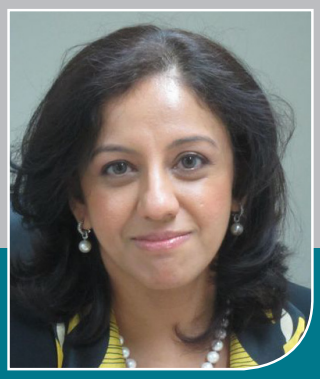
DEMENTIA AND DEPRESSION

Dr. Richa Rastogi



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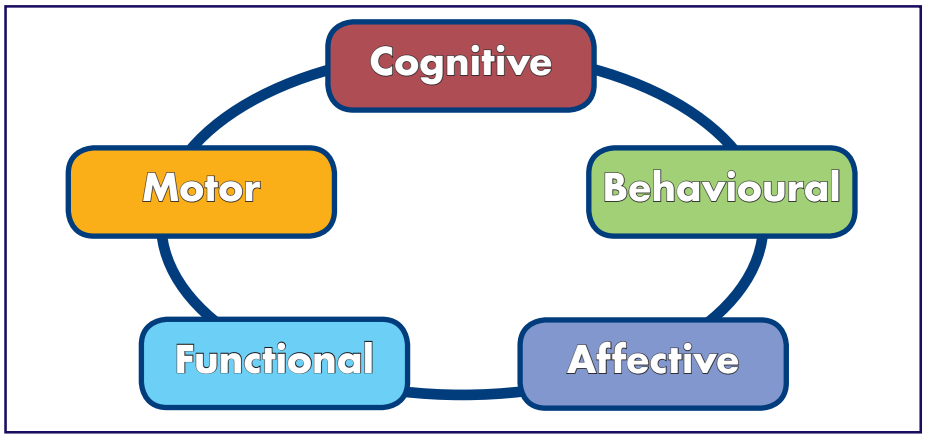

Figure 1. Concept of Dementia

CONCEPT OF DEMENTIA

- Cognitive - earliest to occur with loss of expressive speech and praxis. Retrieval and recall of memory affected
- Behavioural - Agitation, intrusiveness, aggression, wandering
- Functional - ADL are progressively lost
- Affective - Well documented relationship between depression and dementia. Research shown that late onset depression develops to dementia
- Motor - Gait, Parkinson's and myoclonus occur.

DEPRESSION IN DEMENTIA–INCIDENCE AND PREVALENCE

Depression in old age is a common phenomenon. The incidence of depression in the geriatric population is 15-20%. 1 in 5 females and 1 in 8 males will experience depression in their lifetime.

The risk of depression is twice as common in the geriatric population due to more stressful events' experience, losses, transition of life and organic insults. The rate increases to 50% in the presence of acquired brain insult.

The limited studies investigating depression in people with vascular dementia, Lewy body dementia, or dementia associated with Parkinson's disease, suggests that depression may be more common in these syndromes than in Alzheimer's disease.

SYMPTOMS PRESENTATION

Depression may present differently in people with comorbid dementia, particularly when the dementia is advanced. Although typical major depressive disorder (MDD) is seen, the clinical picture often lacks prominent sadness, hopelessness and guilt and is, overall, less severe. Anxiety, psychomotor retardation, loss of energy or appetite, anhedonia, irritability, delusions and hallucinations may all be more common (and prominent) than in people without dementia. These symptoms can also be part of the dementia itself or suggest delirium. Unexpected or rapid change in mood, cognitive deterioration, or increased behavioural and psychological symptoms of dementia (eg, disinhibition, agitation, anxiety or aggression) may be the only indicators of superimposed depression.

Consider early dementia in older people who present with new-onset depression.

ETIOLOGY OF DEPRESSION

- Cardiac failure–mimic somatic symptoms of depression
- Thyroid disease
- Parkinson's Disease-sleep- disturbance, anergia and fatigue commonly mistaken for depression
- Stroke
- Delirium
- Cancer
- Drugs such as beta-blockers, steroids, digoxin and alcohol withdrawal
- Previous history of depression, strong family history, pre-existing physical or psychological trauma and vulnerabilities including certain personality styles such as Cluster C types.

DEPRESSION AND SUICIDE

- 25% is the suicide rate in the elderly
- Highest risk group and 10% increase in last 15 years
- Assessment of suicide risk:

M – male		B - bereaved
A - alcohol	&	L - lonely
D - depressed		U - unwell
		E - elderly

DILEMMAS IN TREATING DEPRESSION

Geriatric depression is a common but complex disorder with atypical features mainly due to behavioural symptomatology and comorbid conditions, which makes diagnosis difficult. The presence of physical symptoms, which are a common presentation, are misleading and not pathonomic of depression as poor sleep, appetite, lethargy and amotivation may be driven by other non-psychological mechanisms.

Psychosis and memory impairment as well as behavioural symptoms can mask diagnosis of depressive disorder.

Examine family history, recent psychosocial triggers, change in affect (apathy or agitation) and look for neurovegetative symptoms.

Dementia is irreversible and hence treating depression can improve or prolong quality of life.

TOOLS FOR SCREENING DEPRESSION IN DEMENTIA

A useful scale is the Cornell Scale for Depression in Dementia (CSDD). In Australia, the CSDD is incorporated into the Aged Care Funding Instrument, which is used to determine the funding allocated to aged care facilities for individual residents. However, due to limited time and staff in such facilities, attention to completing the CSDD is often cursory, and the results rarely alter management for individual residents. Moreover, serial evaluations are uncommon. Regularly combining use of rating scales with a thorough history would improve detection rates.

The domains of CSDD include:

Mood-related	Behavioural disturbance	Physical signs	Cyclic functions	Disturbed thinking
Anxiety	Agitation	Appetite loss	Mood worse in morning	Suicidality
Sadness	Slowed movement	Weight loss	Problems falling asleep	Poor self-esteem
Lack of response to pleasant events	Physical complaints	Fatigue	Waking during night	Pessimism
Irritability	Reduced activities		Waking earlier than usual	Delusions

** Score up to four symptoms per domain, for a total score per domain of 0–8. Scoring system: A = unable to evaluate; 0 = absent; 1 = mild or intermittent; 2 = severe. A total score of over 10 is suggestive of depression and an indication for further investigation.*

TREATMENTS FOR DEPRESSION

Pharmacological therapy, particularly SSRIs, may exert some degree of protection against the negative effects of depression on cognition when people are also taking cholinesterase inhibitors. Cholinesterase inhibitors themselves may slow the rate of cognitive impairment and progression to Alzheimer disease in patients with depression and mild cognitive impairment. Antidepressant medication may also be considered in patients taking cholinesterase inhibitors for cognitive enhancement, or where depression is associated with deterioration in cognition or development of behavioural and psychological symptoms of dementia. In patients with mild depression, non-pharmacological strategies should be attempted first.

Cautious prescribing is paramount in older people, as they are more susceptible to medication side effects, often have multiple comorbid physical illnesses, and may be taking medications that can interact with antidepressants. There must be a clear plan to monitor efficacy and adverse effects. Hyponatraemia is of particular concern and should be screened for. The adage "start low and go slow" (a low starting dose, with small and slow dose titrations) should be followed to avoid potential side effects. Some of the pearls of advice with anti-depressants include:

- SSRI such as Sertraline, Paroxetine, Moclobomide, Venlafaxine and Cymbalta are safe and useful.
- Avoid Fluoxetine due to long half-life and anticholinergic effects.
- There is no evidence that Citalopram is more effective than other anti-depressants.
- Patients with dementia showed good response to antidepressants with 80% showing improvement with a relapse rate of 16%.
- Avoid tricyclic antidepressants due to anticholinergic effects, cardiotoxicity and hypotension.
- MAOI–Moclobemide is useful for treating the elderly.
- Mianserin is useful if patient has hyponatriemia and it helps with insomnia.
- ECT is emerging as a safe option of treatment. It is the first choice treatment in medically compromised elderly and in those who cannot tolerate medications. Although there is increased incidence of memory loss especially in dementia patients however these memory effects are reversible and transient and risk benefit analysis needs to be done.
- For psychotic depression augmentation with Risperidone or Olanzapine can be used. Monitoring for extrapyramidal symptoms and confusion secondary to anticholinergic effects needs to be monitored.
- Avoid Valproic acid due to sedation and high levels of ammonia as well as Carbamazepine due to anticholinergic activity and interacting with CYPD system.

Patients with cognitive impairment may benefit from many types of psychotherapy such as cognitive and interpersonal therapies, validation therapy using empathetic activities using social contact useful.

Music and recreation therapy have demonstrated moderate effect sizes for depression in dementia, including in severe dementia. Planning recreational activities that the person used to enjoy in the company of someone he or she appreciates may enhance response. Regular physical activity has been shown to improve mood, including in people with dementia.

MANAGING AGITATION

- Minor tranquilisers – Short-acting Benzodiazepines such as Xanax, Lorazepam. Long acting can precipitate delirium, withdrawal syndrome
- Major Tranquilisers – Haloperidol, Risperidone, Olanzapine, Seroquel
- Constant reorientation, distraction methods and activity scheduling
- Gabapentin in doses of 100mg twice a day, with therapeutic dose of 400 – 1200mg/day

CONCLUSIONS

Depression is common in people with dementia, and the relationship between mood and cognitive symptoms is complex. The nature of this relationship, disease stage, and environmental and clinician factors all contribute to under diagnosis and under treatment. Although evidence regarding antidepressant treatment is limited and equivocal, there is no cause for therapeutic nihilism. Organic causes of depressed mood should be excluded, physical health optimised, and medications, where possible, rationalised. Best management includes individually tailored psychosocial strategies and, in moderate to severe depression, judicious use of antidepressant medication with a "start low, go slow" approach. Regular review and effective engagement of carers are both essential and may have significant positive impacts for patients and carers. Difficult-to-treat or complex depression is an indication for specialist referral.

References available on request.

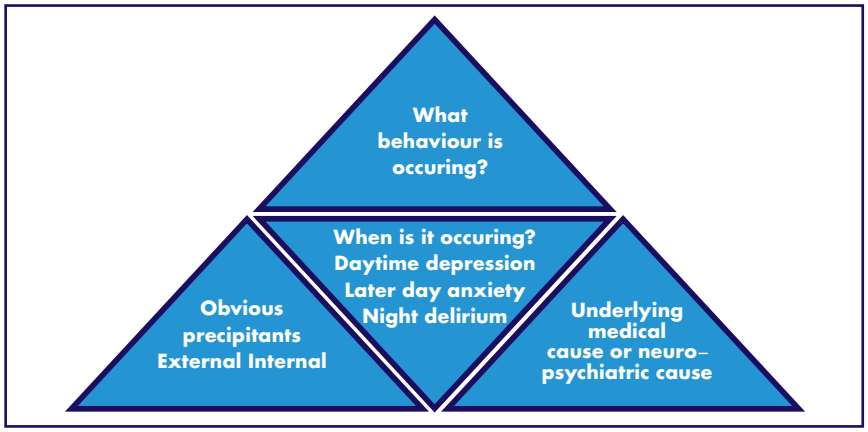

Figure 2. Managing Agitation