

Comorbid Dementia and Depression: The Case for Integrated Care

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ABSTRACT

Dementia is a broad term for major neurocognitive disorders resulting from brain diseases or injuries that most commonly affect older adults. Depressive disorders have a high degree of overlap with the dementias and can further reduce cognitive functioning and quality of life. Evidence links high and progressive depressive symptoms in older adults to the risk of developing dementia. Early symptom recognition and treatment is essential to best practice. An integrated, team-based and person-centered approach enables primary care nurse practitioners, with the support and resources, to meet the multiple health care needs of older adults with comorbid depressive disorders and dementia.

Keywords: comorbid, dementia, depression, integrated care, nurse practitioner

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INTRODUCTION

Dementia and depression are the 2 most common mental disorders in older adults, and both are major causes of disability worldwide.¹ *Dementia* is a broad term that describes major neurocognitive disorders, primarily affecting older adults, that impair functioning in 1 or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition) and interfere with independence in everyday activities.² The most common dementias affecting older adults are caused by Alzheimer disease (AD), vascular disease (VaD), Lewy body disease (DLB), and frontotemporal lobar degeneration (FTD). These diseases differ in distribution of brain pathology, cognitive domains affected, patterns of progression, and neuropsychiatric symptoms (NPS). NPS that include disturbances of mood, perception and behavior, occur at some point in the disease process for nearly all persons with dementia. NPS may contribute to cognitive and functional impairment, caregiver burden, and reduced quality of life.^{3,4} Depressive symptoms are common NPS, having been found in approximately 30% of community-dwelling adults with dementia.⁵

Late-life depression, occurring after age 65, may reflect an episode of recurrent illness, a new onset of

illness (late onset depression), or a symptom of a comorbid medical condition. Late-life depression may be a prodromal feature of dementia,⁶ and older adults with high and increasing symptoms of depression are at greater risk for developing dementia^{7,8} and more rapid progression of symptoms.⁹ Late-life depression tends to include more cognitive and memory impairments than depression in younger adults. Prompt recognition and treatment of late-life depression may reduce the risk of developing dementia and promote improved quality of life among older adults living with dementia.^{10,11} The purpose of this review is to examine the identification, diagnosis, and treatment of depression in older adults with dementia.

IDENTIFICATION AND DIAGNOSIS

Symptom severity rating scales are useful for detection and monitoring of depressive symptoms in individuals with dementia. In early dementia, self-report depression scales, such as the Geriatric Depression Scale may be useful,¹² but as dementia progresses, scales that include an observational component and caregiver interview are recommended. The Dementia Mood Assessment Scale is based on an interview of family or professional staff and has been validated for assessment

of depression in persons with mild to moderate dementia.¹³ The Cornell Scale for Depression in Dementia is based on clinician observation and interview of patient and caregiver and is validated for use across all levels of dementia.¹⁴

Recommended diagnostic case formulation includes a thorough history of present illness and review of symptoms, personality changes, behaviors, and life stressors. The evaluation should include a complete physical examination with a detailed neurological exam and appropriate laboratory and diagnostic testing. Corroborative interviews with family or friends elucidate changes from premorbid functioning and psychosocial risk factors, such as loss, lack of social support, and changes in role.

Major depressive disorder is diagnosed by the presence of persistent (at least 2 weeks) depressed mood and/or loss of interest or pleasure and at least 3 additional symptoms, which may include appetite changes with weight loss or gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or inappropriate guilt, diminished ability to think or concentrate or indecisiveness, and recurrent thoughts of death or suicidal ideation.²

The overlap between the signs and symptoms of depression and those of dementia vary across the dementia disorders. Apathy and cognitive impairment are common to dementia and to late-life depression. The most common neuropsychiatric symptom in the dementias caused by AD, VaD, DLB, and FTD is apathy.¹⁵ Apathy, the persistent loss of motivation or lack of interest, is thought to be related to changes in executive brain functions with frontal lobe dysfunction, resulting in loss of motivation and associated reductions in self-care activities, interest or curiosity in others, and detachment or indifference. Apathy is present in 50%–70% of adults with dementia¹⁶ and has been found in 30% of adults with late-life depression.¹⁷ Misdiagnosis of the behavioral variant of FTD as depression is common because of the shared symptoms of apathy and relative lack of memory impairment.

Cognitive impairment is greater in late-life depression, and especially late-onset depression, compared with depression occurring earlier in life.¹⁸ Cognitive impairments may include diminished

ability to think or concentrate, or indecisiveness and memory complaints. *Pseudodementia* is a term describing a reversible cognitive impairment that mimics dementia but is due to depression. The memory deficits of pseudodementia may result more from general cognitive inefficiency and attention problems than from pathological brain changes, and the depressed adult is more likely than the person with dementia to be aware of those deficits.¹⁹ In addition to depression, reversible conditions that may contribute to cognitive impairment include various medical disorders such as vascular, infectious, traumatic, autoimmune, metabolic, idiopathic and neoplastic, and nutritional abnormalities.²⁰

Of the 4 most common causes of dementia, 3 are characterized by cognitive impairment. Using the *Diagnostic and Statistical Manual of Mental Disorders* diagnostic criteria, AD is diagnosed based on the presence of (1) clear evidence of decline in memory and learning and at least 1 other cognitive domain and (2) a steadily progressive, gradual decline in cognition.² VaD is characterized by onset of cognitive deficits that are temporally related to 1 or more cerebrovascular events. DLB is characterized by fluctuating cognition with pronounced variations in attention and alertness. Memory impairment is not a prominent early feature but may occur with progression of the disease. In contrast, FTD is characterized by relative sparing of learning and memory in early stages of the disease.

TREATMENT OF OLDER ADULTS WITH COMORBID DEPRESSION AND DEMENTIA

Best practice guidelines published by the Detroit Expert Panel on the Assessment and Management of Neuropsychiatric Symptoms of Dementia, recommend an evidence-informed standardized approach to managing depression and other neuropsychiatric symptoms of dementia.²¹ A 4-step approach uses the mnemonic *DICE*. Step 1 is to facilitate having the caregiver DESCRIBE the presenting psychological or behavioral symptom patterns. Step 2 is to INVESTIGATE, that is, to examine, rule out, and identify possible underlying and modifiable causes for the signs and symptoms (eg, pain, anemia). Step 3 is to CREATE and implement a treatment plan by collaborating with the patient, family, and treatment team. Step 4 is to EVALUATE response to treatment

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