Depression is common and, as at other times, can be devastating in later life. Depression is the leading cause of disability and the cost of treating it is greater than that of treating hypertension and diabetes combined. Depression requires optimal management, which is challenging because of its different aetiological factors, comorbidities, and because of the interplay with cognitive impairment and dementia.

**Clinical presentation**

- There are differences between late-life depression and depression at any other age. However, these mainly concern some symptoms being accentuated whilst others are minimised.
- Somatic concerns (hypochondriasis) may predominate, and hypochondriacal delusions are often prominent and easily overlooked. Psychotic symptoms in late-life depression are more common than at younger ages.
- Recent-onset ‘neurotic’ symptoms suggest an underlying depressive disorder. Apathy and amotivation are common in vascular depression and in Alzheimer’s disease.
- Depression is the most common cause for the core cluster of depressive symptoms, but there are other causes: drug and alcohol misuse; dementia; normal pressure hydrocephalus; and physical illnesses.
- Over the last decade the prevalence of depression in later life has fallen, although the rate of depressive symptoms has risen.

**Depression and dementia**

- In later life there are important areas of overlap between dementia and depression, both symptomatically and aetiologically.
- Many patients with late-life major depression have persistent cognitive impairment. Mostly this does not develop into dementia; but severe, recurrent depression may be a significant risk for dementia.
- Dementia is also a risk factor for depression, especially vascular dementia.
- The vascular depression hypothesis proposes that vascular brain disease may predispose to, precipitate or perpetuate late-life depression.

**Assessment and investigation**

- Essential ingredients in assessing late-life depression include: a history, including past history and treatments, collateral history, mental state examination, focused physical examination, relevant laboratory investigations and tests of cognition.
- Although there are good mood rating scales, there is no substitute for a thorough history. A full drug history should be undertaken. A focused physical examination is vital to rule in or out an organic mood disorder, as well as to be aware of comorbidities.
- Physical investigations are also important, including an ECG, given the effect of many psychotropics (including citalopram and venlafaxine) on the QTc interval.
- Cognitive assessment is important as a baseline and to assess for dementia. Specifically designed questionnaires exist to detect depression in older adults. NICE recommend rating scales (NICE, 2009).
Management

- It is helpful to have goals in treatment. The acute phase of treatment lasts 4-12 weeks. Treatment continues for 12 months and the maintenance phase (to prevent recurrence) should last for several years.

- Drug choice should be matched to the patient depending on key symptoms and tolerability. 'Start-low, go slow'.

- ECT is effective in six out of ten patients and is indicated for depression that has not responded to pharmacotherapy. The advantage of ECT is that the effect can be rapid and lead to remission with only residual symptoms after 8-12 treatments.

- Milder forms of depression are not effectively treated with antidepressants. In mild to moderate depression, psychological approaches, such as CBT, are first line. Non-pharmacological interventions can be used alongside pharmacological approaches.

- A combination of medication and a psychological intervention is more effective than either given alone, especially in more severe and/or resistant depression.

Improving remission rates and treatment of resistant depression

- Aim for remission rather than improvement.

- In a meta-analysis of second-generation antidepressants and their efficacy in later life, results show that the effect size for trials of longer duration is greater. So in patients who have responded, more time and augmentation or combinations are preferable to chopping and changing.

- Consider a stepped-care approach. The influential STAR*D study (sequential treatment study) has suggested that earlier augmentation or combination treatment is associated with better outcomes than sequential courses of monotherapy. Recognise cases of partial resistance or more severe resistance.

Key reading


Stanford University (2011) *Geriatric Depression Scale.* [website]

