PRACTICAL PSYCHOPHARMACOLOGY

Modify Depression Treatment for Older Patients

Comorbidities are common, so the initial dosage of any agent should be low and titration cautious.

BY CARL SHERMAN
Contributing Writer

Depression among the elderly is, in most ways, no different than in younger adults. It responds to the same drugs, but patient factors, presentation, and context must be appreciated for optimal treatment.

The most prominent age-linked difference is the prevalence of potentially complicating medical conditions. "Comorbidity is the hallmark of geriatric depression," said Helen Kales, M.D., a psychiatrist at the University of Michigan and the Veterans Affairs Ann Arbor Healthcare System.

The effect is bidirectional: Medical conditions like cardiovascular disease and diabetes may cause or worsen depression, whereas depression can compromise rehabilitation and self-care. Polypharmacy complicates treatment, she said.

A full medical work-up, including thyroid function and blood tests or a review of recent lab results, should be part of the initial assessment. When patients are on a number of medications, communication with other treating physicians is highly advisable, Dr. Kales said.

Especially in late-onset depression—a first episode after age 50 or 60 years—"you must consider the possibility of cerebrovascular disease. Some patients may be in the earliest stages of Alzheimer's disease," said Davangere P. Devanand, M.D., codirector of the late-life depression clinic at the New York State Psychiatric Institute, New York.

At the outset—and certainly if routine depression treatment fails—a full assessment of cognitive status, memory loss, and executive function is indicated, he said.

Depression secondary to cerebrovascular disease often has a distinctive look. These patients may have fewer psychological symptoms, such as guilt and hopelessness, than do others. "But they're apathetic, slowed down. Even without overt dementia, there's executive dysfunction. They can't organize or plan well," Dr. Kales said.

When vascular depression seems likely (according to diagnosed cardiovascular disease or risk factors, or a history of stroke, as well as the clinical picture), then treatment should include aggressive measures—such as blood pressure control and prophylactic aspirin or platelet inhibitor therapy—to limit further damage, she said.

More generally, the initial treatment for geriatric depression, as for younger adults, is one of the newer antidepressants.

Among the selective serotonin reuptake inhibitors (SSRIs), Jeffrey Lyness, M.D., most often chooses sertraline, citalopram, or escitalopram. The sedating and anticholinergic effects of paroxetine sometimes make it less attractive, and a long half-life and drug-drug interactions can be problematic with fluoxetine, although both drugs have demonstrated efficacy in older patients.

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Dr. Lyness may, however, opt for a serotonin-norepinephrine reuptake inhibitor (SNRI) like venlafaxine or duloxetine, or for other agents such as mirtazapine. "By the time they're seen in psychiatric practice, most patients have failed a trial of an SSRI, and they are likely to have a more severe, melancholic type of depression. I'm in the camp that believes [these drugs] are more effective in severe cases," said Dr. Lyness, director of the program in geriatrics and neuropsychiatry at the University of Rochester (N.Y.).

Bupropion may be the first choice when an activating drug is sought for patients who are low in energy and motivation, for those without prominent anxiety or insomnia, or when sexual dysfunction is a concern.

Whatever the agent, initial dosage should be low and titration cautious, particularly with very old patients (those in their 80s and older) and those with substantial medical comorbidity, Dr. Lyness said. Although he might treat an otherwise healthy 62-year-old much like a 45-year-old, an older or sicker patient might well start on a half dose of antidepressant, with a week or two between increases.

"I'd amend the old adage to 'start low, go slow, but don't stop,' " he said. Most older patients will need the same, or nearly the same, dosage as younger ones, even if it takes longer to get there.

Those in whom apathy is prominent often need higher dosages than do others, Dr. Kales observed.

Tolerance problems may be as much emotional as physical. "Patients attribute to the drug symptoms that they actually had before, or tend to worry so much about side effects that they're unable to wait for them to go away," Dr. Lyness noted. "We spend a lot of time and energy getting the patient to hang in there and let the medication do its job."

Frequent—at least weekly—visits during the acute phase of treatment, telephone availability, and psychoeducation for patient and family are important, he said.

An individual who is taking multiple medications may be reluctant to add another. "I reassure them that the drug combination is safe, and that their physical health is likely to do better if they are not depressed," Dr. Lyness said.

Older patients may be slower to respond to antidepressants, and they may require more time for a full trial, said Harold Goforth, M.D., a geriatric psychiatrist at Duke University, Durham, N.C. When improvement is inadequate, medical factors—such as systemic illness, thyroid disease, hypogonadism, and vitamin B_{12} and folate deficiencies—should be reconsidered before further medication trials, he suggested.

There are few data on augmentation in this population, and the best researched strategy in adults (lithium) "is not well tolerated in the elderly," he pointed out. Mental clouding is problematic, and the therapeutic window is reduced. "They can get toxic quite rapidly," Dr. Goforth said.

"Combinations of antidepressants are more often necessary for elderly patients," Dr. Devanand said. When sensitivity to side effects makes it necessary to stop each drug at a subtherapeutic level, both together may be effective.

Dr. Lyness generally combines activating and sedating agents, such as bupropion or venlafaxine with mirtazapine, he said. The most treatment-refractory patients may respond to a tricyclic, possibly in combination with an SSRI, or to an MAO inhibitor.

Dr. Devanand has used low-dose atypical antipsychotics adjunctively, particularly the activating agent aripiprazole. He observed that the stroke risk, which is now a black-box warning, is actually fairly low and based on events in demented—not depressed—individuals, whose "brain physiology differs in many respects."

Electroconvulsive therapy (ECT) is an option not to be overlooked. "It's extremely safe in older patients," and difficulties with medication can make it an attractive alternative, Dr. Goforth said. "I tend not to be very slow in going to ECT if patients are experiencing treatment refractoriness or can't tolerate medication, particularly if depression is severe."

Most treatment guidelines suggest maintenance medication for 9-12 months after one episode of depression and indefinitely after three episodes. "I'd say two are enough," Dr. Lyness said, "and if a first episode was devastating or took a long time to resolve [often the case in late-onset depression], or has not resolved 100%, I'd recommend staying on the full dose indefinitely."

In counseling patients reluctant to remain on medication after recovery, Dr. Lyness often draws an analogy from their experience: "The vast majority have some chronic medical condition, and I point out that they may feel great but they hopefully do keep taking drugs for hypertension or hypercholesterolemia." ■

Intervention Improves Vertigo and Reduces Risk of Falling

BY DAMIAN McNAMARA
Miami Bureau

BOCA RATON, FLA. — Vestibular rehabilitation and balance retraining reduced vertigo and falls in a study of 100 community-dwelling elderly patients with disequilibrium of aging.

The intervention also improved gait and overall quality of life in the study conducted at the Atlanta Ear Clinic between July 2004 and March 2005. The study included 57 women, and the mean age was 79 years.

"We see a lot of elderly people in our population, and vertigo is a common cause of falls," Gaye W. Cronin, an occupational therapist at the clinic, said during a poster session at the annual meeting of the American Head and Neck Society.

At baseline, participants had a medical examination, an audiogram, and an assessment of fall risk, balance, gait, positional vertigo, and oculomotor function. The intervention consisted of balance and vestibular rehabilitation, oculomotor exercises, and repositioning or redistribution exercises for benign paroxysmal positional vertigo (BPPV).

The intervention "would be pretty easy to follow by other physicians," Ms. Cronin told this newspaper.

Vestibular rehabilitation and balance retraining involve movement and exercise intended to decrease or eliminate dizziness or vertigo, improve balance function and safety, improve visual motor control, increase activity levels, and reduce falls or risk of falls. The program is indicated for people with vertigo or imbalance conditions that do not spontaneously resolve within 3-4 weeks, she said.

Ms. Cronin and her associate, Ronald Leif Steenerson, M.D., followed the patients in person or via telephone for 6 months. There was an 80% reduction in the number of falls. "We saw a significant reduction in falls, from 56 falls before the intervention to 11 falls afterward," she said.

The intervention normalized BPPV for 82 of the initial 91 patients (90%) who presented with the condition. Gait was normalized for 55% of the patients. A total of 71% had normalized balance tests, and 54% no longer needed a device to assist with mobility.

The researchers also measured quality of life on a 0 to 10 scale. Scores improved from an average 3.5 at baseline to 7 after the intervention. ■

More information on vestibular rehabilitation and balance retraining is available at www.atlantaearclinic.com.

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