Dysthymia in Older Adults Needs Further Study

BY JEFF EVANS
Senior Writer

STOCKHOLM — Much remains unknown about dysthymia and minor depression in older adults, particularly when it comes to differences in the pathogenesis of early- and late-onset disorders and the interaction of these disorders with comorbidities, Dr. Jeffrey M. Lyness said at the 12th Congress of the International Psychogeriatric Association.

Studying the contributions of early- and late-onset symptomatology to medical comorbidities is a complex proposition. As a result, coming up with specific treatment approaches has proved difficult.

Compared with the number of studies for major depression, relatively few studies have examined the neurobiology of dysthymia, even in younger adults. Studies that have been conducted provide mixed results on whether any real differences or similarities exist between the neurobiology of dysthymia and major depression in either older or younger adults.

Some findings suggest that older male patients with dysthymia may have low serum testosterone levels. Other studies have not clearly indicated whether small-vessel cerebrovascular disease contributes to dysthymia in older patients, said Dr. Lyness, director of the laboratory of depression and medical comorbidity in the geriatrics and neuropsychiatry program at the University of Rochester (N.Y.).

The criteria for dysthymia include symptoms that are less intense but just as chronic as those in major depression, thus creating a "very unusual combination," he said.

The "most striking feature" about dysthymic disorder in older adults may be that it is less common in community settings in elderly individuals (1%) than in younger people in such settings (3%-4%), he said. "It's not clear why that is;" it is not known whether the lower prevalence is a function of aging or if the higher prevalence in younger people is a characteristic of the current younger generation.

In older adults, the male-to-female ratio is nearly 50:50 for dysthymia. This is in contrast with disorders such as major depression, where women make up the greater proportion of those diagnosed.

Patients with minor depression often fail to meet criteria for dysthymia, Dr. Lyness said, because the waxing and waning nature of minor depression does not meet the 2-year criterion for dysthymia.

The set of nine criteria for minor depression in the appendix of the DSM-IV is the same as that for major depression. But only two to four criteria have to be met for minor depression, instead of five or more for major depression. The symptoms also have to be present for most of the day, nearly every day, for at least 2 weeks for both disorders.

It may be best to reserve treatments for patients with troublesome depressive symptoms.

DR. LYNESS

In Dr. Lyness' experience, patients with minor depression often have as many symptoms as do patients with major depression. But they do not meet the criteria for the more severe form of the illness, because they have only two or three miserable days a week but don't feel so bad other days, or they have most of their symptoms for a few hours in the morning or evening.

Minor and "subsyndromal" depressions appear to be on a spectrum between no depression and major depressive disorder based on functional status, neuroimaging scans, and patient outcomes in studies comparing minor and major depression in older adults, he said.

Treatments for minor depression appear to work. But many studies have been plagued by the absence of a difference between active treatments—such as psychotherapy or medications—and placebo, partly because of very high placebo response rates, Dr. Lyness said.

In conducting a series of metaanalyses of trials comparing the efficacy of pharmacotherapy with that of psychosocial therapies in older adults with depression, Dr. Lyness and his colleagues found that psychosocial therapies had "somewhat bigger effect sizes" than did pharmacotherapy in studies that contained less severely depressed patients. The metaanalyses are in press in the American Journal of Psychiatry.

Dr. Lyness suggested that it might be best to educate and observe minor depressive patients who have less severe symptoms and to reserve psychosocial therapies or medications for patients with particularly troublesome symptoms or a history of depression.

Many clinicians suspect that two 75-year-olds who have minor or major depression may be suffering from pathogenetically different disorders when one just had a first episode and the other has had the current episode since 32 years of age. Although such distinctions may be important, they are not easy to study because of the difficulty of determining the actual age of onset in a retrospective manner, Dr. Lyness pointed out.

Investigators must define what they consider to be first onset of depression, especially in older patients who now have major depression but initially met criteria for minor depression when they were younger. The pathogenesis of depression also could change within individuals as they age, even if they have the same symptoms over a long period.

In older adult patients with depression, both early- and late-onset conditions "have strikes against them," because early-onset patients have longer and greater numbers of episodes, whereas late-onset patients may have several acquired biological factors that affect the brain directly, or there may be psychosocial factors that might "be less amenable to change," he said.

Recently, a systematic review of studies of older and middle-aged adults with depressive conditions showed that an earlier age of onset and a larger number of depressive episodes were associated with a worse prognosis. But the presence of medical comorbidities explained most of the differences in prognosis and response to treatment. The review did not distinguish among the subtypes of depression (Am. J. Psychiatry 2005;162:1588-601).

Right now, evidence is too sparse to recommend specific medications or types of psychotherapy based on the older depressed patient's physical comorbidity.

In reviewing studies of about 700 primary care patients at the University of Rochester, Dr. Lyness and his colleagues have found that some physical illnesses—low vision, central nervous system diseases, diabetes, and hypothyroidism—appear to have independent associations with depression. ■

Refractory Depression in Elderly Too Complex for Guidelines

BY LINDA LITTLE
Contributing Writer

ALBUQUERQUE, N.M. — A survey of 50 psychiatrists from across the country provides insight into treatment of refractory depression in the elderly, Dr. William Apfeldorf said at a psychiatric symposium sponsored by the University of New Mexico, Albuquerque.

"Treatment guidelines can help but can't fully address the complexity of a complicated case," said Dr. Apfeldorf of the department of psychiatry at the university.

In the survey, psychiatrists were asked to rate the appropriateness of treatments, with 9 being the treatment of choice, 7-8 being a first-line treatment, 4-6 a second-line treatment, 2-3 being a treatment rarely used, and 1 being a treatment that is never used.

For mild, nonpsychotic major depression in the elderly, the first line of treatment chosen by respondents was pharmacotherapy and psychotherapy. Pharmacotherapy alone was a close second, almost ranking as a first-line treatment.

If the first-line antidepressant failed, the psychiatrists would switch to a different antidepressant if there was no response and would augment the initial prescription if there was a partial response.

The experts were inclined to use a selective serotonin reuptake inhibitor (SSRI) initially. If there was no response, they would treat with either extended-release venlafaxine (Effexor XR) or sustained-release bupropion (Wellbutrin SR). Second-line treatment for nonresponders included another SSRI or nortriptyline or mirtazapine (Remeron). "Venlafaxine XR rated the highest in usage if the original SSRI didn't work," said Dr. Apfeldorf.

For mild, nonpsychotic major depression, pharmacotherapy and psychotherapy were chosen as the first line of treatment.

If a tricyclic is used and there is no response, the next first-line treatment would be venlafaxine XR or an SSRI, according to the experts in the study.

For bipolar disorder, the first choice would be bupropion SR or lithium, then nortriptyline.

"Nothing was considered first line," said Dr. Apfeldorf, "but we were surprised that lithium still showed up."

The psychiatrists chose trazodone (Desyrel) as the first-line treatment of insomnia in the geriatric population, with zolpidem (Ambien) and zaleplon (Sonata) use coming later, Dr. Apfeldorf said.

For residual anxiety, the experts chose to increase the dosage of an antidepressant. If an antidepressant and mood stabilizer were required for the acute phase of anxiety, they would continue treatment with the combination. The first choice of mood stabilizer for the geriatric population was divalproex (Depakote), with lithium the second-line choice.

"The experts did not recommend any complementary medicine agents in late-life depression," he said.

Some experts recommended light therapy as a second treatment to be added to an antidepressant, but most of the experts weren't located in places without a lot of light, Dr. Apfeldorf said.

After the initial episode and treatment, patients should be followed monthly for the first year, then every 1-3 months. Maintenance treatment should continue for 1 year if there was one episode of depression, 2 years if there were two episodes, and more than 3 years if there were three episodes, according to the respondents.

Electroconvulsive therapy is indicated in the geriatric population only if the patient is severely depressed and suicidal or has medical conditions preventing adequate drug treatment, the experts said.

Often, geriatric patients have comorbidities that contribute to depression, such as heart disease. SSRIs were favored for patients with bundle branch block, coronary artery disease, diabetes, and hypotension.

In patients with dementia who also are depressed, the experts chose citalopram (Celexa) and sertraline (Zoloft) as first-line treatments, along with venlafaxine XR.

Other drug combinations with antidepressant drugs also need to be monitored closely, they said. ■