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Antidepressant response in the elderly

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Abstract

It is often stated that depressive phenomenology and prognosis differ between elderly and younger depressed patients, in the direction of more severe symptoms and a poorer outcome in elderly individuals. However, studies addressing the topic remain largely inconclusive, and it has been suggested that potential biases connected with age may have confounded previous assessments. In this work we evaluated a sample of 93 elderly depressed individuals (>60 years) and 186 younger patients. All patients were assessed with the 21-item Hamilton Depression Rating Scale at intake and prospectively followed for 6 weeks during treatment with antidepressants. A number of clinical and demographic features were taken into account to investigate depressive phenomenology and outcome in late-life depression. We found that the high likelihood of medical disorders in elderly patients explained the more severe depressive symptomatology observed in this population. However, independently from physical problems, recovery was slightly slower in elderly compared with younger individuals. Finally, patients who developed their first lifetime episode late in life (>60 years) showed a form of symptomatology similar to that in elderly patients with an earlier onset, but they showed a more positive outcome. In conclusion, the present work suggests that depression in old age is similar to depression in other ages, except for a slightly slower response to pharmacotherapy. Minor health problems increase the severity of depression, but they do not interfere crucially with the efficacy of antidepressant treatment. Finally, late-onset depression is associated with a positive outcome.

Keywords: Depression; Bipolar disorder; Elderly; Symptomatology

1. Introduction

Depression is the most prevalent psychiatric disorder in the elderly (Murphy, 1986), with 10–15% of persons over 60 years suffering from significant depressive symptoms (Blazer and Williams, 1980). It is often stated that depressive phenomenology and prognosis differ between elderly and younger depressed patients, and that symptomatic differences result in difficulties and often failures in diagnosing depression (Stokes, 1993). However, studies addressing the topic remain inconclusive (Mitchell and Subramaniam, 2005).

Geriatric depression has been reported to be more somatic and less ideational than depression in other younger age groups; it seems to be characterized by high rates of anxiety and psychotic symptoms (Koenig et al., 1993; Gottfries, 1998; Lenze et al., 2002; Serby and Yu,

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2003). On the other hand, other studies have challenged the existence of clinically significant differences in symptomatology between younger and older depressed patients (Musetti et al., 1989; Stage et al., 2001; Wetterling and Junghanns, 2004; Nelson et al., 2005).

Evidence regarding outcome and treatment response in relation to age is even less consistent (Mitchell and Subramaniam, 2005). Old age has been associated with a slower improvement during treatment and an overall poorer prognosis (Georgotas et al., 1989; Lebowitz et al., 1997, Zanardi et al., 2003; Fischer et al., 2003; Grigoriadis et al., 2003). In a previous work, our group analysed response to fluvoxamine in 174 non-demented depressed elders and found similar treatment outcome in younger and older subjects, although a slower response was observed in older patients (Zanardi et al., 2003). However, opposite findings have also been reported (Meats et al., 1991; Hughes et al., 1993).

Age at first lifetime depressive episode has been considered a discriminant variable when investigating the symptomatology and outcome of depression in late life and it has been suggested as a feature that may potentially distinguish between different subtypes of depressive illness in old age, with important implications for treatment and prognosis (Herrmann et al., 1989; Heun et al., 2000). Elderly patients with late onset of depressive disorder have been characterized by less personality abnormalities and a low incidence of family history of psychiatric illness (Conwell et al., 1989; Brodaty et al., 2001), but severity and symptomatology have been observed to be quite similar in early- and late-onset elderly patients (Conwell et al., 1989; Brodaty et al., 2001). Old age at onset has been linked to both better (Dew et al., 1997; Reynolds et al., 1998) and poorer outcome (Conwell et al., 1989; Alexopoulos et al., 1996).

Thus, the impact of age and age at onset of depressive disorder in symptomatology and outcome is still a debated issue. It has been suggested that potential biases may have confounded the above-mentioned studies (Mitchell and Subramaniam, 2005). For example, severity of depression may be influenced by concurrent medical problems and time to remission may be longer. Medical comorbidity more likely occurs in people with late-onset depression without a past psychiatric history (Lavretsky et al., 2002). The importance of assessing factors related to patient age and not just to age itself in evaluations of risk factors for poor prognosis has been emphasized (Mitchell and Subramaniam, 2005).

In the present work, we aimed to investigate our sample of depressives taking into account a number of demographic and clinical features that may characterize depression in the elderly and in late-life depressive disorders. We considered the influence of education, marital status, and concurrent medical disorders, which particularly differ in old people compared with younger individuals, as observed in our sample. We considered both the symptomatologic presentation of the illness and the pattern of treatment response (Serretti et al., 2000) during a follow-up period of 6 weeks. Finally, we also focused on old patients who developed their first episode late in life, to investigate their symptomatology and outcome compared to those of elderly patients with a previous history of depressive disorders.

2. Methods

2.1. Sample

The sample comprised 93 patients older than 60 years (mean age: 66.5±4.6), consecutively treated at the Psychiatry Department of St. Raffaele Hospital, Milan, for a major depressive episode. A second sample of 186 patients, younger than the age of 60 (mean age: 46.8± 9.9), were selected from our pharmacological sample (Smeraldi et al., 1998; Zanardi et al., 1998; Serretti et al., 2001) and matched for treatment and drug dosages, sex and diagnosis with elders.

Geriatric depression is usually defined as occurring after the age of 60–65 years (e.g., Steffens et al., 2000), but also later, after the age of 70–80 years (e.g., Haynie et al., 2001). To address the issue, we chose to define "old age" when it fell on or above the upper quartile in the distribution of age in our larger pharmacological sample (Smeraldi et al., 1998; Zanardi et al., 1998; Serretti et al., 2001), which was 61. In this way, quite consistently with other studies, we defined our elderly patients as older than 60.

Elderly and younger patients had been selected for study according the same inclusion/exclusion criteria. Inclusion criteria were DSM-IV diagnosis of major depression (American Psychiatric Association, 2002) and a score ≥21 on the 21-item Hamilton Rating Scale for Depression (HAM-D). Exclusion criteria were severe mental retardation, diagnosis of dementia or cognitive impairment, as indicated by a Mini Mental State Examination (MMSE) score <23 (Folstein et al., 1975), substance abuse/dependence, neurological disorder or clinical/laboratory indications of a severe organic disease potentially impairing evaluations.

Patients included were all Caucasians, affected by major depressive disorder (n=169) or bipolar disorder (n=110). The sample was partially overlapping with a previously analysed sample on the basis of single item