Late Life Depression in the midst of Covid-19 Pandemic, a Preliminary Report - Rossano Bangasan, MD, DFAPA

What is depression and why is it important to know what it is? A lot of my patients would come to my office and start their story during the interview as feeling sad or lonely, or sometimes, from the very start, they may interchangeably use feeling down or depressed on their mood, and not sure if this is the real deal. To begin with, I would tell them, feeling sad or lonely is a natural emotion, it's normal, depending on the situation like you didn't good in the exam, you lost your favorite bag, and things like that. On the other hand, depression is not a normal feeling, it's an illness that can potentially kill a person. It could be feeling sad, lonely, or down on your mood, but it's incorporated with several other symptoms, and that these constellations of symptoms should at least be 2 weeks or more.

Remember the Sig: e caps (prescribe energy caps) - our acronym for Major Depressive Disorder (or MDD) During medical school, we simply taught that if a person is depressed, he should have at least 5 out of these 9 criteria in a period of 2 weeks, and he satisfies the requirement to be labelled as experiencing a major depressive episode at that time. Sig e caps stands for Sleep, Interest, Guilt, Energy Concentration, Appetite, Psychomotor, Suicidality.

Compare this with the DSM-5 TR criteria for MDD Criteria A – Depressed mood and/or Anhedonia PLUS Sig E Caps Criteria B – symptoms bring about significant impairment in social, occupational or other areas of functioning Criteria C - the symptoms are not direct physiological effect of a substance of a GMC Criteria D - not better accounted for by other dx like schizoaffective disorder, schizophrenia Criteria E – no manic or hypomanic episode

Why is it important to know MDD per se? It is very disabling, based on WHO classification, MDD is the 2nd cause of disability and because of that, it increases health care costs by as much as 50-100%, it is very common in the sense that as much as 10-15% of patients seen in primary care settings suffer from MDD, and it is deadly, as severe MDD accounts for over 35,000 suicides per year. All of these got worst, when we were hit by Covid-19 pandemic.

Who are considered older adult, senior citizen or elderly? Older individuals could be between the ages of 55 and 70 where changes in their functionality are starting to be noticeable. Among different counties here in California, elderly are individuals who are 60 years old and above, whereas in the Penal Code, they still are the 65-year-old and above individuals.

Is there any difference between early onset and Late life depression (LLD)? Basically, the presentation of early and late life depression is almost the same except that patients with LLD has less frequent family history of mood disorders, has higher prevalence of dementing disorders, presents to be more impaired during neuropsychological testing have higher rate of dementia development on follow up and has more neurosensory hearing impairment.

How come PCPs were not able to screen those presenting with LLD? Failure to discuss a highly stigmatized mental illness, believing that depression is common and normal in occurrence among elderly individuals, missing the diagnosis because of medical comorbidity, unfamiliarity in prescribing antidepressants, time constraints involved.

What happens to those elderly patients who were presumed to be suffering from MDD by their PCPs? It was said that only 50% or half of those patients presumed to suffer from MDD goes to see a psychiatrist, even if their PCPs encourage them to do so, for variety of reasons, and more likely one of them is the associated stigma that goes with any of the mental illness. They prefer to stay and be treated by their PCPs. Unfortunately, when that happens, it was said that only 1 out of 5 or 20% improve on their symptoms, not even a resolution of their depression. Often the presence of multiple chronic medical illnesses complicates the diagnosis and treatment, making it harder for the PCP to assess for either improvement or worsening of the MDD symptoms. Also, because of physician's concern about side effects patients tend to receive subtherapeutic antidepressant dosages.

What is done to assess Geriatric Depression? Do psychiatric evaluation of the patient and preferably, interview also a family member who is familiar with the patient as a source of collateral information, perform physical as well as neurological examination, do blood work and drug testing using blood or urine, order for some neuroimaging, do clinical rating scales like PHQ-9, HAM-D and the like, plus patient may be subjected to some neuropsychological testing.

Let's say an elderly patient was legitimately diagnosed to have LLD, what is a PCP to do? Before prescribing any medication, look for a medical or other cause for patient's presenting symptoms, psychosocial intervention or talking to the patient (psychotherapy) should be tried first before prescribing medications, clearly identify the target symptoms (insomnia, irritability, etc.) to be treated and monitored, evaluate the patient's capability to take the medication prescribed and start with a low initial dose if ever one has decided to medicate the patient.

Why start with a low initial dose of any medication in an elderly patient? Employing the pharmacokinetic principles that affects absorption, distribution, metabolism and excretion that governs prescribing medications to any patient, especially on the elderly, the ultimate outcome is that the medications gets slowly absorbed, stays more on the body because of their increased half-lives, with associated slower metabolism and reduced excretion of the medication. Hence, the conundrum, start low and go slow when initiating and subsequently increasing the dose of prescribed medication to elderly. Any governing principle/s that one can utilize when choosing an antidepressant for a patient? One should consider the following in making a selection as to what antidepressant to make: prior treatment history of patient, that is, if patient has taken any antidepressant before that has proven to be effective f or him or her, patient's preferences, expertise of prescribing provider, the side effect profile (whether sedating or activating), safety in overdose, availability and costs, as well as drug-drug interactions, especially among elderly individuals who are known to take numerous maintenance medications (polypharmacy).

Are there any medical illnesses among elderly that predisposes them to developing depression later? Yes, the following are the chronic elderly medical conditions and their respective probability of having depression later: stroke (30-60%), coronary artery disease (44%), cancer (1-40%), Parkinson's disease (40%), as well as Alzheimer's dementia (20-50%).

What if patient's depression doesn't improve, what to do next? Minus the possibility that patient is not responsive to the prescribed antidepressant, if patient is not improving on his depressive symptoms you need to ask yourself the following: Is the diagnosis correct, is this a case of psychotic depression where patient needs an antipsychotic to pair with his antidepressant, is patient adhering to taking his

medication and is the dose enough, or are there any other conditions, life stressors, medical conditions that continue to fuel patient's ongoing depression?

What will be our Plan B if the answers to all the above questions were negative? If still after being on antidepressant for a considerable amount of time, and there's no response yet, one may switch to antidepressant from a different class (SSRI, SNRI, TCA, MAOIs) If there's some partial response, one may augment with other antidepressants or may use an FDA-approved antipsychotics for such purpose, or may add lithium, thyroid preparation or stimulants like Ritalin.

What is WHO's stand on mental health disorder like MDD before and after inception of Covid-19 pandemic? WHO said that even before Covid-19, there's almost a billion people living with mental health disorder and that recently (June, 2022) they issued a statement calling all nations to invest more in mental health, saying "the suffering is enormous and has been made worse by the Covid19 pandemic."

Why is it said that the arrival of Covid-19 pandemic, alongside Late Life Depression was termed as a 'perfect storm?' It was said to be a perfect storm because of the many inequities in the so called Social Determinants of Health (or SDOH) that placed racial and ethnic minority groups at increased risk of getting sick and dying from Covid-19, coupled with the medical comorbidities seen in mostly elderly women, Covid-19 risk factors, most notably among which are mental illness such as depression, schizophrenia and other psychotic disorders, and substance use disorder among elderly.

Can you name those inequities in SDOH that placed marginalized groups especially the elderly individuals at increased risk of dying from Covid-19? Yes. They are the lack of safe housing, racism, discrimination, lack of quality education, absence of job opportunities or good income generating jobs, poor access to nutritious foods and opportunities for physical activity, to name a few.

What exactly do you mean by Covid-19 pandemic disproportionately affected marginalized communities (racial minority group)? It is exemplified by the fact that Covid-19 data showed Blacks, Latinos, American Indians and Alaskan natives had an increased ratio of Covid19 related hospitalization and death vs. non-white population. In early 2020, Covid-19 hotspots in predominantly Black counties in the US experienced mortality risk that was 6-fold higher than is predominantly white counties. This just goes to show that race and ethnicity are risk factors for worst outcomes if infected with Covid-19.

You mentioned medical comorbidities that goes with aging, that increases their susceptibility to getting this Covid-19, what are they? Well, to name a few, they are hypertension, high cholesterol, arthritis, diabetes, heart disease, kidney disease, heart failure, COPD, Major Depression as well as Alzheimer's dementia.

In line with the 'Perfect Storm' scenario, you said there are also Covid-19 risk factors that predisposes these elderly folks to far worst outcome, what are they? They are the following: obesity, smoking, alcohol abuse, physical inactivity, pollution, being diabetic, presence of cardiovascular and respiratory illness, having mental illness and of course, having cancer.

Can you elaborate more on mental illness like LLD being a risk factor for Covid-19? Large analysis of US adults found that having a recent diagnosis of mental illness especially late life depression (LLD), schizophrenia or other psychotic disorders, substance abuse, etc., increases the risk of Covid-19 infection in the early pandemic period with the effects being strongest for depression with adjusted odd

ratio of 7.6 and for schizophrenia 7.3. Chances of these group of people being hospitalized is 27% compared to those without diagnosed mental illness only 19%. Also, individuals especially elderly newly diagnosed with substance abuse disorder, more likely to contract Covid-19.

So far, what are the mental health impact of Covid-19? There are direct and indirect effects of Covid - 19 on an individual's brain. Some of the direct effects of Covid-19 are brain stroke, neuroinflammation, cognitive impairment, loss of sense of smell and taste. Whereas the indirect sequelae are the following: depression/headache, anxiety and confusion, loss of memory and focus, sleep deprivation, loneliness and suicidality. There is also the complicated grievance, higher cognitive impairment among those who survived, especially those with severe cases.

Among the mental health impact of Covid-19 that you mentioned earlier is that the younger age group who got Covid-19 are more susceptible to anxiety and depression compared to the elderly people who also had them, why is it like that? It was hypothesized that the reason behind this is that older people are better in managing their emotions, achieving greater day to day emotional stability and has enhanced emotional preparedness better than the younger individuals.

Though this is the case, what can you say in terms of incidence, hospitalization and death rate, comparing younger individuals to older folks? In terms of incidence of cases, hospitalization and death rate, as one gets older, 8 out of 10 Covid deaths reported in the UDS have been on adults 65 years old and older, primarily because of the earlier mentioned presence of chronic medical conditions, various risk factors, and the inequities in social determinants of health.

What are the various coping strategies that were to the elderly individuals who were totally isolated from their love ones during the time of Covid-19 related lockdown? This includes giving them reading and writing materials, instilling hope in them, setting new goals, assisting them to call love ones, creative activities, yoga and exercise. One may also introduce to them apps in phones images/pictures to be colored, puzzles, word search sudoku, games in the telephone are some of the ways to help patients to cope up with the situation.

What were some of the findings that revealed the efficacy of virtual visits (or telepsychiatry) in older adults? They found out that telepsychiatry is feasible, increases access to care, enables specialty consultation yields positive outcomes, allows reliable evaluation, has few negative aspects in terms of communication, generally satisfies patients and providers, facilitates education and empowers parties using it. Likewise, many older patients demonstrated flexibility and interest in the novel use of technology.

On the part of the Providers, what are the benefits of Telehealth? Mental health clinicians has learned to appreciate the benefits of telehealth as they use them, for such expands one's patient base, increases patient flexibility, increase collaboration opportunities between medical disciplines, increases patient adherences, allows f or easy patient follow up, improved patient outcomes and physicians and care teams benefit regarding their mental and physical health.

Stay tuned for more updates re: MH and Covid-19 for solely on these two topics, as of February 2022, there are about 15,000 publications already.

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