Drug Therapy for Geriatric Depression

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Summary

Depression is a common problem in elderly patients. The identification and treatment of depression may be more complex in older than in younger patients because of co-existing illnesses and concurrent drug therapy. In addition, a variety of medical conditions and drugs can cause depression.

The pharmacology and pharmacokinetics of the cyclic antidepressants have been extensively studied. These agents are hepatically metabolised, often to an active agent. The clearance of the parent compound and the active metabolite(s) may be reduced in elderly patients, causing drug accumulation and increased toxicity. The cyclic antidepressants interact with a variety of neurotransmitters and their receptors. While these effects explain many of the adverse effects of the cyclic antidepressants, it is not clear whether the noradrenergic and serotoninergic effects of such drugs explain their antidepressant effects.
Cyclic antidepressant therapy is associated with a variety of adverse effects, including sedation, anticholinergic effects and effects caused by α-adrenergic blockade. The cyclic antidepressants differ in their relative ability to cause these adverse effects. The newer cyclic antidepressants such as the selective serotonin reuptake inhibitors are relatively free of sedative and anticholinergic effects, but cause insomnia, nausea and possibly cardiac arrhythmias. All cyclic antidepressants appear to be equally effective. Therefore, the choice of a cyclic antidepressant for a specific patient must be based on several factors, including the risk of adverse effects.

In elderly patients, the initial dose of cyclic antidepressants should be lower than the usual dose recommended for younger adults, and titrated slowly. All antidepressants require at least 2 to 3 weeks for their antidepressant effects to be seen. Because depression is a relapsing disease, maintenance antidepressant therapy may be indicated to reduce the risk of recurrent depression.

The monoamine oxidase (MAO) inhibitors are effective antidepressants, especially in atypical depression. However, the adverse effects and risk of potentially lethal drug interactions of the older agents preclude their routine use. However, the new reversible MAO inhibitors may prove to be a well tolerated alternative in older patients.

Antidepressant therapy should not be avoided simply because of a patient’s age. However, the clinician must be conservative in the use of cyclic antidepressants in elderly patients and monitor closely for adverse drug reactions.

Depression is a common psychiatric problem in the elderly population. The overall prevalence of major depression ranges from 2 to 14% and an additional 15% experience milder forms of depression (Blazer 1989; Garland & Meyers 1988). Depression has been characterised as early or late onset using the criterion of onset before or after age 60 (Alexopoulos et al. 1988; Cohen & Eisdorfer 1985; Mei-Tal & Meyers 1985). Depression onset in later life is more often associated with medical illness, whereas genetic and familial factors are more common in early onset depression (Alexopoulos et al. 1988; Cohen & Eisdorfer 1985).

The signs and symptoms of depression represent an appropriate response to adverse life events such as financial difficulties and loss of friends, health and mobility. Such events cause a sadness that is of brief duration and appropriate intensity. Major depressions are disorders from which patients usually recover, and are amenable to treatment (Klerman 1988; Salzman & van der Kolk 1984). Treatment of depression in elderly persons may be more complex because of other illnesses and other drug therapy. However, there is no compelling evidence that antidepressant drug therapy is less effective than in younger patients (Plotkin et al. 1987). The response rates of elderly patients treated with antidepressant drugs ranges from 50 to 60% with a high relapse rate when treatment lasts less than 1 year. Many depressed patients (approximately 80%) seek help from primary care physicians rather than psychiatrists (Baldessarini 1985). There are ample data attesting to the under-recognition and misdiagnosis of depression by primary care physicians (Gerber et al. 1989; Keller 1990; Perez-Stable et al. 1990).

The signs and symptoms of major depression should allow a physician to readily make the diagnosis. The diagnostic criteria of major depression are shown in table I.

<table>
<thead>
<tr>
<th>Table I. Diagnostic and Statistical Manual of Mental Disorders Volume III, revised (DSM-III-R) diagnostic criteria of major depression (from American Psychiatric Association 1987)</th>
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<tbody>
<tr>
<td>Depressed mood</td>
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<td>Diminished interest or pleasure in all or almost all activities</td>
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<td>Weight loss/gain or decreased/increased appetite</td>
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<td>Insomnia or hypersomnia</td>
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<td>Psychomotor agitation or retardation</td>
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<tr>
<td>Fatigue or loss of energy</td>
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<tr>
<td>Feelings of worthlessness or excessive or inappropriate guilt</td>
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<td>Diminished ability to think or concentrate, or indecisiveness</td>
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<td>Recurrent thoughts of death or suicidal ideation</td>
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a For the diagnosis of major depression, at least 5 features must be present during a 2-week period, including the first 2 symptoms listed.