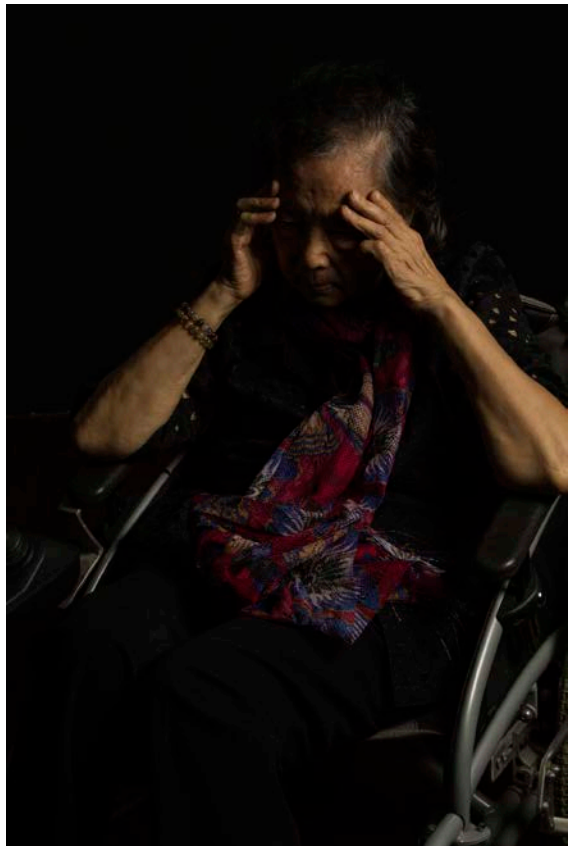
Depression and Delirium of the Older Adult



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Learning Objectives

Upon completion of this module, learners will be able to:

1. Summarize the difference between delirium and depression in older adults
2. Discuss the use of standardized tools for measuring cognitive, behavioral, and/or mood changes to confirm diagnoses
3. Discuss the structured assessment method to make a differential diagnosis based on the clinical features of delirium and depression
4. Apply management principles according to pharmacologic/ nonpharmacologic strategies
5. Identify materials to educate patients and family/caregivers

Delirium vs. Depression

- Delirium and depression can coexist but are not the same diagnosis
- Both have Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria for diagnosis:
  - Delirium is the acute onset of behavioral changes and/or confusion and often has an organic cause; resolution is often as abrupt as onset
  - Depression can be acute or insidious in onset and can last for years; though pathology can exacerbate the depression, it is not the cause of the depression

Note: Depression in the geriatric population can be confused with delirium or dementia

Delirium

Delirium: Definition

DSM-5: Five Key Features of Delirium

1) Disturbance in attention and awareness
2) Disturbance develops over a short period of time, represents a change from baseline, and tends to fluctuate during the course of the day
3) An additional disturbance in cognition

Continued on next slide...

More details included in the module video

Delirium: Definition

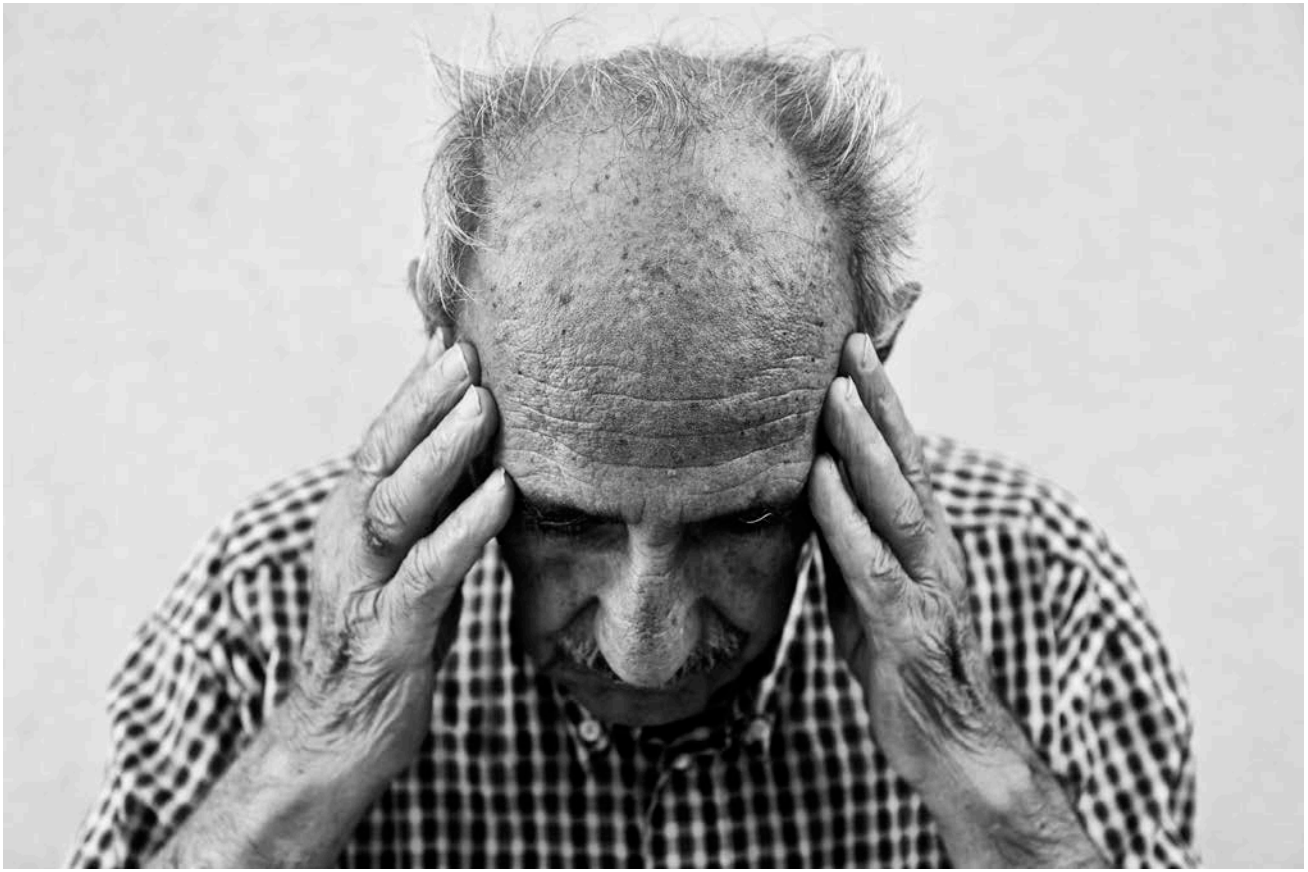
DSM-5: Five Key Features of Delirium (Continued)

4) Disturbances are not better explained by another preexisting, evolving, or established neurocognitive disorder, and do not occur in the context of a severely reduced level of arousal, such as coma
5) There is evidence from the history, physical examination, or laboratory findings that the disturbance is caused by a medical condition, substance intoxication or withdrawal, or medication side effect

More details included in the module video

Three Types of Delirium

- Hyperactive
- Hypoactive
- Mixed



Three Types of Delirium

- **Hyperactive or Agitated Delirium:**

Hyperactive, excitable, restless, picking at bedclothes, irritable. Behavior is detrimental to patient's and staff's well-being and safety.

- **Hypoactive Delirium:**

Lethargic, apathetic, sluggish, unaware, sparse/slow speech. Often "missed" or mistaken for depression or fatigue.

- **Mixed:**

A combination of both agitated and hypoactive delirium

Delirium: Presentation

- Cognitive presentation: Inattention, memory impairment, disorientation
- Behavioral presentation: Agitation or hypoactivity, resistance to care, sleep-wake disturbance
- Psychiatric presentation: Paranoia and delusions, hallucinations (often visual) and illusions, affective lability

Delirium Incidence, Prevalence, and Mortality

Prevalence in Elderly

- Nursing home/post-acute care: 1.4-70% (de Lange et al., 2013)
- During hospitalization: 14-56% (de Lange et al., 2013)
- End-of-life: 83% (Fong et al., 2009)

Hospital

- Prevalence (on admission): 40.4% (Chin et al., 2016)
- Incidence (hospital geriatric ward): 53.3% (Ryan et al., 2013)
- Hospital postoperative: 14% (Gallagher et al., 2014)

Delirium Incidence, Prevalence, and Mortality

Mortality with Delirium

- In-hospital Mortality: 22-76%
- One-year Mortality: 35-40%

(Witlox et al, 2010)

Delirium Factors

Risk Factors

- Advanced age
- Dementia
- Infection
- Central nervous system (CNS) disease
- Polypharmacy
- Beers medications
- Hypoalbuminemia
- Electrolyte abnormalities
- Recent surgery
- Sleep disturbance

Delirium Factors

Risk Factors continued

- Environmental factors
- Sensory changes
- Alcohol abuse
- History of delirium
- History of transient ischemic attacks and strokes
- Cancer with brain metastasis
- Dehydration to constipation

Delirium Factors

Vulnerability Factors

- Impaired vision and/or hearing
- Severe illness on admission
- Preexisting cognitive impairment
- Dehydration
- Serum creatinine ≥ 1.8 mg/dL
- Use of physical restraints
- Use of indwelling catheter
- Malnutrition

Delirium Assessment

- Delirium is “usually multifactorial in elderly people. The multifactorial model of the cause of delirium has been well validated and widely accepted. Development of delirium is dependent on complex inter-relationships between vulnerable patients with several predisposing factors and exposure to noxious insults or precipitating factors.”

(Inouye et al., 2014, p. 912)

Delirium Assessment

Geriatric Evaluation Mnemonic Screening Tool

- **D** Drugs
- **E** Eyes, ears
- **L** Low O_2 states (MI, ARDS, PE, CHF, COPD)
- **I** Infection
- **R** Retention (of urine or stool), restraints
- **I** Ictal
- **U** Underhydration/Undernutrition
- **M** Metabolic
- **S** Subdural, sleep deprivation

(Flaherty & Tumosa, n.d.)

Delirium Screening: Confusion Assessment Method (CAM)

- Acute change or fluctuation in mental status:
  - Assess by history and observation
  - Staff and family can attest to the admission/preoperative or prehospital cognitive status of the patient
- Inattention:
  - Is the patient able to answer a direct question with an appropriate answer?
  - Can the patient stay “on track” in normal conversation?
  - If the answer is no, also look for fluctuations in levels of attention, which can further signal delirium

(Inouye et al., 2014; CAM-ICU tool)
(http://www.icudelirium.org/docs/CAM_ICU_training.pdf)

Delirium Screening: Confusion Assessment Method (CAM)

- Disorganized thinking: Is the patient's speech/thought process rambling, unclear, unpredictable, illogical, and/or irrelevant?
- Altered level of consciousness: Assess the patient for alertness, vigilance, lethargy, stupor, or coma
- CAM-ICU: Confusion assessment method for the intensive care population

More details included in the module video

Inouye et al., 2014;
http://www.icudelirium.org/docs/CAM_ICU_training.pdf)

Medications Associated with Delirium

Resources

- Beers Criteria:
  - https://guideline.gov/summaries/summary/49933/american-geriatrics-society-2015-updated-beers-criteria-for-potentially-inappropriate-medication-use-in-older-adults?q=Beers
- START:
  - http://ageing.oxfordjournals.org/content/36/6/632.abstract
- STOPP:
  - http://www.ncbi.nlm.nih.gov/pubmed/18218287

More details included in the module video

Medications Associated with Delirium

Medications with Anticholinergic Effects

- Anticholinergics, antihistamines, antipsychotics, antispasmodics, cyclic antidepressants, mydriatics

Herbal Medicines

- Burdock root, black henbane, atropa belladonna, mandrake, jimson weed, St. John's Wort, valerian

Miscellaneous Agents

- Hypoglycemics, hypnotics, benzodiazepines, antiarrhythmics, beta blockers, diuretics, digoxin, clonidine, dopamine agonists, corticosteroids, muscle relaxants, anticonvulsants, antiemetics, alcohol, illicit drugs, NSAIDs, opioids, H-2 receptor blockers

(Inouye et al., 2014; Williamson, 2017)

Tests to Evaluate Delirium

Diagnostic Testing

- Laboratory tests:
  - Serum: electrolytes, creatinine, glucose, calcium, CBC
  - Urine: urinalysis and culture
  - Toxicology, liver function, ABGs
- Neuroimaging (CT/MRI)
- Lumbar puncture
- EEG testing

(Williams & DeBattista, 2017)

Delirium Management Principles

- Ensure safety
- Identify and reverse causes: supply oxygen, monitor VS, I/O
- Thoroughly search and treat any organ system failure (labs, imaging)
- Avoid polypharmacy and discontinue unnecessary medications (e.g., cimetidine, naproxen, inhalers)
- Minimize opioids and benzodiazepines
- Repeat physical exam, further labs, radiologic study

(Reuben et al., 2014)

Nonpharmacologic Strategies for Delirium

Environment

- Ensure that lighting is adequate (Zaal et al., 2013)
- Control sources of excess noise (Meagher, 2001; Zaal et al., 2013)
- Provide clear signposts in the patient's location, including a clock, calendar, and chart with the day's schedule (Gonzalez et al., 2014)
- Place familiar objects from the patient's home in the room (Gonzalez et al., 2014; Meagher, 2001)
- Use television or radio for relaxation and to help the patient maintain contact with the outside world (Bryczkowski et al., 2014)

Nonpharmacologic Strategies for Delirium

Environment (Continued)

- Maintain natural diurnal cycle, open blinds/curtains during day and/or keep lights on and room bright, lights out at night (Bryczkowski et al., 2014)

Below are additional nonpharmacologic strategies not covered in the video:

- Provide an unambiguous environment (Bryczkowski et al., 2014; Meagher, 2001)
- Simplify care area by removing unnecessary objects and allow adequate space between beds (Meagher, 2001; Wong, 2003)
- Consider using a private room to aid rest and avoid extremes of sensory experience (Bryczkowski et al., 2014; Meagher, 2001)

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Nonpharmacologic Strategies for Delirium

Communication and Interaction with Patient

- Identify and correct sensory impairments; ensure patients have their glasses, hearing aids, and dentures; and consider whether interpreter is needed (Gonzalez et al., 2014; Mailhot et al., 2014)
- Avoid using medical jargon in the patient's presence because it may encourage paranoia (Mailhot et al., 2014; Meagher, 2001)
- Arrange scheduled treatments to allow maximum periods of uninterrupted sleep
- Provide support and orientation, communicate clearly and concisely (Mailhot et al., 2014)
- Give repeated verbal reminders of the day, time, location, and identity of key persons, such as members of the treatment team and relatives (Mailhot et al., 2014)
- Involve family members and caregivers to encourage feelings of security and orientation (Bryczkowski et al., 2014; Mailhot et al., 2014)

Medication Management

Pharmacologic Strategies (*considered second line*)

NOTE: Avoid antipsychotics for behavioral problems unless nonpharmacologic options have failed or are not possible, and the older adult is threatening substantial harm to self or others.

For acute agitation or aggression that impairs care or safety:

- Antipsychotics
  - Haloperidol 0.5 mg (mild), 1.0 mg (moderate), and 2.0 mg (severe)

(Hui et al., 2017; Meagher, 2001)

Medication Management

<u>For acute agitation or aggression that impairs care or safety</u>: (*continued*)

Atypical Antipsychotics

- Risperidone 0.25-0.5 mg po bid prn, olanzapine 2.5 mg po qhs, quetiapine 25 mg po bid prn (Boettger et al., 2015)

Target prevention measures by controlling symptoms if necessary:

- <u>Pain</u>: Acetaminophen (1 gm q 8 hrs) and oxycodone (2.5-5 mg q 8 hrs)
- <u>Sleep deprivation</u>: Ramelteon 8mg hs, trazodone 12.5-25 mg

(Reuben et al., 2014)

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Pharmacologic Strategies for Delirium

- Strategy 1: Dosing according to severity of symptoms is important
  - Day 1: PRN order
  - Day 2 and beyond: Assess total drug needed from previous day and schedule it over the next day

- Strategy 2: Use effective dose for 48 hours and taper gradually over 1-5 days
  - Be careful for sedation, anticholinergic effects, and box warnings

(Reuben et al., 2014)

Delirium: Prevention

Prevention Tips

- Perform admission cognitive function test to establish a baseline (Mistraletti et al., 2012)
- Remove all lines/catheters as soon as possible (Bryczkowski et al., 2014; Mistraletti et al., 2012)
- Ensure hearing aids, glasses, and teeth are used, and travel with patients on transfer through facilities (Gonzalez et al., 2014; Mailhot et al., 2014; Meagher, 2001; Wass et al., 2008)
- Encourage family participation in hospital care (Bryczkowski et al., 2014)
- Encourage good sleep hygiene, and do not interrupt sleep for vital signs, blood draws, or daily weights (Bryczkowski et al., 2014)

Patient Self-Care Strategies: Delirium

Prevention Tips (Continued)

- Encourage self-care and participation in treatment (e.g., ask patient for feedback on pain) (Meagher, 2001; Vaurio et al., 2006)
- Maintain activity levels; ambulatory patients should walk at least three times daily (Meagher, 2001; Wong, 2003)
- Nonambulatory patients should undergo full range of movement exercises for 15 minutes three times daily (Meagher, 2001; Mistraletti et al., 2012, Wong, 2003)

Delirium: Prevention

Additional prevention tips not mentioned in the video

- Treat underlying medical and/or medication causes (Bryczkowski et al., 2014)
- Obtain a nutrition/dietary consult, ensure hydration (Mistraletti et al., 2014)
  - *Referral Cue: Refer patients to a registered dietitian*
- Encourage frequent reorientation by staff (Inouye et al, 1999)
- Check for clocks, schedule boards, and visible calendars in patients' rooms (Mistraletti et al., 2012)
- Order physical therapy/early mobilization (Inouye et al, 1999)
  - *Referral Cue: Refer patients to a physical therapist*

Assessment Question 1

You are assessing a 70-year-old man at your acute care facility. He reports a sudden change (new onset) in attention and awareness that fluctuates during the day. You suspect delirium. What screening tool would you use? *(Select One)*

a) Mini–Mental State Examination (MMSE)
b) Mental Status Assessment of Older Adults: The Mini-Cog
c) Confusion Assessment Method (CAM)
d) Beck's Depression Inventory

Assessment Question 1: Answer

You are assessing a 70-year-old man at your acute care facility. He reports a sudden change (new onset) in attention and awareness that fluctuates during the day. You suspect delirium. What screening tool would you use? *(Select One)*

a) Mini–Mental State Examination (MMSE)

b) Mental Status Assessment of Older Adults: The Mini-Cog

c) Confusion Assessment Method (CAM) (Correct Answer)

d) Beck's Depression Inventory

Assessment Question 2

Which of the following is <u>not</u> an appropriate nonpharmacologic therapy for the older adult with delirium? (Select One)

a) Correct sensory impairments; ensure patients have their glasses, hearing aids, and dentures
b) Provide a 40- to 60-watt night light
c) Use television or radio for relaxation
d) Leave patient in quiet/non-stimulant room without clock or calendar

Assessment Question 2: Answer

Which of the following is <u>not</u> an appropriate nonpharmacologic therapy for the older adult with delirium? (Select One)

a) Correct sensory impairments; ensure patients have their glasses, hearing aids, and dentures

b) Provide a 40- to 60-watt night light

c) Use television or radio for relaxation

d) Leave patient in quiet/non-stimulant room without clock or calendar (Correct Answer)

Depression

Depression: Definition

DSM-5

- Presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function

(Jongenelis et al., 2004; NIH Consensus Conference, 1992)

Depression: Definition

DSM-5 Criteria for Major Depressive Disorder (MDD)

- Specific symptoms, and at least 5 of these 9 must be present nearly every day:
  1. Depressed mood or irritable most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful)
  2. Decreased interest or pleasure in most activities, most of each day
  3. Significant weight change (5%) or change in appetite
  4. Change in sleep: Insomnia or hypersomnia

(Jongenelis et al., 2004; NIH Consensus Conference, 1992)

Depression: Definition

5. Change in activity: Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Worthlessness/Guilt: Feelings of worthlessness and/or excessive or inappropriate guilt
8. Concentration: Diminished ability to think or concentrate, and/or more indecisiveness
9. Suicidality: Thoughts of death or suicide, or has suicide plan

(Jongenelis et al., 2004; NIH Consensus Conference, 1992)

Depression: Other Depressive Disorders

Other Depressive Disorders Include:

- Persistent depressive disorder (dysthymia)
- Disruptive mood dysregulation disorder
- Substance/medication-induced depressive disorder
- Depressive disorder due to another medical condition
- Other specified depressive disorder
- Unspecified depressive disorder

(Jongenelis et al., 2004; NIH Consensus Conference, 1992)

Depression: Factors

- Risk Factors: Multiple medications, social isolation, widowed, divorced, or separated marital status, economic status, comorbid medical conditions, uncontrolled pain, insomnia
- Biological Factors: Medical illness, such as Parkinson's, Alzheimer's, cancer, diabetes or stroke, vascular changes in the brain, chronic or severe pain, previous history of depression, substance abuse
- Social Factors: Loneliness, isolation, recent bereavement, lack of a supportive social network, decreased mobility due to illness or loss of driving privileges

(Jongenelis et al., 2004; NIH Consensus Conference, 1992)

Depression: Factors

- Psychological Factors: Traumatic experiences, abuse, damage to body image, fear of death, frustration with memory loss, role transitions
- Common Precipitants: Arguments with friends or relatives, rejection or abandonment, death or major illness of loved one, loss of pet, anniversary of an event, major medical illness or age-related deterioration, medication noncompliance

(Jongenelis et al., 2004; NIH Consensus Conference, 1992)

Depression and the Older Adult

Overview

- Depression in the elderly is NOT a normal part of aging (https://www.cdc.gov/aging/mentalhealth/depression.htm)
- Underdiagnosed and undertreated (https://www.cdc.gov/aging/pdf/cib_mental_health.pdf)

Presentation

- Vegetative signs and cognitive disturbances more common
- Multiple physical complaints of chronic pain, including orthopedic pain, no apparent physical cause
- Experience sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, tiredness, and poor concentration

(Mitchell et al., 2013)

Depression: Background

Serious Outcomes

- Depression is more common in people who also have other illnesses (such as heart disease or cancer) or whose function becomes limited
- Increased comorbidity, impaired functioning, increased mortality, and suicide
- In 2014, suicide rates were highest among men aged 75 and over
- Depression is clearly associated with functional impairment and effects disability status over time
- Depression complicates the course of Alzheimer's Disease; increase in disability; physical aggression; caregiver depression and burden

(CDC, 2017; Curtin et al., 2016; Fiske et al., 2009; Gøtzsche, 2014)

Depression: Incidence

- In 2015, an estimated 5.2 million adults aged 50 or older had a major depressive episode in the past year
- Defined as having a period of 2 weeks or longer in the past 12 months when they experienced a depressed mood or loss of interest or pleasure in daily activities, and they had at least some additional symptoms, such as problems with sleep, eating, energy, concentration, and self-worth

(Center for Behavioral Health Statistics and Quality, 2016)

Depression: Incidence

- Depressive symptoms have higher frequency in:
  - Oldest old population (age > 85)
  - Women
  - Those living with a physical disability or cognitive impairment
  - Lower socioeconomic status (Blazer, 2003)
- The rates of geriatric depression are between 12% and 30% in institutional settings (including assisted living, supportive living, and nursing homes/long-term care facilities)
  - Notably, the rates are up to 50% for residents specifically in long-term care facilities (Park & Unutzer, 2011)

Screening

- Geriatric Depression Scale (GDS)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Patient Health Questionnaire-2 (PHQ-2)
- Nutrition status
- Lab tests (blood, urine, electrolytes - hypoalbuminemia, cholesterol, dehydration)
- Activities of Daily Living (ADLs)
- Social functioning
- Medications
- Mobility and balance, sitting and standing blood pressure
- Electrocardiogram if cardiac disease is present

(Blazer, 2003)

Screening

- Screening in primary care is critical
- Screen older adults for depression at the initial visit
- Screening instruments on the following slide demonstrate at least fair sensitivity in detecting depression
- Screen for medical etiology
  - Include thyroid stimulating hormone, complete blood count, basic metabolic panel (chem 7), folate, and B12
  - Also include polysomnography if sleep disorder (i.e., OSA) suspected

(U.S. Preventive Services Task Force, 2016)

Screening/Assessment Tools

Geriatric Depression Scale (GDS)

- Short Form: 15-question survey, score > 5 needs a comprehensive assessment
  - http://geriatrictoolkit.missouri.edu/cog/GDS_SHORT_FORM.PDF
- Long Form: 30 questions, 1 point each question
  - Normal 0-9
  - Mild depressive 10-19
  - Depressive 20-30
  - http://neurosciencecme.com/library/rating_scales/depression_geriatric_long.pdf

(Sheikh & Yesavage, 1986)

Screening/Assessment Tools

Patient Health Questionnaire-2 (PHQ-2)

- Initial screening ("First Step" approach) for major depressive episode
  (Kroenke et al., 2003)
- "Yes" answer to either of two questions is considered positive, and it is highly sensitive for detecting major depression in persons over age 65
- During the past 2 weeks, have you been bothered by feeling down, depressed, or hopeless?
- During the past 2 weeks, have you been bothered by having little interest or pleasure in doing things?
  - http://www.cqaimh.org/pdf/tool_phq2.pdf

(Sheikh & Yesavage, 1986)

Screening/Assessment Tools

Patient Health Questionnaire-9 (PHQ-9)

- For screening, diagnosing, monitoring, and measuring severity of depression
- Nine-item, patient-rated depression scale to assess symptoms to make a tentative depression diagnosis (Kroenke et al., 2001)
  - http://www.cqaimh.org/pdf/tool_phq2.pdf

Assessment Question 3

You are seeing a healthy 70-year-old man for a health maintenance visit. What tool would you use to screen for depression? (Select One)

a) Mini–Mental State Examination (MMSE)

b) Geriatric Depression Scale (GDS)

c) Mental Status Assessment of Older Adults: The Mini-Cog

d) CAGE Questionnaire

Assessment Question 3: Answer

You are seeing a healthy 70-year-old man for a health maintenance visit. What tool would you use to screen for depression? (Select One)

a) Mini–Mental State Examination (MMSE)

b) Geriatric Depression Scale (GDS) (Correct Answer)

c) Mental Status Assessment of Older Adults: The Mini-Cog

d) CAGE Questionnaire

Depression Management

Management Principles: Depression

- A meta-analysis found the selection of treatment for depression should consider a number of clinical variables, such as characteristics and severity of depressive episodes, co-occurring and residual symptomatology, medical comorbidities, and the patient's preference to treatment (pharmacotherapy, psychotherapy, or a combination)
- Cognitive behavioral therapy (CBT) and interpersonal psychotherapy have demonstrated efficacy in treating major depressive disorder to a degree that is similar to that provided by antidepressant drug treatment

(Guidi et al., 2016)

Management Principles: Depression

- The sequential administration of psychotherapy after response to acute-phase pharmacotherapy, either alone or in combination with antidepressant drugs, may play a role in reducing relapse and recurrence in major depressive disorder
- Management outcomes: Improved quality of life, enhanced functional capacity, possible improvement in medical health status, and lower health care costs
- Screening for Suicide:
  - Columbia-Suicide Severity Rating Scale (C-SSRS) is a screening tool for evaluating depression
  - Free instrument, considered gold standard in all clinical trials
  - http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/

(Guidi et al., 2016)

Management Principles for Older Adults with Cognitive Deficits

- CBT focused on problem-solving has better effectiveness than supportive therapy in randomized clinical trials among older adults with depression and cognitive deficits

(Simon et al., 2015)

Nonpharmacologic Strategies for Depression

- Somatic therapy
- Psychotherapy
- CBT
- Cognitive bibliotherapy
- Problem solving therapy
- Brief psychodynamic therapy
- Life review therapy
- Electroconvulsive therapy (ECT)
- Opportunity to improve physical function
- Aerobic exercise; weight training
- Exercise – one efficacious treatment!

(Fiske et al., 2009)

Pharmacologic Strategies for Depression - Overview

Management Considerations

- Treatment should be individualized on the basis of:
    - Patient history
    - Past response to medicines
    - Severity of illness
    - Concurrent illnesses and medications
    - Likeliness of treatment adherence, efficacy, tolerability and cost
- In older adults, effects may not occur until 8-12 or 16 weeks of therapy

(Blazer, 2003, Taylor , 2014, AGS Geriatrics at your Fingertips, 2017)

Pharmacologic Strategies for Depression - Overview

General Recommendations

- Low initial dosing and monitoring for adverse effects is recommended
- Continue an antidepressant 4-6 weeks after titrating to a therapeutic dose
- If response is inadequate, consider switch to another 1st line agent
- 2nd line treatments or referral to a psychiatrist may be considered
- Combining antidepressants can lead to significant adverse effects
- Adverse drug withdrawal symptoms may occur with sudden discontinuation of the treatment (should taper the dose to minimize)

(Blazer, 2003, Taylor , 2014, AGS Geriatrics at your Fingertips, 2017).

Pharmacologic Strategies for Depression - Overview

General Recommendations

- 1st Episode: approximately 6-12 months of continual therapy
- 2nd Episode: 2+ years continual therapy, or consider indefinite therapy
- 3rd or More Episodes: 3+ years continual therapy or consider indefinite

Lifetime risk of recurrence may approach 70%

(Blazer, 2003, Taylor , 2014, AGS Geriatrics at your Fingertips, 2017).

Pharmacologic Strategies for Depression - Overview

<u>Follow Geriatric Prescribing Principles</u>: Start Low and Go Slow

- <u>Major depression</u> **(First-line therapy)** + ongoing psychotherapy
  - SSRI s (Selective Serotonin Reuptake Inhibitors)
  - Examples include:
    - Citalopram (10-20 mg), sertraline (25-100 mg) and paroxetine (10-40 mg)

- <u>Common adverse effects</u> – ***older adults are at increased risk***
  - Nausea, diarrhea, headaches, increased fall risk, hyponatremia, abnormal bleeding, cardiac conduction abnormalities (i.e., QT prolongation)

(Taylor, 2014, Blazer, 2003).

Pharmacologic Strategies for Depression - Overview

Follow Geriatric Prescribing Principles: Start Low and Go Slow

- Major depression **(Second line therapy)** + ongoing psychotherapy
  - SNRIs (Serotonin-Norepinephrine Reuptake Inhibitors) or other agents with novel mechanisms
- Examples:
  - Duloxetine 20-60 mg, venlafaxine XR 75-225 mg, mirtazapine 15-45 mg
- Common adverse effects – ***older adults may be at increased risk***
  - Increased risk of falls, sedation, dizziness, dry mouth, constipation, headaches, possible hypertension

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(Taylor 2014, Blazer 2003).

Pharmacologic Strategies for Depression - Overview

- Unipolar Psychotic Major Depression (a severe subtype of major depression)
  - SSRIs plus antipsychotic agents (risperidone, olanzapine), use electroconvulsive therapy (ECT), if therapy is not effective.

- Persistent Depressive Disorder (previously "Dysthymia")
  - SSRIs plus psychotherapy

- Minor Depression
  - Education plus watchful waiting for depression lasting < 2weeks
  - Switch to SSRIs plus psychotherapy if symptoms persist

(Taylor, 2014, Blazer, 2003).

Pharmacological Treatments to AVOID in Older Adults

Medications to AVOID In Older Adults With Depression

Medication	Undesired Effects
Amitriptyline	Anticholinergic, sedating, hypotensive
Amoxapine	Anticholinergic, sedating, hypotensive, extrapyramidal effects, neuroleptic malignant syndrome
Doxepin	Anticholinergic, sedating, hypotensive
Imipramine	Anticholinergic, sedating, hypotensive
Maprotiline	Seizures, rashes
Protriptyline	Very anticholinergic, can be stimulating
St. John's Wort	Drug interactions, photosensitivity, hypomania
Trimipramine	Anticholinergic, sedating, hypotensive

(AGS Geriatrics at your Fingertips, 2017).

Caregiver Self-Care Strategies: Depression

- Continue to assess signs of depression in the caregiver (mood and emotion)
- Take advantage of group support programs to reduce the social isolation of older adults
- Encourage the patient to participate in skill training
- Assist older adults in behavioral activation
  - Using behavioral therapy, working with depressed patients to reengage in activities they have avoided (i.e., social engagements or physical activity)
  - Refer patient to a therapist

(Fiske et al., 2009)

Health Care Provider/Caregiver Strategies: Depression

- Practitioner roles are flexible, and practitioners should pay attention to the treatment needs and preferences of older adults
- Prevention: Treat older adults before they reach a full disorder
- Reduce the risk of adverse outcomes
    - Screen for suicidal risk followed by effective treatment
- Reduce risk of suicidal behaviors
    - Early recognition of patient at risk, referral, and interventions for depression

(Fiske et al., 2009; Hensley, 2012; Schulz & Martire, 2004)

Assessment Question 4

Alternative therapies for depressive older adults include all of the following except:

a) Support from family

b) Focus on negatives

c) Participate in skill training

d) Group support programs

Assessment Question 4: Answer

Alternative therapies for depressive older adults include all of the following except:

a) Support from family

b) Focus on negatives (Correct Answer)

c) Participate in skill training

d) Group support programs

Person-Centered Care Goals

Care Planning: Person-Centered Care Goals

Six core elements were identified most frequently:

- Education and shared knowledge
- Involvement of family and friends
- Collaboration and team management
- Sensitivity to nonmedical and spiritual dimensions of care
- Respect for patient needs and preferences
- Free flow and accessibility of information

(Hensley, 2012)

Patient, Family/Caregiver Education

Delirium

- Etiology of delirium: explain what delirium is, how common it is, what the usual course is
- Provide reassurance: delirium is usually temporary symptoms of a medical condition
- Psychiatric consultation can aid in distinguishing delirium from a primary psychiatric disorder and in managing the behavior disturbances associated with delirium
- www.americandeliriumsociety.org

(Martin-Plank, 2014)

Patient, Family/Caregiver Education

Depression

- Educate about antidepressant side effects such as headache, nausea, sleeplessness or drowsiness, agitation, and sexual problems
- Educate caregivers to continue assessment processes; mood and emotional responses
- Educate about the importance of medication adherence to prevent recurrence

(Boltz et al., 2016)

Care Planning Goals: Delirium

- There is evidence to prevent delirium, but no evidence to change the course of delirium once it develops
- Therefore, prevention first, achieve remission second
  - Assess for risk of delirium by MD, PharmD, Nurses/PA, PT/OT, SW
  - Reduce relapse and recurrence
  - Improve quality of life and functioning
  - Improve medical health and reduce mortality
  - Reduce health care costs ($143-152 billion/year) (Leslie & Inouye, 2011)

Assessment Question 5

The diagnosis of delirium must be distinguished from depression and dementia. Which one of the following symptoms is typical of delirium?

a. Acute in onset with clouding of the sensorium
b. Feelings of hopelessness
c. Poor effort on testing
d. Feelings of worthlessness and/or excessive or inappropriate guilt

Assessment Question 5

The diagnosis of delirium must be distinguished from depression and dementia. Which one of the following symptoms is typical of delirium?

a. Acute in onset with clouding of the sensorium (correct answer)
b. Feelings of hopelessness
c. Poor effort on testing
d. Feelings of worthlessness and/or excessive or inappropriate guilt

Resources

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www.**pogoe**.org, *Hartford, Portal of Geriatric Online Education*. Accessed July 6, 2016

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