

Recognising depression in elderly patients in general practice

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Abstract

Background: Older patients with depression may not complain of sadness or feeling depressed on presentation. Delay in diagnosis can cause significant suffering to the patient and their families with increased health expenditure resulting from complications.

Objective: This article outlines an approach to help with diagnosis and assessment, of elderly patients with depression in the primary healthcare setting.

Discussion: Recognising depression in old people is not always easy as its presentation may differ from that of younger people. Older people tend to under report depressive symptoms and may not concede that they are depressed. This could be due to age, lack of cognisance of the disorder, shame or a belief in not talking about depression or admitting to not coping - it may also be embedded in their culture. Some common depressive symptoms such as poor sleep, chronic unexplained pain, poor concentration or impaired memory are wrongly ascribed to old age, dementia or poor health. As a result, depression in old age may go undetected and untreated for a long time. An assessment process which is less time consuming but has high sensitivity leading to the direct diagnosis of depression can help general practitioners in their busy general practice to facilitate management tailored to individual needs.

Key words: depression, elderly patients, general practice

Types of depression

Major Depression: Severe symptoms that interfere with ability to work, sleep, concentrate, eat, and enjoy life. Most people would experience multiple episodes, although some may experience only a single episode in their lifetime.

Persistent depressive disorder (Dysthymia): Symptoms are less severe than those of major depression but last a long time (at least two years).

Minor Depression: Symptoms that are less severe than those of major depression and dysthymia, and symptoms do not last long (1) [National institute of Mental Health, NIH].

Presenting symptoms of older patients with depression

The frequently encountered symptoms of late-life depression are persistent low mood or sadness (lasting two weeks or more), low energy, feeling hopeless or worthless, fidgeting and pacing, uncontrolled worries about health or finances, poor attention and concentration, sleep disruption, weight changes, other physical symptoms such as chronic inexplicable pain or gastrointestinal symptoms. Such symptoms on presentation should raise some suspicion in the general practitioner to consider further assessment for depression. One should bear in mind that older people tend not to divulge depressive symptoms and may not always acknowledge being sad or depressed. This could be due to age, shame or belief in not talking about depression or coping poorly (2). [Depression in older people, Black dog institute]. Depression with agitation is common and biological symptoms may not manifest that often. One important sign of depression is when people isolate themselves socially. Often depressed persons will give divergent explanations rather than explaining their symptoms as a medical illness. The cognitive and functional impairment and anxiety are more common in older people than in younger adults with depression.

Why to assess for depression

Depression in older adults (65 years and older) is associated with emotional suffering. It increases the costs of health care, morbidity, risk of suicide, and mortality. Depression is common and remains a significant problem for older adults (3).

Medical illnesses are a common trigger for depression in the older population and often it worsens the symptoms of physical illness. Correct early diagnosis and treatment would reduce the physician's workload as physical symptoms will decrease with resolution of depression (4). The results of non-treatment may lead to non-adherence with medication and other treatments, self-neglect, or non-attendance at clinic.

Assessment in general practice

A thorough history, corroborative information and mental state examination is required for proper diagnosis. It is essential to do a physical examination. Investigations to consider when depression is suspected; Full blood count, Urea and electrolytes, Liver function tests, Thyroid function tests Vitamin B12, Folate, Fasting glucose, Bone profile, Further tests dictated by clinical presentation.

Severity can be assessed by DSM V (Diagnostic and Statistical Manual; in Australia) or ICD-10 criteria. However minor depression which is more common in the elderly will not fulfil the necessary criteria for major depression (5). When screening is positive for depression, the diagnosis should be confirmed using DSM-V or ICD-10 criteria. When symptoms do not meet the criteria for depression, other mental health disorders should be considered, such as bereavement, dysthymia, medication induced depressive disorder (6). The primary care physician will not have enough time to complete the assessment in one sitting although recognition can be achieved accurately within routine consultations. It is worthwhile to arrange follow up appointments which will provide additional time to allow not only recognising the illness, but also to device management plan and establishing a therapeutic relationship with the patient (6). Opportunistically the annual health assessment may be used for screening.

Discerning Depression Delirium and Dementia: Depression, delirium and dementia can all present in a similar way, hence it is important to distinguish depression from the others. Typically, an acute behavioural or mood change is suggestive of delirium. Once medical conditions are excluded, depressive symptoms characterised by more pervasive or chronic low mood state with or without cognitive impairment should be considered. Patients with dementia are less likely to report their problems than are the patients with depression (7).

Scales used for assessment of depression : The Geriatric Depression Scale has been validated the best among the depression screening instruments (8) and is suggested for routine use in primary health care service due to its high sensitivity (9). The majority of patients screening positive for depression will not meet criteria for major depression and screening instruments are not sufficient for diagnosis, but this would indicate the need for more detailed follow-up by the primary care physician to determine whether the person's depressive disorder progresses, and to explore other possible causes for depression (such as hypothyroidism or medication or substance use) and assess for co-existing psychiatric disorders (10). The Cornell Scale for Depression in Dementia (CSDD) is suitable for patients with dementia (4).

How to improve recognition

There are some doctors who are more adept in recognising depression than others. Such physicians tend to make more eye contact with the patient and are generally good listeners. They tend to ask direct, informed questions with psychological or social content. Certain behaviours in doctors can make it more difficult to detect depression as they may inhibit the distressed patient by asking closed questions or questions derived from theory rather than from the patient's unique situation (11).

Studies have shown that greater identification occurs in those consultations where patients mention psychological symptoms early and mention more symptoms; where the consultation is longer; and where the doctor shows high empathy and tolerance while also following up the patient's answers with further discussion. It is also advantageous if the physician is able to comprehend non-verbal behaviour (6).

Interview skills training has been shown to improve recognition of depression and other mental disorders as the skills taught are maintained over time and have an impact on satisfaction and outcome (6).

Conclusion

Depression in elderly can be difficult to diagnose. Failure to identify and treat depression increases mortality and morbidity in the elderly population increasing demands on relatives, health and social services. Early detection and management will reduce the workload of the physician in the medium to long term. Family physicians can increase their ability to recognise depression by improving interview skills and undertaking mental health skills training and using appropriate tools for diagnosis.

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