DOWNLOAD PDF INTERFACE BETWEEN DEMENTIA AND DEPRESSION

Chapter 1 : The Difference between Dementia & Depression

Given that between one third and one half of older people with depression also have dementia, this is a defining discussion for our field. Further, it is well established that over the course of dementia as many as two thirds of patients develop depression ii.

Mental disorders Summary Depression in people with dementia is a common presentation in primary care, but it is often missed or mismanaged. This problem has substantial public health implications and adversely affects the quality of life and physical health of patients and carers. Many aspects of diagnosis and management remain controversial. A high degree of suspicion and repeated assessment is essential for diagnosis. Medication use should be considered. Psychological and social strategies should be incorporated into most management plans. This is a republished version of an article previously published in MJA Open D epression and dementia are common syndromes in older people and are usually managed by general practitioners. Comorbidity compounds the impact on patients, carers and health services. Thus, identification and effective management of depression in people with dementia remains a challenging task in clinical practice. This article provides a clinically oriented selective review of current knowledge about depression in dementia, specifically aimed at primary care practitioners. Practice pearls are provided Box 1. Although the literature overwhelmingly focuses on Alzheimer disease, here we also discuss mild cognitive impairment and other types of dementia. Mild cognitive impairment refers to a clinical status where a patient performs below norms on cognitive tests but does not have dementia. Either the patient or someone who knows him or her well should have noticed a change from premorbid cognitive function. Statistically, people with mild cognitive impairment are at increased risk of developing dementia over time, although the individual risk can vary significantly. There is now reasonable evidence that a history of depression is a risk factor for developing dementia, particularly when the depression occurs early in life or is severe. It is likely that a complex intertwining of multiple factors is variably involved in different individuals. Assessment Depression in people with dementia remains underdiagnosed, particularly in residential care settings. Depression may present differently in people with comorbid dementia, particularly when the dementia is advanced. Although typical major depressive disorder MDD is seen, the clinical picture often lacks prominent sadness, hopelessness and guilt and is, overall, less severe. These symptoms can also be part of the dementia itself or suggest delirium. When obtaining a patient history, patients may underreport, and their carers overreport, symptoms of depression. The use of standardised questionnaires is helpful only if they are validated in this population, which is not the case for many of the common depression rating scales. However, due to limited time and staff in such facilities, attention to completing the CSDD is often cursory, and the results rarely alter management for individual residents. Moreover, serial evaluations are uncommon. Obtaining as much history as possible regarding mood and behavioural symptoms from the patient and carers, such as family or residential care staff, is essential, particularly when communication difficulties are evident. This should be repeated at regular intervals eg, 6-monthly or if there is any evidence of a significant change in behaviour. Physical illnesses, prescription medications, functional disability, social isolation, life stressors, bereavement and other losses are also important, as they may increase vulnerability to depression. Management Management of a patient with depression and dementia should encompass biological, psychological, social, cultural and spiritual factors, particularly those that may have precipitated or may be perpetuating the depression. A focused physical examination and investigations are essential to exclude any treatable medical cause for low mood. Such causes are more likely to be present in older people and may include physical illness and prescription medications. Common medical causes of depressed mood are listed in Box 3 , and important screening investigations for an organic cause are listed in Box 4. Patients also frequently present with physical illness and depressed mood where there is a known association, but it is neither causal nor reversible eg, depression and ischaemic heart disease. Overall physical health should be reviewed and optimised, and the depression should be specifically treated. Addressing vascular risk factors is particularly important. Risks associated with depression in people with dementia must be considered throughout, as they may determine the type, location and urgency of

treatment. Every patient with depression should be asked directly but sensitively about suicidal thoughts, plans and intent Box 5. Other risks include harm to others or to relationships due to agitation, aggression or irritability; loss of accommodation or a move to institutional care; and medical compromise. Generally, most depression in people with dementia can be managed in the community. Pharmacotherapy Recent studies, including a large, double-blind, randomised, placebo-controlled trial of the selective serotonin reuptake inhibitor SSRI sertraline and the noradrenalineâ€"serotonin specific antidepressant NaSSA mirtazapine in people with Alzheimer disease, 16 and a meta-analysis of seven placebo-controlled trials of antidepressants, 17 have failed to demonstrate effectiveness of antidepressant medication for depression in the context of dementia. However, these studies may have had significant limitations, including significant heterogeneity between studies in the meta-analysis, that affected their conclusions. Thus, the effectiveness of antidepressant medications in this population is currently in question. Studies that included patients with mild depressive symptoms, 16 , 40 thought to respond poorly to medication, may have diluted any response seen in those with more severe illness. One study group considered possible indicators for early antidepressant treatment, such as past history of antidepressant response, present or past suicide risk, and high distress levels. A riskâ€"benefit approach, tailored to the individual patient, should be employed. Antidepressant medication may also be considered in patients taking cholinesterase inhibitors for cognitive enhancement, 38 or where depression is associated with a deterioration in cognition or development of behavioural and psychological symptoms of dementia. In patients with mild depression, non-pharmacological strategies should be attempted first. Cautious prescribing is paramount in older people, as they are more susceptible to medication side effects, often have multiple comorbid physical illnesses, and may be taking medications that can interact with anti-depressants. There must be a clear plan to monitor efficacy and adverse effects. Data regarding the rate of adverse events are conflicting, but such events may be significantly increased. However, many older patients may still require similar doses of antidepressants to younger adults. There is little evidence that any class of antidepressants is superior. There is no research regarding management of difficult-to-treat depression in dementia. A systematic review of difficult-to-treat depression in older people including studies that did not exclude people with cognitive impairment identified only three randomised drug trials, including one placebo-controlled trial. Failure to respond to antidepressant medication should prompt review of the diagnosis, patient adherence to medication, and the dose and duration of treatment. Following this, difficult-to-treat depression in people with dementia is an indication for referral to specialist services. Non-pharmacological management Patients with cognitive impairment may benefit from many types of psychotherapy. Any specific causes of psychological distress should be addressed. In older patients with dementia, these are often manifold and may include boredom, loneliness, restricted access to meaningful activities, and overstimulation. Music and recreation therapy have demonstrated moderate effect sizes for depression in dementia, including in severe dementia. Regular physical activity has been shown to improve mood, including in people with dementia. Formal, structured therapies, including cognitive and interpersonal therapies, may also have some role. However, a recent review of ECT in people with depression and dementia suggested that it can be effective and that cognitive side effects are not universal. Familial or institutional carers should be involved throughout the process of assessment and management. They are often best placed to notice a change in behaviour that may indicate depression and can be enlisted to provide some of the non-pharmacological treatment approaches. They also face a significant burden in caring for a person with dementia and depression. Due consideration should be given to this burden and the impact on the mental health and quality of life of the carers themselves. Conclusions Depression is common in people with dementia, and the relationship between mood and cognitive symptoms is complex. The nature of this relationship, disease stage, and environmental and clinician factors all contribute to underdiagnosis and undertreatment. Although evidence regarding antidepressant treatment is limited and equivocal, there is no cause for therapeutic nihilism. Organic causes of depressed mood should be excluded, physical health optimised, and medications, where possible, rationalised. Regular review and effective engagement of carers are both essential and may have significant positive impacts for patients and carers. Difficult-to-treat or complex depression is an indication for specialist referral.

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Chapter 2 : Warning â€“ Depression Masking as Dementia | Alliance Home Health Care

More recently, a retrospective cohort study found a significant association between dementia and a history of depression symptoms that first reported within one year or more than 25 years before the onset of dementia (Green et al.,).

Chapter 3 : The interface between dementia and depression (Book,) [blog.quintoapp.com]

*Interface Between Dementia and Depression: pocketbook [D P Devanand, Steven Roose] on blog.quintoapp.com *FREE* shipping on qualifying offers. This study looks at various aspects of dementia and depression in older people, such as neuroimaging and neurobiology.*

Chapter 4 : The clinical interface of depression and dementia.

The interface between dementia and mental health An evidence review POLICY PAPER ii This paper was prepared by: Dementia and depression 9.

Chapter 5 : Depression as a Risk Factor for Dementia | Everyday Health

The nature of the link between depression and dementia is still unclear. Given the projected growth of the older segment of the population, a better understanding of the link between them is important, especially for possible treatment and prevention.

Chapter 6 : Seniors and Depression: The difference between depression and dementia

Depression develops faster than dementia (dementia takes weeks or months to develop). Despite memory lapses, those with depression will be able to remember something when asked. Impaired judgment in those with depression is usually caused by the lack of concentration.

Chapter 7 : Depression and dementia | The Medical Journal of Australia

Objectives To review the complex relationship between late life depression and dementia, to discuss the underlying mechanisms and implications for the diagnosis and treatment of both conditions.

Chapter 8 : The interface between dementia and mental health | Mental Health Foundation

Depression is a risk factor for dementia, researchers report, and people with more symptoms of depression tend to suffer a more rapid decline in thinking and memory skills. While the study found.

Chapter 9 : Alzheimer's or depression: Could it be both? - Mayo Clinic

The clinical interface of depression and dementia. Raskind MA(1). Author information: (1)Veterans Affairs Puget Sound Health Care System, Mental Health Service, and the Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle , USA.