



## Review

# Depression and the older medical patient—When and how to intervene

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## ABSTRACT

Depression in the elderly, particularly those with chronic physical health problems, is a common, but complex problem. In this paper we review the research literature on both the epidemiology and management of depression in the older medical patient. After a general overview of depression in the elderly, we discuss some of the particular issues relevant to depression and co-morbid physical illness amongst elderly patients. Depression can be difficult to diagnose in medically unwell older adults, particularly when there is substantial overlap in symptomatology. The epidemiology and evidence base for the treatment of depression in a number of chronic health problems common in an older adults population are then discussed, specifically cardiac disease, cerebrovascular disease, cancer, chronic kidney disease, chronic obstructive pulmonary disease, and Parkinson's disease. For many of these conditions there is emerging evidence that treatments can be effective in reducing depressive symptoms. However, these potential benefits need to be balanced against the often-increased risk of adverse events or interactions with medical treatments. Although co-morbid depression is consistently associated with poorer medical outcomes, there is limited evidence that standard anti-depressive therapy has additional benefits in terms of physical health outcomes. Collaborative care models appear particularly well suited to medically unwell older adult patients, and may provide more generalised benefits across both mental and physical health measures.

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## 1. Introduction and methods

There has been a growing recognition of the prevalence and impact of depression in older patients, particularly those with physical illness. This paper reviews the recent literature on depression in the medically ill older patient, focusing on both epidemiological and management studies. After a general overview of depression in the elderly (and specifically in the physically ill), we focus on a number of conditions for which comorbid depression is prevalent in this age group. Where possible, we have focused on studies specifically investigating older patients; however many relevant studies of these conditions have also included some middle aged subjects.

## 2. Depression in the elderly

### 2.1. Epidemiology

Large scale epidemiological surveys report that depression affects about 5% of those 65 and older [1]. There has, however, been recent concern regarding clinicians' ability to correctly identify which older adults are depressed, with validation studies using structured interviews only confirming major depressive episodes in about 18% of older adults whom clinicians felt may be depressed [2]. This is much poorer than similar studies of younger adults, presumably because of the difficulty differentiating depression from non-specific symptoms associated with ageing and many common medical problems.

Despite difficulties with identification, depression in the elderly is associated with greater morbidity and mortality. The increased mortality has been highlighted by Almeida et al. [3] who examined death rates in males aged 68–88 years. They found that the adjusted mortality hazard of men with clinically significant depression was significantly elevated (at 1.98) with rates rising as the severity of symptoms increased: from 1.39 for those with questionable symptoms to 3.32 for those with severe depression.

### 2.2. Management

Mitchell and Subramaniam [4] found in a systematic review of depression in old age compared to middle age, that while there did not appear to be any clinically significant difference in response or remission rates to antidepressants and ECT, older patients appeared to be at higher risk of relapses into further episodes.

The benefit of antidepressants in older patients was confirmed in a meta-analysis by Kok et al. [5]. Analysing 51 randomised controlled trials (RCTs) of antidepressants in the acute treatment of depression, they found that all classes of medications were more effective than placebo in achieving response, with no demonstrable differences in either response or remission rates between the various classes of antidepressants. Furthermore, there were no differences in effectiveness in the more severely depressed patients. The numbers needed to treat (NNT) for response and remission were 6.7 and 14.4, respectively.

The safety of antidepressants in this age group was examined in a UK cohort study of depressed patients over 65 years from 570 general practices [6]. Compared to no antidepressants, SSRI antidepressants were associated with greater rates of falls (hazard ratio [HR] 1.66) and hyponatraemia (HR 1.52). SNRIs and mirtazapine were also associated with increased risk of all-cause mortality (HR 1.66), attempted suicide (HR 5.16), stroke (HR 1.37), fracture (HR 1.64) and epilepsy (HR 2.24). Almeida et al. [3] also found that adjusted mortality rates increased with use of antidepressants irrespective of current depressive symptoms. It is not possible to determine from these reports whether the increased deaths on those with antidepressants reflected the more severe depression in those prescribed antidepressants, or was an effect of the antidepressants *per se*. The higher death rates reported by Coupland et al. [6] with the SSRIs and SNRIs may be explained by these 'less toxic' antidepressants being used more commonly in patients with concurrent serious physical illnesses (such as cardiac disease).

In addition to antidepressants and ECT, psychological treatments have also been shown to be effective in older depressed

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