Brescia, 28 aprile 2006

Depressione e sintomi somatici

Renzo ROZZINI
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Choosing and Using an Assessment Tool

ROBERT L. KANE
Assessment has become a central technology in the care of older persons. It is safe to argue that, at any age and in a variety of contexts (medical and social services), systematic assessment is preferred over haphazard practice.
Despite the banality of such a simple statement, traditional care is not systematic. For many cases the lack of a systematic approach may not be critical, but in the care of and delivery of service to older persons, where presenting problems are often complex and multidimensional, systematic approaches are not merely preferable, they are necessary.
Assessment is seen as the basis for sorting out problems and assigning clients to their appropriate place. If only it were that easy! Assessment is a means of identifying client characteristics.

Translating assessment into actions is still more an art than a science.
Health policy

Should we screen for depression?

Simon Gilbody, Trevor Sheldon, Simon Wessely

Summary points

Depression is common in patients in primary care and hospital settings but often is not recognised by healthcare professionals.

Opportunistic screening and population level screening for depression have been supported in recent policy recommendations in the US and UK.

The UK National Screening Committee has issued clear criteria, and all screening programmes should be judged against these criteria before implementation.

The use of these criteria indicates that screening for depression is unlikely to be a clinically effective or cost effective way to improve the mental wellbeing of the population.
La depressione nell’anziano

- **Diagnosi**: la domanda è espressa in termini complessi sia per quanto riguarda il linguaggio comunicativo, sia per l'interazione degli ambiti che determinano la qualità della vita dell'anziano.
GERIATRIC DEPRESSION SCALE (GDS forma breve)

1. Siete fondamentalmente soddisfatti della vostra vita?
2. Avete interrotto molte delle vostre attività e dei vostri interessi?
3. Ritenete che la vostra vita sia vuota?
4. Vi annoiate spesso?
5. Siete di buon umore la maggior parte del tempo?
6. Temete che vi stia per capitare qualcosa di male?
7. Vi sentite felici la maggior parte del tempo?
8. Vi sentite spesso indifesi?
9. Preferite stare a casa, piuttosto che uscire a fare cose nuove?
10. Pensate di avere più problemi di memoria della maggior parte delle persone?
11. Pensate che sia bello stare al mondo oggi?
12. Vi sentite inutili?
13. Vi sentite pieni di energia?
14. Pensate di essere in situazione priva di speranza?
15. Pensate che la maggior parte delle persone stia meglio di voi?
In many parts of Chinese society, the experience of depression is physical rather than psychological. Many depressed Chinese people do not report feeling sad, but rather express boredom, discomfort, feelings of inner pressure, and symptoms of pain, dizziness, and fatigue. These culturally coded symptoms may confound diagnosis among Chinese immigrants in the United States, many of whom find the diagnosis of depression morally unacceptable and experientially meaningless; this cultural pattern changes over time but continues to diverge significantly from the experiences of other groups. The pattern of somatization may be unfamiliar to U.S. clinicians and may further complicate the concept of depression, which, according to biomedicine, can be an emotion, a symptom, or a disease.

N Engl J Med 2004, 351;951-953
In older patients with medical disorders and multiple somatic complaints, clinicians should consider the possibility of depression. Rating scales emphasizing somatic symptoms associated with depression may provide a more accurate measure of depression severity than those excluding such symptoms.
The Hamilton rating scale for depression

- Depressed mood
- Guilt feelings
- Suicide
- Insomnia – early
- Insomnia – middle
- Insomnia – late
- Work and activities
- Retardation – psychomotor
- Agitation
- Anxiety – psychological
- Anxiety – somatic
- Somatic symptoms GI
- Somatic symptoms – General
- Sexual dysfunction - menstrual disturbance
- Hypochondrias
- Weight loss
- Insight
- Diurnal variation
- Depersonalization
- Paranoid symptoms
- Obsessional and compulsive symptoms
CLINICIAN'S CORNER

A 75-Year-Old Man With Depression
Kurt Kroenke, MD, Discussant

JAMA. 2002;287:1568-1576.
Update: A 75-Year-Old Man With Depression

In a Clinical Crossroads article published in March 2002, Kurt Kroenke, MD, discussed the prevalence, natural history, differential diagnosis, evaluation, and treatment of depression in older adults. The patient, Mr S, had been having difficulties with depression for about 2½ years following coronary artery bypass graft surgery and subsequent complications. About 2 years earlier, Mr S started taking venlafaxine XR (75 mg/d) with initial improvement of his symptoms. However, even with an increase in the dose, his depression worsened. He acknowledged a lack of energy, lack of interest in his usual activities, social withdrawal, loss of appetite, and hypersomnia. His symptoms improved after seeing a social worker and a further increase in his dose of venlafaxine XR to 150 mg/d. Mr S wondered whether he could discontinue his antidepressant medication.

In his discussion, Dr Kroenke explained that for a first episode of major depression, discontinuing medication after 4 to 9 months of remission would be an acceptable option. However, he noted that some studies suggest that in older adults depression is more likely to persist. Dr Kroenke recommended that Mr S remain active and pursue enjoyable activities such as traveling.

Several months ago, the patient and his physician provided us with comments on the year that had passed since the conference.

Mr S: The Patient
I am doing very well. I have not had any new medical problems and am still taking the antidepressant. I am also exercising a bit, which I was not doing a year ago. I have been spending more time at our vacation home, and overall have been enjoying life this past year.

Dr W: The Primary Care Physician
Mr S has been doing pretty well. All of his medical problems have been quite stable, and he has not developed any new problems. He is exercising now 3 to 4 times weekly. He is quite active in his retirement and has not had any difficulties with his depression. He remains on the venlafaxine XR (150 mg/d), along with atorvastatin, digoxin, furosemide, terazosin, mephobarbital, primidone, metoprolol, moexipril, and warfarin.

Risa B. Burns, MD
Erin E. Hartman, MS

REFERENCE
L’assessment geriatrico permette di definire lo stato di salute del paziente e di collocarne l’affettività nel contesto clinico.

Il paziente geriatrico affetto da depressione è sempre affetto da comorbilità.
Maarten Van Heemskerk (1498-1574), Saturno-Crono
Indications for Referral to a Psychiatrist:

Suicidal thoughts, in particular plans to commit suicide
Substance abuse (alcohol or illicit drugs)
Bipolar disorder
Psychosis (hallucinations or delusions)
Psychotherapy needed as primary or adjunct treatment
Drug-refractory (more than 2 or 3 failed antidepressant trials)
Complexity due to psychiatric comorbidity
La depressione che ho incontrato
• La depressione dell’ammalato cronico, del disabile;
• Associata alla malattia grave (i.e. il cancro). Aumenta col tempo la soglia della sofferenza? O aumenta la disperazione silenziosa;
• La depressione del caregiver;
• Il depressione legata della decrepitezza senile (ogni cosa è un problema; vengono meno le cose che davano piacere, diventano difficili le cose normali; non si può più);
• La sofferenza di chi sta perdendo la memoria;
• La depressione caratterologica (verso la quale si fatica a provare compassione);
• La sofferenza della perdita: del coniuge, del figlio, degli amici.
• La vergogna per la separazione dei figli.
• La sofferenza dell’adulto che si separa (l’abbandono); la sofferenza della solitudine.
• La sofferenza causata dalla malvagità umana (di fronte alle prove delle crudeltà raccapriccianti che gli uomini sono capaci di commettere ai danni di altri esseri umani)(Cogne, Tommy).
Depression in the elderly
George S. Alexopoulos

Panel 1: Classification and diagnosis of geriatric depressive disorders

**Major depressive disorder**
Five of the following symptoms must be present: depressed mood, diminished interest, loss of pleasure in all or almost all activities, weight loss or gain (more than 5% of bodyweight), insomnia or hypersomnia, psychomotor agitation or retardation, fatigue, feelings of worthlessness or inappropriate guilt, reduced ability to concentrate, recurrent thoughts of death or suicide.
At least one of the symptoms must be either depressed mood or diminished interest or pleasure. The syndrome should last at least 2 weeks, lead to distress or functional impairment, and not be a direct effect of substance use, a medical condition, or bereavement.

**Minor depressive disorder**
At least two but fewer than five of the symptoms of major depressive disorder must be present.
The syndrome should last at least 2 weeks, lead to distress or functional impairment, and not be a direct effect of substance use, a medical condition, or bereavement.
This diagnosis can only be made in patients without a history of major depression, dysthymia, bipolar, or psychotic disorders.
Dysthymic disorder
Sad mood for more days than not accompanied by another two symptoms of major depressive disorder. A duration of at least 2 years is required. An episode of major depression might not be present during the first 2 years of the disorder.

Bipolar I disorder (most recent episode depressed)
Individuals meet criteria for major depressive disorder and have a history of at least one manic episode or a mixed episode.

Adjustment disorder with depressed mood
Individuals who develop depressed mood, tearfulness, or hopelessness within 3 months of the occurrence of a stressor. The syndrome should lead to great distress or disability, and should subside within 6 months of the removal of the stressor.

Bereavement is not considered a stressor for an adjustment disorder.
Epidemiology

1–4% of the general elderly population has major depression, equivalent to an incidence of 0.15% per year. Twice as many women as men are affected. Both the prevalence and the incidence of major depression double after age 70–85 years. Similarly, the number of elderly people with bipolar disorder is increasing, because the absolute number of old people is rising and, possibly, because the proportion of elderly individuals with this illness is increasing. Minor depression has a prevalence of 4–10%. Dysthymic disorder, characterised by low-intensity symptoms of depression that last 2 years or longer, occurs in about 2% of elderly people.

A very old person is particularly prone to significant symptoms of depression. An increase in disability and cognitive impairment, a fall in socioeconomic status, and the high proportion of women who survive their partner’s death might explain this pattern.

Prevalenza di depressione, rilevata attraverso l'impiego di diverse scale, in alcuni studi epidemiologici del GRG

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>assente</th>
<th>moderata</th>
<th>severa</th>
<th>età</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nel territorio:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brescia (1986)*</td>
<td>1201</td>
<td>66.2</td>
<td>27.5</td>
<td>6.3</td>
<td>70-75</td>
</tr>
<tr>
<td>Ospitaletto (1992)**</td>
<td>549</td>
<td>73.5</td>
<td>23.1</td>
<td>3.4</td>
<td>&gt;70</td>
</tr>
<tr>
<td>Tirano (1993)**</td>
<td>183</td>
<td>75.8</td>
<td>17.0</td>
<td>7.1</td>
<td>&gt;60</td>
</tr>
<tr>
<td>Coccaglio (1995)***</td>
<td>390</td>
<td>64.6</td>
<td>30.0</td>
<td>5.4</td>
<td>&gt;70</td>
</tr>
<tr>
<td><strong>In ambulatorio medico:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PEQOL (1992)#</td>
<td>462</td>
<td>60.4</td>
<td>23.8</td>
<td>15.8</td>
<td>&gt;75</td>
</tr>
<tr>
<td><strong>In RSA:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PROLOGUS (1994)***</td>
<td>178</td>
<td>37.2</td>
<td>21.5</td>
<td>41.3</td>
<td>&gt;70</td>
</tr>
<tr>
<td><strong>In Ospedale:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GERU (1996)***</td>
<td>998</td>
<td>39.9</td>
<td>24.3</td>
<td>35.8</td>
<td>&gt;65</td>
</tr>
<tr>
<td>ACE (2003)**</td>
<td>3015</td>
<td>59.2</td>
<td>29.7</td>
<td>11.1</td>
<td>&gt;65</td>
</tr>
</tbody>
</table>

*BDI; **GDS (short form); ***GDS (complete form); #BSI.
Psychosocial adversity

Low economic status, poor physical health, disability, social isolation, and relocation often lead to an adjustment disorder with depressed mood or trigger more severe depressive syndromes than previously present. Additionally, caregivers of elderly disabled individuals are twice as likely as non-caregivers to develop symptoms of depression. Depressive symptomatology is most likely to develop during long-term caregiving. Additional predisposing factors are a care recipient with behavioral problems and receipt of limited help from others. After placement of the elderly individual in a nursing home, a quarter of caregivers develop symptoms of depression, which remain relatively unchanged over time in women but worsen in men.

The elderly are at high risk for depression because they are more likely than younger people to have experienced illness, death of loved ones, impaired function and loss of independence. The cumulative effect of negative life experiences may be overwhelming to an older person.

Fattori precipitanti una malattia depressiva o eventi che inducono una “ragionevole” risposta maladattativa?

Qual’è il loro significato clinico?
Major depression has been the bread and butter of psychiatry. In 1997, by far the most common conditions treated by psychiatrists were mood disorders: (53.7%, with the vast majority being major depression), compared with 14.6% for schizophrenia and 9.3% for anxiety disorders. Patients received an average of two medications prescribed by psychiatrists, most commonly antidepressants (62.3%). Between 1985 and 1995, office-based psychiatry visits became shorter, fewer included psychotherapy, and more included a medication prescription. In addition, the increase in antidepressant prescriptions after 1985 was far the less severely ill psychiatric patients. Depression is major depression, major depression is a biological disorder, and biological disorders are treated with medications.

Dan Blazer, The Age of Melancholy 2005
Reactive depression ... is not an illness but a reaction, a response to conditions of loss and disappointment. This response is highly subjective ... [It] can be normal and transient [or] neurotic (one of the most frequent neurotic symptoms). For a neurotic depression, there may be an organic predisposition but [one] can always find also predisposing psychic factors involving loss.

Dan Blazer, The Age of Melancholy 2005
The *DSM-IV-TR* diagnosis that implies a psychosocial etiology is *adjustment disorder with depressed mood*. Most of the mentions of *depressive reaction* are by *nonpsychiatrists*.

Dan Blazer, *The Age of Melancholy* 2005
Significato clinico

Depressione e mortalità
Crude and adjusted associations of GDS score with 60-month *mortality* in a community-dwelling population aged 70 and over.

<table>
<thead>
<tr>
<th>GDS</th>
<th>n/deaths</th>
<th>$RR^a$</th>
<th>95% C.I.</th>
<th>$RR^b$</th>
<th>95% C.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2</td>
<td>227/35</td>
<td>1.0</td>
<td></td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>3-5</td>
<td>159/41</td>
<td>1.7</td>
<td>1.1-2.8</td>
<td>1.5</td>
<td>0.9-2.4</td>
</tr>
<tr>
<td>6-15</td>
<td>136/53</td>
<td>3.0</td>
<td>1.9-4.6</td>
<td>1.9</td>
<td>1.2-3.1</td>
</tr>
</tbody>
</table>

$p<0.0001^a$  \hspace{1cm} $p<0.005^b$

A: crude analysis.
B: adjusted for age, gender, education (years of schooling), cognitive status (MMSE), number of diseases, disability (BADL).

*(Rozzini et al., Arch. Int. Med., 2000)*
Associazione tra depressione, *mortalità e riospedalizzazione* a sei mesi in pazienti anziani dimessi da un reparto di geriatria

<table>
<thead>
<tr>
<th>Eventi</th>
<th>RR</th>
<th>95% C.I.</th>
<th>RR</th>
<th>95% C.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortalità</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No depressione</td>
<td>15</td>
<td>1.0 Rif.</td>
<td>1.0</td>
<td>Rif.</td>
</tr>
<tr>
<td>Si depressione</td>
<td>54</td>
<td>1.98 1.07-3.68</td>
<td>1.87</td>
<td>1.01-3.52</td>
</tr>
</tbody>
</table>

Re-ospitalizzazione

<table>
<thead>
<tr>
<th>Eventi</th>
<th>RR</th>
<th>95% C.I.</th>
<th>RR</th>
<th>95% C.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No depressione</td>
<td>87</td>
<td>1.0 Rif.</td>
<td>1.0</td>
<td>Rif.</td>
</tr>
<tr>
<td>Si depressione</td>
<td>196</td>
<td>1.49 1.08-2.06</td>
<td>1.43</td>
<td>1.02-1.99</td>
</tr>
</tbody>
</table>

*Analisi di regressione di Cox aggiustata per età, sesso, vivere solo, comorbilità e disabilità*

Caratteristiche di pazienti ospedalizzati e livelli di colesterolemia suddivisi per diverso disturbo dell’umore

<table>
<thead>
<tr>
<th></th>
<th>Assenza di depressione N=241</th>
<th>Depressione reattiva N=540</th>
<th>Depressione Magg.&amp;distimia N=137</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Media±ds (%)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Età</td>
<td>76.9±7.7</td>
<td>79.7±7.2</td>
<td>76.6±6.9</td>
</tr>
<tr>
<td>Sesso femminile</td>
<td>(53)</td>
<td>(71)</td>
<td>(87)</td>
</tr>
<tr>
<td>Numero malattie</td>
<td>5.0±1.7</td>
<td>5.5±1.9</td>
<td>4.9±1.9</td>
</tr>
<tr>
<td>Charlson Index score</td>
<td>6.3±2.1</td>
<td>7.1±2.4</td>
<td>5.7±2.1</td>
</tr>
<tr>
<td>Barthel index (premorboso)</td>
<td>93.8±11.9</td>
<td>81.2±22.4</td>
<td>87.9±17.2</td>
</tr>
<tr>
<td>Decadimento cognitivo (MMSE)</td>
<td>26.3±3.8</td>
<td>24.3±4.1</td>
<td>25.6±3.3</td>
</tr>
<tr>
<td>Sintomi depressivi (GDS)</td>
<td>1.2±0.8</td>
<td>6.2±2.8</td>
<td>7.9±3.9</td>
</tr>
<tr>
<td>Colesterolemia (mg/dl)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;200 mg/dl</td>
<td>211±49.7</td>
<td>200±47.8</td>
<td>220±46.8</td>
</tr>
<tr>
<td>150-199 mg/dl</td>
<td>(56.0)</td>
<td>(53.5)</td>
<td>(70.8)</td>
</tr>
<tr>
<td>&lt;149 mg/dl</td>
<td>(29.5)</td>
<td>(29.3)</td>
<td>(20.4)</td>
</tr>
<tr>
<td>Albuminemia (g/dl)</td>
<td>4.2±0.5</td>
<td>4.0±0.6</td>
<td>4.1±0.7</td>
</tr>
</tbody>
</table>

Curve di mortalità in una popolazione di ultrasessantenni ricoverati in un’U.O. di Geriatria stratificata secondo le diagnosi di depressione.

Log rank, $P<0.001$

<table>
<thead>
<tr>
<th>Depr&amp;dist.</th>
<th>No depr.</th>
<th>Dist.Aggiust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soggetti (n)</td>
<td>174</td>
<td>476</td>
</tr>
<tr>
<td>Morti (n)</td>
<td>4</td>
<td>60</td>
</tr>
</tbody>
</table>
Crude and adjusted associations of diagnosis of depression with 6-month mortality in a hospitalized population aged 60 and over.

<table>
<thead>
<tr>
<th></th>
<th>n/deaths</th>
<th>( RR^a )</th>
<th>95% C.I.</th>
<th>( RR^b )</th>
<th>95% C.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression&amp;dystimia</td>
<td>174/4</td>
<td>1.0</td>
<td>1.0</td>
<td></td>
<td>1.0</td>
</tr>
<tr>
<td>No depression</td>
<td>476/60</td>
<td>4.3</td>
<td>1.3-14.1</td>
<td>2.7</td>
<td>0.9-9.0</td>
</tr>
<tr>
<td>Adj. Depressed mood</td>
<td>425/65</td>
<td>7.0</td>
<td>2.2-22.7</td>
<td>3.9</td>
<td>1.2-12.9</td>
</tr>
</tbody>
</table>

\( a \): crude analysis.

\( a \): adjusted for age, gender, cognitive status (MMSE), anemia, renal diseases, COPD, liver diseases, GE diseases, diabetes, stroke, serum albumin, disability (BADL), APACHE II, HF, cancer.
Chi soffre di più?

È indicato un trattamento farmacologico?
## Association of groups of risk (HF&depression) with 6-month mortality in hospitalized elderly patients

<table>
<thead>
<tr>
<th></th>
<th>N/events</th>
<th>A RR</th>
<th>95% C.I.</th>
<th>A</th>
<th>95% C.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No HF and no depression</td>
<td>353/14</td>
<td>1.0</td>
<td>Reference</td>
<td>1.0</td>
<td>Reference</td>
</tr>
<tr>
<td>No HF and yes depression</td>
<td>361/23</td>
<td>1.9</td>
<td>0.9-4.0</td>
<td>1.8</td>
<td>0.8-4.3</td>
</tr>
<tr>
<td>Yes HF and no depression</td>
<td>47/7</td>
<td>3.2</td>
<td>1.0-10.3</td>
<td>3.1</td>
<td>1.0-10.4</td>
</tr>
<tr>
<td>Yes HF and yes depression</td>
<td>39/8</td>
<td>6.9</td>
<td>2.6-18.3</td>
<td>5.8</td>
<td>2.1-16.6</td>
</tr>
<tr>
<td>Disability in BADL</td>
<td>143/22</td>
<td>2.8</td>
<td>1.6-4.9</td>
<td>2.2</td>
<td>1.1-4.6</td>
</tr>
<tr>
<td>Serum albumin (&lt;3.5 g/dl)</td>
<td>112/16</td>
<td>2.4</td>
<td>1.3-4.4</td>
<td>2.0</td>
<td>0.9-4.1</td>
</tr>
<tr>
<td>APACHE (APS score &gt;5)</td>
<td>76/14</td>
<td>3.3</td>
<td>1.7-6.2</td>
<td>2.3</td>
<td>1.1-5.0</td>
</tr>
</tbody>
</table>

A: crude analysis. B: adjusted for potential confounders (disability, serum albumin, and APACHE)

Variables failing to qualify for entering the multivariate regression model were: age, male gender, cognitive impairment, anemia (Hem<8g/dl), diabetes mellitus, COPD, and GI diseases.

Depression and Negative Outcomes in Patients With Heart Failure

The rate of rehospitalization in patients without HF and depression was 35%; in patients without HF and with depression was 38%; in patients with HF and without depression was 44%; and in those with HF and with depression was 67% ($\chi^2$ test: $p<0.01$).

The problem is to understand if depression is a *comorbidity*, the clinical relevance of which could be unmasked by the somatic event, or a psychic symptom *marker of frailty* revealing the lack of competence toward a distressful event. In the first case the treatment could be effective in reducing negative outcomes; in the second, useless or negative.

_Renzo Rozzini and Marco Trabucchi, Arch Int Med, 2003; 163:498-499_
Treating depression in later life

We need to implement the evidence that exists
Depression (ACOVE, Ann Int Med, 2005)

**IF** a vulnerable elder receives a diagnosis of depression, **THEN** antidepressant treatment, psychotherapy, or electroconvulsive therapy should be offered within 2 weeks after diagnosis unless there is documentation within that period that the patient has improved or unless the patient has substance abuse or dependence, in which case treatment may wait until 8 weeks after the patient is in a drug- or alcohol-free state.

**IF** a vulnerable elder is started on an antidepressant medication, **THEN** the following medications should not be used as first- or second-line therapy: tertiary amine tricyclics (amitriptyline, imipramine, doxepin, clomipramine, or trimipramine), monoamine oxidase inhibitors (unless atypical depression is present), benzodiazepines, or stimulants (except methylphenidate).
**IF** a vulnerable elder has no meaningful symptom response after 6 weeks of treatment, **THEN** 1 of the following treatment options should be initiated by the 8th week of treatment: Medication dose should be optimized or the patient should be referred to a psychiatrist (if initial treatment was medication) or medication should be initiated or referral to a psychiatrist should be offered (if initial treatment was psychotherapy alone).

**IF** a vulnerable elder responds only partially after 12 weeks of treatment, **THEN** 1 of the following treatment options should be instituted by the 16th week of treatment: Switch to a different medication class or add a second medication to the first (if initial treatment includes medication), add psychotherapy (if the initial treatment was medication), try medication (if initial treatment was psychotherapy without medication), consider electroconvulsive therapy, or refer to a psychiatrist.
IF a vulnerable elder with a history of cardiac disease is started on a tricyclic antidepressant, THEN baseline electrocardiography should be performed before initiation of or within 3 months before treatment.
Results: Patients with minor or subsyndromal depression had intermediate depressive and functional outcomes. Mean adjusted 1-year Hamilton depression score was 10.9 (95% CI, 9.6 to 12.2) for those with initial major depression, 7.0 (CI, 5.9 to 8.1) for those with minor or subsyndromal depression, and 2.9 (CI, 1.6 to 4.2) for those without depression ($P < 0.001$ for each paired comparison). Compared with patients who were not depressed, those who had minor or subsyndromal depression had a 5.5-fold risk (CI, 3.1-fold to 10.0-fold) for major depression at 1 year after controlling for demographic characteristics ($P < 0.001$). Cerebrovascular risk factors were not associated with a diagnosis of depression at 1 year after controlling for overall medical burden. Initial medical burden, self-rated health, and subjective social support were significant independent predictors of depression outcome.

Conclusions: The intermediate outcomes of minor and subsyndromal depression demonstrate the clinical significance of these conditions and suggest that they are part of a spectrum of depressive illness. Greater medical burden, poor subjective health status, and poorer subjective social support confer a higher risk for poor outcome.

Maintenance Treatment of Major Depression in Old Age

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Results
Major depression recurred within two years in 35 percent of the patients receiving paroxetine and psychotherapy, 37 percent of those receiving paroxetine and clinical management sessions, 68 percent of those receiving placebo and psychotherapy, and 58 percent of those receiving placebo and clinical-management sessions (P = 0.02). After adjustment for the effect of psychotherapy, the relative risk of recurrence among those receiving placebo was 2.4 times (95 percent confidence interval, 1.4 to 4.2) that among those receiving paroxetine. The number of patients needed to be treated with paroxetine to prevent one recurrence was 4 (95 percent confidence interval, 2.3 to 10.9). Patients with fewer and less severe coexisting medical conditions (such as hypertension or cardiac disease) received greater benefit from paroxetine (P = 0.03 for the interaction between treatment with paroxetine and baseline severity of medical illness).

Conclusions
Patients 70 years of age or older with major depression who had a response to initial treatment with paroxetine and psychotherapy were less likely to have recurrent depression if they received two years of maintenance therapy with paroxetine. Monthly maintenance psychotherapy did not prevent recurrent depression.
Figure 2. Time from Randomization to Recurrence.
The relative risk of recurrence among patients receiving placebo was 2.4 times that among patients receiving paroxetine (P = 0.02; chi-square statistic = 9.77 with 2 df). No effect of maintenance psychotherapy on recurrence was detected. Kaplan–Meier survival analysis with log-rank chi-square statistics was used to test for overall differences in recurrence rates among the groups. P values were based on the log-rank chi-square test.
Figure 3. Effect of the Number and Severity of Concomitant Medical Illnesses on the Efficacy of Maintenance Therapy with Paroxetine.

Patients with a greater number of and more severe concomitant medical illnesses, as indicated by scores of 10 or more on the Cumulative Illness Rating Scale for Geriatrics (CIRS-G), had higher rates of recurrent depression and did not fare as well during treatment with paroxetine as those with fewer and less severe concomitant medical illnesses. Although both paroxetine use and the score on the CIRS-G affected risk (main or direct effect, P=0.004), paroxetine was more effective in preventing recurrence in patients with fewer and less severe concomitant medical illnesses (interaction effect, P=0.03). Kaplan–Meier survival analysis with log-rank chi-square statistics was used to test for overall differences in recurrence rates among the groups. P values were based on the log-rank chi-square test.