Geriatric Depression in LTC

Simon Woo, MD, FRCPC
Geriatric Psychiatry

Land Acknowledgement

- **This presentation is broadcasted from the traditional territories of the Kwikwetlem, Musqueam, Squamish, Stó:lō and Tsleil-Waututh First Nations**.

Conflicts of Interest

- No financial dealings with any pharmaceutical companies
- Remuneration for this activity is from conference organizer only
- Medications will be discussed in generic names

Objectives

- Appreciate how depression presents in older adults
- Gain insight as to how depression will present in older adults with cognitive changes
- Understand the initial management of depression in older adults

Outline

- Depression in older adult vs. general adult
- Depression in patients with Major Neurocognitive Disorder vs. Cognitively intact
- Treatment considerations for depression in older adult
- Special scenario of Parkinson's Disease and Post Stroke

Pre-test

- Which of the following symptoms will older adult more likely to express in depression?
  - A) sadness
  - B) stomach upset
  - C) suicidality
  - D) guilt

Pre-test

- Which of the following screening tests should we regularly use for older adult depression?
  - A) Beck Depression Inventory (BDI)
  - B) Hamilton Depression Rating Scale (HAM-D)
  - C) PHQ 9
  - D) Quick Inventory of Depressive Symptomatology-Self-Report (QIDS-SR)

Pre-test

- Which of the following antidepressant is most likely to cause SIADH?
  - A) Mirtazapine
  - B) Bupropion
  - C) Nortriptyline
  - D) Citalopram

Pre-test

- Which of the following medications is considered first line for Parkinson's Depression?
  - A) Sertraline
  - B) Bupropion
  - C) Venlafaxine
  - D) Nortriptyline

Outline

- Depression in older adult vs. general adult
- Depression in patients with Major Neurocognitive Disorder vs. Cognitively intact
- Treatment considerations for depression in older adult
- Special scenario of Parkinson's Disease and Post Stroke

Depression in Older Adult vs. Adult

- Common risk factors = female; unmarried; poverty; chronic illness; isolation; FHx; substance use
- More unique to older adults:
  - Loss and grief
  - Care taking responsibilities
  - Cognitive impairment
  - > 75 years old
  - Poor social support
  - Lower Education

Adult Depression

- MSIGECAPS

REVIEW ARTICLE | VOLUME 34, ISSUE 2, P469-487, JUNE 01, 2011

Geriatric Depression in Primary Care

Mijung Park, RN, PhD • Jürgen Unützer, MD, MPH, MA

DOI: https://doi.org/10.1016/j.psc.2011.02.009

Older Adult Depression

- May not report feeling sad
- More anhedonia, avolition
- Somatic symptoms
- Poor energy or fatigue
- Attribute symptoms to physical causes or stressful life events

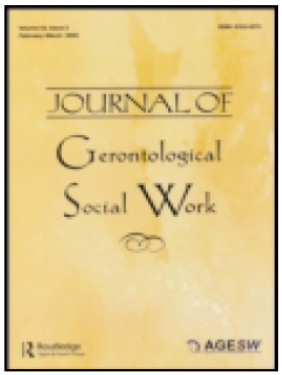
Older Adult Depression

- “I don’t know” to a lot of questions as oppose to confabulation or living in the past
- Not participate in physical, speech or occupational therapy
- Poor self care
- Feels like a burden

Older Adult Depression

- Ddx = Dementia and Delirium
  - Delirium has hallmark of fluctuation and acute change in attention and cognition
  - Dementia tends to be insidious course and they still put in good effort for questions you ask them but they will either struggle with answer or will look for help from others

Using Depression Scales in Older Adults



Routledge
Taylor & Francis Group

Journal of Gerontological Social Work

ISSN: 0163-4372 (Print) 1540-4048 (Online) Journal homepage: https://www.tandfonline.com/loi/wger20

Screening for Geriatric Depression in Residential Care Facilities: A Systematic Narrative Review

Anna Azulai & Christine A. Walsh

To cite this article: Anna Azulai & Christine A. Walsh (2015) Screening for Geriatric Depression in Residential Care Facilities: A Systematic Narrative Review, Journal of Gerontological Social Work, 58:1, 20-45, DOI: 10.1080/01634372.2014.904469

To link to this article: https://doi.org/10.1080/01634372.2014.904469

Using Depression Scales in Older Adults

- PHQ 9 is the most robust and effective scale as it can be used for any cognitive status
  - Can also be done via multiple staff observation inputs
- GDS 12R is the only scale designed specifically for residential care

Patient Health Questionnaire (PHQ-9)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For office coding: Total Score _____ = _____ + _____ + _____

Total Score _____

Geriatric Depression Scale

Items to omit for GDS – 12R

Date: 2016-08-12 Patient Name: TEST, TEST

	Yes	No	
1. Are you basically satisfied with your life?	0	1	
2. Have you dropped many of your activities and interests?	1	0	
3. Do you feel that your life is empty?	1	0	
4. Do you often get bored?	1	0	
5. Are you are you in good spirits most of the time?	0	1	
6. Are you afraid something bad is going to happen to you?	1	0	
7. Do you feel happy most of the time?	0	1	
8. Do you often feel helpless?	1	0	
9. Do you prefer to stay at home, rather than going out and doing new things?	1	0	
10. Do you feel you have more problems with memory than most?	1	0	
11. Do you think it is wonderful to be alive?	0	1	
12. Do you feel pretty worthless the way you are now?	1	0	
13. Do you feel full of energy?	0	1	
14. Do you feel your situation is hopeless?	1	0	
15. Do you think that most people are better off than you are?	1	0	
Total (over 5 indicates depression)			

Using Depression Scales in Older Adults

ELSEVIER

Archives of Gerontology and Geriatrics

Volume 87, March–April 2020, 104002



Review

Diagnostic accuracy of various forms of geriatric depression scale for screening of depression among older adults: Systematic review and meta-analysis

Yuvaraj Krishnamoorthy, Sathish Rajaa, Tanveer Rehman

Using Depression Scales in Older Adults

- Geriatric Depression Scale better for elderly with higher sensitivity and specificity
- Diagnostic performance much better with shorter forms of GDS like the GDS 15 and 10 compared to GDS 30

Outline

- Depression in older adult vs. general adult
- Depression in patients with Major Neurocognitive Disorder vs. Cognitively intact
- Treatment considerations for depression in older adult
- Special scenario of Parkinson's Disease and Post Stroke

European Geriatric Medicine 6 (2015) 479–486

Controversies in geriatric medicine

Depression and dementia. A review

G. Cipriani *, C. Lucetti, C. Carlesi, S. Danti, A. Nuti

Neurology Unit, Hospital of Versilia, Lido di Camaiore (Lu), Italy

Depression in Major Neurocognitive Disorder - Challenges

- Diagnosis is challenging due to overlapping of symptoms
- Most older adults do not endorse affective symptoms

Depression in Major Neurocognitive Disorder - Challenges

MNCD

- Memory loss
- Agitation
- Sleep wake disturbance
- apathy

Depression

- Decreased concentration and processing speed
- Irritability
- Sleep loss
- Fatigue
- anhedonia

Depression in Major Neurocognitive Disorder - Challenges

- Many people confuse apathy in MNCD as depression
  - Apathy typically looks like they just sit there with no distress but they cannot plan to do anything so they just sit in silence
  - Patients with apathy will have positive affect and enjoyment when they are brought to do tasks or go on outings

Depression in Major Neurocognitive Disorder - Challenges

- Cornell Scale for Depression in Dementia (CSDD) is designed specifically for patients with MNCD
  - Can be administered by caregivers
  - Problem: shows low levels of agreement with gold standard and requires a lot of resources in time to administer
  - Perhaps PHQ9 is better

Screening Tool: Cornell Scale for Depression in Dementia (CSDD)

Scoring System: a = unable to evaluate
0 = absent
1 = mild or intermittent
2 = severe

Ratings should be based on symptoms and signs occurring during the week prior to interview. No score should be given if symptoms result from physical disability or illness.

A. Mood-Related Signs				
1. Anxiety anxious expression, ruminations, worrying	a	0	1	2
2. Sadness sad expression, sad voice, tearfulness	a	0	1	2
3. Lack of reactivity to pleasant events	a	0	1	2
4. Irritability easily annoyed, short-tempered	a	0	1	2
B. Behavioral Disturbance				
1. Agitation restlessness, handwringing, hairpulling	a	0	1	2
2. Retardation slow movements, slow speech, slow reactions	a	0	1	2
3. Multiple physical complaints (score 0 if GI symptoms only)	a	0	1	2
4. Loss of interest less involved in usual activities (score only if change occurred acutely, i.e., in less than 1 month)	a	0	1	2

C. Physical Signs

1. Appetite loss eating less than usual	a	0	1	2
2. Weight loss score 2 if greater than 5 lb. in one month	a	0	1	2
3. Lack of energy fatigues easily, unable to sustain activities (score only if change occurred acutely, i.e., in less than 1 month)	a	0	1	2

D. Cyclic Functions

1. Diurnal variation of mood symptoms worse in the morning	a	0	1	2
2. Difficulty falling asleep later than usual for this individual	a	0	1	2
3. Multiple awakenings during sleep	a	0	1	2
4. Early-morning awakening earlier than usual for this individual	a	0	1	2

E. Ideational Disturbance

1. Suicide feels life is not worth living, has suicidal wishes or makes suicide attempt	a	0	1	2
2. Poor self-esteem self-blame, self-deprecation, feelings of failure	a	0	1	2
3. Pessimism anticipation of the worst	a	0	1	2
4. Mood-congruent delusions delusions of poverty, illness or loss	a	0	1	2

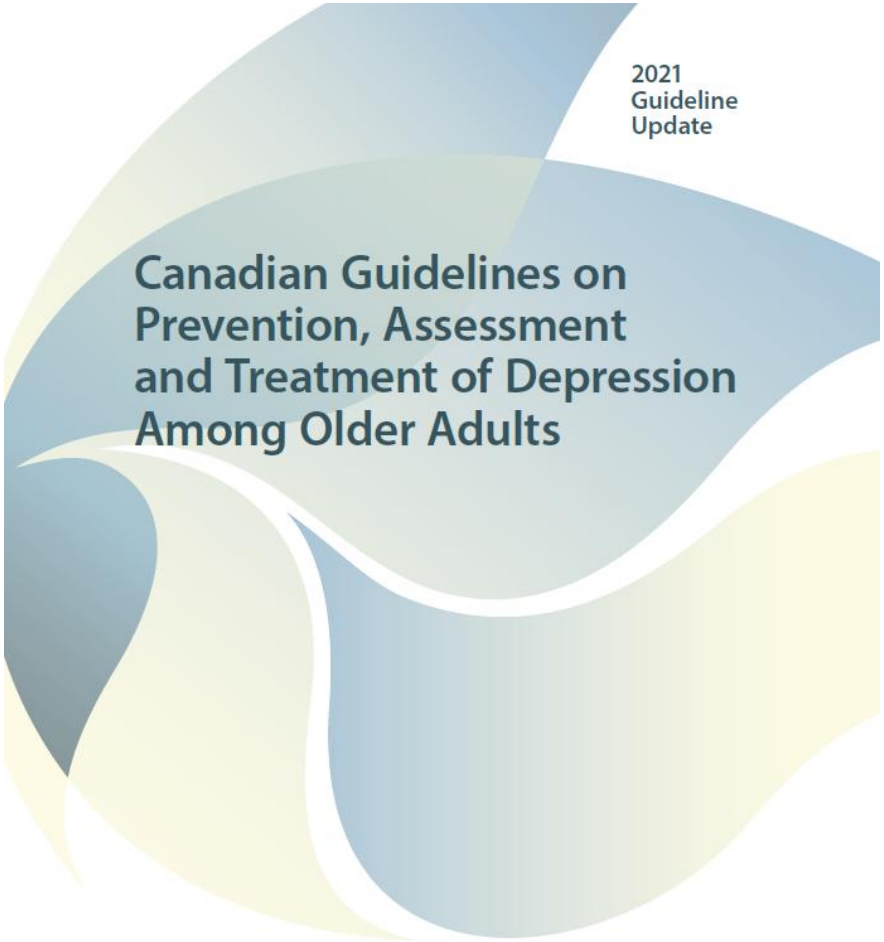
Scoring:

A score >10 probably major depressive episode
A score >18 definite major depressive episode

Outline

- Depression in older adult vs. general adult
- Depression in patients with Major Neurocognitive Disorder vs. Cognitively intact
- Treatment considerations for depression in older adult
- Special scenario of Parkinson's Disease and Post Stroke

Treatment Considerations



Treatment Considerations

- Depends on severity and situation
  - Severe without psychosis = ECT should be considered
  - Severe with psychosis = combination of antidepressant and antipsychotic; if not effective ECT should be considered
  - Mild to Moderate = psychotherapies and antidepressants
  - Co-morbid dementia = limited evidence for antidepressant for mild to moderate depression

Treatment considerations

- Psychotherapies
  - Exercise and mind body interventions (e.g. tai chi, yoga) show promising evidence
  - CBT and Problem Solving Therapy have most evidence
    - Problem solving therapy can be used in MNCD
  - Also evidence for behavioural therapy, behavioural activation, reminiscence, psychodynamic and interpersonal psychotherapy

Problem Solving Therapy

- https://www.racgp.org.au/afp/2012/september/problem-solving-therapy
- “Works on basis of discovery (find solution); performance (implementing the solution) and verification (assessing the outcome)”
- “clinician helps the patient to become empowered to learn to solve problems for themselves”

Treatment Considerations

- Antidepressants
  - Duloxetine and sertraline are considered first line
  - Alternatives are escitalopram and citalopram due to low risk of drug interaction

Antidepressant problems

- QTC
- SIADH
- Anticholinergic
- GI bleed

QTC prolongation

QTC prolongation

COMBINED LIST OF DRUGS THAT PROLONG QT AND/OR CAUSE TORSADES DE POINTES (TDP)

CredibleMeds®

CredibleMeds® has reviewed available evidence for the drugs on the following list and place them in one of three designated categories: Known Risk of TdP (KR), Possible Risk of TdP (PR) or have a Conditional Risk of TdP (CR). The full description of these categories can be found on the CredibleMeds.org website.

Generic Name	Brand Name
Alfuzosin (PR)	Uroxatral
Amantadine (CR)	Symmetrel and others
Amiodarone (KR)	Cordarone and others
Amisulpride (CR)	Solian and others
Amitriptyline (CR)	Elavil (Discontinued 6/13) and others
Amphotericin B (CR)	Fungilin and others
Anagrelide (KR)	Agrylin and others
Apomorphine (PR)	Apokyn and others
Aripiprazole (PR)	Abilify and others
Arsenic trioxide (KR)	Trisenox
Artenimol+piperaquine (PR)	Eurartesim
Asenapine (PR)	Saphris and others
Astemizole (KR)	Hismanal
Atazanavir (CR)	Reyataz and others
Atomoxetine (PR)	Strattera
Azithromycin (KR)	Zithromax and others
Bedaquiline (PR)	Sirturo
Bendamustine (PR)	Treanda and others
Bendroflumethiazide or bendrofluazide (CR)	Aprinox
Bepridil (KR)	Vascor
Bortezomib (PR)	Velcade and others
Bosutinib (PR)	Bosulif
Buprenorphine (PR)	Butrans and others
Capecitabine (PR)	Xeloda
Ceritinib (PR)	Zykadia
Chloral hydrate (CR)	Aquachloral and others
Chloroquine (KR)	Aralen
Chlorpromazine (KR)	Thorazine and others
Cilostazol (KR)	Pletal

Generic Name	Brand Name
Ciprofloxacin (KR)	Cipro and others
Cisapride (KR)	Propulsid
Citalopram (KR)	Celexa and others
Clarithromycin (KR)	Biaxin and others
Clomipramine (PR)	Anafranil
Clozapine (PR)	Clozaril and others
Cocaine (KR)	Cocaine
Crizotinib (PR)	Xalkori
Cyamemazine (cyamepromazine) (PR)	Tercian
Dabrafenib (PR)	Tafinlar
Dasatinib (PR)	Sprycel
Degarelix (PR)	Firmagon
Delamanid (PR)	Deltyba
Desipramine (PR)	Pertofrane and others
Dexmedetomidine (PR)	Precedex and others
Diphenhydramine (CR)	Benadryl and others
Disopyramide (KR)	Norpace
Dofetilide (KR)	Tikosyn
Dolasetron (PR)	Anzemet
Domperidone (KR)	Motilium and others
Donepezil (KR)	Aricept
Doxepin (CR)	Sinequan and others
Dronedarone (KR)	Multaq
Droperidol (KR)	Inapsine and others
Efavirenz (PR)	Sustiva and others
Eribulin mesylate (PR)	Halaven
Erythromycin (KR)	E.E.S. and others
Escitalopram (KR)	Cipralex and others
Esomeprazole (CR)	Nexium and others

Generic Name	Brand Name
Ezogabine (Retigabine) (PR)	Potiga and others
Famotidine (PR)	Pepcid and others
Felbamate (PR)	Felbatol
Fingolimod (PR)	Gilenya
Flecainide (KR)	Tambocor and others
Fluconazole (KR)	Diflucan and others
Fluoxetine (CR)	Prozac and others
Flupentixol (PR)	Depixol and others
Fluvoxamine (CR)	Faverin and others
Furosemide (frusemide) (CR)	Lasix and others
Galantamine (CR)	Reminyl and others
Garenoxacin (CR)	Geninax
Gatifloxacin (KR)	Tequin
Gemifloxacin (PR)	Factive
Granisetron (PR)	Kytril and others
Grepafloxacin (KR)	Raxar
Halofantrine (KR)	Halfan
Haloperidol (KR)	Haldol (US & UK) and others
Hydrochlorothiazide (CR)	Apo-Hydro and others
Hydrocodone - ER (PR)	Hysinglaâ„¢ ER and others
Hydroxychloroquine (CR)	Plaquenil and others
Hydroxyzine (CR)	Atarax and others
Ibogaine (KR)	None
Ibutilide (KR)	Corvert
Iloperidone (PR)	Fanapt and others
Imipramine (melipramine) (PR)	Tofranil
Indapamide (CR)	Lozol and others
Isradipine (PR)	Dynacirc
Itraconazole (CR)	Sporanox and others

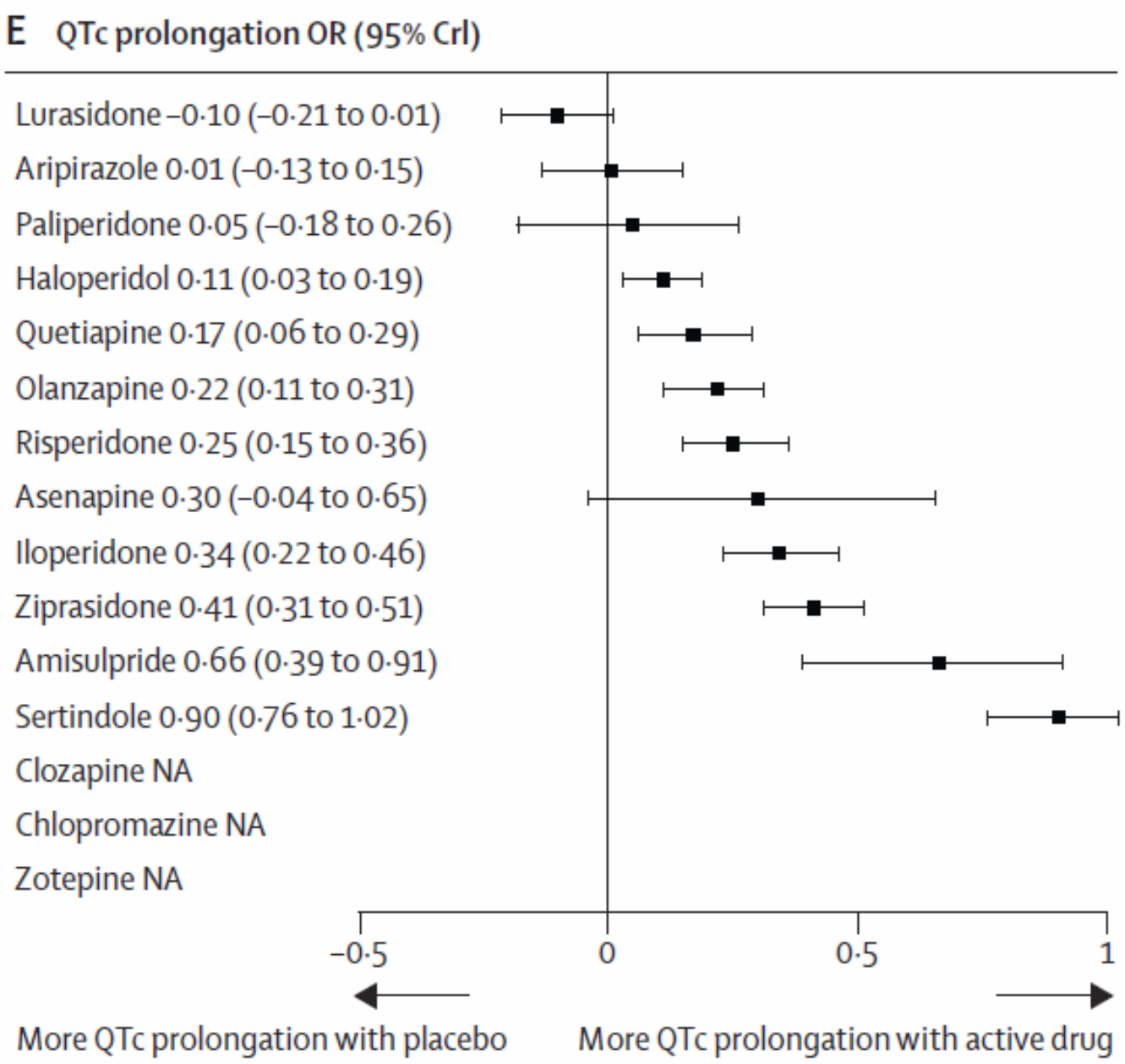
If list is printed, check website at www.crediblemeds.org • Please see Disclaimer below • List continued over

QTC prolongation

Antipsychotics	TCAs	SSRIs + others
Amisulpride	Amitriptyline	Citalopram
Aripiprazole	Desipramine	Escitalopram
Asenapine	Doxepin	Fluoxetine
Chlorpormazine	Imipramine	Fluvoxamine
Clozapine	Nortriptyline	Mirtazapine
Haloperidol		Paroxetine
Olanzapine		Sertraline
Paliperidone		Trazodone
Quetiapine		Venlafaxine
Risperidone		
Ziprasidone		

QTC prolongation

Mood Stabilizer	Substance related	Other meds
Lithium	Buprenorphine	Amiodarone
	Methadone	Azithromycin
		Ciprofloxacin
	Cocaine	Clarithromycin
		Erythromycin
Cholinesterase Inhibitor		Levofloxacin
Donepezil		Metronidazole
Galantamine		Moxifloxacin
		Esomeprazole
		Metoclopramide
		Pantoprazole


E QTc prolongation OR (95% CrI)
Lurasidone –0·10 (–0·21 to 0·01)
Aripirazole 0·01 (–0·13 to 0·15)
Paliperidone 0·05 (–0·18 to 0·26)
Haloperidol 0·11 (0·03 to 0·19)
Quetiapine 0·17 (0·06 to 0·29)
Olanzapine 0·22 (0·11 to 0·31)
Risperidone 0·25 (0·15 to 0·36)
Asenapine 0·30 (–0·04 to 0·65)
Iloperidone 0·34 (0·22 to 0·46)
Ziprasidone 0·41 (0·31 to 0·51)
Amisulpride 0·66 (0·39 to 0·91)
Sertindole 0·90 (0·76 to 1·02)
Clozapine NA
Chlopromazine NA
Zotepine NA
–0·5
0
0·5
1
More QTc prolongation with placebo
More QTc prolongation with active drug

SIADH

SIADH - SSRIs & others

- Risk factors:
  - older age
  - female sex
  - concomitant use of diuretics
  - low body weight
  - lower baseline serum sodium concentration

COMMENTARY

THE AMERICAN JOURNAL of MEDICINE®

Antidepressants and Hyponatremia

SEE RELATED ARTICLE, p. 56

Yeong-Hau H. Lien, MD, PhD[a,b]
[a]*Department of Medicine*
College of Medicine
University of Arizona
Tucson
[b]*Arizona Kidney Disease and Hypertension Center*
Tucson

The American Journal of Medicine, Vol 131, No 1, January 2018

Table Comparison of Risk for Hyponatremia Among Antidepressants in 4 Population-Based Studies

	Sweden[7]		Canada,[6]	Denmark[5]		Britain[4]	
Antidepressants	New (<29 d)	Long-term (>85 d)	New (<30 d)	New (<14 d)	Long-term (>180 d)	New (<28 d)	Long-term (>85 d)
SSRI				8.7	1.18	7.7	0.75
Citalopram	5.5	0.57	5.8				
Escitalopram	2.5	0.63	4.78				
Sertraline	5.0	0.75	7.3				
Paroxetine			8.0*				
Fluvoxamine			2.7*				
Fluoxetine			5.3*				
TCA	1.6	0.77		5	1.35	2.6	0.67
Amitriptyline							
Nortriptyline							
Clomipramine							
SNRI				6.3	1.62		
Duloxetine			8.0*				
Venlafaxine	5.3	0.95					
NaSSA				3.2†	0.96†		
Mirtazapine	2.5	0.76	3.17				
Other						6.3‡	0.62‡

Study population: Sweden: Population based case–control study with patients aged >18 years with hospitalization due to hyponatremia (2005-2014)[7]; Canada: Population based case–control study with patients aged >65 years receiving antidepressants (2003-2012)[6]; Denmark: residents aged >18 years (1998-2012)[5]; Britain: Patients aged >65 years with depression (1996-2007).[4] Hyponatremia definition as primary outcome: Sweden: Hospitalization with hyponatremia as primary diagnosis[7]; Canada: Hospitalization with hyponatremia as 1 diagnosis[6]; Denmark: Na <135 mEq/mL[5]; Britain: Diagnosis of hyponatremia.[4] Duration of antidepressant therapy: new and long-term therapy for each study defined as in Table.

NaSSA = noradrenergic and specific serotonergic antidepressant; SNRI = serotonin–norepinephrine reuptake inhibitor; SSRI = selective serotonin reuptake inhibitor; TCA = tricyclic antidepressant.

*Low events and odd ratio calculated from Table S7 of the cited reference.[6]

†NaSSA includes mirtazapine and mianserin.[5]

‡Other includes venlafaxine and mirtazapine.[3]

SIADH

- CCSMH guideline suggests sodium level done within 2-4 weeks of using SSRI or SNRI
  - Screening for history of hyponatremia and other risk factors for hyponatremia (e.g. diuretics)
  - Lower risk for hyponatremia with TCAs, bupropion and mirtazapine

Anticholinergic

American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults

*By the 2019 American Geriatrics Society Beers Criteria® Update Expert Panel**

JAGS 67:674–694, 2019
© 2019 The American Geriatrics Society

Table 7. Drugs With Strong Anticholinergic Properties

Antiarrhythmic	Promethazine
Disopyramide	Pyrilamine
	Triprolidine
Antidepressants	
Amitriptyline	
Amoxapine	
Clomipramine	Antimuscarinics
Desipramine	(urinary incontinence)
Doxepin (>6 mg)	Darifenacin
Imipramine	Fesoterodine
Nortriptyline	Flavoxate
Paroxetine	Oxybutynin
Protriptyline	Solifenacin
Trimipramine	Tolterodine
	Trospium
Antiemetics	
Prochlorperazine	Antiparkinsonian agents
Promethazine	Benztropine
	Trihexyphenidyl
Antihistamines (first generation)	
Brompheniramine	Antipsychotics
Carbinoxamine	Chlorpromazine
Chlorpheniramine	Clozapine
Clemastine	Loxapine
Cyproheptadine	Olanzapine
Dexbrompheniramine	Perphenazine
Dexchlorpheniramine	Thioridazine
Dimenhydrinate	Trifluoperazine
Diphenhydramine (oral)	
Doxylamine	Antispasmodics
Hydroxyzine	Atropine (excludes ophthalmic)
Meclizine	Belladonna alkaloids
Clidinium-chlordiazepoxide	Scopolamine (excludes ophthalmic)
Dicyclomine	
Homatropine (excludes ophthalmic)	Skeletal muscle relaxants
Hyoscyamine	Cyclobenzaprine
Methscopolamine	Orphenadrine
Propantheline	

GI bleed

GI bleed - SSRIs & others

nature publishing group

CLINICAL AND SYSTEMATIC REVIEWS

CME

Risk of Upper Gastrointestinal Bleeding With Selective Serotonin Reuptake Inhibitors With or Without Concurrent NonSteroidal Anti-Inflammatory Use: A Systematic Review and Meta-Analysis

Rebecca Anglin, MD, PhD[1,2], Yuhong Yuan, MD, PhD[2], Paul Moayyedi, MB ChB, PhD[2], Frances Tse, MD, MSc[2], David Armstrong, MA, MB BChir[2] and Grigorios I. Leontiadis, MD, PhD[2]

Am J Gastroenterol 2014; 109:811–819; doi:10.1038/ajg.2014.82; published online 29 April 2014

GI bleed - SSRIs & others

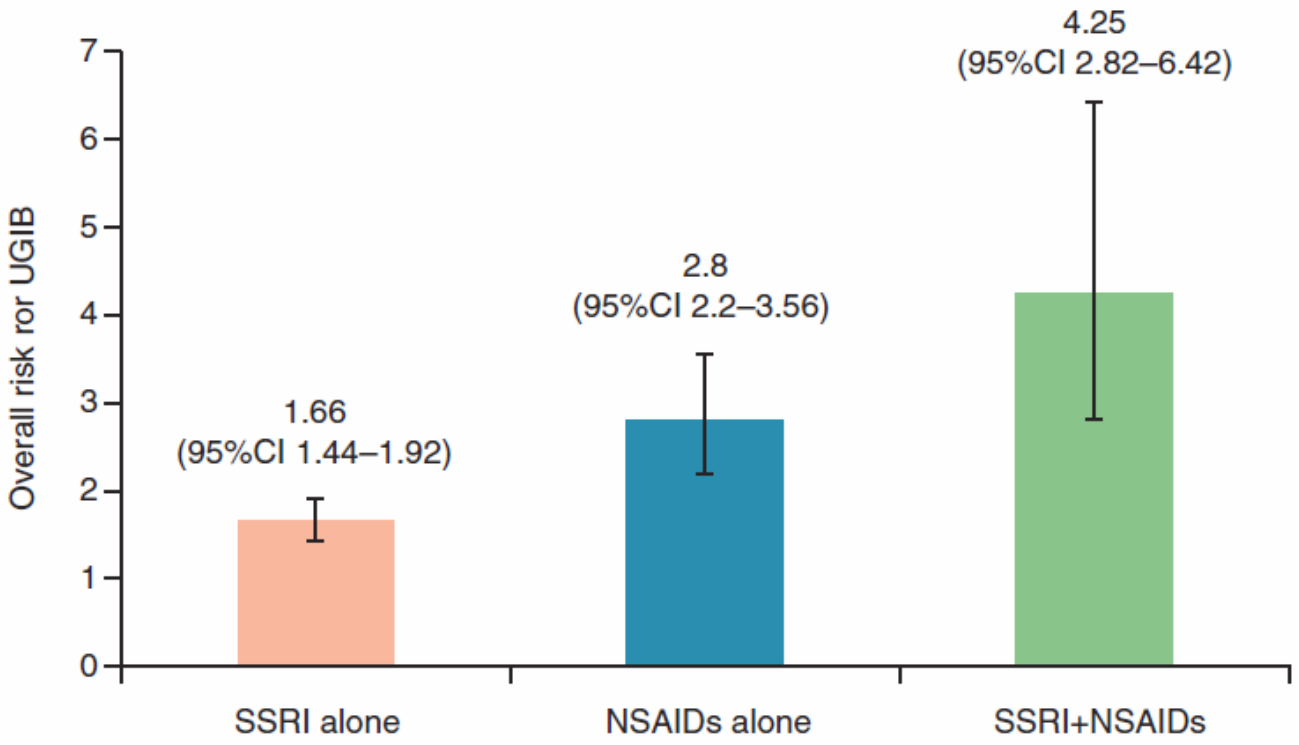


Figure 3. Relative contributions of selective serotonin reuptake inhibitors (SSRIs) and nonsteroidal anti-inflammatorys (NSAIDs) to the risk of upper gastrointestinal (GI) bleeding.

Outline

- Depression in older adult vs. general adult
- Depression in patients with Major Neurocognitive Disorder vs. Cognitively intact
- Treatment considerations for depression in older adult
- Special scenario of Parkinson's Disease and Post Stroke

Parkinson's Depression

Psychiatry and Preclinical Psychiatric Studies - Review Article | Published: 04 January 2022

Parkinson and depression: review and outlook

Gerd Laux

Journal of Neural Transmission **129**, 601–608 (2022) | Cite this article

Parkinson's Depression

- Overlap of symptoms issue:
  - Fatigue, loss of energy, psychomotor retardation, slowing of intellectual functions, difficulty in concentration, reduced appetite and insomnia
- Need to delineate if the symptoms are related to on/off phenomenon (if so, the fix is dopamine and not antidepressants)
- SSRIs are first line with SNRI as alternative
  - Efficacy demonstrated for nortriptyline, venlafaxine XR, despiramine, citalopram and paroxetine
- TCAs can also be used

Post-Stroke Depression

Post-Stroke Depression: A Review

Robert G. Robinson, M.D., Ricardo E. Jorge, M.D.

Am J Psychiatry 173:3, March 2016

Post-Stroke Depression

- Usually have later age at onset
- Greater cognitive impairment
- Less family and personal history of depression
- Greater physical impairment than nonvascular depression
- CCSMH guidelines state SSRI is first line regardless of ischemic or hemorrhagic type
  - Second line = SNRIs and mirtazapine
  - Methyphenidate may be considered if apathy is significant

Summary

- Older adult depression generally have less affective symptom but more somatic and cognitive symptoms
- There are many scales like PHQ9, GDS15 and CSDD that can be used to screen depending on scenario
- Antidepressant choice is based on side effect profile and risk of drug interaction
- Parkinson's depression can be due to on/off phenomenon
- Post Stroke depression can be managed similarly

Objectives

- Appreciate how depression presents in older adults
- Gain insight as to how depression will present in older adults with cognitive changes and other special scenarios
- Understand the initial management of depression in older adults

Pre-test

- Which of the following symptoms will older adult more likely to express in depression?
  - A) sadness
  - B) stomach upset
  - C) suicidality
  - D) guilt

Pre-test

- Which of the following symptoms will older adult more likely to express in depression?
  - A) sadness
  - B) stomach upset
  - C) suicidality
  - D) guilt

Pre-test

- Which of the following screening tests should we regularly use for older adult depression?
  - A) Beck Depression Inventory (BDI)
  - B) Hamilton Depression Rating Scale (HAM-D)
  - C) PHQ 9
  - D) Quick Inventory of Depressive Symptomatology-Self-Report (QIDS-SR)

Pre-test

- Which of the following screening tests should we regularly use for older adult depression?
  - A) Beck Depression Inventory (BDI)
  - B) Hamilton Depression Rating Scale (HAM-D)
  - C) PHQ 9
  - D) Quick Inventory of Depressive Symptomatology-Self-Report (QIDS-SR)

Pre-test

- Which of the following antidepressant is most likely to cause SIADH?
  - A) Mirtazapine
  - B) Bupropion
  - C) Nortriptyline
  - D) Citalopram

Pre-test

- Which of the following antidepressant is most likely to cause SIADH?
  - A) Mirtazapine
  - B) Bupropion
  - C) Nortriptyline
  - D) Citalopram

Pre-test

- Which of the following medications is considered first line for Parkinson's Depression?
  - A) Sertraline
  - B) Bupropion
  - C) Venlafaxine
  - D) Nortriptyline

Pre-test

- Which of the following medications is considered first line for Parkinson's Depression?
  - A) Sertraline
  - B) Bupropion
  - C) Venlafaxine
  - D) Nortriptyline

