

Depression: Diagnosis

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Week 1

Educational Objectives:

1. Identify when screening for depression is useful and effective
2. Recognize how depression may present in the elderly
3. Understand how to screen for evidence of depression in the elderly and, if found, how to distinguish between normal reactions to stressors (e.g., grief) and depression
4. Identify medical disorders and medications that can mimic symptoms of depression

CASE ONE:

Ms. Downs is a 35-year-old woman with no significant past medical history who presents for a physical exam. You haven't seen her for a couple of years. She takes no medicines. She is married and a former nurse. She is currently a stay-at-home mom caring for three children, ranging in age from 2 to 8 years. She has no complaints.

Questions:

1. **Would you screen her for depression? Why or why not? Which patients are at especially high risk for depression?**

Current guidelines from the US Preventive Services Task Force (USPSTF, 2009) do not recommend routine screening for depression unless there is specific staff-assisted depression care support in place in the office in which you work. Without such support, patients with positive screening tests showed no difference in clinical outcome compared to those not screened. The USPSTF found that in studies where screening was effective, that is, made a clinical difference in the outcome, facilities had specific personnel and protocols designed to address and support those with positive screens. At a minimum, these resources included a nurse assigned to screen the patient and inform the physician of all who had a positive screen as well as a protocol to ensure prompt referral for treatment. Facilities that showed the greatest benefit to screening had significant supports in place: this support included training for staff and physicians, follow-up visits with a nurse specialist for assessment, education and discussion of patient preferences and goals as well as follow-up support for patients; and reduced co-pays for

patients referred for psychotherapy and ongoing support for medication adherence for those prescribed medications.

A Cochrane review of the topic from 2005 likewise found that screening of all patients was not found to have any impact on clinical outcomes, although in three small studies screening a subset of patients did improve likelihood of diagnosis. Work continues to better define this group.

In the Fancher article, the authors mention that screening of only those at increased risk of depression may be a more cost-effective approach. The USPSTF guidelines also identify certain groups at increased risk of depression but do not explicitly recommend screening these groups. What they do say is that “there may be considerations that support screening for depression in an individual patient.” The USPSTF lists those at higher risk of depression, including persons with other psychiatric disorders, including substance abuse, persons with a family history of depression, persons with chronic medical diseases, and persons who are unemployed or of lower socioeconomic status. Also women are at higher risk than men. In the elderly, significant depressive symptoms are associated with common life events including medical illness, cognitive decline, bereavement and institutional placement in residential or inpatient settings.

So, based on the USPSTF recommendations, this patient should not be screened for depression unless the office in which you work has some support designed for follow-up and treatment referral.

CASE ONE CONTINUED:

In the course of giving you her history, Ms. Downs tells you that her husband has recently lost his job, and she feels panicked about the loss of income and the possible (future) loss of their home. You decide to screen her for depression (if you didn't already).

2. Which screening tool will you use to evaluate her depression? Why choose that test?

There is no evidence that one screening test is better than another, so clinicians can choose the method that best fits their personal preference, the patient population served, and the practice setting. The article in the Annals recommends the two question screening test shown on page 785:

- *Over the past two weeks have you felt down, depressed, or hopeless?*
- *Over the past two weeks have you felt little interest or pleasure in doing things?*

CASE ONE CONTINUED:

The patient admits that she has felt down and depressed for the past three months since her husband lost his job, but thinks it might have started even before that. She also feels anxious and worried all the time.

3. Now what would you do?

Screening tests are useful only to highlight those who are at risk of having depression. In order to fully evaluate the patient, you need to see if she fits the criteria of Major Depressive Disorder (MDD). In addition to depressed mood, the patient must have additional symptoms of the disease. Two widely used symptom scales for this are given below. There is no sensitivity or specificity for SIGECAPS, but SALSA was shown to have a sensitivity of 97% and specificity of 94% when a cut off of two out of four symptoms was used as a positive (Brody 1998).

SIG E CAPS

- S Sleep alterations (too much or too little)*
- I Interest in activities is decreased*
- G Guilty or worthless*

- E Energy changes (too much or too little)*

- C Concentration decreased*
- A Appetite alterations (eating too much or too little)*
- P Psychomotor retardation or agitation*
- S Suicidal thoughts*

To get the diagnosis of MDD, the patient must have a depressed mood and four or more of the symptoms of the SIG E CAPS criteria for over two weeks. When depressed mood and more than two of these symptoms are present almost daily for two weeks, the patient can be diagnosed with minor depression. If depressed mood and more than two of these symptoms has been present for at least two years, the patient can be diagnosed with dysthymia.

You can also use SALSA:

- S Sleep disturbance*
- A Anhedonia*
- LS Low Self esteem*
- A Appetite disturbance*

Patients with two or more of these symptoms, occurring every day for two weeks, are highly likely to have Major Depression Disorder.

4. The patient scores 5 on the SIGECAPS. Now what?

She has Major Depressive Disorder. Both medications and psychotherapy have been shown to be effective for the treatment of depression. Before initiating discussions of treatment, she needs to be evaluated for suicidal thoughts and intentions. Is there a history of suicide attempts in the past? A history of attempted suicide is the most significant predictor of successful suicide. Assessing access to lethal means, especially firearms, is essential to the prevention of suicide. There are some studies that suggest that suicide is often an impulsive decision and easy access to the means of death increases the likelihood of a successful attempt. The Fancher article suggests that you might want to contract for safety, however, there is little evidence that this effort does any good. Active intention to commit suicide is an indication for hospitalization.

In addition, before starting antidepressants you might consider screening for bipolar disorder, as well as other psychiatric comorbidities (e.g., anxiety, panic attacks, substance abuse). In a study published in the Journal of the American Board of Family Medicine, one in five patients already taking antidepressants had a positive screen for bipolar disorder (Hirshfeld, 2005). The authors of that study used the Mood Disorder Questionnaire, (MDQ) a one page questionnaire that can be found at http://www.dbsalliance.org/site/PageServer?pagename=rx_for_clinicians, landing under the sub-heading Clinician Resources, then screening tools.

While you're at it, you might want to screen your depressed patients for Intimate Partner violence because of the association between these conditions.

*If there is no suicidal or homicidal intent (which would necessitate more immediate action), those found to have major depression will benefit from antidepressants or specific psychotherapeutic approaches including Cognitive Behavioral Therapy or Brief Psychosocial therapy. Treatment of depression will be the subject of another chapter, however, one **new recommendation** in the USPSTF guidelines was that clinicians should consider avoiding SSRIs in the treatment of those between the ages of 18 and 29 and those over the age of 65. For young adults, there is an increased risk of suicidal behavior (although because suicides remain a rare result, there was no increase in suicide deaths in these studies) with the use of SSRIs, particularly paroxetine. In the elderly there was an increase in the risk of an upper GI bleed. If this patient were on NSAIDs for chronic pain, you might think twice about using SSRIs because the combination of SSRI and NSAIDs was found to be associated with a higher risk of upper GI bleed as well.*

She also complains of symptoms of anxiety. Anxiety is common among depressed patients with up to 72% having anxiety symptoms of at least moderate severity. Most antidepressant therapy will also treat anxiety.

CASE TWO:

Faye Tigue, a 72-year-old woman presents to your office complaining of insomnia. She has a history of hypertension for which she takes verapamil. She has also been diagnosed with CAD, based on an abnormal EKG which showed evidence of a clinically silent MI in the past, and she takes an aspirin, metoprolol, and atorvastatin. She says she's not particularly sad, just tired. She is obese (BMI 30) with a flattened affect and appears tired, but her exam is otherwise unremarkable.

5. How would you approach this patient? Is she depressed?

Maybe. Sleep disturbances are common among those with depression but also among the elderly. Although depression is less common in the elderly than it is in the younger adult population, studies suggest a prevalence of 10-15% among patients seen in an outpatient setting and up to 20% in inpatient settings. While many of these patient will have a history of depression, up to half will not. Depression often presents differently in the elderly than younger adults. They often do not endorse feelings of dysphoria or guilt. They may not even complain of depression or sadness. Other common complaints among the elderly depressed patient include psychomotor retardation, loss of interest in living, and hopelessness about the future. Memory loss and loss of some executive function also often accompany depression, although it isn't clear if these are a result of depression or cause.

It's important to catch depression in the elderly because it has been linked to poorer outcomes, as it has in many settings. Although MDD is common among the elderly, minor depression is even more common and has also been linked to poorer outcomes (Lyness, 2006).

Depression is also common among those certain chronic diseases. Patients with neurological diseases such as dementia, stroke or Parkinson's have a much higher rate of depression. Up to 25% of elderly patients with heart disease meet criteria for MDD, and 25% other patients meet criteria for minor depression. Diabetes is also associated with an increased incidence of depression, although recent studies cloud the issue: it isn't clear if the diabetes causes the depression, or the depression causes the diabetes (Fiske, 2009).

In addition, before you diagnose her with a depressive disorder, you should rule out diseases that could cause the symptoms of which the patient complains. In addition, she is on medications that have depression as a side effect.

Medical conditions that can mimic depression include hypo and hyperthyroidism, hypercalcemia, vitamin B12 deficiency, Cushing's disease, hepatitis, and renal failure. Substance abuse also commonly results in depression and may be unsuspected in the elderly. Given her body habitus, sleep apnea should be considered as a cause of insomnia and fatigue.

She is on two medications that have been linked to an increased risk of depression, loproressor and verapamil. Other medications that have been linked to depression include CNS medications, digitalis, steroids, hormones, anti-Parkinson's meds, and benzodiazapines.

CASE TWO CONTINUED:

She scores one out of four on the SALSA scale. You screen her for substance abuse and sleep apnea which she doesn't appear to have. You change her from the verapamil and metoprolol – two medications linked to depressive symptoms and start HCTZ. You checked her TSH and Vitamin B12 level which are normal. She comes back a month later, after you've changed her medications but continues to complain of fatigue and interrupted sleep. She tells you that her symptoms started after the death of one of her grandchildren in a car accident several months ago.

6. Could this simply be grief?

This is a common scenario among the elderly for whom loss and bereavement are more common. Grief doesn't require treatment unless it is very severe or long lasting. Depressive symptoms are an expected reaction to loss, but pervasive symptoms lasting more than two months may signify a depressive disorder. A meta-analysis of prospective studies of depressive symptoms and disorders in adults over 50 found that bereavement more than tripled the risk of depression, with the largest effect size of any risk factors examined. Even so, bereavement confers less risk of depression for older adults than for middle-aged adults. Older adults are more likely than younger adults to resolve regrets associated with the loss, and such resolution has been linked to better adaptation after loss (Fiske, 2009).

Based on the duration of the symptoms, Ms. Tigie can be diagnosed with minor depression, and treatment options should be discussed. Although evidence of the effectiveness of treating minor depression with medications is not robust, improvement in depressive symptoms has been shown to be associated with lower morbidity and better outcomes. Elderly patients with minor depression are at increased risk for developing major depression. The New England Journal of Medicine article recommends a policy of watchful waiting and support rather than medications, although the Fiske and Baldwin references list pharmacotherapy as possible treatments, as well as talk therapy.

Primary References:

1. U.S. Preventive Services Task Force, Screening for Depression in Adults: U.S. Preventive Services Task Force Recommendation Statement. *Annals of Internal Medicine*. 2009; 151(11): 784-792. <http://www.annals.org/content/151/11/784.full.pdf+html>
2. Unutzer J. Late life depression. *New England Journal of Medicine*. 2007; 357:2269-2276. <http://content.nejm.org/cgi/content/full/357/22/2269>

Additional References:

1. US Preventive Services Task Force. Screening for depression. 2002 www.ahrq.gov/clinic/uspstf/uspstfdepr.htm.
2. Brody DS, Identifying patients with depression in the primary care setting: a more efficient method. *Archives of Internal Medicine*. 1998; 158: 2469-2475.
3. McConnell Lewis, L. No-harm contracts: A review of what we know, suicide and life-threatening behavior. *Suicide and Life-threatening Behavior*. 2007; 37(1): 50-57
4. Fiske, A et al. Depression in older adults. *Annu Rev Clin Psychol*.2009; 5:363-389.
5. Gilbody, S et al. Screening and case finding instruments for depression, *Cochrane Database of Systematic Reviews*. 2005; Issue 4. Art. No.: CD002792.
6. Gluck, TP et al. Assessment and treatment of depression following myocardial infarction. *American Family Physician*. 2001; 64:641-648, 651-652.
7. Lyness, JM, Moonseong H, Dato CJ, Ten Have TR, Katz IR Drayer R, Reynolds, CF, Alexopoulos BS, Bruce ML, Outcomes of Minor and Subsyndromal Depression Among Elderly Patients in Primary Care Settings. *Annals of Internal Medicine*. 2006; 144:496-504.
8. Baldwin RC, Anderson D, Black S, et al. Guideline for the management of late-life depression in primary care. *Int J Geriatr Psychiatry*. 2003; 18:829-838.
9. Lebowitz BD, Pearson JL, Schneider LS, et al. Diagnosis and treatment of depression in late life: consensus statement update. *Journal of the American Medical Association*. 1997; 278:1186-1190.
10. Hirschfeld, RMA, Cass AR, MD, Holt, DCL Carlson, CA, Screening for Bipolar Disorder in Patients Treated for Depression in a Family Medicine Clinic. *The Journal of the American Board of Family Practice*. 2005; 18:233-239.
11. Fancher, T, Kravitz R. In the clinic: depression. *Annals of Internal Medicine*. 2007; 146(9): ITC5-1. <http://www.annals.org/cgi/reprint/146/9/ITC5-1.pdf>

Lisa Sanders received her M.D. from Yale School of Medicine and completed her training at Yale's Primary Care Internal Medicine Residency Program. Her clinical and academic interests include clinical reasoning and diagnostic errors, as well as obesity, and nutrition. She writes a monthly column on diagnosis for The New York Times Magazine and most recently is the author of "Every Patient Tells a Story: Medical Mysteries and the Art of Diagnosis." She also wrote "The Perfect Fit Diet: How to Lose Weight, Keep it Off and Still Eat the Foods You Love." Before entering medical school, Sanders was a producer for CBS News, where she covered medicine and health.