Question One:
How should one approach the elderly patient with depression?
- What agents and interventions are preferred?
- What agents should be avoided?

Question Two:
If late life depression is refractory to pharmacologic agents, what is role of ECT?
- Or transmagnetic stimulation?

Question Three:
When depression coexists with dementing or neurologic illnesses, what are the unique considerations for treatment?

Multiple Small Feedings of the Mind:
Psychiatry

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March 7, 2015

Questions?
Multiple Small Feedings of the Mind: Psychiatry

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of the Mind: Psychiatry

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Question One
How should one approach the elderly patient with depression?

- What agents and interventions are preferred?
- What agents should be avoided?

Agents to consider avoiding:
- Antidepressants:
  - Fluoxetine, paroxetine, TCA's, trazodone
  - Antipsychotics in Augmentation Strategy
  - Risperidone, olanzapine, quetiapine (certain patients)

Ritalin and stimulants
- Cardiac, tics, anxiety

Course
- Treatments highly effective
  - Especially combination or augmentation strategies
  - Longer to respond
Late Life Depression (LLD): "Masked" Depression Subtypes

The Approach:
- Recognition and Diagnosis
- Typical Symptomatic Clusters that lead to certain treatments
Consider...

- Weight
- Appetite
- Ambulatory status
- Sleep
- Restlessness
- Energy
- Ruminative thoughts
- Pain
- Bowel movements
- Medical co-morbidities
Multiple presentations/Co-morbidities

- Agitated, Masked Depression (physical symptoms), Ruminative
- Apathetic, Vascular Depression
- Dysthymia, Grief/Loss, Adjustment
- Depression in dementia *(to discuss later)*
Treatments Targeted at Symptom Clusters

- **Agitated, Masked Depression (physical symptoms), Ruminative**
  - Antidepressants: SSRI (citalopram, escitalopram, sertraline)
  - SNRI (venlafaxine, mirtazapine, duloxetine)
  - Combination: SSRI plus bupropion, mirtazapine, nortriptyline, other
  - Augmentation: Atypical antipsychotics (quetiapine, olanzapine, aripiprazole, loxapine, ziprasidone), Mood Stabilizers (lithium, valproic acid)

- **Apathetic, Vascular Depression**
  - Antidepressants: sertraline, bupropion, SNRI's
  - Combination: sertraline and bupropion
  - Augmentation: methylphenidate, other stimulants, modafinil
Agents to consider avoiding...

Antidepressants:
- Fluoxetine, paroxetine, TCA's, trazodone

Antipsychotics in Augmentation Strategies:
- Risperidone, olanzapine, quetiapine (in certain patients)

Ritalin and stimulants in certain cardiac, tics, anxious patients
Course

- Treatments highly effective
  - Especially combination or augmentation strategies
- Longer to respond
- Higher recurrence rates
- Consider seasonal patterns in treatment

Consider long term maintenance pharmacologic treatment along with psychotherapy, usually supportive
Question Two:
If late life depression is refractory to pharmacologic agents, what is role of ECT?

- Of transmagnetic stimulation?
pharmacologic agents
what is role of ECT?

Of transmagnetic stimulation?

**Electroconvulsive Therapy (ECT)**

- Highly effective and safe in the geriatric population
- Should be considered earlier
  - Evidence suggests even after one trial of medications, certainly after a trial of augmentation or combination
- May require 12-15 treatments
- Best presentation: melancholic, agitated/anxious, somatic and ruminative/psychotic
- Treatment series versus Booster series
- Time in seizure is critical
- Seizure threshold is higher in elderly
- Must start medications toward end of treatment or high relapse/recurrence rates

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**Transmagnetic Stimulation**

- Less supportive evidence
- Research is expanding supportive of widespread
- Effects may be better of pain and depression, not in depression
- Several studies include but more needed
- Patients studied are generally responders to at least one trial and ECT
Transmagnetic Stimulation

- Less supportive evidence
- Research is expanding but generally not supportive of widespread use
- Effects may be better on pain
- Repetitive Transcranial Magnetic Stimulation (rTMS)
- High Frequency rTMS level A efficacy in pain and depression, more level B efficacy in depression
- Several studies including Sham Studies, but more needed
- Patients studied are generally non-responders to at least one antidepressant trial and ECT
Issues

- Location (left dorsolateral prefrontal cortex)
- Type of magnetics and frequency
- High cost of units
- Number of treatments
- Training of practitioners
- Home (weak) rTMS
- Tightening of approved indications

Many other indications under study including:
- Craving disorders
- Obsessive compulsive
- ALS
- MS
- Tinnitus
  ...and many more!

- Few side effects
- Less efficacy/effectiveness gap between clinical trials and clinical treatments
  ...too early to consider for widespread use!
Many other indications under study including:

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...and many more!
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  ...too early to consider for widespread use!
Question Three: When depression coexists with dementing or neurologic illnesses, what are the unique considerations for treatment?

"Other" Neurologic Illnesses

Examples:
- Parkinson's Disease
- Post Stroke Depression
- Primary Progressive Aphasia
- Multiple Sclerosis
- Symptoms focus on anxiety, concentration, panic more
Dementia

- Classify type of dementia and stage - Alzheimer's, Fronto-temporal, Lewey Body, Vascular, Mixed
- Always try to build a case for Depression and use of Antidepressants to target behaviors
- Use Target Symptoms not necessarily a Diagnosis
- Behavioral Disorders in Dementia- Subtypes: - Verbally Agitated, Physically Aggressive, Physically Non-Aggressive, Hiding and Hoarding
- Treatment Choices: SSRIs, primarily citalopram, sertraline, escitalopram
- "Other" Behavioral Examples: Paroxetine, Antipsychotics/Mood Stabilizers
"Other" Neurologic Illnesses

Examples:
- Parkinson's Disease
- Post Stroke Depression
- Primary Progressive Aphasia
- Multiple Sclerosis
- Symptoms focus on anxiety, concentration, panic more than sadness, guilt
- High rates of personality change, paranoia, illusions, psychosis in neurologic conditions that induce depressive symptoms, apathy
References:


