key points

SELECTED BY

Dr Phillip Bland
Former GP, Dalton-in-Furness, UK

Depression in older adults is common. Depressive symptoms may be part of a recurrent depressive disorder or experienced for the first time in later life as a result of changes in risk and resilience factors. Bipolar disorder rarely presents for the first time in older adults and a presentation of elevated mood and symptoms of mania should prompt investigations to exclude organic pathology and delirium.

Risk factors for late life depression can be classified using a biopsychosocial framework. There is an association between cerebrovascular pathology, vascular risk factors and depression. Physical illnesses, particularly those associated with frailty, are also important risk factors for depression. Conditions such as chronic or severe pain, Parkinson's disease and COPD may have direct effects on the brain, or indirect effects on important psychosocial risk factors such as lack of sleep, reduced mobility and social isolation. Visual or hearing loss can lead to low self-esteem, isolation, loneliness and depression.

Depression has a distinct presentation in late life and low mood may not be the predominant presenting symptom. Indeed, when asked directly, older patients may deny that they feel sad or low in mood. They may present with physical symptoms, apathy, cognitive symptoms, agitation, retardation, fatigue or weight loss. Cognitive decline associated with depression is often misdiagnosed as dementia. Moreover, depression is frequently comorbid with dementia, particularly vascular dementia, so it is essential to consider depression as a potential cause of any new symptoms in such patients.

Assessment of an older person presenting with possible symptoms of depression should be similar to that of any younger person. Assessment of suicidality is essential: older people are far less likely to articulate their suicidal thoughts. The main risk factors for suicide in older people are social isolation and depression. An assessment of cognition and a medication review should be carried out: depression is a recognised side effect of certain beta-blockers, montelukast, corticosteroids and PPIs. Blood tests include: FBC, renal profile, thyroid function tests, glucose, B_{12} and folate.

For persistent subthreshold symptoms, or mild to moderate depression, low intensity psychological or psychosocial interventions should be considered. These could include sleep hygiene advice, behavioural activation, CBT, structured exercise, referral to a befriending service or social prescribing. If symptoms persist or depression is moderate to severe, pharmacological or high intensity psychological therapies should be considered. SSRIs should generally be offered first line; sertraline and citalopram are often preferred because of the lower risk of interactions.

Referral to specialist mental health services may be indicated if there is: risk of suicide, risk of self-neglect, poor response to treatment, significant psychiatric comorbidity, psychotic symptoms, diagnostic difficulty (commonly differentiation between depression and early cognitive impairment) or new onset or undertreated bipolar disorder.