DEPRESSION

Pre-test Questions

1. Which of the following antidepressants is a good first-line choice for this patient?
   a. Amitriptyline
   b. Escitalopram
   c. Fluoxetine
   d. Aripiprazole

2. Which of the following features is NOT part of the DSM-IV-TR criteria for major depressive disorder?
   a. Symptoms lasting for greater than 1 week
   b. Sad mood
   c. Anhedonia
   d. Changes in appetite

3. In using the Geriatric Depression Scale, which score would lead to a classification of severe depression?
   a. 1
   b. 2
   c. 0
   d. 6

4. Which of the following statements is/are true regarding depression in geriatric patients?
   a. Depression in this population is very commonly unrecognized and undertreated.
   b. Geriatric patients with depression often have symptoms such as memory impairment that are uncommon in younger depressed patients.
   c. Geriatric patients have complex social factors that should always be considered when diagnosing depression because of their potential impact on the problem.
   d. All of the above

5. To treat this patient’s back pain, which of the following would NOT be appropriate first-line management?
   a. Physical therapy
   b. NSAIDs
   c. Referral to orthopedic surgery
   d. Low-back strengthening exercises
6. Which of the following statements is FALSE?
   a. Suicide is twice as frequent in the elderly population.
   b. Depression in more common in men than in women.
   c. Depression is more common in hospitalized patients than in those in the community.
   d. More patients avoid becoming depressed if they move to a safer environment.

7. An 86-year-old woman presents to your office for follow-up of her chronic back pain secondary to spinal stenosis. She had been relying on her husband for assistance with some of her activities of daily living until he passed away 4 months ago. Because she could not fully care for herself she had to move into an assisted living facility. She has lost several pounds and has a sad affect, and upon interview she reports that since she moved she no longer plays cards with her former neighbors. What do you think is the most likely diagnosis?
   a. Normal bereavement
   b. Adjustment disorder with depressed mood
   c. Major depressive disorder
   d. Minor depressive disorder
Patient TD is an 86-year-old man with a history of prostate cancer, hyperlipidemia, and HTN who complains of having had severe low back pain for several weeks. He says the pain is aching and constant and is only relieved somewhat with rest and NSAIDs. He says he is “tired of taking all those pills,” and his daughter, who accompanies him on the visit, says she thinks some of them might have irritated his stomach because he seems to be eating much less. His family physician ordered X-rays of the L-spine that showed no fractures or acute facet joint abnormalities.

His daughter notes that he has always been quite stoic but lately has been complaining a lot about this back pain, and also of other aches and pains in various parts of his body. She says that it must be fairly bad, since she has seen him become tearful at times, although he tends to get upset at things more easily of late. When asked directly, he says he feels like his “whole body is wearing out” and like he “just can’t go anymore.” He had been fairly active in the community until his wife passed away a few months ago, when he began spending most of his time at home alone. His daughter says he had been neglecting the housework and occasionally forgot to pay his bills on time, which prompted him to move in with her several weeks ago. When asked about his behavior, she notes that his attention seems poor and he sometimes has difficulty making simple decisions.

Upon examination his vital signs are normal. Upon physical exam he is in no distress but is a bit disheveled. He has good ROM in the limbs and at the waist, no tenderness to palpation over the spinous processes, and a negative straight-leg raising test bilaterally. A neurological exam is unremarkable. When asked about his mood, he admits to feeling worried about the future but otherwise denies any feelings of sadness.

Medications include: propranolol 40 mg PO BID, amlodipine 5 mg PO daily, hydrochlorothiazide 50 mg PO daily, atorvastatin 20 mg PO daily, ibuprofen 400 mg PO q8h PRN pain, Ultram 50 mg PO TID, and bicalutamide 150 mg PO daily.

Tasks

1. Develop a differential diagnosis of the patient’s pain.

2. What studies would you pursue in a work-up?

3. The patient’s laboratory work-up is normal except for an ESR value of 18 mm/h. An MRI of the thoracic and lumbar spine shows disc height loss at T12–L1, L1–L2, L2–L3, and L3–L4, and disc bulge at L3–L4 with associated spinal canal stenosis and mild neuroforaminal stenosis. What would you recommend as management?

4. Review the PowerPoint slideshow entitled “Depression in the Elderly.” What situational features, behaviors, and symptoms regarding this patient make you consider diagnoses of dementia, depression, delirium, or pseudodementia?

5. Using the DSM-IV criteria, identify symptoms of depression in this patient.
Although depression in the elderly is a common problem, it is frequently overlooked, for many reasons. Some assume depression is part of aging, and elderly adults often live isolated, with few around to notice their symptoms. Sometimes diagnosis can be difficult, since depressive symptoms may present with symptoms similar to those of dementia. Another factor is that physicians are more likely to concentrate on physical complaints than psychological complaints. Finally, many depressed seniors are reluctant to talk about their feelings or ask for help.

Anhedonia is an important clue. Can the individual or the caregiver articulate something the patient looks forward to doing? Many times a simple straightforward question can help you recognize the problem: “Do you feel depressed?” Other common symptoms and signs include change of sleep pattern and loss of appetite with or without weight changes. If the patient is in an inpatient rehab setting, observations from the therapy team can provide crucial information in diagnosing depression. For instance, a patient’s expression of hopelessness, lack of motivation to participate in therapies, and passiveness in communication may prompt you to question his or her psychological well-being.

As physiatrists specialized in treating pain, we should recognize the close association and interaction of pain and depression. In older adults, pain prevalence is higher than in younger adults for various reasons, including the association of pain with degenerative musculoskeletal problems and other medical conditions. Clinical depressive symptoms are also prevalent in this population, ranging from 3% to 26%. Chronic pain conditions increase the risk of depressive symptoms; conversely, the presence of depressive symptoms increases the risk of onset of pain over time. Clinically, pain induces a stress response that increases irritability, agitation, and a feeling of helplessness. Depression, on the other hand, generalizes and magnifies pain while reducing coping skills for pain. Both pain and depression can affect sleep and lead to chronic insomnia, which can in turn worsen both conditions. Thus, recognizing the depression-pain dyad is essential in proper pain management.

I had a patient years ago who had knee arthritic pain that was under good control. One day she was brought in by her daughter, who reported “significantly worsened pain” as she observed that her mother was more agitated, engaged in less daily activity, and some days even would not get out of bed. When I examined her, the arthritis condition was stable; however, she was very tearful and responded very slowly to any questions. She was sent to a geriatric psychiatrist for further evaluation and was diagnosed with severe depression. After proper treatment of depression, her “pain” was improved without changing pain management.

Clinically, we also need to differentiate between somatization disorder by DSM-IV criteria and the effects of psychological conditions, including depression, on pain manifestation. By DSM-IV criteria of somatization, diffuse pain (in at least 4 different sites) is only one criterion; there should be additional visceral, sexual, and/or neurological complaints. Another mistake that residents sometimes make is to equate positive Waddell signs with somatization. Multiple positive Waddell signs indicate only possible psychosomatic influence, not excluding true underlying pain etiology.
In patient TD, depression after his wife’s death generalized and worsened his pain. Acute loss of loved ones/friends is more common in older adults and may lead to depression. In evaluation of such patients, do not ever dismiss pain while also evaluating for depression. Successful treatment relies on proper and timely treatment for both pain and depression.
Post-test Questions

1. Which of the following antidepressants is a good first-line choice for this patient?
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   a. Normal bereavement
   b. Adjustment disorder with depressed mood
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   d. Minor depressive disorder
Answer Key — Questions

1. — b
SSRIs are a good first-line treatment option for depression in older individuals. Escitalopram has a better side-effect profile in this population than fluoxetine. Aripiprazole is a second-line agent, used in addition to an initial antidepressant medication to boost its effect. Amitriptyline and the other tricyclic antidepressants should be avoided in the geriatric population because of anticholinergic effects. Difficulty—hard

2. — a
Symptoms must be present for greater than two weeks. The rest of the choices are included in the DSM-IV-TR criteria. Difficulty—easy

3. — d
On the Geriatric Depression Scale, a score above 5 is suggestive of depression. Difficulty—hard

4. — d
All of the statements are true regarding depression in the geriatric population. Difficulty—easy

5. — c
Referral to surgery is not appropriate initial management. Medications, PT, and gentle exercise should be used, and the patient should be seen after a few weeks to re-evaluate the efficacy of treatment. Only if more conservative treatments fail should a patient be referred for surgery. Difficulty—moderate

6. — d
Patients who experience forced relocation are more likely to become depressed than their peers or those who choose to relocate.

7. — c
This patient has sad mood, anhedonia, and weight/appetite changes lasting more than 2 weeks. Her symptoms have lasted longer than normal bereavement and are characteristic of major depression, not adjustment disorder. She has more than 2 symptoms. So minor depressive disorder is not the correct answer.
Answer Key — Vignette Tasks

Develop a differential diagnosis of the patient’s pain.
- Spinal metastases
- Pathologic fracture
- Muscle strain
- Osteoarthritis
- Spondylosis
- Spondylolysis
- Spondylolisthesis
- Spinal stenosis
- Somatization

What studies would you pursue in a work-up?
- Plain spine films complete — review studies. CT or MRI imaging of the thoracic and lumbar spine. ESR, CRP, PSA, DRE/prostate exam, CMP with alkaline phosphatase, Ca levels.
- Ensure timely follow-up with urologist.

The patient’s laboratory work-up is normal except for an ESR value of 18 mm/h. An MRI of the thoracic and lumbar spine shows disc height loss at T12–L1, L1–L2, L2–L3, and L3–L4, and disc bulge at L3–L4 with associated spinal canal stenosis and mild neuroforaminal stenosis.
What would you recommend as management?
- PT for low back pain with activity/exercise regimen
- NSAIDs, muscle relaxants for pain
- Follow-up in 3 to 4 weeks — determine efficacy, tolerance of meds
- Surgical evaluation deferred until efficacy of nonsurgical intervention determined

What situational features, behaviors, and symptoms regarding this patient make you consider diagnoses of dementia, depression, delirium, or pseudodementia?

Using the DSM-IV criteria, identify symptoms of depression in this patient.
- Appetite changes
- Anhedonia, loss of interest
- Lack of concentration, indecisiveness
- Loss of energy
- Sad mood (has tearfulness, although he denies the sad mood)
- Symptoms have been ongoing for several weeks (>2 weeks)