCAs)	
Nortriptyline 10–25 qhs / 25–100 qhs	■ Constipation, dry mouth, orthostatic hypotension, diabetes; avoid if closed-angle glaucoma or prostatic disease; may be fatal in overdose ■ Therapeutic window 50–150 ng/mL serum level
Other	
Bupropion 75 q12h /150 q12h 150 qam / 300 qam	■ Dopaminergic, noradrenergic; agitation, insomnia, seizures; no anxiolytic properties ■ For apathetic depression, when TCA/SSRI are ineffective ■ Available in immediate-release, sustained-release, and extended-release tablets
Buspirone[OL] 5 q12h/ 30 in divided doses	■ Only for augmentation, not a benzodiazepine substitute ■ Antianxiety agent with no dependence
Mirtazapine 7.5 qhs / 15–45 qhs	■ Prolonged half-life, dry mouth, weight gain; reduce dosage for renal insufficiency; potential for neutropenia; sedation ■ When depression resistant to TCA/SSRI; sedative, useful for insomnia
Trazodone 25 qhs /100-150 qhs	■ For augmentation when depression is partially responsive to TCA/SSRI ■ Very sedating; rare cases of priapism with high dosages ■ Potentially useful for sleep disturbance

NOTE: GAD=generalized anxiety disorder; PTSD=posttraumatic stress disorder; OCD=obsessive-compulsive disorder, OL=off-label

Prescriber Response Guidelines at 4 Weeks Based on the Patient Health Questionnaire-9 and the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) Studies

PHQ-9 Score or Change	Outcome	Clinician Response
No decrease or increase	Nonresponse	Switch medication
Decrease of 2–4 points	Partial response	Add medication (augmentation)
Decrease of ≥5 points	Response	Maintain medication
Score <5	Remission	Maintain medication