Doctors Module- 11

NPHCE MODULE

Psychiatric problems in elderly

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Learning objectives:

By the end of the chapter, non-specialist medical officers should be able to:

1. Understand the burden of psychiatric problems in elderly
2. Identify psychiatric disorders in elderly
3. Assessment of psychiatric disorders in elderly
4. Pharmacological and non-pharmacological management in elderly

Introduction

The elderly population of India is steadily increasing. This vulnerable population is more prone to psychiatric problems. These psychiatric problems in elderly are more complex and challenging than those encountered in young- and middle-aged patients due to host of medical and environmental conditions. Apart from these the systemic medical conditions like kidney disorders, endocrine disorders, infections can manifest only with psychiatric symptoms.

The common psychiatric illnesses in elderly include:

- Delirium
- Dementia
- Depression
- Late-onset anxiety disorders
- Late-onset psychosis

Delirium and dementia are covered under CNS module

DEPRESSION

Depression is considered to be 'Disorder of losses'-

- loss of mood (sadness of mood);
- loss of interest in pleasurable activities (anhedonia);
- loss of energy (easy fatigability).
- In elderly depressed/sad mood remains the most common presentation but may not be spontaneous complaint and has to be observed.
- Loss of appetite and loss of weight is commonly reported.
- Suicidal ideation is also more common
- Loss of attention, memory, concentration and decreased memory and decision making (pseudodementia)
- Psychotic symptoms may also present in elderly depressives.

Table 1. Characteristics of depression, delirium and dementia

	Depression	Delirium	Dementia
Onset	Weeks to months	Hours to days	Months to years
Mood	Low/apathetic	Fluctuates	Fluctuates
Course	Chronic; responds to treatment.	Acute; responds to treatment	Chronic, with deterioration over time
Self-Awareness	Likely to be concerned about memory impairment	May be aware of changes in cognition; fluctuates	Likely to hide or be unaware of cognitive deficits
Activities of Daily Living (ADLs)	May neglect basic self-care	May be intact or impaired	May be intact early, impaired as disease progresses
Instrumental Activities of Daily Living (IADLs)	May be intact or impaired	May be intact or impaired	May be intact early, impaired before ADLs as disease progresses

ANXIETY

Anxiety symptom may be part of medical and psychiatric disorders like hypoglycaemia, hyperthyroidism, cardiac arrhythmias, pulmonary emboli, delirium, depression, dementia and psychotic disorder. It could be related to medications like ephedrine, anticholinergic drugs and benzodiazepine withdrawal.

Anxiety in elderly can present in different ways –

1. Constant excessive worrying or preoccupation about day to day or trivial issues, along with restlessness, dizziness, palpitations, feeling of muscular tension which persist for months together.
2. Patients can also present with phobia which are irrational and excessive fear of specific situations with secondary avoidance. Obsessions can occur. Obsessions and phobias may be a sign of underlying dementia.
3. Elderly with anxiety in general present more commonly with autonomic symptoms like palpitations and dizziness; have restlessness and difficulty in sleeping and over-involvement in family matters.
4. Somatoform disorders - Psychological distress may manifest in the form of different physical symptoms instead of psychological symptoms. They can present with persistent pains, headaches, hyperventilation syndrome, irritable bowel syndrome etc.
5. Hypochondriasis - Here patient has a persistent belief in the presence of at least one serious physical illness underlying the presenting physiological symptoms. Although thought to be common in elderly, it is a diagnosis of exclusion and is associated with anxiety and somatic complaints, but not with depression, suicidality or short term outcome

Management:

Primary level assessment:

- ✓ Detailed history is required and should deal with mood, effect on daily functioning, precipitating causes and severity (mild dysthymia to severe depression)
- ✓ Geriatric depression scale -2 or more yeses indicate depression
    - Are you basically satisfied with your life
    - Do you often get bored
    - Do you often feel helpless
    - Do you prefer to stay at home rather than going out and doing new things
    - Do you feel pretty worthless the way you are now
- ✓ Geriatric depression scale-short form (source http://www.stanford.edu/ yesavage/GDS.html, public domain), 15 point scale >5 suggestive of depression, >10 indicative of depression
- ✓ Assess for secondary causes of anxiety and depression – personal and family issues
- ✓ Vision or hearing impairment
- ✓ Drugs -beta blockers, weight reducing drugs can cause depression

Secondary level

The laboratory tests to rule out co-morbid medical conditions are: complete blood counts, thyroid stimulating hormone, vitamin B12 & folate levels (vegetarians), electrocardiogram, Fasting blood sugar, serum electrolytes, blood urea & creatinine.

Treatment

Detecting and treating medical conditions like hypothyroidism, diabetes, anaemia and vitamin deficiencies etc. is an important aspect of the management.

Psychological interventions –

Psychological interventions are very useful. Psychotherapy is indicated in mild to moderate severity of depression and anxiety. Different types like supportive, cognitive-behavioral and interpersonal psychotherapy can be used.

Pharmacological treatment –

Common medications preferred for anxiety, depression and somatoform disorders in elderly are selective serotonin reuptake inhibitors [SSRIs] like Escitalopram and Sertraline due to their better tolerability.

The side-effects which should be monitored are gastrointestinal symptoms, and in some cases sexual dysfunction and increased risk of bleeding tendency. Also drug interactions with other concurrent medications should be checked for.

Benzodiazepines like clonazepam [dose 0.25 to 0.5 mg /d] can be used only for acute control of anxiety or for treating insomnia. These medications can cause drowsiness and secondarily unsteadiness, hence caution should be exerted. They can be abused by patients hence should be used for short duration at lowest possible dose. Avoid continuous use beyond 2 weeks.

Patient with psychosis requires a safe environment. Agitated and suspicious elderly needs inpatient hospitalization.

LATE ONSET PSYCHOSIS

Elderly patients can present with abnormal behavior associated with agitation, hallucinations and delusions and behavioural abnormalities. It may be associated with dementia, drug intake (like anticholinergics, levosulpiride), depression. Rarely bipolar disorder and schizophrenia can present.

Assessment

Careful history taking from family members and others as well as functional cognitive assessments should be done.
Once delirium is excluded look carefully for dementia or any psychiatric disorders

Treatment

Antipsychotic medications should be used cautiously in late-onset psychotic disorders are risperidone, quetipine and haloperidol. Drug induced extra pyramidal symptoms, orthostatic hypotension and weight gain, prolongation of QT interval are major side effects. Long term use to be considered in consultation with psychiatrist.

Referral indications

Patients need to be referred to a psychiatrist in following situations –

1. Patient not responding to treatment
2. Patients with multiple psychiatric issues
3. Patients with severe symptoms and presence of psychotic symptoms like hallucinations
4. Patient with suicidal ideas or attempts
5. Patient with severely reduced activity, food intake, sleep or personal care
6. Patients with severe or multiple and complex psychosocial stressors
7. Patient needing primarily psychological intervention which is not available
8. Patients with comorbid dementia or neurologic issues

Case scenario:

1. Mr S 66 years elderly male, was referred to the outpatient clinic for complaint of forgetfulness and behavioural abnormalities. Since retirement at the age of 60, he constantly looses objects and forgets names of his relatives. Although he has been staying in his locality since 10 years, but, now would often forget his way to home. He would ask for food again and again. He recently become agitated with hallucinations of snakes in the bathroom and refused to eat. His sleep was disturbed. He recently had been prescribed tolterodine for BPH.

   On examination, patient was agitated but fully oriented. He scored 15/30 on Montreal Cognitive Assessment. He was unable to follow instructions properly. Lab investigations were within normal limit, computed tomography scan of brain showed generalised diffuse cerebral atrophy. He was diagnosed as a case of dementia with psychosis. Tolterodine was stopped. Patients was started on tablet Donepezil 5 mg in the morning with lorazepam 1mg at night for 1 week. His agitation reduced after a week and he was continued on donepezil.

2. A 65-year lady, widowed 2 years back and staying alone for 8 months [earlier staying with daughter], not having any medical or past psychiatric problem, comes with 5 months' history of sadness of mood, loss of interest in pleasurable activities, decreased food intake and sleep, multiple bodyaches, feeling of hopelessness. These complaints have increased since last 2 months. What is this lady suffering from and how should you treat her?

Follow up and progression

- Improvement occurs in most patients.
- Follow up every 2 weeks would be beneficial

Summary

Anxiety, depression, somatoform disorders and late onset psychosis are common psychological problems in elderly needing early intervention. They are associated with delirium and dementia needing appropriate management. Lack of awareness amongst people lead to under-reporting of anxiety and depressive symptoms unless asked actively. Hence physicians need to be proactive. Both pharmacological and psychological management is available, safe and effective. Management should be comprehensive and individualised as per the patient.

Links

- http://www.nimh.nih.gov/health/publications/older-adults-and-depression/index.shtml
- http://www.healthline.com/health/depression/elderly
- http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/depressioninolderadults.aspx
- http://nihseniorhealth.gov/anxietydisorders/aboutanxietydisorders/01.html

Further reading

International Classification of Diseases and Related Health Problems (ICD-10)

Kaplan & Saddock's Comprehensive Textbook of Psychiatry 9th edition