NEW FACTS ABOUT...

Depression
in older adults

This information is about major depression, defined by DSM-IV as a period of at least two weeks during which a patient experiences mood disturbances that last most of the day (feeling sad and/or loss of interest in pleasurable activities) and experiences at least four other symptoms.[1] The prevalence of major depression is 2.3 to 3.2 percent in men and two to three times higher in women.[2] Among the elderly, the prevalence may be lower;[3] however, primary care providers recognize depression in only one-third to one-half of cases, and an even smaller proportion receive appropriate care.[2,3] Depression is prevalent in general medical practice, affecting about 25 percent of outpatients, making it second only to hypertension.[4] Similarly, depression affects up to 25 percent of patients in a nursing home setting.[5] Depression is costly, having direct and indirect costs estimated at $43 billion annually.[6]

Recognition and treatment for depression is likely to improve overall quality of life and can be cost-effective.[7] The following are some important findings on depression:

Depression is very prevalent among patients with chronic illness, reaching rates of 14 percent to over 70 percent.[2] Elderly patients suffer disproportionately from chronic illnesses.[8] Elderly patients presenting with these chronic conditions may benefit from being questioned about depression.

Monitoring the effectiveness of depression treatment requires identifying and serially evaluating the presenting symptoms of depression.[5,9] Therefore, when a patient is diagnosed with major depression, eliciting and documenting the DSM-IV target symptoms[1] will help with treatment.

Guidelines indicate that elderly patients being treated with medication for depression should not be started on tertiary amine tricyclics (such as amitriptyline, imipramine or doxepin), monoamine oxidase inhibitors (unless treating atypical depression), benzodiazepines or stimulants as first- or second-line therapy because these medications have more side effects and generally no better efficacy than other available antidepressant medications.[3,5]

Observational studies have shown that many patients in primary care are treated for depression with inadequate doses and duration of antidepressant medication.[10,11] If a patient has no meaningful symptom response after six weeks of medication treatment, it is unlikely depression will remit unless the dosage is optimized, the medication is changed, an adjunctive treatment is added, or psychotherapy is initiated.[3,12]

A randomized trial found that patients with three or more episodes of depression who received a placebo maintenance therapy had an 80 percent chance of relapse compared to a 20 percent chance for those on maintenance antidepressant treatment.[12] Patients who have experienced three or more episodes of depression are candidates for at least 12 months of therapy and may require lifetime therapy.

Untreated depression is associated with increased morbidity and mortality.[5] Unfortunately, depression is both under-diagnosed and under-treated in primary care.[3,11] Providers who search for depression and employ available effective treatments can improve outcomes for their depressed patients.

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