SharedCare
Partners for Patients

YOU DECIDE

EVIDENCE SUMMARY

Antidepressants in the Frail Elderly With Dementia and Depression

Focus – The focus of this You Decide sheet is on Long Term Care residents with dementia and depression, although the practice points could be applied to frail elderly with dementia and depression in the community, if they have someone who can provide collateral information.

EVIDENCE FOR USE-INITIATION OF ANTIDEPRESSANTS

Benefit

Randomized control trials (RCTs) have not demonstrated a statistically significant benefit of antidepressants over placebo in the elderly with dementia or for residents in care homes with or without dementia.[1,2] Reasons given for this are: small, short-term studies with heterogeneous populations mixing major depressive disorder with minor depression, large placebo effects and the difficulty of distinguishing depression symptoms from frailty/multiple co-morbid conditions and from dementia. However, clinically, there are elderly who may respond to antidepressants, especially when severe depression symptoms are present. The practice points below give direction on who to select for a trial of treatment and for whom one should consider discontinuing the antidepressant.

Harm

		Placebo (%)	ADX (%)		
	Outcome	**EVENT RATES**		**Risk Diff (%)**	**NNH for 8-12 weeks**
Frail older adult with mild-mod dementia 8 studies, Av age 71-89, mostly community[1]	Withdrawal for AE	6.1	10.9	4.8	21
	Dizziness	14	30	16	7
	Diarrhea	17	30	13	8

- Side effects[1] are statistically significant and, more importantly, clinically significant, in the frail elderly population.
- There may also be an increased fall risk, particularly when an antidepressant is initiated or as part of the polypharmacy associated with falls in the frail elderly.[3]
- Hyponatremia is also a concern with the SSRIs, with a higher prevalence in the frail elderly on meds that contribute to fluid-electrolyte imbalances.[4,5]

Practice Points

- The uncertainty of the clinical diagnosis of depression in the frail elderly, especially those with dementia, is the main practice point. This is particularly important as antidepressants are the second most commonly prescribed drug in LTC (60% of residents), perhaps in part because the Inter-RAI Geriatric Depression Scale used in LTC, while raising the possibility of depression, cannot distinguish between depression, frailty/multiple co-morbid conditions and dementia-this requires a tailored assessment.[1,7]

- Non-specific presentations are more common, where low mood may not be endorsed, while a general feeling of being unwell may be present.[6] More specific for depression would be anhedonia (versus apathy with dementia) as well as feelings of hopelessness and guilt. The Cornell Scale for Depression (proven useful when dementia as well as co-morbid medical conditions are also present) can be administered to screen for depression as well as monitoring for therapeutic effect.[8,9] This would be followed by applying the DSM-5 criteria to confirm the diagnosis, particularly to distinguish major depressive disorder from minor depression.[10]

- Non-pharmacologic approaches, tailored to the person, should be tried first for dysthymia and mild-moderate depression in the LTC population with dementia. This would include activities, exercise and socialization.[11,12]

- Pharmacologic treatment- Due to the uncertainty of both the diagnosis of depression and the benefit of antidepressants in the frail elderly with dementia, a therapeutic trial with identification, monitoring and review of person-specific target symptoms is recommended for both:
    - Drug initiation- there is consensus to treat severe major depressive disorder with antidepressants and also to consider antidepressants for less severe depression which persists with non-pharmacologic approaches alone; review in 4-8 weeks[1,12]

    - Drug review, tapering, discontinuation for residents already on an antidepressant- antidepressants should be reviewed for initial and ongoing indication, effectiveness, adverse effects, dosage and need to continue, especially in relation to polypharmacy and the changing clinical status of the frail elderly with dementia. Cautions for discontinuation would include where the depression has been severe and/or difficult to treat and where previous tapering trials have not been successful. If a trial of tapering and discontinuation is being considered, a monitoring and review approach should be set up for both recurrence of target depression symptoms as well as for symptoms of the antidepressant discontinuation syndrome (flu-like; insomnia; nausea; sensory disturbance; hyperarousal).[13] Tapering schedules can be found in a variety of sources, including Medstopper.[14]

References

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