Managing physical illness and depression

Dr Mavis Evans discusses the special problems—and the rewards—involved in managing depression in physically ill older patients

Depression in elderly people is strongly correlated with physical illness, especially chronic progressive disease and painful or disabling conditions. Mortality among the depressed elderly is at least double that expected, even when controlled for physical illness and age.

Physically ill depressed patients are more likely to be admitted to hospital than those not depressed, they have increased in-patient mortality and significantly more days in hospital. However, outcome studies of treatment of depression in the elderly have shown response to be generally good. Psychiatric intervention has been shown to increase recovery rate, with reduced duration of hospital stay and need for residential care after discharge and, therefore, also reduced costs[1].

Key points

- 20 per cent of elderly patients with chronic physical problems are also depressed
- Depression in the elderly may present as physical complaints
- SSRIs are well tolerated and effective
- Response to treatment may take eight to 12 weeks to become noticeable
- Social support, both to treat mild depression and to prevent further relapse, is important

Special problems

Confusion over the cause of somatic symptoms (for example anorexia, insomnia and anergia) may confound the diagnosis. Many elderly people do not talk of unhappiness or misery; they complain of loss of appetite, poor sleep or pain—that is, they somatise. This can lead to unnecessary investigations and even prescriptions for medication to treat these symptoms, rather than the underlying depression. If depression is considered during the interview, direct questioning on mood will often uncover the problem.

It is often assumed that depression in the presence of physical illness is reactive and therefore less amenable to medication and that it will resolve on treatment of the medical condition. Concerns about multiple drug therapy and potential side-effects in a frail population may persuade many physicians against attempting antidepressant therapy.

There is a delay in response to antidepressant treatment in the elderly[2] with response to treatment sometimes taking as long as eight to 12 weeks. This may be a factor in the therapeutic nihilism prevailing among physicians treating this age group, who consider treatment to have failed if no response has been seen after a month. It is important to stress to patients this time delay before response is seen, as they may otherwise believe treatment a 'failure' after compliance with the initial one month prescription and not return for further advice or treatment, with risk of subsequent morbidity and even mortality. Advising patients that the medication is acting on their brain and therefore has to be 'gentle', taking time to have a noticeable effect, will keep their confidence and belief that recovery is possible.