Chronic Illness and Seniors: Successfully Managing Depression and Anxiety While Growing Older

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How Seniors are Different

• Some conditions found mostly in the elderly
  – Dementia

• Some conditions look different in the elderly
  – Depression

• Some problems with treatment related to age
  – Delirium
CONDITIONS FOUND MOSTLY IN THE ELDERLY
What is Dementia?

• Acquired, global decline in cognitive function
• Memory deficit and problems in other areas
  – Speech
  – Recognition
  – Physical tasks
  – Executive function
• Bad enough to interfere with day-to-day function
What Dementia Is Not

• Dementia is not a “normal” part of aging
  – Different from age-related cognitive changes
  – Like a child falling off their growth curve

• Dementia might be incurable
  – It is not untreatable
    • Medications
    • Precautions
    • Environmental management
Dementia Facts and Figures

• Very common in older people
  – 5.7 million Americans suffer from AD
  – One in 10 Americans over 65

• Greatest risk factor is age
  – Prevalence rises with each decade
    • But 200,000 younger Americans have it as well
  – Others risks include low education and head injury

• Demographics
  – 2/3 of patients are women
  – Older African-Americans twice the prevalence of whites
Alzheimer’s Disease

• Insidious onset, progressive course
• Often there is a family history
• Loss of “cholinergic neurons”
  – Relevant for treatment
  – Will become relevant for diagnosis
• Diagnosis of exclusion
  – 100% confirmation requires an autopsy
  – 90% accurate clinical diagnosis
    • exclude reversible causes
• Doctors don’t know how to talk about it
Dementia Pitfalls

• Delay in diagnosis
  – Average AD patient is diagnosed at 3 years
  – Stigma contributes to under diagnosis

• Patient and family not given a prognosis
  – Failure to appreciate the progressive nature
  – Lack of planning for challenges
  • Transportation
  • Med administration
  • Home safety
Other Types of Dementia

• Vascular
  – Less gradual onset, stepwise progression
  – Findings on an exam, “patchy” symptoms
  – Findings on a brain scan

• Dementia With Lewey Bodies
  – Fluctuating symptoms
  – Parkinsonism
  – Visual hallucinations

• Frontotemporal Dementia
  – Personality change, speech problems
  – Younger onset, rapid progression
Parkinson’s Disease

• Motor Features
• Depression
• Apathy
• Emotionalism
• Anxiety
• Psychosis
Clinical Features

- **Motor Triad**
  - Pill-rolling resting tremor
  - Rigidity
  - Slow or absent movement
  - Delirium, mood changes, and psychosis are risks of treatment

- **Cognitive deficits**
  - “Subcortical” pattern
    - About 25% develop and Alzheimer's-like pattern
  - Executive dysfunction
  - Visuospatial impairment
  - Memory impairment
  - Attention deficits
Depression in Parkinson’s Disease

• Prevalence of major depression ~40%
  – Moderate to severe intensity
  – Frequently accompanied by anxiety symptoms

• Is it a reaction?
  – Depression can precede motor symptoms
    • Depression might be an early sign
  – Depression correlates with motor impairment
    • Improved motor function does not remit depression
    • Treatment of depression improved motor function
Anxiety in Parkinson’s Disease

• Clinically significant syndromes in 40%
  – Generalized anxiety disorder
  – Social phobia
  – Panic disorder in as much as 25%

• Can precede or accompany a depression
  – May persist after the depression is treated

• Distinct from “understandable” worry
  – Probably some combination of biological and psychological factors
Apathy and Emotionalism in PD

• Apathy
  – A state of diminished motivation
  – Can occur with depression
  – 12% have apathy without depression

• Emotionalism
  – inappropriate, unmotivated sentimentality
  – 40% report increased tearfulness
  • Does not imply depression, but can coexist with it
Stroke

- Poststroke Depression
- Poststroke Anxiety Disorder
- Other conditions
  - Catastrophic reaction
  - Pathological affect
  - Poststroke psychosis
Poststroke Depression

• Prevalence probably around 35%
  – Depends on setting, interval, criteria
  – Not clear if it matters which side the stroke is on

• Diagnosis can be difficult
  – Communication problems
  – Sleep, appetite, and energy changes are expected

• Average duration is about 9 months
  – Some can last for years

• Medications are effective in controlled trials
Poststroke Anxiety Disorder

• High comorbidity with depression
  – Appears to be associated with cortical lesions
• Associated with poor recovery of ADL’s
• Benzodiazepines are potentially risky
  – Might consider buspirone or antidepressants
Seizures in the Elderly

• Most are secondary to other symptomatic causes
• Treatment is to resolve the underlying cause

• Acute stroke (esp. hemorrhaglic)
• Alcohol withdrawal
• Alzheimer’s disease
• Cerebrovascular disease
• Electrolyte disturbances
Use of Anticonvulsants

- Patients commonly put on preventative medications
- All of these can cause delirium.
- Balance risk of seizures against risks of the drug.
A Rose by Any Other Name

- Pseudobulbar Affect
- Hypofrontality
- Dysexecutive Syndrome
- Disinhibition
- Emotional Incontinence
Conditions Associated with Disinhibition

• Frontal Lobe Tumors
• Closed Head Trauma
• Cerebrovascular Accident
• ADHD
• Tourette’s Syndrome
• Neurodegenerative disorders
  – Huntington’s disease
  – Parkinson’s disease
  – Frontotemporal dementia
  – Alzheimer’s disease
• Mania
• Intoxication
John Martyn Harlow on Phineas Gage

“He was now fitful, irreverent, and grossly profane, showing little deference for his fellows. He was also impatient and obstinate, yet capricious and vacillating, unable to settle on any of the plans he devised for future action. His friends said he was "No longer Gage."

"The equilibrium between his intellectual faculties and animal propensities seems to have been destroyed."
CONDITIONS THAT ARE COMPLICATED IN THE ELDERLY
Depression in the Elderly

• Rate of depression in the elderly is about 15% compared to 5% in younger persons
• Need to consider depression when there is
  – A change in behavior
  – A decline in function
• Elderly people have accumulated more losses
  – Are their feelings normal?
  – Will their mood respond to treatment?
  – What kind of treatment is needed?
Depression Issues

- May be confused with other conditions common in the elderly
  - Dementia
  - Bereavement
  - Chronic pain

- May present with somewhat different symptoms
  - Often more focused on bodily issues
  - Subjective memory complaints
Pseudodementia

- A depressed person who appears demented
  - Sometimes called “the dementia of depression”
  - Does not refer to purely subjective complaints

- It is possible to have both conditions
  - In fact dementia is associated with high rates of depression
  - More common in patients with family history of mood disorders
Catastrophic Reactions

• Patient is confronted with an impairment
  – excessive outburst of emotion or behavior
  – may be fueled by a mood disorder

• Behavioral intervention
  – Keep your head
  – Talk the person down
  – Try to minimize the exposure

• There may be a role for medication
Anxiety Issues

• What is the nature of the episodes
  – Are they discrete or present all the time?
  – Environmental stressors
  – Precipitating factors

• Start with environmental and behavioral management

• Role for medications is limited
  – Tranquilizers are a terrible idea
TREATMENT ISSUES RELATED TO AGE
Medication Issues in Older People

• Age related changes in metabolism and clearance

• Large number of other medications
  – Drug-drug interactions
  – Affordability

• Patients are easily made delirious
Features of Delirium

- Relatively acute onset with fluctuating course
- Disorganized thinking
- Alteration in level of consciousness
- Inattention
- Associated symptoms
  - Inappropriate behavior
  - Disorientation
  - Psychosis
Types of Delirium

• Hypervigilant
  – Commonly found in drug intoxication and withdrawal
  – Patient is agitated, psychotic, and uncooperative

• Somnolent
  – Patient is lethargic, sluggish and withdrawn
  – This type is most often undiagnosed
Costs of Delirium

• Extremely common in hospitalized elderly
  – 32-67% undiagnosed
  – Associated with 10-65% mortality rates
    • Even when corrected for medical severity

• Enormous financial impact
  – 7% of persons >65 become delirious annually
  – Cost in 1998 estimated at 8 billion dollars

• Severe impairment
  – Patients cannot learn new information
  – Cannot solve problems
  – Cannot engage in meaningful goal-directed activity
The Beers List

- 53 “potentially inappropriate” meds and classes
  - To be avoided in the elderly
  - To be avoided in elderly with certain conditions
  - To be used with caution in the elderly
- Based on scientific review and outcome studies
- Periodically updated
Some Beers Drugs

• Antihistamines
• Older tricyclic antidepressants
• Antipsychotics for behavior in dementia
• Benzodiazepines
• Chronic use of sleeping pills like zolpidem
• Sliding scale insulin
• Ditropan
Remain Hopeful

- Incurable does not mean untreatable
- Untreatable conditions may have treatable consequences
- Patients and families can still benefit from education, prognosis, and support
  - regular follow-up is crucial