DEPRESSION IN THE OLDER PATIENT:
EVALUATION AND MANAGEMENT

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WHY ARE WE TALKING ABOUT THIS??

- Depression is...
  - Widely misunderstood; patients, families, and providers think old, sick people are *supposed* to be depressed
  - Under-diagnosed
  - Undertreated
  - An opportunity to improve someone's quality of life
YOU'D NEVER SAY, "IT'S JUST CANCER, GET OVER IT."

So why do some say that about depression?
Prevalence of depressive disorders in various patient populations

* Prevalence range varies according to study.  


UpToDate 2017
RISK FACTORS FOR GERIATRIC DEPRESSION

- Female gender
  - Though this declines with age
  - Above age 80 gender differences rapidly fade
- Lower socio-economic level
- Less social support
  - Especially those divorced or widowed
- Recent adverse life events
  - Death and other losses
- Medically ill
  - Especially chronic pain, neurological disorders, endocrine disorders, COPD, MI, cancers
IMPACT OF DEPRESSION: COSTS

- More office visits
- More ED visits
- More meds
  - Rx and OTC
- Longer hospital stays
- Overall higher healthcare costs
IMPACT OF DEPRESSION: MORTALITY

- Post MI pts had 4 fold risk of death
- Post stroke pts has 3.4 times risk of death
- Pts admitted to a NH have 2 times one year mortality
**Differential Diagnosis**

- **Dysthymia**
  - “neurotic depression”
  - Less severe but longer lasting
  - Poor self-esteem or capacity for enjoyment
  - Treated like MDD

- **Bipolar Disorder**
  - Try to get that history of that one manic episode
A WORD ON SUICIDE:

White men over 85 have the highest rate of completed suicides!

- Medically ill
- Impending NH placement
- Chronic pain
- Social isolation
- Family history of suicide
- Previous attempt
Maybe you have to know the darkness before you can appreciate the light.

Madeline L'Engle
DIAGNOSING DEPRESSION
DSM-5 diagnostic criteria for a major depressive episode

A. Five (or more) of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

NOTE: Do not include symptoms that are clearly attributable to another medical condition.

1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observations made by others (e.g., appears tearful). (NOTE: In children and adolescents, can be irritable mood.)

2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation)

3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5 percent of body weight in a month), or decrease or increase in appetite nearly every day. (NOTE: In children, consider failure to make expected weight gain.)

4) Insomnia or hypersomnia nearly every day

5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

6) Fatigue or loss of energy nearly every day

7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by their subjective account or as observed by others)

9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the direct physiological effects of a substance or to another medical condition.

NOTE: Criteria A through C represent a major depressive episode.

NOTE: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual’s history and the cultural norms for the expression of distress in the context of loss.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic or hypomanic episode.

NOTE: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.
A Mnemonic for the Criteria for Depression

S leep changes: increase during day or decreased sleep at night
I nterest: loss of interest in activities that used to interest them
G uilt (worthless): depressed people tend to devalue themselves
E nergy (lack): common presenting symptom (fatigue)
Cogniton/Concentration: reduced cognition &/or difficulty concentrating
A ppetite (& wt. change); usually declined, occasionally increased
P sychomotor: agitation (anxiety) or retardation (lethargic)
S uicide/death preoccupation
SIG E. CAPS; VEGETATIVE SYMPTOMS

S: sleep
I: interest
G: guilt
E: energy
C: concentration
A: appetite
P: psychomotor changes
S: suicidal thoughts
SIG E. CAPS; VEGETATIVE SYMPTOMS

S: sleep
I: interest
G: guilt
E: energy
C: concentration
A: appetite
P: psychomotor changes
S: suicidal thoughts

These symptoms are less useful in medically ill people. Not sensitive or discriminating.
### Short Patient Health Questionnaire (PHQ-2)

Over the past two weeks, how often have you been bothered by any of the following problems?

| Little interest or pleasure in doing things? | 0 = Not at all  
| 1 = Several days  
| 2 = More than half the days  
| 3 = Nearly every day |
| Feeling down, depressed, or hopeless | 0 = Not at all  
| 1 = Several days  
| 2 = More than half the days  
| 3 = Nearly every day |

**Total point score:**

<table>
<thead>
<tr>
<th>PHQ-2 score</th>
<th>Probability of major depressive disorder (percent)</th>
<th>Probability of any depressive disorder (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>15.4</td>
<td>36.9</td>
</tr>
<tr>
<td>2</td>
<td>21.1</td>
<td>48.3</td>
</tr>
<tr>
<td>3</td>
<td>38.4</td>
<td>75.0</td>
</tr>
<tr>
<td>4</td>
<td>45.5</td>
<td>81.2</td>
</tr>
<tr>
<td>5</td>
<td>56.4</td>
<td>84.6</td>
</tr>
<tr>
<td>6</td>
<td>78.6</td>
<td>92.9</td>
</tr>
</tbody>
</table>

**Score interpretation[^1]:**

Reference:


PHQ-2 reproduced with the permission of Pfizer Inc.
## PHQ-9 depression questionnaire

<table>
<thead>
<tr>
<th>problems</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling bad about yourself, or that you are a failure, or that you have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Thoughts that you would be better off dead, or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong> =</td>
<td>—</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
</tbody>
</table>

**PHQ-9 score ≥10: Likely major depression**

**Depression score ranges:**

- 5 to 9: mild
- 10 to 14: moderate
- 15 to 19: moderately severe
- ≥20: severe

**If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

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*PHQ: Patient Health Questionnaire.*

Developed by Drs. Robert L Spitzer, Janet BW Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer, Inc. No permission required to reproduce, translate, display or distribute.
Geriatric Depression Scale (Short Form)

Patient's Name: ___________________________ Date: ________________

Instructions: Choose the best answer for how you felt over the past week. Note: when asking the patient to complete the form, provide the self-rated form (included on the following page).

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Answer</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Are you basically satisfied with your life?</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Have you dropped many of your activities and interests?</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Do you feel that your life is empty?</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Do you often get bored?</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Are you in good spirits most of the time?</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Are you afraid that something bad is going to happen to you?</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Do you feel happy most of the time?</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Do you often feel helpless?</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Do you prefer to stay at home, rather than going out and doing new things?</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Do you feel you have more problems with memory than most people?</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Do you think it is wonderful to be alive?</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Do you feel pretty worthless the way you are now?</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Do you feel full of energy?</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Do you feel that your situation is hopeless?</td>
<td>YES / NO</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Do you think that most people are better off than you are?</td>
<td>YES / NO</td>
<td></td>
</tr>
</tbody>
</table>

TOTAL

(Sheikh & Yesavage, 1986)

Scoring:
Answers indicating depression are in bold and italicized; score one point for each one selected. A score of 0 to 5 is normal. A score greater than 5 suggests depression.
Assessing Depression in the Context of Dementia

CORNELL SCALE FOR DEPRESSION IN DEMENTIA (CSDD)
Base ratings on symptoms and signs occurring during the prior week
No score should be given if symptoms result from physical disability or illness

Mood-Related Signs
1. Anxiety (anxious expression, ruminations, worrying)  A 0 1 2
2. Sadness (sad expression, sad voice, tearfulness)  A 0 1 2
3. Lack of reactivity to pleasant events  A 0 1 2
4. Irritability (easily annoyed, short-tempered)  A 0 1 2

Behavioral Disturbance
5. Agitation (restlessness, hand wringing, hair pulling)  A 0 1 2
6. Retardation (slow movements, slow speech, slow reactions)  A 0 1 2
7. Multiple physical complaints (score 0 if GI symptoms only)  A 0 1 2
8. Loss of interest (score only if change occurred acutely, i.e., in less than 1 month)  A 0 1 2

Physical Signs
9. Appetite loss (eating less than usual)  A 0 1 2
10. Weight loss (score 2 if greater than 5 pounds in 1 month)  A 0 1 2
11. Lack of energy (score only if change occurred acutely, i.e., in less than 1 month)  A 0 1 2

Cyclic Functions
12. Diurnal variation of mood (symptoms worse in the morning)  A 0 1 2
13. Difficulty falling asleep (later than usual for this individual)  A 0 1 2
14. Multiple awakenings during sleep  A 0 1 2
15. Early-morning awakening (earlier than usual for this individual)  A 0 1 2

Ideational Disturbance
16. Suicide (feels life is not worth living, has suicidal wishes, or makes suicide attempt)  A 0 1 2
17. Poor self-esteem (self-blame, self-deprecation, feelings of failure)  A 0 1 2
18. Pessimism (anticipation of the worst)  A 0 1 2
19. Mood-congruent delusions (delusions of poverty, illness, or loss)  A 0 1 2

A = unable to evaluate  0 = absent  1 = mild or intermittent  2 = severe  Score greater than 12 indicates depression

WORKUP OF DEPRESSION

- Get a good history
  - Round up all the symptoms
  - Good pain assessment
  - SIG E. CAPS

- Talk to the family about previous symptoms, tx

- Ask about alcohol

- Of course, assess the family and home situation
WORKUP OF DEPRESSION

- Medications!
  - See next slide….

- Medical conditions
  - Thyroid, B12, diabetes, etc
  - Early dementia or Parkinson's
  - Infections (UTI?)
  - Chronic pain or other untreated symptoms
  - Pancreatic cancer…
IS IT MEDICATION?

- Pain medications
  - codeine, hydrocodone
- High blood pressure medications
  - clonidine, reserpine
- Hormones
  - estrogen, progesterone, prednisone
- Cardiac medications
  - digitalis, propranolol
- Alcohol
DR VICKI’S FIRST RULE OF GERIATRICS

- If a bad thing is happening to a patient, a drug did it until proven otherwise
- Remember, these folks have old kidneys, livers, brains
WORKUP OF DEPRESSION

- Physical Exam
  - weight (look at the trend over the last year)
  - cleanliness and grooming

- Labs: almost always normal!
  - CBC, Chem15, TSH, B12, UA, Vit D
  - consider ESR, HIV, RPR, tox screen, chest x-ray in appropriate clinical situations

- Neuroimaging (CT or MRI)? —almost always normal
The case of Eva, an 80 year old lady

- History of CHF, DM, OA
- Poor sleep, some weight loss from poor appetite, “pain all over”
- No longer able to get out to grocery or errands
- Is she depressed?
Eva’s SIG E. CAPS

- She denies depressed mood or lack of pleasure in things
- Positives: sleep, appetite, energy
- Negatives: interests, guilt, concentration, suicidality

- Her GDS score is 3
Eva’s SIG E. CAPS

- She denies depressed mood or lack of pleasure in things
- Positives: sleep, appetite, energy
- Negatives: interests, guilt, concentration, suicidality

Not depressed!
Remind yourself that it's okay not to be perfect.
THE CASE OF GEORGE, A 78 YEAR OLD MAN

- He comes in frequently about dizziness, sore muscles, constipation, sleep issues
- His daughter reports more irritability and anger over the last year
- His wife died two years ago
- He moved in with his daughter 3 months ago after a fall

- His GDS score is 12/15
# Grief vs. Depression

<table>
<thead>
<tr>
<th></th>
<th>Grief</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>Feelings that results from a particular loss</td>
<td>Feelings that have no specific basis</td>
</tr>
<tr>
<td><strong>Symptoms and signs</strong></td>
<td>Sleep and appetite disturbances,, poor concentration, social withdrawal</td>
<td>Sleep and appetite disturbances,, poor concentration, social withdrawal AND Hopelessness, guilt, anhedonia</td>
</tr>
<tr>
<td><strong>Other factors</strong></td>
<td>Still can enjoy things Comes in waves Able to look forward</td>
<td>Enjoys very little Constant No hope for future</td>
</tr>
</tbody>
</table>
DEPRESSION VS. DEMENTIA

- Apathy is a common symptom in dementia

- Often mistaken for depression...

- How to tell them apart?
  - In apathy, no emotional changes or lasting emotional feelings.

- Screen for depression

- May need psychiatrist or neuropsych testing
THE CASE OF GEORGE, A 78 YEAR OLD MAN

- He comes in frequently about dizziness, sore muscles, constipation, sleep issues
- His daughter reports more irritability and anger over the last year
- His wife died two years ago
- He moved in with his daughter after a fall

So depressed!
WHAT’S THE DEAL WITH DEPRESSION AND DEMENTIA??
DEPRESSION IN DEMENTIA: INCIDENCE

• Depression present in about 20-40% of dementia patients

• Rate is about 4 times that of the normal population

• Less common in AD, more common in other dementias (subcortical, vascular)
  ○ US: 25-30% of vascular dementia, 15-20% of AD

• Almost 75% of dementia patients report at least 1 symptom in previous month, most common being depression, apathy and irritability
Diagnosis of Geriatric Depression in Dementia

- Depression can be hard to diagnose in dementia
  - Communication issues
    - Patients with moderate to severe dementias do not verbally communicate their mood
  - Symptoms of other disorders can overlap with depression
    - Alzheimer’s patients have little appetite, lose concentration, become isolative
    - Parkinson’s patients lose affect, have slowed speech and movements
    - Frontal lobe injuries present with apathy, often misinterpreted as depression, or frequent crying not related to mood
DIAGNOSIS OF GERIATRIC DEPRESSION IN DEMENTIA

- **Useful to use:**
  - Frequent, dysfunctional sad, downcast mood
  - New agitation and/or sudden loss of interest
  - Psychic rather than vegetative features
    - Vegetative features often are multifactoral
      - i.e. poor sleep may have four or five causes
  - Use caregiver reports from home or the NH
  - The patient’s past medical and psychiatric history
DIAGNOSIS OF GERIATRIC DEPRESSION IN DEMENTIA

- If unsure, TREAT FOR DEPRESSION
  - Medications safer and more effective these days
  - ECT a viable option
    - Reserve for patients who are not eating or have psychosis
  - Much worse to miss than over-treat
ONCE WE MAKE THE DIAGNOSIS, NOW WHAT???
MANAGEMENT OF DEPRESSION

- Optimal treatment is combined psychotherapy and medication therapy
  - Cognitive behavioral therapy well-studied

- However psychotherapy (by SW, PhD, or MD) can be difficult to access and poorly reimbursed

- Consider community resources, such as Adult Day Care, volunteers, etc
MANAGEMENT OF DEPRESSION

- Remember that prescribing ANY antidepressant is only one part of a comprehensive treatment plan for depression.

- You or someone else should be doing some sort of psychotherapy.

- You or someone else should be helping the person address stressors in their life.
ANTIDEPRESSANTS 101

- Favorite SSRIs—well studied
  - Sertraline (Zoloft®)
  - Escitalopram (Lexapro®)

- Avoid Citalopram (Celexa®)
  - The QT prolonging thing is annoying
  - Lots of drug interactions (tramadol)

- Avoid fluoxetine (Prozac®)
  - Super long half life

- Avoid paroxetine (Paxil®)
  - Some withdrawal issues
Using fluoxetine as the reference medication, the researchers analyzed various second-generation antidepressants. Sertraline and escitalopram had the best combination of efficacy and acceptability.

GERI DOSING:
START LOW, GO SLOW, BUT GO!
Take smallest dose they make and cut in half to start....
PRESCRIBING AN ANTIDEPRESSANT

- Call the patient in a week or so to address any side effects or concerns
- Schedule a follow-up visit about 3-4 weeks after the initial prescription. (Sooner if closer monitoring or supportive therapy is needed.)
  - Check sodium at that time
- If significant side effects appear, switch to a different SSRI or decrease the dose by half.
- If there is no improvement, or only partial improvement at four week follow-up, double the dose and follow up again in four weeks.
PRESCRIBING AN ANTIDEPRESSANT

- If there is still no improvement at second four-week follow-up, either:
  - Add a norepinephrine-increasing antidepressant (SNRI, mirtazapine)
  - Switch to venlafaxine (Effexor®)

OR
- Refer to a psychiatrist
SSRIs: COMMON SIDE-EFFECTS

- Decreased libido and/or decreased sexual functioning (erectile/ejaculatory dysfunction, anorgasmia)
- Headache
- Nausea
- Sweating
- Dry mouth
- Sleepiness or insomnia
- Diarrhea or constipation
- Rash and/or itching
- Tremor
- Dizziness
- Weakness (asthenia)
- Abnormal dreams

**Hyponatremia**
- More in elderly
- More in women
- More if diuretics (HCTZ!)
- Class effect; will happen in all
ANTIDEPRESSANTS 101

- My secret geriatric lifesaver!

- **Mirtazapine (Remeron®)**
  - Sedating so useful for pts with insomnia
  - More activating at higher doses
  - Improves appetite so good for weight gain
  - Start 7.5 mg at bedtime
  - Titrate slowly
ANTIDEPRESSANTS 101

SNRIs (Serotonin-Norepinephrine Reuptake Inhibitors) or (dual uptake inhibitors)

- Venlafaxine (Effexor®)
  - SSRI withdrawal-type symptoms can be especially bothersome with this drug.

- Duloxetine (Cymbalta®)
  - Some pain relieving properties
  - Activating medications
  - GI symptoms seen esp. at first
ANTIDEPRESSANTS 101

- Bupropion (Wellbutrin®)
- The most stimulating (amphetamine-like) antidepressant
- Few or no sex-inhibiting side effects

- Available in immediate release, sustained-release (SR; 12 hour), and extended-release (XL; 24 hr) forms.

- Usual initial dosing: XL, 150 mg QAM
ANTIDEPRESSANTS 101

- Very limited use of TCAs in depression
  - Although SMALL doses are good for neuropathic pain
    - Nortriptyline 10 mg QHS

- Never use MAOIs
  - Leave this to the psychiatrists
WHAT SHOULD YOU EXPECT FROM MEDICATION TREATMENT?

- How long does it take to work?
  - 8 to 12 weeks in young patients
  - May stretch to 12-16 weeks in the elderly

- Can you see changes earlier?
  - Often see improvement in appetite and sleep and energy
    - Good sign of response
“It does not matter how slowly you go as long as you do not stop.”

—Confucius
PREVENTING SSRI WITHDRAWAL SYNDROME

- When discontinuing an SSRI, decrease dosage very slowly. (10 to 25% every two weeks, slowing down even more if symptoms appear.)
- This may require splitting pills, dividing contents of capsules, or using liquid fluoxetine as a substitute.
THE CASE OF WALTER, AN 88 YEAR OLD MAN

- Hospitalized for 3 weeks for pneumonia, heart failure, renal failure
- Now at a SNF and doing poorly
- Refusing therapy, not eating
- Scores 11/15 on GDS
The case of Walter, 88 year old man

- Don’t have time to wait for an SSRI

- Consider a stimulant
  - Methylphenidate (Ritalin®)
  - Start 2.5 or 5 mg with breakfast and lunch
  - Increase based on response and pulse, BP
  - It is schedule II so you need monthly written Rx

- P.S. this was a wonder drug for him!
TREATMENT RESISTANT DEPRESSION

- Make sure long enough treatment at an adequate dose

- Re-evaluate your diagnosis
  - Bipolar
  - Dementia

- Psychiatry evaluation
- Consider ECT
ECT

- Consider for
  - severely ill (not eating, weight loss)
  - psychotically depressed
  - Suicidal ideation
  - Limited response to meds

- Requires an inpatient stay

- Surprisingly safe!
What are some other treatment tips?
LIGHT THERAPY

- Usually used to treat Seasonal Affective Disorder with specially build lamps
- Parameters for use are 7000 lx intensity at 20 inches exposure, about 60 minutes, in the morning after arousal
- Has been used in the treatment for unipolar depression in special population (pregnant and elderly patients)
- Shows improvement compared to the placebo studies using blue or red light exposure
LIGHT THERAPY
“It’s for my depression. Go get your own.”
**Sleep Problems**

- Normal aging associated with less and lighter sleep, so very common in many older pts

- Key question:
  - Is insomnia impacting their functioning?

- Review sleep hygiene
  - Caffeine
  - Nap habits
  - Limit screens in the evening and at night
SLEEPING PILLS ARE A PROBLEM....

- **Benadryl® is bad**
  - Active ingredient *diphenhydramine* has anticholinergic side effects
    - Dry eyes
    - Dry mouth
    - Constipation
    - Urinary retention
    - Mental confusion

- **Benzodiazepines:**
  - Associated with hip fracture
  - Best is lorazepam (Ativan) 0.5 mg at HS
  - Only recommended for short term use

- **The Z meds**
  - Zolpidem (Ambien®) 5-10mg at HS; short term
SLEEPING PILLS, IF LONG TERM USE NEEDED

For chronic use, consider trazodone 25-50mg QHS
  • Safe for dementia patients as well

Mirtazapine (Remeron®) helps with sleep but increases appetite

Consider melatonin low dose about 2 hours before bed
Books Work For Me As Sleeping Pills
CONCLUSIONS:

- Depression is common, and under-recognized, but worth looking for.
- Counseling along with medications can improve quality of life.
- Improving sleep can help as well.