

only 43.9 per cent of those prescribed an older TCA received adequate antidepressant doses (defined as 75 mg/day, which is less than the adequate dose for younger patients, namely 125 mg/day).

These findings are of concern, as prescribing antidepressants at doses lower than those shown to be effective confers no therapeutic benefit but still exposes patients to the risk of adverse events including falls, the single largest contributor to direct injury costs in the elderly¹.

Reasons for prescribing patterns

Depression in older patients may be missed owing to its frequent manifestation in the form of symptoms not immediately identifiable as depressive, such as anxiety or somatic complaints. It may also not be diagnosed if the symptoms displayed by the patient are

viewed as a 'normal' response to the ageing process, physical impairment or living alone—a tendency which is unfortunately common in primary, as well as secondary and tertiary, care. Doctors may be reluctant to prescribe medication to elderly patients because of concerns about adverse effects and lack of knowledge about the different side-effect profiles of the various agents. This may explain the sub-therapeutic doses observed in the study described above.

The more frequent use of TCAs in patients aged over 65 could be explained by the reluctance of general practitioners to prescribe a new antidepressant to a patient who has previously shown a good response to an older TCA. The delay in response to antidepressant treatment in the elderly, sometimes as long as six weeks, may not be appreciated and may consequently discourage both patients and their doctors from continuing with a particular drug for more than a month or so². Finally, the costs of the newer drugs, together with scepticism about their efficacy compared with the older 'tried and tested' TCAs, may be employed as arguments against their use as first-line treatments.

Solutions

It is important for doctors treating elderly patients, both in primary care and in the hospital setting, to maintain a high index of suspicion of depression so that it does not go undetected in patients with atypical symptoms and signs. Once the illness has been diagnosed, appropriate treatment should be started without delay. In my view, the treatment of choice is an SSRI, which offers the best combination of effectiveness and tolerability. A previous response to older antidepressants with troubling side-effects should not preclude the use of the newer drugs. The medication should be prescribed for at least six weeks and response carefully assessed before it is discontinued. The choice of SSRI should depend on the particular patient's symptom profile—for example, when there are accompanying anxiety, paroxetine (Seraxat) or citalopram (Cipramil) may possibly be more appropriate.

In the long term, only about a quarter of people aged 65 and over who have suffered a depressive episode will remain completely well. There is conflicting evidence about the relapse rate after medication is stopped, but those patients with very severe depression, two or more recurrences in the previous two years or chronic social or physical problems should be

