Rapid Depression Assessment in Geriatric Patients

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KEYWORDS

• Geriatric • Elderly • Depression • Rating scale • Assessing depression
• Patient Health Questionnaire • Geriatric Depression Scale

KEY POINTS

- Depression is common in geriatric patients with multiple comorbid medical illnesses and is often underdiagnosed and undertreated.
- Initial screening for depression can easily be accomplished in the waiting room.
- The clinical interview remains the gold standard for diagnosing geriatric depression, and it should be done with sensitivity to the privacy, but also the need to get information from a reliable informant.
- Illicit substances and medical conditions may significantly contribute.
- Suicide assessment should be done in a step wise manner.

INTRODUCTION

In the 2013 Global Burden of Disease Study, the second leading cause of years lived with disability was major depressive disorder, both worldwide and in the United States.[1] Among the elderly, the prevalence of depression is estimated to be 14% to 42% among residents in US nursing homes and 1.8% among elderly living in private households.[2] This places a significant burden both on patients, their families, and society. After adjusting for age, sex, and extent of chronic disease, the total health care cost for elderly patients with depression was 47% to 51% higher than elderly

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patients without depression.[3] Possible reasons for increased spending include symptom amplification, increased rates of medication/medical recommendation nonadherence, decreased functional ability, and a direct impact of depression on the course of medical illness.

Factors significantly associated with either depression or depressive symptoms among the elderly include comorbid chronic medical disorders, cognitive impairment, health-related functional impairment, lack of or loss of close social contacts, and a prior history of depression. Increasing age has not consistently been associated with increasing prevalence of depression, and evidence suggests that any age-related effects on depression are more linked to chronic health problems and functional impairment.[4] Chronic diseases such as stroke, loss of hearing, loss of vision, cardiac disease, and chronic lung disease significantly increase the risk of depression in old age.[5]

SCREENING FOR DEPRESSION

Waiting Room

Patients can be provided a GDS-30/GDS-15 (Geriatric Depression scale) or PHQ-2 and then PHQ-9 (Patient Health Questionnaire) while waiting in the waiting area, Patients can be provided a GDS-30/GDS-15 (Geriatric Depression Scale) or PHQ-2 and then PHQ-9 (Patient Health Questionnaire) while waiting in the waiting area.

The GDS-30 is the most evaluated screening tool in the acute inpatient setting, with cut-off values of 10 or 11 appearing to demonstrate the highest sensitivity.[6] Shorter versions of the GDS-30, such as the GDS-15, GDS-4, or GDS-5, have demonstrated conflicting results across studies.[7,8] While the GDS-30 displayed a sensitivity and specificity among inpatients of 84.2% and 79.3%, respectively, the sensitivity of the GDS-15 across 3 inpatient studies was low (32.2%).[9] Scoring on the GDS 30 inferred as 0 to 9 to be normal, 10 to 19 to be mild depression, and 20 to 30 to be severe depression. GDS-15 is inferred as 0 to 4 to be no depression, 5 to 10 suggestive of a mild depression, and 11+ suggestive of severe depression.

The GDS was found to be a valid measure of mild-to-moderate depressive symptoms in Alzheimer patients with mild-to-moderate dementia.[10] However, Alzheimer patients who disavow cognitive deficits also tend to disavow depressive symptoms, and the GDS should be used with caution in such patients, keeping in mind they may not be accurate reporters of their symptoms.

The PHQ-2[11] is a valid screening tool for major depression in older people but should be followed by a more-comprehensive diagnostic process (ie, PHQ-9).[12] PHQ-9 has 9 items, each of which is scored 0 to 3, providing a 0 to 27 severity score. Scores of 5, 10, 15, and 20 are cutoffs for mild, moderate, moderately severe, and severe depression, respectively. Although its specificity differs by age, sex, and ethnic groups, these differences appear to be of little clinical significance.

Clinical Encounter

During a face-to-face clinical encounter, the clinician needs to be observant, as multiple clues for depression can be obtained with focused history taking. Assessment of geriatric depression can be a difficult at times.[13,14] Late-life depression still remains a challenge and is unfortunately and commonly underdiagnosed and inadequately treated.[15] In the United States, older men and older African Americans and Hispanics are at even greater risk of unrecognized/undiagnosed depression. The public health concerns of ineffectively treated depression in late life will increase over time as the population continues to age.