HAH Healthcare Association of Hawaii | HHERF Hawaii Hospital Education and Research Foundation | HADI Hawai'i Alzheimer's Disease Initiative

Welcomes You To

Geriatric Depression & Dementia

Presented by Aida Wen, MD
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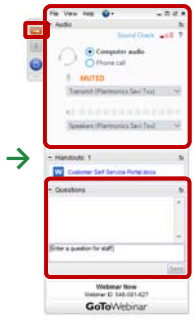
August 2, 2017
10:00 – 11:00 a.m.



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GERIATRIC DEPRESSION & DEMENTIA

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Department of Geriatric Medicine
2017

University of Hawaii Center on Aging

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Learning Objectives:

At the end of the presentations, the participant will be able to:

- Recognize the challenges in the diagnosis of depression in the elderly.
- Develop comprehensive strategies for the treatment of depression in the elderly

Mrs. K

- Mrs. K is an 80 year old Japanese female. She has been having persistent fatigue and shortness of breath x several months and has been presenting to the ED with increasing frequency, at least 6-7 times in the last 2 months. She sleeps poorly. She used to be quite independent, including driving, and had traveled to Japan about 10 months ago with her daughter. But since then, she has lost about 20 lbs in the past year, feels very weak, and now doesn't leave the house (except to go to doctor's appointments and the ED). Her daughter now brings her in for evaluation.

Diagnosis

Diagnostic Criteria for Major Depressive Episode

Essential Symptoms

1. Depressed mood
2. Anhedonia

Physical Symptoms

3. Changes in sleep
4. Change in appetite or weight
5. Fatigue
6. Change in psychomotor activity

Psychological symptoms

7. Feelings of guilt or worthlessness
8. Difficulty in thinking, concentrating, or making decisions
9. Recurrent thoughts of death, suicidal plans or attempts

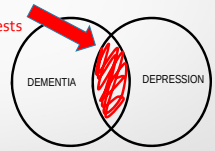
Adapted from *DSM-IV*

Clinical Presentation in the Elderly

- Depression Symptoms
  - Mood changes less pronounced with less subjective depression, more irritability
  - Low energy, insomnia, low appetite, anxiety, cognitive changes and somatic complaints are more frequent

Confounded…by Dementia

- Overlap with dementia symptoms
  - Impaired concentration
  - Forgetfulness
  - Lack of motivation, Apathy
  - Dropping many activities and interests
  - Self-neglect
  - Psychomotor retardation
  - Sleep disturbance



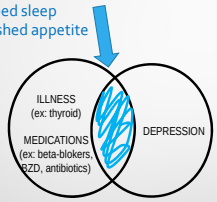
- Persons with dementia cannot self-report symptoms accurately.

"Pseudodementia"

- Depressive Dementia = A syndrome seen in older adults in which they exhibit symptoms consistent with dementia but the cause is actually Depression.
- Short and abrupt onset
- REVERSIBLE

Confounded… by Medical Illness

- Symptoms of depressive and physical disorders often overlap
  - Fatigue
  - Disturbed sleep
  - Diminished appetite

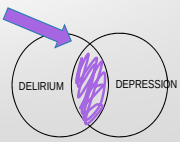


- Seriously ill or disabled persons may also focus on thoughts of death or worthlessness, but not suicide

Confounded by….Delirium

- Delirium caused by acute medical problems
- Delirium may be misdiagnosed as depression
  - Ex: hypoactive delirium
  - Ex: with psychotic features
- Antidepressants can worsen delirium

CAM
A acute change MS
I Inattention
D Disorganized
A Altered consciousness
1&2 and either 3 or 4



…and not to be Confused with Grief Reactions

- Elderly may experience multiple stressors and losses
  - Medical burden
  - Some loss of independence
  - Loss of roles/ community/ friends or family
- Bereavement is different because:
  - Most disturbing symptoms resolve in 2 months
  - Not associated with marked functional impairment

Clues to depression in outpatient primary care

- Persistent pain, headache, fatigue, insomnia, GI symptoms, arthritis, multiple diffuse symptoms, or weight loss
- Frequent calls and visits
- High utilization of services

Clues in hospitalized patients

- MI, CABG, hip fracture, or stroke
- Delayed recovery
- Treatment refusal
- Discharge problem
- Readmission (Increased rates of hospital readmissions)

Clues in the nursing home

- Apathy, withdrawal, or isolation
- Failure to thrive
- Agitation
- Delayed rehabilitation
- Especially high rates of depression in cognitively intact nursing home patients

Screening Strategy

- Initial Screening
  - Mini-cog → MMSE or SLUMS
  - PHQ-2 → PHQ-9
- Mild-Moderate Dementia
  - Geriatric Depression Scale
  - PHQ-9
- Advanced Dementia
  - Cornell Scale for Depression in Dementia
  - PHQ-9 OV (nursing home)

Initial Screening: PHQ-2

- Over the last 2 weeks, how often have you been bothered by the following problems?
  - A. Little interest or pleasure in doing things?
  - B. Feeling down, depressed, or hopeless?
    - Not at all (0)
    - several days (1)
    - more than half the days (2)
    - nearly every day (3)

These symptoms are less likely to be confounded by a medical illness

For Mild- Mod Dementia: PHQ-9

- Over the last 2 weeks, how often have you been bothered by the following problems?
  - Feeling tired or having little energy?
  - Poor appetite or overeating?
  - Trouble falling asleep, staying asleep or sleeping too much?
  - Feeling bad about yourself- that you are a failure or have let yourself or your family down?
  - Trouble concentrating on things?
  - Moving or speaking so slowly that others noticed? Or being so fidgety or restless that you have been moving around more than usual?
  - Thoughts that you would be better off dead or of hurting yourself?
- IS USEFUL for MONITORING RESPONSE.

Geriatric Depression Scale (15 Item)

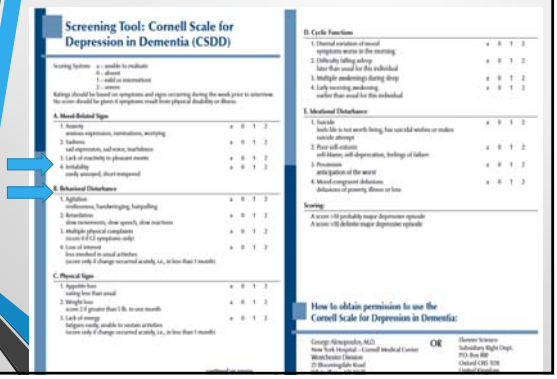
- YES/NO responses
- Asks more questions about feelings
- Fewer Somatic and Sleep Queries
- Does not ask about suicidal or death ideation
- NOT useful for assessing treatment response

Table 39.4—The Geriatric Depression Scale (GDS, 15-item)

Choose the best answer for how you felt over the past week.

1. Are you basically satisfied with your life? yes/no
2. Have you dropped many of your activities and interests? yes/no
3. Do you feel that your life is empty? yes/no
4. Do you often get bored? yes/no
5. Are you in good spirits most of the time? yes/no
6. Are you afraid that something bad is going to happen to you? yes/no
7. Do you feel happy most of the time? yes/no
8. Do you often feel helpless? yes/no
9. Do you prefer to stay at home, rather than going out and doing new things? yes/no
10. Do you feel you have more problems with memory than most? yes/no
11. Do you think it is wonderful to be alive now? yes/no
12. Do you feel pretty worthless the way you are now? yes/no
13. Do you feel full of energy? yes/no
14. Do you feel that your situation is hopeless? yes/no
15. Do you think that most people are better off than you are? yes/no

Moderate to Advanced Dementia



Screening Tool: Cornell Scale for Depression in Dementia (CSDD)

How to obtain permission to use the Cornell Scale for Depression in Dementia:

OR

How to Use the CSDD

- The CSDD is designed to assess depression in elderly residents with dementia
- Takes ~ 20 minutes to administer
- The ratings should be based on depressive symptoms and signs **occurring during the week prior to the interview**.
- No score should be given if symptoms result from physical disability or illness.
- Information is obtained from interview of a caregiver as well as from direct observation and interview of the patient
- If there are discrepancies in ratings, the rater should re-interview both the caregiver and the patient to resolve the discrepancies
- The final ratings represent the rater's clinical impression rather than the responses of the caregiver or the patient

Moderate to Advanced Dementia

- Nursing Home PHQ-9 Observation Version
  - For those unable to complete PHQ-9 interview
  - Validated against Cornell Depression Scale
    - includes caregiver report, patient report, observations of behavior and medical record review.

Nursing Home PHQ-9 OV

Characteristic	Cornell Scale for Depression in Dementia[a]	Patient Health Questionnaire-9 Observation Version[b]
Method of administration	Clinician interview of caregiver and patient (discrepancies resolved with second caregiver interview); chart review for weight loss item.	Staff assessment of behaviors, signs, or symptoms of mood distress.
Time to complete	Caregiver interview = 20 minutes; resident interview = 10 minutes	Caregiver interview = 10 minutes
Time frame	Past week	Past 2 weeks
Number of items	19	10
Content	1. Anxiety 2. Sadness 3. Lack of reactivity to pleasant events 4. Irritability 5. Agitation 6. Retardation 7. Multiple physical complaints 8. Loss of interest[c] 9. Appetite loss 10. Weight loss[c] 11. Lack of energy[c] 12. Diurnal variation of mood 13. Difficulty falling asleep 14. Multiple awakenings during sleep 15. Early morning awakening 16. Suicide (i.e., feels life is not worth living, has suicidal wishes, or makes suicide attempts) 17. Poor self-esteem 18. Pessimism 19. Mood-congruent delusions	1. Little interest or pleasure in doing things 2. Feeling or appearing down, depressed, or hopeless 3. Trouble falling or staying asleep; sleeping too much 4. Feeling tired or having little energy 5. Poor appetite or overeating 6. . Indicating feeling bad about self, is a failure, or has let self or family down 7. Trouble concentrating on things, such as reading the newspaper or watching television 8. Moving or speaking so slowly that other people have noticed, or the opposite—being so fidgety or restless that resident has been moving around a lot more than usual 9. States that life isn't worth living, wishes for death, or attempts to harm self 10. Being short-tempered, easily annoyed

Symptom frequency

Phillips et al. Res Gerontol Nurs. 2012 Jan; 5(1): 34–42

Course of Depressive Symptoms in NH residents

- A longitudinal study over 74 months of 1158 nursing home residents; 26 nursing homes in Norway; moderate dementia
- Cornell Scale for Depression in Dementia
- **RESULTS:** "Irritability" was the most prevalent, incident and persistent CSDD symptom. Other mood symptoms were lower at all subsequent assessments. This persisted after adjusting for the severity of dementia.
- The severity of depression as measured by CSDD decreased over 74 months when adjusting for relevant resident variables.
- Poorer physical health, higher number of medications, more severe dementia and use of antidepressants were associated with higher depression score.

Borza, et al. J Affect Disord 2015 Apr 1;175:209-16

Behavioral and Psychological Symptoms of Dementia (BPSD)

- Scales that measure BPSD:
  - Neuropsychiatric Inventory (NPI)
  - BEHAVE-AD
- Common items:
  - Delusions (fear of theft, spouse imposter)
  - Hallucinations
  - Agitation/Aggression (verbal, physical, resists ADL's, other agitation)
  - Anxiety and Phobias
  - Aberrant motor behavior (wandering, purposeless activity, inappropriate activities)
  - Depression (tearfulness, whimpering)
  - Irritability/ Lability (bad temper, argues)
  - Sleep and nighttime behavior disorders
  - Appetite/Eating changes

BEHAVIORS= COMMUNICATION

Other considerations….

Dementia patients have more Depression

- Higher prevalence of depression among patients with Dementia (20-40%)
  - Vascular Dementia (44.1%)
  - Diffuse Lewy Body Dementia (30%)
  - Alzheimer's (18.5%)
  - Mild Cognitive Impairment (20%)
  - No Dementia (8.6%)

Enache, et al. Depression in Dementia: Epidemiology, Mechanisms, and Treatment. Curr Opin Psychiatry. 2011; 24(6):461-472

Depression may increase the risk for Dementia

- Depressive symptoms may hasten conversion from MCI to Alzheimer's disease (AD) (Goveas et al., 2011; Mourao et al., 2015; Royall et al., 2013).
- History of depression (especially early-onset depression) increases the risk of developing AD (Baba et al., 2011; Royall et al., 2013; Richard et al., 2013).
- Research suggests that effective management of depression may be a possible intervention target for MCI and possibly dementia (Mourao et al., 2015).

Consequences

- Depression increases morbidity & mortality
  - CAD, post MI
  - Diabetes
  - Cancer
  - Stroke
- Untreated Depression increases medical costs
  - More likely to refuse treatment or have poor adherence to treatment (3X higher non adherence)
  - Higher rates of hospitalization

Consequences

- Depression increases overall disability
  - Results in more time in bed, poor social contact, delayed recovery and rehabilitation
- Depression increases Suicide risk
  - One fourth of all suicides occur in persons over 65 years old
- Depression increases incidence of Dementia

Treatment approach

First, Do No Harm: Beer's Criteria, STOPP Criteria

AVOID:

- Tertiary TCA: e.g. Amitriptyline, doxepin, imipramine
  - highly anticholinergic
- Antipsychotics: 1st and 2nd generation
  - Risk for CVA, mortality
- Benzodiazepines: Short and long acting
  - slower metabolism, risk for falls
- Non-bzd hypnotics: e.g. eszopiclone, zolpidem
  - Delirium, falls, fx
- SSRI's
  - For history of clinically significant hyponatremia

First, Do No Harm: Other Common Errors

- Ignoring side effects and drug interactions
- Not following up on adherence
- Underdosing
- Stopping too soon (minimum 6-9 months)

Types of antidepressants

CLASS	EXAMPLES
SSRI	Escitalopram, citalopram, sertraline, paroxetine
SNRI	Duloxetine, venlafaxine, desvenlafaxine
MAOI	Phenelzine, selegiline, tranylcypromine
TCA	Nortriptyline, desipramine
Dopamine/norepinephrine	Buproprion
Alpha-1 adrenergic & 5HT2	Trazodone
Alpha-2 adrenergic & 5-HT2	Mirtazapine

All with similar efficacy and lag periods

The Usual Strategy for Geriatric Patients

- Individualized selection of antidepressants based on patient characteristics and side effect profile (e.g. insomnia, anorexia, anxiety)
- Start low: half the younger adult dose
- Go slow: Titrate after 2-4 weeks as needed.
- Change treatment if min/no response in 4-8 weeks

2001 US Expert Consensus Guidelines
2006 Canadian Guidelines

The problem with "usual care"

- Increasing use of medications for depression,
  - Antidepressant usage in depressed outpatients –
    - 1987: 37% → 1997: 75% (Olfson et al, 2002)
  - Decreasing use of psychotherapy
- Low Efficacy
  - Only 19% of patients with late-life depression have a reduction in depressive symptoms
  - Absence of benefit and increased risks with antidepressants compared to placebo, for patients with depression and dementia

Mulsant et al. A systematic approach to pharmacotherapy for geriatric major depression. Clin Geriatr Med. 2014 Aug;30(3):517-34. doi: 10.1016/j.cger.2014.05.002. Epub 2014 Jun 14.

Banerjee et al. Sertraline or mirtazapine for depression in dementia (HTA-SADD): a randomized, multicenter, double-blind, placebo-controlled trial. Lancet. 2011 Jul 30;378(9789):403-11. doi: 10.1016/S0140-6736(11)60830-1. Epub 2011 Jul 19

Newer Strategies

- Greater use of Non-pharmacologic Approaches
- Use of Algorithms
- Different Approach for Dementia patients

Non-pharmacologic treatment

- Try to address:
  - Family issues
  - Caregiver support (especially for dementia patients)
  - Substance abuse rehab
  - Maximize function (e.g. hearing aid, PT/OT)
  - Improving medical status
  - Exercise
  - Nutritional needs

Cognitive Behavioral Therapy

- May be valuable for cognitively intact residents who are willing:
  - Group or Individual
- Some residents may not be amenable to "therapy."
  - Cultural or Generational
- Cognitive behavioral therapy is comparable to antidepressants in response
- Memory and attentional difficulties may impair effectiveness

Behavioral Activation (BA)

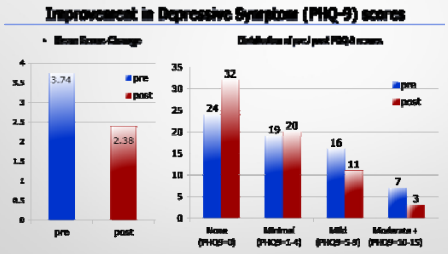
- "Outside in" approach that focuses on engaging the patient in behaviors that improve mood and counter depressive tendencies to isolate and be inactive.
- Change how people feel by changing what they do. Motivation is not necessary.

Strategy for BA

- Structure & schedule activities that follow a plan, not a mood.
- Emphasize activities that are naturally reinforcing.
  - # 1: Goal setting: Patient chooses pleasant activities/ personally important goals
  - # 2: Encouragement: Help patient to make a plan to achieve goal
  - # 3: Goal achievement: Patient completes activity and staff tracks activities and mood
  - # 4: Reinforcement: Praise success/ goal achievement

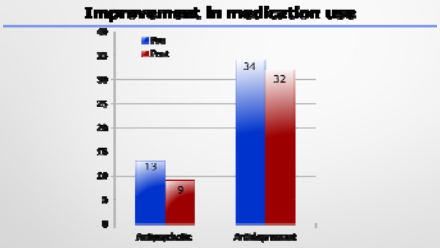
From Behavioral Activation for Depression: A Clinician's Guide. Martell, Dimidjian, and Herman-Dunn

BA and Depression Outcomes



N=66

BA and Depression Outcomes



Nonpharmacological Strategies that work for Dementia Behaviors

- LITERATURE REVIEW:
- Iosief et al. BMJ Open 2017;7e012759. doi:10.1136/bmjopen-2016-12759.
  - Systematic review of systematic reviews of non-pharmacological interventions to treat behavioral disturbances in older patients with dementia. The SENATOR- OnTop Series 2017
- Livingston, et al. Health Technology Assess. 2014; 14 (39)

Meaningful Activities

Music Therapy

Sensory Stimulation

Caregiver Training

Work Activities

Kahala Nui Memory Support Unit

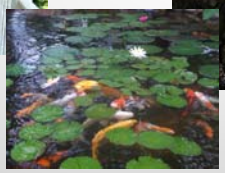
Self-Care

Leisure Activities

Hale Kuike

"Las Vegas" at Kahala Nui

Relaxing Activities


Music Therapy (Interactive)

Hale Kuike

Pierre Grill

Examples:
Music along with…
Singing
Playing instrument
Tapping Rhythmn
Moving
Dancing
Exercise
Reminiscence
Mealtime
Live Music

Interactive, Singing Along, Playing Instruments, Dancing

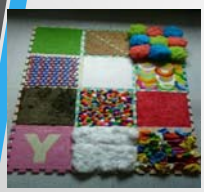
Snoezelen Multisensory Environment



VISUAL and COLOR STIMULATION

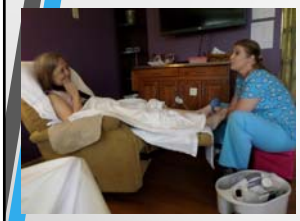
Especially for Later Stages of Dementia

TOUCH



- Less Bored or Inactive
- Happier and Content
- More Enjoyment

Namaste Care



Especially for Later Stages of Dementia

GENTLE ADL CARE
RANGE OF MOTION

SOFT TOUCH
SOUNDS

SOOTHING

Algorithm for Stepped Care Approach

Outcomes in Two Randomized Studies Comparing an Stepped—Care Approach vs. Treatment-As-Usual for the Treatment of Late-Life Depression

Study	N	Treatment algorithm	Outcomes
IMPACT (Unutzer et al, 2001; Unutzer et al, 2002)	1801	Step 1: AD (typically a SSRI) or PST (8-12 weeks) Step 2: -Non-response: Switch to other AD or PST -Partial response: Combine with other AD or PST Step 3: -Combine AD and PST -Consider ECT or other specialty services	Rate of response (50% reduction in depression score) after 12 months: Intervention: 45% Usual care: 19%
PROSPECT (Mulsant et al, 2001; Bruce et al, 2004; Alexopoulos et al, 2005; Alexopoulos et al, 2009)	599	Step 1: Optimize current AD (if applicable) Non-response - Switch to: Step 2: citalopram 30 mg once a day Step 3: bupropion SR 100-200 mg twice a day Step 4: venlafaxine XR 150-300 mg once in AM Step 5: nortriptyline (target 80-120 ng/ml) Step 6: mirtazapine 30-45 mg in the evening Partial response – Add: Step 2: bupropion SR 100-200 mg twice a day Step 3: nortriptyline (target 80-120 ng/ml) Step 4: lithium (target 0.60-0.80 mEq/l) Then, steps 2, 4, 6 for non-responders Also, IPT can be used as an alternative to AD or as an augmentation to AD.	Rate of response (HDRS score of 10 or below) - After 4 months: Intervention: 33% Usual care: 16% - After 12 months: Intervention: 54% Usual care: 45%

AD: antidepressant; ECT: electro-convulsive therapy; IPT: interpersonal therapy; HDRS: Hamilton depression rating scale; PST: problem-solving therapy; SSRI: selective-serotonin reuptake inhibitor

Mulsant et al. A systematic approach to pharmacotherapy for geriatric major depression. Clin Geriatr Med. 2014 Aug;30(3):517-34. doi: 10.1016/j.cger.2014.05.002. Epub 2014 Jun 14.

Proposed Antidepressant Algorithm

Updated Pharmacotherapy Algorithm for the Treatment of Late-Life Depression

	Majority consensus and minority alternative
Step 1	Escitalopram Alternatives: sertraline, duloxetine
Step 2 for minimal or non-response)	Switch to duloxetine Alternatives: venlafaxine, desvenlafaxine
Step 3 for minimal or non-response	Switch to nortriptyline Alternative: bupropion
Step 2-3 for partial response	Augment antidepressant with lithium or an atypical antipsychotic Alternatives: combine SSRI or SNRI with mirtazapine or bupropion
Duration of each step	6 weeks Alternatives: 4 weeks; 8 weeks

SSRI: selective-serotonin reuptake inhibitor; SNRI: serotonin-norepinephrine reuptake inhibitor

Mulsant et al. A systematic approach to pharmacotherapy for geriatric major depression. Clin Geriatr Med. 2014 Aug;30(3):517-34. doi: 10.1016/j.cger.2014.05.002. Epub 2014 Jun 14.

Treatment of Behavioral & Psychological Symptoms of Dementia (BPSD)

- Depression, Aggression, Agitation
- The FDA has not approved any medications to treat BPSD
- Cholinesterase inhibitors, antipsychotics, antidepressants, anticonvulsants and mood stabilizers have been used to treat BPSD symptoms

Treatment of Behavioral & Psychological Symptoms of Dementia (BPSD)

- Dementia specific medications: Memantine, Donepezil, Rivastigmine, Galantamine
  - 12-month randomized, open-label trial (n=41-48 in each arm)
  - Memantine and Rivastigmine may be effective in improving BPSD with mild-mod AD without major side effects;
  - Especially agitation, aggression, anxiety and phobias.

Cumbo E. Liori LD. J Alz Disease 2014;39 (3):477-85.

Treatment of BPSD

Table 2. Behavioral Symptom Change After Initiation of Antipsychotics or Antidepressant Treatment in Nursing Home Residents with Alzheimer's Diseases and Related Dementias

Treatment	Episodes, n	n (%) Improved	Unchanged	Worsened	P-Value*
Antipsychotic					
Total	2,060	1,052 (51.1)	739 (35.9)	269 (13.1)	.09
Baseline behavioral symptom score					
1–3	1,755	872 (49.7)	638 (36.4)	245 (14.0)	.00
4–6	253	150 (59.3)	80 (31.6)	23 (9.1)	
7–9	52	30 (57.7)	21 (40.4)	1 (1.9)	
Antidepressant					
Total	1,673	804 (48.1)	659 (39.4)	210 (12.6)	
Baseline behavioral symptom score					
1–3	1,447	672 (46.4)	576 (39.8)	199 (13.8)	<.001
4–6	194	117 (60.3)	66 (34.0)	11 (5.7)	
7–9	32	15 (46.9)	17 (53.1)	0 (0.0)	

- Antidepressants and Antipsychotics
  - Efficacy similar with >85% improving/stable

Huang et al, J Am Ger Society 63:1757-1765, September 2015

Symptom-based Medication Options for BPSD

Paranoia	
mild	citalopram, prazosin, *sertraline, escitalopram*
severe	risperidone, olanzapine, aripiprazole, *quetiapine*
Depression	antidepressants
Apathy	cholinesterase inhibitors (ChEI), methylphenidate *buproprion*
Anxiety/Agitation	
mild	citalopram, trazodone, prazosin, *ChEI/memantine*
severe	risperidone, olanzapine *quetiapine, benzos, valproate, gabapentin, buspirone*
Sexual Aggression	citalopram, risperidone
Insomnia	melatonin, doxepin, trazodone, *mirtazepine*
PRNs	
mild behaviors	trazodone
emergency	IM haloperidol, IM olanzapine

Second line options in italics

Desai 2012

Slide courtesy of Dr. Brett Lu

Summary of Pearls

- Depression is often difficult to recognize in Older Adults
- Screen for Depression using the appropriate tools
- Evaluate Medications/ Medical Conditions/ Labs
- Consider Dementia Behavior (agitation/ irritability) as a manifestation of Depression
- Maximize Non-pharmacologic and pharmacologic strategies

Remember…

a person with dementia lives from moment to moment…

…Focus your energies on Creating Moments of JOY

-- Jolene Brackey

Case Discussion

Mrs. K

- Mrs. K is an 80 year old Japanese female. She has been having persistent fatigue and shortness of breath x several months and has been presenting to the ED with increasing frequency, at least 6-7 times in the last 2 months. She sleeps poorly. She used to be quite independent, including driving, and had traveled to Japan about 10 months ago with her daughter. But since then, she has lost about 20 lbs in the past year, feels very weak, and now doesn't leave the house (except to go to doctor's appointments and the ED). Her daughter now brings her in for evaluation.

PMH

- HTN
- Hypercholesterolemia
- Osteoporosis
- Hypothyroidism
- After her return from Japan, her cough and fatigue were worked up, and she was diagnosed with MAI pneumonitis, and has been on Clarithromycin and Albuterol Nebulizers for at least 3 months.

PMH…already worked-up

- What she doesn't have:
  - No previous psych history.
  - Normal thyroid function
  - Extensive workup ruled out cancer (mammography, colonoscopy, bronchoscopy, including total body CT)
  - Extensive workup ruled out cardiac disease, arrythmias, valvular disease, or CHF.
  - Pulmonary workup without mildly impaired PFTs, no significant compromise, with normal O_2 sats.
  - Sent home from ED visits each time with negative work-up, increased dose of benzodiazepines, and follow-up with PCP

Medications

- Colestid 1gm po daily
- Miacalcin nasal spray in alt nostrils daily
- Albuterol MDI
- Albuterol Nebulizer
- Pulmicort Nebulizer
- Lorazepam 0.25 mg po QID prn anxiety
- Atenolol 25 mg mg daily
- Clarithromycin 500 mg po BID x3 months
- Levothyroxine 50 mcg daily

Social History

- Habits
  - Tobbaco x5 years, no etoh, no drugs
- Education
  - High school
- Hobbies/ Interests
  - Previously enjoyed shopping, yardwork
- Support System
  - Husbamd died 8 yrs ago. 2 daughter, 1 son. The daughters take shifts. Alone after dinner.
  - Tired from taking her to ER frequently

Functional Status

- IADLS
  - Now dependent in all iADLs
    - Daughter took over meal prep, shopping, finances, medications, household, transportation
- ADLS
  - Independent in all ADLs
  - No falls

EXAM

- Awake, well groomed, NAD, but tired and almost fell asleep during exam
- Heent, Cardiac, Abd exam WNL
- Lungs-no crx, wheezing, poor inspir effort
- Neuro- unable to arise from chair without assist, gait slow but steady, good arm swings, good turns, DTR intact, sensation ok, strength 5/5 symmetrical
- MMSE 23/30 (missing date, floor, 2/5 spelling World backwards,
- Clock Drawing: Intact
- Word list Generation: 12 words
- GDS 4/15

ASSESSMENT & PLAN

1. Fatigue-
   - due to depression, chronic infection, benzodiazepine, beta-blocker,
2. Dyspnea-
   - due to MAI pneumonitis, continue Antibiotics and Pulmicort neb.
3. Anxiety-
   - episodes of panic- cyclical, due to nebs—trial d/c of albuterol nebs. , exacerbated by benzodiazepine rebound anxiety—switch to long acting Clonazepam 0.25 mg qd
4. Weight Loss-
   - anorexia due to meds? Depression?

PLAN

NON-PHAMACHOLOGICAL INTERVENTION

- Increased support and environment change- Care Home trial x1-2 months during med adjustment.
- Provided more activities
- Also increased "prophylactic" exams by physicians.

PHARMACOLOGIC

- Discontinue albuterol nebs
- Taper benzodiazepine and replace with SSRI
- Treat depression and anxiety with SSRI (escitalopram).
  - Preferences based on side effect profile:
  - First Line Choices = Escitalopram, Sertraline
- If not improved after 4 weeks, consider adding/switching to another agent
  - If pain- consider duloxetine
  - If insomnia, anxiety, and anorexia consider mirtazapine
  - If apathetic- consider buproprion
- Would avoid Aricept (anorexia), might consider Exelon Patch.
- Replace B-blockers with Lisinopril.
- Try to switch Antibiotics (Antibiotic Associated Encephalopathy is particularly high with quinolones, macrolides, Cefipime, Ceftaz)

Follow-up

After weaning OFF Benzodiazepines and titrating up her antidepressant:

- Repeat MMSE= 26/30, better able to concentrate (world backwards)
- GDS=0/15,
- Weight gain of 20 lbs over next 6 months.
- Mood brighter, smiling affect, more energy
- She now has friends and activities—and Decided to stay at the care home!

Questions?

Type your questions into the Questions tab of your Control Panel.

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Geriatric Depression & Dementia

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