Late-Life Depression

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Over the past half-century, life expectancy has been increased (1). Therefore, the world's elderly population is growing at an unprecedented rate and currently is at its highest level in human history (2). According to WHO estimation, mental health disorders are the most common cause of disabilities in people worldwide and over 300 million people are estimated to suffer from depression, equivalent to 4.4% of the world's population. Between 1990 and 2007, the number of all-ages YLDs attributed to depressive disorders increased by 33·4%, becoming the third leading cause of all-ages YLDs in 2007 (3). The point prevalence of the major depressive disorder in the elderly is more than 5% in men and about 8% in women. Although depression affects people of all ages, the risk is increased by poverty, unemployment, life events such as the death of a loved one or other kinds of loss, physical illness, and alcohol and substance use (4). Depressive symptoms of the elderly are even more prevalent in Iran. In a meta-analysis, prevalence of depression among Iranian elderly was estimated to be 43% of whom 5% suffered from severe symptoms of depression (5). Diagnosis of depression and depressive symptoms like dysthymia is almost clinical and possible through an interview. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the diagnosis of a Major Depression Episode (MDE) requires five or more symptoms to be present within 2 weeks (6). One of the symptoms should be a depressed mood or anhedonia. The secondary symptoms are appetite or weight changes, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, diminished ability to think or concentrate, feelings of worthlessness or excessive guilt, and suicidality (6). Unfortunately, DSM and other systems of classification of the disease do not have age-specific diagnostic criteria for MDE in the elderly and many symptoms of depression like loss of interest, lack of energy, physical complaints can be caused by medical diseases. However, ageism among patients and health care providers is an important concern which indicates depressive symptoms are part of the normal aging process.

The clinical course is predicted by the initial medical burden, self-rated health, and subjective social support. The likelihood of recurrence is high in patients with a history of frequent episodes, late age of illness onset, history of dysthymia, medical disease, and high severity and chronicity of the depressive episodes. More than 70% of patients who are treated recover if the depression is uncomplicated and comorbid conditions are not present (7). There are some recommended diagnostic workups including standard symptom checklists Geriatric Depression Scale (GDS), assessment of social stressors, medical history, nutritional status, medications, functional status, screening for cognitive impairment, physical examination, and laboratory tests, such as chemistry screens and electrocardiogram if antidepressants are prescribed. TFT, MRI, screening for vitamin deficiencies, and polysomnography are recommended if there is clinical evidence of indication.

The aims of treatment are remission of depression, reduction in the risk of recurrence, improvement of cognitive and functional status and development of skills or provision of supports (8). Treatment options are psychotherapy, pharmacotherapy, neurostimulation and family therapy. Behavioral interventions like weekly activity schedules, mastery and pleasure logs, and graded task assignments are beneficial (9). Telepsychiatry may be an efficacious option for homebound elders (10).

There are some general rules about the pharmacotherapy of old-age depression. First, benzodiazepines should generally be avoided (8). Patients with late-life depression respond slowly to treatment and the minimal length of an antidepressant trial should be 3 to 4 weeks before a switch or an augmentation (11). SSRIs are still first choice medications to treat late-life depression and although they are generally safe, they may increase the risk of falls (12). SNRIs are the best second choices and duloxetine is a good choice for depression with comorbid pain (13). Bupropion is a choice for patients with treatment resistance and does not cause cognitive side effects and cardiotoxicity (14). Mirtazapine is another option for frail depressed nursing home patients with anorexia (12). Vortioxetine which is a newer antidepressant may improve memory and executive dysfunction (15).

To sum up, older adults are vulnerable to biological, not social causes of depression (16). For moderate to severe depression, a combination of antidepressant therapy and psychotherapy is optimal (17). Electroconvulsive therapy is indicated for more severe and treatment-resistant depressive disorders in late life and is generally well tolerated (18).

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