Treating Older Patients with Depression in Primary Care

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(No financial disclosures)

Background

- Up to 37% of older adults in primary care suffer from impairing depressive symptoms
- Strong association between depression and non-suicide mortality
- Leads to higher health care utilization
- Complicates course of medical illnesses (eg – increased rate of death post-MI)

Case

- 72 year old woman with history of depression, DM II, HTN, breast cancer presents with 3 month history of recurrent depressive symptoms
- Depression symptoms: fatigue, insomnia, anhedonia, low motivation, feelings of being a burden/worthlessness, feels physically slowed, poor concentration, thoughts that she'd be better off dead
- Past psych: 2 prior episodes of depression, no inpatient admits, no suicide attempts, Prozac was helpful in past
- Current meds: tamoxifen, metformin, metoprolol

Case

- So how will you treat her?

Initial Evaluation

- Look for medical causes or medication side effects
- Assess cognitive functioning (check for dementia, delirium, executive dysfunction assoc w/depression)
- Ask about suicidality
  - Most older adults who commit suicide see their physician within months prior, 1/3 within a week
- Assess for co-morbid disorders
  - Alcohol or drug use
  - Anxiety
  - Complicated grief

Risk factors for suicide attempts in elderly

- More likely to :
  - be widow(er)s,
  - live alone
  - perceive their health status to be poor
  - experience poor sleep quality
  - lack a confidant
  - experience stressful life events, such as financial discord and interpersonal discord

Treatment

- Therapy - Problem Solving Therapy, Interpersonal Therapy, Cognitive Behavioral Therapy

- Medication – strongest evidence for moderate to severe depression

Medication considerations

- Selection of medication
  - Medical co-morbidities (eg – obesity, DM, seizures)
  - Depression symptoms (eg – insomnia, weight loss)
  - Psychiatric co-morbidities – screen for bipolar disorder
  - Drug-drug interactions
  - Cost/insurance coverage

Medication considerations

- Medical co-morbidity
  - Pay attention to possible side effects, eg:
    - Bupropion – seizure risk
    - Venlafaxine – exaccerbates HTN at doses >150mg
    - SSRIs – hyponatremia
    - paroxetine, mirtazapine – weight gain
    - citalopram – prolonged QTc above 40mg (20mg in older adults >60)

Medication considerations

- Depression symptoms
- Consider pt's unique depression symptoms, eg:
  - Insomnia - consider sedating SSRI
  - Low energy, physical slowing - consider more activating SSRI or wellbutrin
  - Poor appetite, weight loss – paroxetine, mirtazapine
  - Weight gain – citalopram, fluoxetine
  - Seasonal affective disorder – light therapy

Medication considerations

- Assess for co-morbid psychiatric conditions
  - Always screen for bipolar disorder
  - If have co-morbid anxiety – favor SSRIs, avoid bupropion, consider adjunctive treatment like benzo
  - Consider complicated grief

- Always assess alcohol and drug use
  - Explain how alcohol can interfere with sleep

Drug-drug interactions

- Fluoxetine, paroxetine – potent inhibitor of cytochrome P450 2D6 enzyme
  - Many possible interactions including tamoxifen (decrease tamoxifen levels), metoprolol (increase beta blocker levels), metformin (higher risk of hypoglycemia)
- Citalopram – metabolized by 3A4 and 2C19
  - Tagamet, PPIs can raise citalopram levels (max dose when on these = 20mg due to risk of prolonged QTc)
- Zoloft – moderate inhibition of 2D6 and 2B6
- Wellbutrin – metabolized by 2B6 and inhibits 2D6
- Lexapro, Mirtazapine – relatively few drug-drug interactions
- Venlafaxine – metabolized by 2D6

Medication considerations

- Cost
  - Fluoxetine, paroxetine, citalopram, sertraline, bupropion, venlafaxine, mirtazapine are all generic, but costs vary

Medication considerations

- Dosing
  - Start low, go slow
- How long to continue after remission?
  - 1 year for first episode
  - 2+ years for 2nd episode
  - 3+ years for 3 or more episodes

What if the first medication doesn't work?

- After 3-6 weeks at highest tolerable dose:
  - Partial response: augment
    - With another complimentary antidepressant
    - With agent for anxiety or insomnia (consider adding from beginning)
    - With therapy
  - No response: switch

Helpful reference

- Depression in Late Life: Review and Commentary
  - Dan G. Blazer *FOCUS 2009;7:118-136.*