

Prevalence of Depressive Symptoms in Physically-Ill Elderly Inpatients

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Abstract

Depression is a common disorder in the elderly. It frequently had poor prognosis, and constitute a major health problem that can be life threatening if not recognized and treated. Also, depressive symptoms frequently overlap with those of physical illnesses, that are usually present in old age. We therefore set out to determine the rate of depressive symptoms in a sample of 546 inpatient physically-ill elderly Egyptian patients. We used the Geriatric Depression Scale to detect depressive symptoms and SCID I interview based on DSM III-R to diagnose depressive disorders. We also used the Short Portable Mental State Questionnaire to test the orientation, recent and remote memory, as well as the Activities of Daily Living Scale to measure the functional status of the patients. We found that 79.2% of our patients had depressive symptoms, in contrast to only 43% mounting to depressive disorder. The rate of depressive disorder was the highest at the age of 60-65, as it reached upto 22%. It was also found that depression was significantly related to heart failure, renal failure, liver failure, cerebrovascular stroke and cancer. However, it was highly significantly related to hypertension. On the other hand, an insignificant statistical relation was found between depression and Parkinsonism, diabetes mellitus, peptic ulcer, chest disease, visual and hearing handicap, and memory impairment or early dementia, as well as with degree of disability. We conclude that we are in need for orientation of general practitioners as well as our colleagues in the different specialties dealing with geriatric patients to be able to detect depression in this particular group of patients, as it is often treatable and potentially reversible.

Introduction

A generation ago, geriatric depression was regarded as either a natural reaction to the privation and multiple losses that accompany old age, or an irreversible consequence of cerebral degeneration heralding a dementia. Even if physicians overcome their expectation of the inevitability of depression in old age, an unhealthy nihilism concerning the effects of antidepressant treatment in this group held away (Ford and Sbordone, 1980).

Depression is common in the elderly, has a poor prognosis, and constitutes a major health problem that can be life threatening if not recognized and treated. The difficulties in the diagnosis of depression in the elderly stem from the fact that depressive symptoms may be viewed by the older person, the family and the physician

as a normal consequence of the process of aging; and that depressive symptoms frequently overlapped with those of physical illness that are usually present in old age (Gomez and Gomez, 1993).

In Egypt, a diagnosis of depression was made in **40%** of cases of elderly people attending the geriatric outpatient clinic, in Zagazig University, (Fawzy et al., 1982), while Ashour et al. (1993) reported a 65% prevalence rate of depressive symptomatology in a similar study in Ain Shams University.

Physical illness has long been identified as a major factor in late-life depression (Murphy, 1982). The most common among those are fever, dehydration, decreased cardiac output, electrolyte disturbance and hypoxia. Hyponatremia and

hypercalcemia (associated especially with malignancy) may also cause an elderly patient to appear depressed (Kane et al., 1994). Stroke (Dam et al., 1989), especially where the cerebral lesion is in the anterior left hemisphere (Robinson et al., 1984), malignant disease (Evans et al., 1991), occult carcinoma (Whitlock and Siskind, 1979), myocardial infarction (Murphy and Macdonald, 1992), and chronic obstructive airway disease (Borson and McDonald, 1989) seem to be especially associated with depression.

Usually the depression is an adjustment disorder or a major depressive illness precipitated by the stress of physical illness, but occasionally it is intrinsic to the physical disorder e.g. endocrine disease such as Cushing's syndrome (Haskett, 1985), hypothyroidism (Tappy et al., 1987) and hyperthyroidism (McAllion and Pater-son, 1989).

Thus, physical illness and infirmity are potent precipitants of late-onset depressive illness. Reaching a diagnosis of depression in a physically ill old person is not always easy and how to treat it is far from always clear (Pitt, 1995). Diurnal variation in mood, late insomnia and suicidal ideas may all suggest depressive illness but are also explicable by physical diseases. Many symptoms will wake the patient early; arthritis and Parkinson's disease make it difficult to start moving in the morning. Severe pain or dyspnea may well make the patient long for death, as even opponents of euthanasia would concede. (Pitt, 1995)

Not only are depressive symptoms under-diagnosed but they also tend to be under-rated by older patients in questionnaires (Lyness et al., 1995). Thus, the interaction between depression and medical illness is complex, especially in the elderly patients, and particularly in the hospital setting. Differential diagnosis in this population is quite broad, encompassing both psychiatric and medical etiologies. With

appropriate diagnosis, treatment of depression can both improve quality of life and decrease health resource utilization (Stewart, 1991).

Thus, this group of patients is particularly important to study.

The objective would be:

1. To identify physical disorders which put the elderly patients at an increased risk for depression.
2. To identify the effect of these physical illnesses on the severity of depressive disorder and the cognitive impairment accompanying either physical disorder alone or with depressive disorder.
3. To study the presentation, as well as the quality of life in this group of patients in our Egyptian community.

Subjects and Method:

This study was conducted in the general medical inpatients departments, Ain Shams University Hospitals, Cairo, Egypt. These departments constitute of 260 beds.

Subjects

Inclusion criteria:

Patient age: above 60 years.

Exclusion criteria:

Patients with severe memory impairment, or in severe medical complications so that proper psychological and psychiatric evaluation would be impossible as those in coma, or system failure encephalopathy.

Patients with previous history of bipolar disorders or depressive disorders.

Method:

All patients admitted to the general medical department were examined by the medical resident to receive a provisional diagnosis. This was followed by further medical consultation by senior staff to reach a final diagnosis. The sample was

then classified according to their final diagnosis written in their files (e.g. cardiovascular, endocrinal groups, etc.).

All patients admitted to the medical departments were subjected to the Geriatric Depression Scale (15 items) and Short Portable Mental Status Questionnaire. This was done by two clinical psychologists. Patients who appeared to be depressed by the GDS, were then reassessed by a psychiatrist, using the SCID-I interview based on DSM-III-R classification.

1. Geriatric Depression Scale.

It is formed of 15 items : It has been devised by Sheikh and Yesavage (1986). Taking only 5-7 minutes to administer, it consisted of the items from the original scale (30 items) and showed highest correlation with the depressive symptoms. Correlation with the parent scale was significant ($r=0.66$). Validity and reliability of the Arabic version has been tested.

2. Short Portable Mental Status Questionnaire (SPMSQ)

It is composed of 10 questions. It has the ability to test the orientation, recent and

remote memory. The validity and reliability of the Arabic version has been tested.

3. Activities of Daily Living Scale:

It is a commonly used measure of functional status. It has been developed by Katz et al., (1963). It provides a simple means of summarizing a person's ability to carry out basic tasks needed for self-care. Experience with it suggests that these functional abilities tend to be lost in a generally constant order from bathing to feeding. The ADL score provides an easy means of monitoring change in the basic functioning of an elderly patient and correlating the effects of intervention with that change.

Statistical analysis was done using IBM Microstat Package.

Results:

A total of 546 patients were evaluated, 338 males and 208 females, The mean age ($\pm$ SD) was 63 $\pm$ 3 years.

The relation between the degree of disability as assessed by ADL and rates of depressive symptoms was found to be statistically insignificant ($p > 0.05$) among inpatient physically ill elderly patients.

Table (1)

Rates of depressive symptoms and syndromes among inpatient physically ill elderly.

Variable	Percentage
- Depressive symptoms	79.2%
- Depressive disorders	43%
- Adjustment disorders	12%
- Depressive episode	23%
- Mild	4%
- Moderate	9%
- Severe	10%
- Dysthymic disorder	8%

Table (2)
Relation between rates of depressive syndromes and age of the patients.

Age of the patients	Rates of Depression
- 60-65	22%
- 65-70	14%
- > 70	7%
Sex of the patient	
- Male	25%
- Female	18%

Table (3)
Relation between depression and various physical disorders.

Variables	chi-square	P-Value
- Hypertension	70.379	<0.0001**
- Heart failure	4.754	< 0.05*
- Parkinsonism	0.002	> 0.05
- Renal failure	2.808	<0.05*
- Liver failure	3.171	<0.05*
- Cerebrovascular stroke	4.037	<0.05*
- Diabetes Mellitus	0.560	> 0.05
- Peptic ulcer	0.12	> 0.05
- Chest disease	0.170	> 0.05
- Cancer	5.020	< 0.05*
- Visual and hearing handicap	0.370	> 0.05
- Memory impairment-early dementia.	1.674	> 0.05

Discussion

It might be expected that the prevalence of depression in general hospital wards would be a good deal higher than in the community but not all surveys agree that this is markedly so (Pitt, 1993).

In our study, it was found that 79.2% of our elderly patients in general hospital suffer from mild to severe depressive symptoms, but the rate of depressive disorders was 43% according to SCID-I, (major affective disorder, depressive episode 23%, dysthymic disorder 8%, and adjustment disorders 12%). However, the rates in other studies were markedly different in range. So, Bergmann and Eastham (1974) using clinical assessment found it to be 5% in Newcastle. On the contrary Magni et al. (1985) in Padua using Zung found it to be 42%; Cooper (1987) in Mannheim reported a rate of 21%. Later, Kafonek et al. (1989) studying long-stay patients in Baltimore using DSM-III found a rate of 21% of all depressive syndromes. Finally, Pitt (1991) in East London tried to discriminate between rate of major depression and other depressive syndromes using Brief Assessment Scale (BAS), so they found it to be 6.5% and 5.5% respectively.

This variation may be due to the use of different instruments in the assessment of depression, different cut-off points on the same instrument or different diagnostic criteria, according to which cognitively impaired patients were excluded. Furthermore the nature of the area served by the hospital and its alternative resources, the nature of the hospital, (acute or long stay unit) and the demographic profile of the patients could have an impact on the population under investigation and the consequent results.

In our study it was found that depressive syndromes occur in 7% of the patients above 70 years. Similarly, Feldman et

al. (1987) in Oxford using Present State Examination (PSE) reported a rate of 5% in those aged 70 or more compared to 12.5% in those aged 55-69, and 18% in those aged 17-54.

In our study it was found that depressive syndromes were 25% in males and 18% in females, while previously Kay et al. (1987) tried to discriminate between the rate of depression in males and females in the nursing homes and long-stay patients in Hobart using Geriatric Mental Status Schedule (GMS) and ICD-9, and found it to be 25% and 30% respectively.

Searching for a relation between depression and different types of physical disorders, some controversy was found between our results and others. In our study, we found an insignificant correlation between chest diseases and depression. In contrast to the results of Isoaho et al. (1995).

Our rate of depression among patients with cardiovascular disease showed a high statistically significant relation to hypertension and a significant statistical relation to heart failure. It is worth mentioning that this group of patients is particularly important, as it was found that cardiovascular disease is the principal cause of death noted in mortality studies of depression (Murphy et al., 1988). In pre-ECT era, Maltzberg (1937) found that the rates of death from heart disease in a large hospital sample of patients with "involutional melancholia" was eight times the expected rate in the age-matched general population. A more recent study by Rabins et al. (1985) has confirmed this observation. In some cases, a severe, stressful event may induce both the depression and the heart disease, this was observed in the study by Parkes et al. (1969).

As regards cerebrovascular disorders, it was found that the rate of depression among these patients is significantly relat-

ed to stroke ($p < 0.05$), while it was insignificantly related to cerebral hemorrhage ($p > 0.05$). Our results showed that 65.5% of patients with stroke had depressive symptoms, while 19.5% had severe depression. However, House (1987) found that major depression has been reported immediately after a stroke for 23% of stroke patients and 6 months later for 34% of them, with at least another 20% having minor depression. Starkstein and Robinson (1989) made a similar estimate of its prevalence as between 30% and 50%. Wade et al. (1987), in a community study of 976 patients, found that 25-30% of them were depressed on at least one of three occasions in the year following a stroke. In contrast to this, House et al. (1991) found only 12% of 128 patients identified in the community and seen one month after their stroke to be according to the Present State Examination (PSE) cases of depression.

Depression associated with stroke is often chronic. Wade et al. (1987) found that 50% of their depressed patients remained so for over a year. A similar rate of chronicity was identified by Eastwood et al. (1989) at four months.

The problem of detecting depression may be particularly severe in stroke patients. This is most evident in the context of aphasia (Koenig and Studenski, 1988) or acute concurrent medical illness (Eastwood et al., 1989). The difficulty involved in using rating scales to detect depression in stroke patients was one of the major problems, which also faced us in our study. It is also worth mentioning that this group of patients is important as it is at a high risk for complications from the combination of both disorders. These complications may play a role in the poor prognosis and high mortality of patients.

In contrast to what was reported by Mayeux (1990), Mayeux et al. (1981) and Dooneief et al (1992), who con-

firmed the high prevalence of depression in Parkinson Disease, we did not find a significant relation between Parkinsonism and depression. This may be due to the small number of parkinsonian patients in our study (11 patients) who may not be a real representative sample of parkinsonian patients.

Similar to the results of Massie and Holland (1990) we found a statistically significant relation between depression and the diagnosis of cancer in our inpatient sample. It is worth mentioning that there is a well-documented relationship between depressive illness and certain types of cancer, like cerebral tumors especially temporal or mid-line ones particularly meningiomas and pituitary tumors Whitlock (1978). Depression is also a recognized prodroma of certain types of carcinoma elsewhere in the body, such as stomach, lung, and pancreas, and it may precede the physical manifestations of cancer by some time (Fras et al., 1968).

Depression in cancer patients may also be an adjustment disorder, or may be due to associated hypercalcemia or chemotherapy treatment. Finally, the recent finding that depression is specifically associated with impaired T-lymphocyte function (Bartrop et al., 1977; Schliefer et al., 1985) suggests that in some cases it may be the depression that is causative, increasing vulnerability to those disease (both neoplastic and infectious) that are related to compromised immune surveillance.

We also found a significant correlation between liver failure and renal failure and the occurrence of depression. Insignificant correlation was found between peptic ulcer, diabetes mellitus and depression.

The risk for clinically significant depression is said to be greater among disabled than among nondisabled people (Gurland et al., 1988). Unfortunately, no measure

of level of disability resulting from the health event or severity of the health event is available (Ensel, 1991). So, in our study we used a measure of Daily Living instead, to find the relationship between the ability to perform the daily activity and the severity of depression. However, we failed to find a statistically significant relation between the degree of impairment of the patient's role on Daily Living and the occurrence depression. Also, we failed to find a statistically significant relation between a specific types of handicap that are visual, hearing handicap, urinary incontinence, rheumatoid arthritis as well as paraplegia or quadriplegia and the occurrence of depression. This contrasts with the findings of Valvanne et al. (1996) who reported a close connection between major depression and objective health and functional capacity. Both our findings as well as Valvanne's and others suggest the important role of physical illnesses and disability in the etiopathogenesis of major depression. (Goldberg et al., 1979; Berkman et al., 1986; Griffiths et al., 1987; Kennedy et al., 1989).

It is worth mentioning that this difference between our patients and other patients can be explained by the cultural difference between our society and other societies abroad. Our society is still largely formed of extended families where the elderly handicapped is properly taken care of and his/her needs are met by all the other family members. This significantly contrasts with the American as well as the European families which are largely formed of nuclear families where every person has to take care of himself/herself and this increases the suffering of the handicapped who become markedly helpless.

Estimates of the prevalence of depression in the community also vary (Pitt, 1993). Another difficulty clinicians face in the recognition of depression in the medically ill elderly is that it may present covertly,

in particular with psychosomatic symptoms or with hypochondriasis, which may lead to confusion with the coexisting physical illness. Cavanaugh et al. (1983) suggested that the diagnosis should be borne in mind particularly when there is dysphoria or anhedonia, which does not respond to treatment of the underlying medical condition.

It is also worth mentioning that there is cultural difference in the prevalence of depressive disorder among the physically ill patients, which may be due to the difference in the perception of physical illness, the difference in family role as well as in the social support system of patients in the different cultures.

In our study, an insignificant relation was found between either memory impairment or early dementia and depression. This contrasts with what was found in previous studies, (Parmelee et al., 1991) who suggested that depression is a risk factor for subsequent cognitive impairment, at least among some elderly institution residents. Although, they are classified as separate disorders, they overlap each other in a complex way. Dementia is an organic disorder that has cognitive disturbance as a main symptom, while depression is regarded primarily as an affective disorder. However, depression can have cognitive deficits and therefore simulate dementia (Forsell et al., 1993).

So, physical examination should be carried out at first presentation of depression for two reasons. First, ill health is a common trigger for severe depression and is closely linked to prognosis. Secondly, depressive illness may be triggered by a large number of physical and neurological illnesses and some of these are not suspected at presentation (Baldwin, 1991). These symptoms may resolve when the underlying physical illness is treated or the drug treatment discontinued (Arie and Levy, 1993).

It is also worth mentioning that cognitive functions assessment should be carried out at **first** presentation, at least using the mini-mental state examination, as well as **OR** regular follow up assessment for this group of patients.

Elderly patients with depression and concomitant medical illnesses often do not receive optimal care for their depression. Most often, assuming that the depression is recognized, potentially effective medication is withheld because the depression is assumed to be "caused" by the medical illness or is considered a contraindication to the use of medication (Schneider and Olin, 1995). **So**, we are in need for orientation of our general practitioners as well as our colleagues in the different specialties dealing with geriatric patients to be able to detect depression in this particularly vulnerable group of patients as it is often treatable and potentially reversible. This will be of utmost importance for proper and early management to relieve their suffering and to rescue these patients from the unneeded extra-risk.

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الاعراض الاكتئابية فى المرضى كبار السن

يعتبر الاكتئاب من الامراض الشائعة فى كبار السن و الاكتئاب فى كبار السن يمثل مشكلة صحية خطيرة و قد تهدد حياة المريض لو لم يتم اكتشافها و علاجها.

و قد تم البحث عن الاعراض الاكتئابية و اضطرابات الاكتئاب فى عينة من ٥٤٦ مريض من اقسام الداخلى بمستشفى عين شمس الجامعى و قد استخدم المسح الاكتئابي لكبار السن اضافة الي اختيارات اخرى لقياس درجة الوعي و النشاط اليومي للمريض و قد وجد ان ٧٩٪ من المرضى يعانون من الاعراض الاكتئابية كما يعانون ٤٣٪ من اضطرابات الاكتئاب المختلفة. و قد وجد ان المرضى الاكثر عرضة للاكتئاب هم مرضى القلب، الفشل الكلوي، الفشل الكبدى و مرضى النزيف المخى والسرطان و قد لخص البحث اهمية معرفة الطبيب الممارس العام بمرض الاكتئاب و اعراضه حتى يتم علاجه فى الوقت المناسب.

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