Care of Older Adults who have an Acute Illness with Concurrent Depression

Rebecca M Radue, MD
Geriatric Psychiatry Fellow
University of Wisconsin Hospital and Clinics

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Disclosures

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Mention of off-label use of stimulant medications in the treatment of depression

Mention of off-label use of ketamine in the treatment of depression
Objectives

Describe how to screen for and assess depression among acutely ill older patients.

Describe clinical tips of when to recognize depression among hospitalized older patients.

Describe the initial treatment/care for older adults who become depressed during their acute illness.
The Scope of the Problem
Depression in Older Adults in Acute Care

Prevalence of Depression in Older Adults Across Settings

Kessler et al. 2005, Arch General Psychiatry
Tooke et al. 2018, Royal College of Psychiatrists’ Centre for Quality Improvement.
Depression in Older Adults in Acute Care has Significant Negative Consequences

- Longer lengths of stay and increased cost of care
- Poor engagement with treatment, nutrition, OT/PT services
- Increased risk of re-admission and poor compliance with follow-up
- Increased functional impairment and caregiver burden
- Increased risk of mortality

Covinsky et al. 1997, Ann Internal Med
Covinsky et al. 1999, Ann Internal Med
How Best to Assess Older Adults for Depression in the Acute Care Setting?
What does Depression look like in Older Adults?

- Irritability vs low mood
- Hopelessness
- Being withdrawn
- Somatization
- Alexithymia – inability to describe mood
- More cognitive impairment
- Psychotic symptoms if present could be subtle (delusional guilt)
- Subsyndromal Depression, “Minor Depression” much more common
Best Depression Screening Tools for Older Adults

Systematic Review in 2012 found the Geriatric Depression Scale was the most validated instrument, but no scales developed for our specific population

- GDS 15 cutoff of 5/6, GDS 30 cutoff of 10/11
  - 5+ positive on GDS 15: sensitivity 74-100%, specificity 53-98%*
- GDS 5 acceptable screener if time constraints, cutoff 2/3
  - Validated as effective, sensitivity 98%, specificity 85%*

PHQ-2 and PHQ-9 acceptable and validated

Other rating scales may overestimate due to physical symptoms

*primary care population

Watson et al. 2003 J Fam Pract
Hoyl et al. 1999 J Am Geriatr Soc
5 Item Geriatric Depression Scale

1. Are you basically satisfied with your life? YES/ NO
2. Do you often get bored? YES/ NO
3. Do you often feel helpless? YES/ NO
4. Do you prefer to stay at home rather than going out and doing new things? YES/ NO
5. Do you feel pretty worthless the way you are now? YES/ NO

If two or more are positive, further investigation is warranted
Making the Diagnosis

Symptom review
  DSM 5 criteria for MDD → low mood/anhedonia + SIGECAPS (5+ total sx x2 wks)

Differential Diagnosis
  Due to substance
  Due to medication
  Due to medical condition
  Hypoactive delirium
  Subsyndromal depression ("minor depression")

Functional impact on ADLs and care engagement
Collateral from supports is critical if available
What do we not want to miss?

Hypoactive delirium can be misdiagnosed as depression
Thorough suicide risk assessment is important
Screen for substance use
Screen for sleep apnea
Don’t miss depression with psychotic features
More likely to miss depression in some cultural minority elders
How and When to Treat?
When to Treat

Just about always!
Where there’s significant functional impairment, we should treat

Remember:
“Minor depression” more likely in older adults
Also more likely to be functionally impairing
Can have significant impact on health and recovery
Doesn’t mean we don’t treat
Non-Pharmacologic Considerations

Get patients up and moving ASAP
PT/OT consults
Pet Therapy, Music Therapy, Chaplain consult
Activities
Volunteer Service Visits
Reduce CNS depressant medications and polypharmacy
Consider psychiatry consultation when symptoms severe or picture murky
Consider capacity assessment (especially w/severe depression +/- psychosis)
Pharmacologic Considerations

start low
go slow
but go
Pharmacologic Considerations

Drug-Drug Interactions
Drug-Disease Interactions
Side Effect Profile
Renal and Hepatic Impairment with some drugs
Cognitive barriers to adherence post-discharge
Financial barriers to adherence post-discharge
Antidepressant Options

specific serotonin reuptake inhibitors (SSRIs): sertraline, citalopram, escitalopram

serotonin-norepinephrine reuptake inhibitors (SNRIs): duloxetine, venlafaxine

others: mirtazapine, bupropion

augmentation: combinations, lithium, thyroid hormone (T3), buspirone, stimulants, atypical antipsychotics (aripiprazole, olanzapine, quetiapine XR, brexpiprazole)
Special Pharmacotherapy Considerations

Hyponatremia, bleeding risk with serotonergic antidepressants
Black box warning for atypical antipsychotics (if dementia and using for augmentation)
Black box warning for QTc prolongation in citalopram
Psychotic depression → antidepressant + antipsychotic a/o ECT
Severe apathy a/o needing fast response → Consider stimulant
  Preferred agent is methylphenidate
  Dosing generally low, but want adequate trial
  Often IMPROVES rather than suppresses appetite
When to Consider Neuromodulation

Electroconvulsive therapy is still our most efficacious treatment for acute depression, including among older adults

- Safe
- Effective
- No absolute, only relative contraindications

Some emerging evidence for the use of ketamine infusion

- Case reports only for older adults
- Recently used successfully at Madison VAH in older adult with post-stroke depression, saw rapid improvement that sustained x2 months thus far
Thank you!

Questions?
rradue@uwhealth.org