DEMENTIA NEWSLETTER *for* PHYSICIANS

Vol. 3, No. 3 | OTTAWA | Fall 2003

A Publication of the Dementia Network of Ottawa

In This Issue...

Contributors...

Dr. Louise Carrier
Medical Director
Geriatric Psychiatry Community Services of Ottawa

Dr. Linda Gobessi
Geriatric Psychiatrist
Geriatric Psychiatry Community Services of Ottawa

Disponible en français

Translation courtesy of/
Traduction gracieuseté de:
Makers of / fabricants de

JANSSEN-ORTHO Inc.

Reminyl

For More Info...

Marg Eisner
Alzheimer Society of Ottawa
1750 Russell Road, Suite 1742
Ottawa, ON K1G 5Z6
Telephone: (613) 523-4004
E-mail: meisner@alzheimerott.org

Depression in Dementia

By Dr. Louise Carrier MD FRCP (C)
Medical Director
Geriatric Psychiatry Community Services of Ottawa

Depressive symptoms are frequently reported in AD patients with prevalence rate for depressed mood ranging from 40-50% and 10 to 20% for major depressive disorder. Depression is most often seen early in the course of the dementia, from mild to the moderately severe, but decreases in the severe and advanced stages of the disease. This may be in part due to our lack of operational criteria to detect depression in the severely demented patients. There are at least 3 major reasons why identifying and treating depressed mood in AD is important: (a) it causes excess disability, (b) it has a negative effect upon caregivers, and (c) it is potentially treatable.

Assessment consideration

There is considerable overlap in symptomatology between depressive syndrome and dementia such as gradual loss of social isolation, decreased energy and difficulty with concentration, changes in appetite and sleep patterns. Apathy is a common neuropsychiatric symptom of dementia. It is defined as an absence of feeling and is distinguishable from moody sullenness. The apathetic patient, contrary to the depressed patient, is not in emotional distress. Although he will not initiate activities and shows a lack of motivation, the affective response to positive interactions and activities initiated by others is usually normal. It should be differentiated from depressed mood as it benefits from cholinesterase inhibitors. The depressed patient presents with a pervasive depressed mood or irritability, poor mood reactivity, anhedonia (or lack of pleasure), intrapsychic symptoms such as a sense of hopelessness and self-deprecatory statements, and may express death wishes. Depression will respond to antidepressant therapy. Approximately 20% of AD patients will have a major depression that will require Concurrent medical illnesses and drug use must be excluded as possible causes of depression.

Continued on page 2

If you would like to receive this newsletter electronically, send your email address to hferraton@alzheimerott.org

Depression in Dementia
(continued from page 1)

Recently a group of expert in late-life depression and Alzheimer's disease met to elaborate consensus diagnostic criteria for depression in Alzheimer's disease (Table 1). Although criteria were derived from the DSM-IV-TR criteria for Major Depressive Episode there are a few differences to reflect the fact that depression of AD may be less severe or persistent, with waxing and waning symptomatology. In attributing a symptom to depression of AD the clinician must judge that the symptom is not better accounted for by a primary depression, other mental disorder, other medical condition or adverse effects of medication (for example, loss of weight in a patient presenting with dysphagia).

Conclusion

Patients with AD and depression have been shown to be more functionally impaired when compared to matched AD patients without depression. Antidepressant medication will, in a majority of cases, improve the symptoms of depression, decrease the excess disability, and optimize the cognitive functioning.

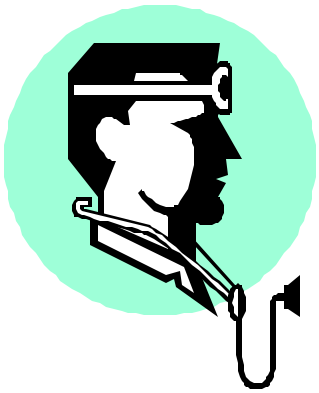


Table 1

Provisional Diagnostic Criteria for Depression of Alzheimer's disease

Three or more of the following symptoms have been present during the same 2-week period and represent a change from previous functioning: at least one of the symptoms is either 1) depressed mood or 2) decreased positive affect or pleasure.

1. clinically significant depressed mood
2. decreased positive affect or pleasure in response to social contacts and usual activities
3. social isolation or withdrawal
4. disruption in appetite
5. disruption in sleep
6. psychomotor change (agitation/retardation)
7. irritability
8. fatigue or loss of energy
9. feelings of worthlessness, hopelessness or excessive inappropriate guilt
10. recurrent thoughts of death, suicidal ideation, plan or attempts

Theses symptoms cause clinically significant distress or disruption in functioning.

The symptoms are not better accounted for by other conditions.

All criteria are met for Dementia of the Alzheimer's type (DSM-IV)

Treatment of Depression in Dementia

Dr. Linda Gobessi MD FRCPC
Geriatric Psychiatrist
Geriatric Psychiatry Community Services of Ottawa

Depression is a common behavioural and psychological complication of Alzheimer's Dementia (AD). Treatment targeting depressive symptoms has become an important aspect of comprehensive care. Despite the importance of depression in AD, there is little evidence-based data to guide treatment. Generally a combination of pharmacologic and non-pharmacologic approaches is used.

Currently, treatment begins by completing a comprehensive and rigorous assessment that includes interviewing the patient as well as the caregiver. As the dementia advances, difficulties in communication underline the need for collateral information. Medical conditions including pain, medications and other substances need to be reviewed as they may contribute to depressive symptoms or mimic depression. Similarly, psychosocial changes should be explored as they may be important precipitating factors and a focus for non-pharmacologic interventions. In addition, the safety of the patient must be assessed in order to determine the appropriate location for treatment. This includes an evaluation of the risk of suicide. Suicidal ideation is uncommon in the more advanced stages, but does occur in mild stages of AD when insight is more likely to be preserved.

In order to evaluate the effectiveness of any treatment, it is useful to establish a list of target symptoms. Rating scales such as the Cornell Scale for depression in dementia can also be used to follow treatment response.

Pharmacologic Therapy

Consensus expert panels generally recommend selective serotonin-reuptake inhibitors (SSRIs) as first line agents because of their favourable side effect profile. Other agents such as Venlafaxine, Bupropion, Mirtazapine and Moclobemide have also been used to treat elderly depressed patients. Tricyclic antidepressants (TCAs) are generally avoided, but secondary TCAs such as Nortriptyline and Desipramine may be used. One of the main concerns is anticholinergic side effects which will contribute to cognitive impairment. There are only a few trials that have specifically investigated the efficacy of antidepressant therapy in AD. Hence guidelines on how to choose an antidepressant are extrapolated from the literature and experience of treating non demented elderly depressed patients.

See insert on various Pharmacologic Therapies

Guidelines:

- Document physical symptoms and illnesses that may interfere with or be exacerbated by antidepressants. Choose a drug which is least likely to complicate your patient's medical problems.
- Avoid serious drug interactions by listing all medications, over the counter preparations, herbal remedies, and alcohol. Check for interactions. The most significant interactions involve drugs with a narrow therapeutic range.
- Choose a drug with a reasonable elimination half-life, a low potential for accumulation and that has dosing flexibility.
- Consider previous response to antidepressants.
- Consider the specific symptom profile of your patient.

Once a medication is selected, remember to start low, go slow, but keep going. Increase slowly while monitoring for adverse reactions. Remain in close contact with the patient or family. Elderly patients may need frequent dosage adjustments and close monitoring of emerging side effects. Continue the trial of medication until the patient receives adequate doses or has significant clinical effects or prohibitive adverse reactions. Antidepressant medication should be continued for two years if this is the first episode and indefinitely if it is a recurrent disorder.

There has been some evidence that cholinesterase inhibitors (CIs) may diminish mild symptoms of depression.

Continued on page 4

Treatment of Depression in Dementia
Continued from page 3

However, if a major depressive syndrome is present, antidepressant medications are indicated and should be added to the current CI bearing in mind any potential drug interactions.

Electroconvulsive Therapy (ECT)

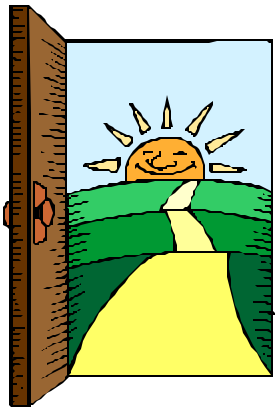
ECT is used on occasion in patients with AD but is generally limited to individuals who are unable to tolerate medications, have a previous response to ECT, or are having severe or refractory symptoms secondary to the depression. High rates of delirium after ECT have been reported as might be expected, but it can also lead to significant improvement. It is an important therapeutic option that should not be forgotten.

Non-pharmacologic Therapy

Patients with depressive symptoms early in their dementia may respond to insight-oriented psychotherapy, life review or reminiscence therapy. In the moderate to late stages, other techniques such as behavioural therapy, music and art therapies can be important. Activities offered in day programs provide valuable opportunities for socialization and sources of self esteem. Arranging activities to maximize success and avoid failure can help alleviate frustration and improve patients' self view. In a randomized trial of behavioural interventions (pleasant activities and caregiver problem solving) versus a control wait-list condition in depression in AD, both interventions were noted to improve depressive symptoms in patients as well as caregivers and the improvement was sustained for six months.

Referring the patient to a psychiatrist can be helpful to clarify the diagnosis, initiate treatment, or re-evaluate the current treatment.

Depression in AD is a treatable condition. Appropriate treatment can improve the quality of life of the patient and caregiver. Both pharmacologic and non-pharmacologic interventions should be utilized to optimize outcome.



Local Research Projects on Dementia

Provided by L.W. Chambers, Chair of the Research Committee of the Dementia Network of Ottawa
President, Élisabeth Bruyère Research Institute

	Title of Project:	Contact Person:	Website/E-mail address
1.	Canadian Study on Health and Aging	Ian McDowell	www.csha.ca
2.	CanDRIVE	Malcolm Hing	www.candrive.ca
3.	Research on Alzheimer's Caregiving in Canada: Current Status and Future Directions	Larry Chambers	lchamber@scohs.on.ca
4.	E-learning for Health Care Teams in Long-term Care Facilities	Colla MacDonald	cjmacdon@uottawa.ca

THANK YOU

The Dementia Network of Ottawa would like to thank Novartis, Janssen-Ortho, and Pfizer for sponsoring this edition of the Dementia Newsletter for Physicians.

NOVARTIS
JANSSEN-ORTHO Inc.
Pfizer