




Management of Depression in Older Adults

Older people respond well to treatments for depression. The management of depression in older people essentially follows the same step-wise pathway as in younger adults (See NZGG algorithms⁷) and chronological age should not be a barrier to specific therapies.¹⁰ There is evidence to support the use of the same range of psychological therapies as in younger adults and if pharmacological management is required, an SSRI is also considered the first-line antidepressant.¹⁰

 For further information see “Depression in elderly people”, BPJ 11 (Feb, 2008).

Active support and liaison with other agencies

Successful management of depression depends largely on enabling the patient to be an active participant in the care process. A collaborative partnership between practitioner and patient is a consistent predictor of therapy outcomes for both pharmacological and psychological treatments.


Self-management includes exercise, activities (involving family/whanau and friends), advice on sleep hygiene, improving lifestyle and diet and avoiding alcohol.

Enjoyable social and intellectual activities, involving family and friends if possible, should be encouraged, such as; domestic leisure activities, walking, dancing, gardening, reading, music and social games. Voluntary organisations, support agencies and some care facilities may also offer services.

Exercise

The available evidence generally supports the benefits of exercise for older people with depression.⁷ In most trials participants have been closely supervised undertaking relatively intense exercise programmes. Although this may not be possible in all community or care facility settings, it is generally accepted that exercise has beneficial effects in any age group. Exercise regimens need to be tailored to

the individual, taking in to account any physical or medical restrictions. Social exercises, such as walking groups or dancing combine the benefits of physical activity with social interaction.

 Find out about local initiatives, for example access to discounted rates for group activities such as Tai Chi and swimming pool classes.

Psychological therapy

As with younger adults active management and psychological therapy should be considered in all older adults with depression.

A range of psychological therapies have been shown to be effective in older people with depression but it is unclear what type of therapy works best and if they are more effective if combined with antidepressants.⁷

Antidepressants

In moderate to severe depression, treatment with an antidepressant is an option but this should always be used in conjunction with non-pharmacological treatment such as active support and psychological therapy. As with any medicine prescribed for an older person, antidepressants need to be monitored carefully due to the increased risk of adverse reactions and drug interactions compounded by

Table 2: Comparative properties of SSRIs and similar agents

SSRI	Properties
Citalopram	Less drug interactions than other SSRIs due to minimal effect on hepatic CYP450 isoenzymes May cause less nausea than other SSRIs Short half-life –caution with discontinuation syndrome
Escitalopram	Similar to citalopram
Sertraline	Intermediate risk of drug interactions; somewhere between citalopram and fluoxetine/paroxetine Short half-life –caution with discontinuation syndrome
Fluoxetine	Significant number of important drug interactions due to hepatic enzyme inhibition Long half-life (one to two weeks) means slower reversal of adverse effects but discontinuation syndrome unlikely Requirement for longer washout period if switching to an alternative antidepressant Active metabolite (norfluoxetine) also inhibits hepatic enzymes
Paroxetine	Very short half-life –caution with discontinuation syndrome Significant number of important drug interaction due to hepatic enzyme inhibition. Tends to have more anticholinergic effects than other SSRIs so may be less suitable in older people
Other agents:	Refer to specific cautions in medicine datasheets
Venlafaxine, Mirtazapine	Venlafaxine can raise blood pressure and should be used with caution in people with significant cardiovascular disease Mirtazapine can cause weight gain

polypharmacy and medical co-morbidities. Poor adherence due to forgetfulness and confusion with multiple medicines therapy are also of concern.

In frail older people, antidepressants should generally be started at a lower dose than normal (e.g. half the normal adult doses) with gradual increases in dose.

An SSRI is first-line

An SSRI is considered to be the first choice antidepressant in an older person as they have similar effectiveness to tricyclic antidepressants (TCAs) and are better tolerated. There is no evidence that any one SSRI is better on the grounds of clinical effectiveness, but citalopram, escitalopram or sertraline may be preferred as they are generally better tolerated and are less likely to cause significant drug interactions than paroxetine or fluoxetine. For a comparison of the properties of individual SSRIs see Table 2.

Tricyclic antidepressants (TCAs)

Although not the preferred treatment for older adults with depression, TCAs may still be used if an SSRI is not tolerated or ineffective. Anticholinergic adverse effects may be poorly tolerated and are dose related. Treatment should be started with a low dose and titrated upwards gradually.

Nortriptyline is the preferred choice as it causes less postural hypotension, sedation and anticholinergic effects than the other TCAs.

Consider the potential for adverse effects and drug interactions

Older adults should be carefully monitored for the adverse effects of antidepressants, such as sedation, hypotension, anticholinergic effects, sleep disturbance and hyponatraemia (see sidebar “Antidepressant-induced hyponatraemia”). In general, older people appear to be more sensitive to adverse drug reactions and clinically

significant drug interactions are more likely due to the increased prevalence of multiple drug therapy.

Antidepressants and the risk of falls

Depression is a risk factor for falling and people who do fall seem to be at increased risk of developing depression. Drug treatment is an independent risk factor for falls and overall, SSRIs are no safer than TCAs. The risk of falls and fractures with SSRIs is similar to that with TCAs.¹¹

Antidepressants can contribute to the risk of a fall by a range of different mechanisms, including:

- Sedation and impaired reaction times
- Impaired balance
- Insomnia, alerting effects and deranged sleep patterns leading to daytime drowsiness and increased nocturia
- Orthostatic hypotension
- Cardiac rhythm and conduction disorders
- A tendency to cause movement disorders

Regularly monitor all older people started on an antidepressant for increased fall risk, e.g. sedation, change in sleep pattern, gait change.

Antidepressants and co-morbidities

Depression associated with co-morbid medical conditions increases with age and the possible effects of the antidepressant on concurrent disease has to be considered, and may influence the choice of medicine.

Cardiac disease: TCAs may cause or aggravate arrhythmias and hypotension, especially postural hypotension. SSRIs are generally safer. Venlafaxine needs to be used cautiously especially in people with hypertension.

Epilepsy: Most antidepressants lower seizure threshold. Ensure epilepsy is well controlled and use low doses with gradual titration.

Glaucoma: TCAs can precipitate acute narrow angle glaucoma. SSRIs are less likely to be a problem but paroxetine is less preferable due to its stronger anticholinergic effects.

Prostatic disease: TCAs may cause urinary obstruction in men with prostatic hypertrophy.

Parkinson's disease: SSRIs or TCAs can be used but individual response should be monitored closely. The risk of interaction between antidepressants and anti-Parkinson medicines is high. TCAs may be poorly tolerated and can

aggravate constipation and postural hypotension. SSRIs may occasionally worsen extrapyramidal symptoms.

Depression with dementia

Depression often co-exists with dementia but can be difficult to differentiate and response to intervention is variable. However, depression in this sub-group should be treated in the same way as all older people with depression. Response to treatment should be closely monitored and the diagnosis reviewed if there is no improvement.⁷ The potential for drug interactions, e.g. between antipsychotics and antidepressants, needs to be considered.



Antidepressant-induced hyponatraemia

There has been increasing awareness of the risk of hyponatraemia after starting antidepressants.¹² Many guidelines in primary and secondary care are now being updated to include monitoring advice.

Risk factors for antidepressant-induced hyponatraemia include; older age, low body weight, female gender, previous history of hyponatraemia, reduced renal function and concurrent intake of other hyponatraemic medicines, such as diuretics. Most reports have been linked to SSRIs but hyponatraemia can occur with any antidepressant including TCAs and newer drugs such as venlafaxine and mirtazapine.

Hyponatraemia due to antidepressants or thiazide diuretics usually occurs in the first four weeks of treatment. All patients taking antidepressants should be observed for signs of hyponatraemia (dizziness, nausea, lethargy, confusion, cramps and seizures). Monitoring recommendations vary slightly but a general consensus (especially for high risk patients) is as follows:

- Check baseline sodium level before starting the antidepressant

- Check sodium after two weeks and again after three months. Consider checking again after 12 months.
- Consider checking sodium after a dose increase of the antidepressant or addition of any other potentially hyponatraemic medicine, e.g. a diuretic
- If possible, avoid the combination of a diuretic and an antidepressant (particularly an SSRI) in people already at higher risk of hyponatraemia. Close monitoring is especially important in such patients.
- If a drop in sodium level is seen, but the patient does not have clinical symptoms of hyponatremia, it is still possible to remain on the antidepressant. Sodium levels need to be monitored more closely but they usually do not worsen and sometimes return to normal.

Prescribers should also be aware of other factors that may exacerbate or promote hyponatraemia in a person already taking an antidepressant or a diuretic. For example, fluid replacement (during acute gastrointestinal disturbance) with plain water instead of electrolyte solution may acutely aggravate hyponatraemia to dangerous levels.¹³