

depression seek medical help frequently and their attendance rates in GP surgeries are higher than for their non-depressed counterparts. In elderly patients, presentation is often atypical, with anxiety symptoms being much more prominent than in younger patients'. Added to a natural reluctance to present with what may be psychological symptoms, both patients and relatives may wrongly perceive that symptoms are a natural development of old age, particularly where bereavement, deteriorating physical health or loneliness are present.

By the time the patient is referred to secondary care, even if the diagnosis is still unclear, the geriatrician or old age psychiatrist at least has the luxury of an extended consultation and access to secondary inves-

on the recognition and treatment of the condition and in the management of the short time available during the consultation.

Recognition of depression

Depression is not a natural development of old age but is seen more frequently in the elderly than in younger age groups'. It is important that it is diagnosed and treated correctly and, as such, each member of the primary healthcare team should keep the possibility of depression firmly in mind when dealing with elderly patients.

Depression may be precipitated by social factors such as loneliness, isolation or physical ill health' and, while it is important that these matters are addressed, the

Table 1: Four-item depression scale

Are you dissatisfied with your life?	Yes	No
Do you feel your life is empty?	Yes	No
Are you afraid that something bad is going to happen to you?	Yes	No
Do you feel unhappy most of the time?	Yes	No

Score 1 for yes, 0 for no. Score more than one point, screen with full Geriatric Depression Scale

Table 2: Vulnerability checklist

Does the patient have a history of depression?	Yes	No
Is the patient socially isolated	Yes	No
Does the patient suffer from chronic physical ill health?	Yes	No
Has there been a recent bereavement?	Yes	No

Score 1 for yes, 0 for no. The higher the score, the greater the vulnerability

tigations. By contrast, general practitioners have limited consultation time and are faced with an illness which not only can present in the elderly with physical symptoms but also has 'many faces', making it less easy to diagnose'.

All members of the primary care team should be encouraged to look proactively for symptoms of depression in the elderly. The RSM report offers GPs help in achieving this with clear take-home messages

Table 3: Advice for older patients receiving antidepressants

- Antidepressants do work, but they must be taken in the correct dose and for the correct length of time—probably many months
- The benefit of antidepressant drugs will take at least two weeks to be evident. For elderly patients it may be four or six weeks
- For SSRIs the most common side-effect is mild nausea, but this will pass within five to seven days for the majority of patients'
- The patient should not stop taking the medication without first consulting the doctor

outcome for the patient will be greatly improved by treatment of the underlying depression in addition to what is often perceived as the primary problem.

Important indicators of depression in the elderly include anxiety, fatigue, hopelessness, loss of concentration, recent changes in health, and a sudden change in consulting behaviour¹. Constant awareness of the diagnosis is probably the most effective method of detection in primary care, but use of specific instruments such as the Geriatric Depression Scale is advocated by many clinicians and recommended by the Royal College of Physicians and the British Geriatrics Society. It may be most appropriate to include this as a screening tool in the annual assessment of the over-75s. While the Geriatric