Depression in The Elderly: Difficulties in Diagnosis and Management

Ranitya R, Satrio S*, Ervano T*, Setiati S***

INTRODUCTION

Depression is a significant problem that is common among elderly patients. The prevalence is quite high, effecting approximately 15% of the population of over 65 years.[1] Among patients with chronic diseases and those with a longer care the prevalence of depression is even higher, which is 10% to 60%. Several studies demonstrate that the comorbidity of depression and physical diseases a patient suffers creates a worse prognosis and increases mortality.[2,3] Disease management becomes more difficult and not optimal because depression could cause the patient to eat less and become less cooperative in following the treatment, thus resulting in a poorer medical condition.

Depression is generally commonly found in the elderly. Nevertheless, diagnosing depression in the elderly is not easy. Approximately 60% of depression patients have a co-morbid physical disease.[2]Detection of depression among geriatric patients is often delayed due to unspecific symptoms. Delayed detection results in delayed management, which has a bad impact on the patient's medical condition and response to treatment. This is also why co-morbidity of diseases and depression has a higher mortality rate. The following are several cases of hospitalized patients suffering from depression and a co-morbid illness.

CASE 1

A 70-year old male, was admitted to the of Cipto-Mangunkusumo National Central General Hospital in April 2003. The patient had a clinical history of longstanding diabetes mellitus complicated by heart disease and hypertension, and also suffered from depression, causing the patient to neglect taking care of himself and coming for regular treatment. The condition continued up to the point that the patient suffered from acute heart failure and pneumonia, causing him to be hospitalized. The patient had difficultly breathing, refused to eat, became weak and immobilized. Urination and defecation had to take place on the bed and became difficult to control. Longstanding immobilization resulted in decubitus ulcer, urinary and bowel incontinence, pneumonia, and hypoalbuminemia. The patient had never had any severe illness that required hospitalization. After hospitalization, even the though the acute condition of heart failure and pneumonia have been alleviated, the patient continued to demonstrate symptoms of depression, loss of enthusiasm and interest and lack of appetite. The patient underwent psychotherapy and received pharmacological treatment for depression, aside from treatment for his other physical ailments. Unfortunately, the patient demonstrated a slow response to treatment and a very poor medical condition. The patient finally died due to multiple complications.

CASE 2

A 75-year old woman, was admitted to the in-patient ward of Cipto-Mangunkusumo National Central General Hospital in May 2003 due to poor intake, diarrhea, pneumonia, and hypocalemia. The patient was known to have had longstanding hypertension and had come for her regular check-ups at the hospital. After few days of admission, the patient's appetite was still unsatisfactory, and the patient appeared sad and lonely and had difficulty sleeping. The patient's family rarely

* *Department of Internal Medicine, Faculty of Medicine of the University of Indonesia,Dr. Cipto Mangunkusumo National Central General Hospital, Jakarta*

** *Division of Geriatrics, Department of Internal Medicine, Faculty of Medicine of the University of Indonesia, Dr. Cipto Mangunkusumo National Central General Hospital, Jakarta*

came to visit because they were busy. The patient was a homemaker and a church activist in Ambon. Her husband had died a long time ago, and the patient was forced to move to Jakarta in 1998 due to the ethnic conflict that took place in her hometown. In Jakarta, she stayed with her married daughter. The patient's relationship with her daughter and son-in-law was not harmonious, and there were frequent conflicts. The patient stated that one of the causes of conflict is that the house she had bought with her own money had been sold without her consent and knowledge, which had made her sad and regretful. The patient was treated for her infection, while her medical condition was treated. She received antidepressants and supportive psychotherapy for her depression. She was released after her medical condition, intake, and mobilization had improved. The patient then did not keep her regular medical appointments and was once hospitalized in an out-of-town hospital.

DISCUSSION

Depression is an important problem in the elderly, and has a complex setting of biological and psychosocial factors.1 Depression is often found to accompany various chronic degenerative diseases in the elderly. The prevalence of depression is higher among in-patients compared to outpatients, and approximately 60% of patients with depression have a co-morbid chronic disease.[2,3]

Co-morbidity of depression and chronic diseases such as diabetes, coronary heart disease, and hypertension is associated with a reduction in body function and quality of life as well as a worse prognosis. Various studies found an increased mortality in patients with depression accompanying chronic disease compared to those without symptoms of depression.[4,5] In the cases reported here, depression caused a reduced appetite, which eventually lowered the patient's nutritional status and delayed healing. In severe conditions, the patient may even resist administered treatment, which of course makes further management very difficult. Such condition is very dangerous, since poor compliance to treatment will cause hospital readmission.[6] This should be preventable if depression with co-morbidity is better managed earlier.

Co-morbidity of depression and chronic diseases is also significant because symptoms and complaints of depression is often obscured by more prominent somatic symptoms.[2,7] Medical evaluation of depression in elderly inpatients should be more closely scrutinized. Studies report that depression often goes undetected during primary care, and thus remains untreated. A large number of depression cases that are detected do not receive adequate treatment.[8] Study results demonstrates that the best treatment for depression is the administration of psychotherapy along with the appropriate pharmacological treatment (antidepressants). Due to physiological changes with advancing age, elderly patients should receive extra care on the contraindication, side effect, and drug interaction. Problems that are also commonly encountered is that the administration of antidepressants may need to be postponed due to unaccommodating medical conditions.[9]

Psychosocial aspects play an important role in the development of depression in the elderly. Difficult socio-economic conditions, retirement (post power syndrome), and various conflicts with family members are predisposing and precipitating factors for the development of depression.[10] The sense of isolation or being cast away is a cause. Aside from that, lack of support from family members or caregivers could also become a problem. In the cases reported above, there is also elderly abuse, where the elderly patient received abuse such as the confiscation of their right to property ownership and lack of adequate attention during their illness. These are actually forms of negligence that elderly people unfortunately often suffer from their family or people they are most close to.[11] Some of these maltreatment are actually illegal, as abroad, many cases of elderly abuse could receive legal assistance from authorized legal bodies. This should be known and follow up is necessitated, since in Indonesia, elderly abuse has yet received adequate attention from the government and the community.

CONCLUSION

Depression in the elderly and co-morbidity with physical illnesses could aggravate prognosis and increase mortality risk. Early detection of depression is very important, even though it is often difficult to achieve, and should be conducted by all physicians/clinicians. Delayed management of depression results in difficult in disease management and poor medical conditions. Proper management of depression with co-morbidity is holistic, comprehensive, and interdisciplinary, encompassing biological and psychosocial aspects.

REFERENCES

1. Blazer DG. Depresion. In : Hazzards WR, Blass J, eds. Principles of geriatric medicine and gerontology. 4th edition. Mc Graw Hill; 1999 : 1331-1339.
2. Darmono S. Penatalaksanaan komorbiditas depresi dengan gangguan kondisi medik umum pada usia lanjut. KONAS I Asosiasi psikogeriatri Indonesia; 14-18 Juni 2003 di Hotel Borobudur Jakarta.
3. Roose SP, Glassman AH, Seidman SN. Relationship between depression and other medical illness. JAMA 2001; 286 (14):1687-9.
4. Unutzer J, et al. Severe depression linked to increased risk of death. Geriatrics 2002 ; 57 : 48-51. (abstract)
5. Penninx B, et al. Minor and major depression and the risk of death in older persons. Arch Gen Psychiatry 1999;56: 889-95.
6. Wholley MA, Browner WS. Association between depressive symptoms and mortality in older women. Arch Intern Med 1998; 158 : 2129-35.
7. Damping CE. Diagnosis klinis depresi pada pada pasien geriatric. Prosiding Temu Ilmiah Geriatri 25 - 26 Mei 2002 di Hotel Sahid Jaya Jakarta.
8. Finkel SI. Depression in the very old: differences in presentation and approach to treatment : a case example. Geriatrics 2003 ;58:48-52.
9. Evers M, Marin DB. Effective management of major depressive disorder in the geriatric patient. Geriatrics 2002; 57(10) : 36 – 40.
10. Setiabudhi T. Aspek psikososial penatalaksanaan depresi pada lanjut usia. KONAS I asosiasi psikogeriatri Indonesia;14-18 Juni 2003 di Hotel Borobudur Jakarta.
11. Darmabrata W. Elderly abuse (Penganiayaan pada orang-orang lanjut usia). KONAS I asosiasi psikogeriatri indonesia; 14 - 18 Juni 2003 di Hotel Borobudur Jakarta.

Pralax® SIRUP

Laktulosa 3,35 g

Benefit dari Pralax® sirup

1. Pencegahan dan pengobatan ensefalopati hepatik yang cepat dan nyata.
2. Efektif pada pasien-pasien hemoroid dan susah BAB terutama pada wanita hamil.
3. Merupakan laksansia fisiologis.
4. Dengan rasa dan aroma anggur.
5. Harga ekonomis.

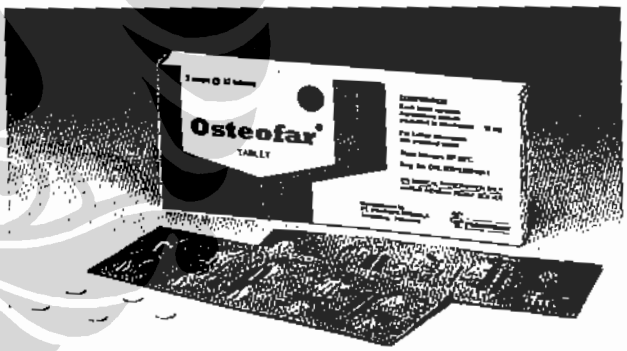
Secara klinis terbukti bahwa Pralax® sirup efektif terhadap kasus-kasus:

1. Ensefalopati hepatik
   a. Pre koma hepatikum
   b. Koma hepatikum
2. Konstipasi
3. Hemoroid

www.fahrenheit.co.id

Benefit dari Osteofar® tablet adalah :

1. Meningkatkan densitas massa tulang dengan nyata sehingga mencegah terjadinya fraktur
2. Terbukti efektif pada osteoporosis terutama pasca menopause
3. Merupakan "drug of choice" pada penyakit Paget's
4. Dosis sederhana yaitu 1 X sehari
5. Harga ekonomis



teofar®

Alendronat 10 mg

www.fahrenheit.co.id.

FAHRENHEIT