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Article

Ipsa Senectus Morbus Est? Approaching the Unmet Needs in Geriatric Depression: Results From a National Survey

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Abstract: Depressive disorders represent the leading contributors to mental health-related global burden, and they are often diagnosed in the context of many comorbid disorders, such as cardiovascular disorders, Stroke, Parkinson's Disease, Major Neurocognitive Disorders and Headache, thus worsening their outcomes. Depression is a challenge for “real-world” clinicians, due to the low rates of remission despite the increasing number of antidepressant strategies currently available. Indeed, current antidepressant strategies often fail to achieve acceptable rates of remission. One of the main challenges of “real-world” management of depression is represented by geriatric depression, which is common and under diagnosed. The challenge of diagnosis and treatment of geriatric depression in real world calls for the need of a deeper exploration of its management in clinical practice. This is the purpose of the present cross-sectional survey, aimed at evaluating the clinical approach to late-life depression in a sample of expert physicians working in geriatric settings in Italy, thus trying to provide useful insights on geriatric depression care.

Keywords: antidepressants; comorbidity; trazodone; psychiatry; neurology; geriatrics; elderly

Introduction

Depressive disorders represent the leading contributor to mental health-related global burden; globally, they have been calculated to lead to 5 million years lived with disability (YLD), thus being ranked as the major cause of non-fatal health loss (7.5% of all YLD) [1], with a suicide rate of 700.000 people per year [2]. In Italy, patients diagnosed with depressive disorders represent the most prevalent population in charge to mental health services (34.6/10.000 people), with females almost doubly affected than males (43.2 vs 25.4/10.000 people) [3]. Depressive symptoms have been reported in one out of ten primary care patients [4], and they often arise in the context of many other comorbid disorders, such as endocrine dysfunctions, cardiovascular disorders, stroke, Parkinson's Disease, Major Neurocognitive Disorders (e.g., Alzheimer's Disease) and headache, thus complicating their progress and treatment, as well as increasing their burden and affecting the outcomes [5,6]. Moreover, since depression is significantly associated with chronic medical disorders, this frequent comorbidity, whenever misdiagnosed, may considerably impair the patient's perception of medical care as well as increase the economic burden [7]. Consolidated evidence, indeed, supports the view of envisioning depression as a mind-body disorder, trying as much as possible to tailor the antidepressant

treatments on the individual features of the patient, such as physical characteristics, psychological fragilities, comorbidities, pharmacological treatments, and combining pharmacological and psychotherapeutic treatments to maximize their effectiveness [8,9].

One of the main challenges of “real-world” management of depression is represented by geriatric depression. Indeed, world population is increasingly growing old, and the proportion of elderly people has been estimated to increase to 1.4 billions by 2030 and to 2.1 billions by 2050 [10]. Recent studies reported a 35.1% global prevalence of depression in older people [11]. Several unmet needs have been associated to the management of geriatric depression: misdiagnosis, underdiagnosis, management of comorbidities, difficulties in choosing safe and effective treatments. All of them may potentially determine a poor prognosis. Depression in older age, indeed, has been associated to worsening of physical and cognitive functions [12], as well as to adverse outcomes due to chronic diseases multimorbidity [13]. When approaching depression in elderly patients, physicians often find themselves dealing with a complex condition characterized by suffering, abandonment, and generally compromised functioning. Late-life depression is often diagnosed in the context of multiple comorbidities, both medical and neurological. In fact, cardiovascular and cerebrovascular diseases, thyroid dysfunctions, adrenocortical disorders, diabetes, vitamin B12 and folic acid deficiency, as well as malnutrition, represent the most common medical conditions associated with geriatric depression [14]. Also, multiple treatments, which are often used to manage these conditions in elderly people (e.g., antihypertensive medications) may contribute to exacerbate, or to develop, depressive symptoms [15]. Last, but not least in importance, poor psychosocial conditions, such as low economic status, abandonment, isolation and relocation, and senile decrepitude (i.e., the loss of abilities and pleasure), which often come with people in the late stages of their lives, may trigger depressive symptoms or worsen pre-existing depression [15]. Moreover, depression has been reported in 30% of people diagnosed with vascular dementia or Alzheimer’s Disease, and in 40% of patients diagnosed with dementia associated to Parkinson’s or Huntington’s diseases [16]. Thus, finding the appropriate treatment combination for elderly people with depression, trying to avoid as much as possible pharmacological interactions, side effects, and to maximize the effectiveness, may represent a hard task for physicians [17,18].

The challenge of diagnosis and treatment of geriatric depression in real world calls for the need of a deeper exploration of its management in clinical practice. This is the purpose of the present cross-sectional survey, aimed at evaluating the clinical approach to late-life depression in a sample of expert physicians working in geriatric settings in Italy, thus trying to provide useful insights on geriatric depression care.

Methods

The present cross-sectional survey-based study follows the STROBE (Strengthening the Reporting of Observational studies in Epidemiology) guidelines, matching the appropriate checklist [19]. Geriatrics-working physicians were recruited to participate in this survey through the Italian Society of Geriatrics and Gerontology (SIGG) and were only eligible if they had active membership. SIGG has 868 active members, and a total of 175 physicians responded to the survey (confidence level = 95%, confidence interval = 6.62%). Participant recruitment and data collection occurred between September and November 2023, with individual emails containing the survey link at launch, and a reminder after four weeks. A 20-items questionnaire was developed based both on literature review [20–23] and on the a priori knowledge of the subject by the developing team. The team was composed by seven expert physicians in the fields of Psychiatry, Neurology and Geriatrics, which firstly debated the issue of unmet needs in the treatment of geriatric depression based on their own experience, and then reviewed the literature to generate ideas in order to develop and implement the questionnaire. The survey assessed demographic, employment and clinical practice characteristics, as well as the basic knowledge in the field of geriatric depression diagnosis and treatment. Then, it delved into the possible unmet needs in the management of geriatric depression according to the sample of physicians surveyed. The 20-item questionnaire is entirely shown in Supplementary Material.

Questionnaire responses were analyzed in terms of simple distribution (percentage) of the answers, with a descriptive analysis, and reported in figures.

Results

As above mentioned, a total of 175 geriatrics-working physicians responded to the survey, with an approximate response rate of 20%, as compared to the total amount of SIGG registered physicians. Demographic data of the sample have been summarized in Table 1. 42.3% of respondents were under 40 years old, and the majority (64%) were females. Mostly, they declared a clinical experience between 6 and 25 years in the field of geriatrics, and, indeed, the majority were specialized in Geriatrics (94.28%). The most part was working in the Public National Health System (59.4%), preferentially in acute cases-dealing wards (38.85%). The geographic distribution favored North Italian regions (65%). Forty percent of physicians declared that they dealt often, or very often, with elderly patients diagnosed with depression showing unsatisfied care needs (Figure 1). Indeed, the main challenges regarding those needs were represented by medical comorbidities (44.6%) and by scarceness of patients' or caregivers' support (39.4%). The respondents agreed at 37.71% that the main obstacle to care was the stigma associated to depression in elderly, followed by physical barriers making it difficult to access health services (26.3%). Indeed, due to multiple comorbidities and difficulties, most part of physicians declared to take advantage of a multidisciplinary approach to depression treatment in geriatric patients (Figure 1). However, non-compliance to treatments (32.6%), followed by lack of effective treatments (27.4%) and difficulties in managing pharmacological interactions (24%) were considered the main causes of therapeutic failure (Figure 2). Physicians agreed that the main consequences of geriatric depression may be represented by a worsening in cognitive functioning (35.4%), social withdrawal (33.7%) and daily autonomies limitations (29.7%). Thus, patients might benefit from domestic support services (36%), individualized cognitive and physical rehabilitation programs (35.4%), as well as psychoeducational intervention for both patients and caregivers (28.6%) (Figure 2).

Table 1. Demographic characteristics of the sample of SIGG surveyed physicians.

Total Sample (n)	175
Age	
30-35	50 (28.6%)
36-40	24 (13.7%)
41-45	14 (8%)
46-50	16 (9.1%)
51-55	25 (14.3%)
56-60	12 (6.9%)
61-65	20 (11.4%)
66-70	10 (5.7%)
>70	4 (2.3%)
Gender	
Male	63 (36%)
Female	112 (64%)
Years of experience	
1-5	47 (26.9%)
6-10	19 (10.9%)
11-15	20 (11.4%)
16-20	23 (13%)

21-25	24 (13.7%)
26-30	8 (4.6%)
31-35	12 (6.9%)
36-40	10 (5.7%)
41-45	8 (4.6%)
46-50	4 (2.3%)
Specialization	
Geriatrics	165 (94.3%)
Internal medicine	8 (4.6%)
General medicine	2 (1.1%)
Work structure	
Public structure	104 (59.4%)
Private structure	26 (14.9%)
University hospital	40 (22.9%)
Third sector organisation	2 (1.1%)
Freelancer	3 (1.7%)
Working environment	
RSA	25 (14.3%)
Acute care unit	68 (38.8%)
Rehabilitation ward	18 (10.3%)
Long-term care	6 (3.4%)
Home care	19 (10.9%)
Outpatient clinic	33 (18.9%)
Emergency room	4 (2.3%)
Research institute	2 (1.1%)
Geographical distribution	
Northern Italy	114 (65.1%)
Central Italy	33 (18.9%)
Southern Italy	28 (16%)

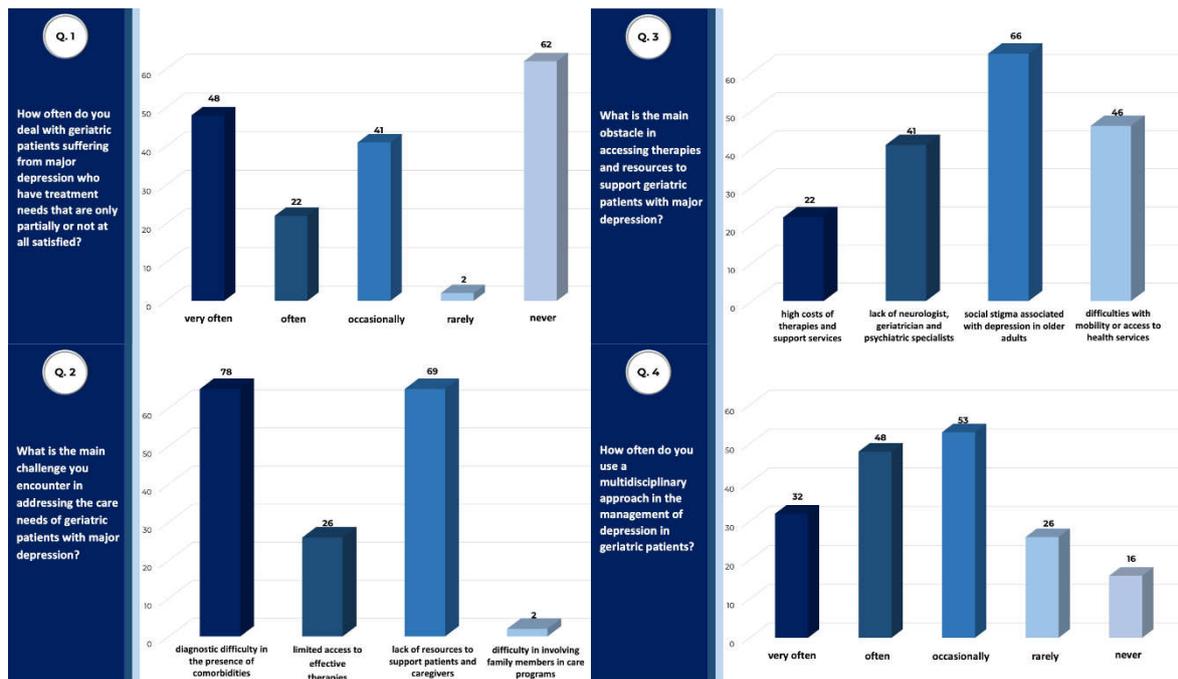


Figure 1. Answers to queries 1, 2, 3 and 4 of the questionnaire submitted to SIGG members, relative to results described. Raw data are reported (tot. surveyed physicians =175).

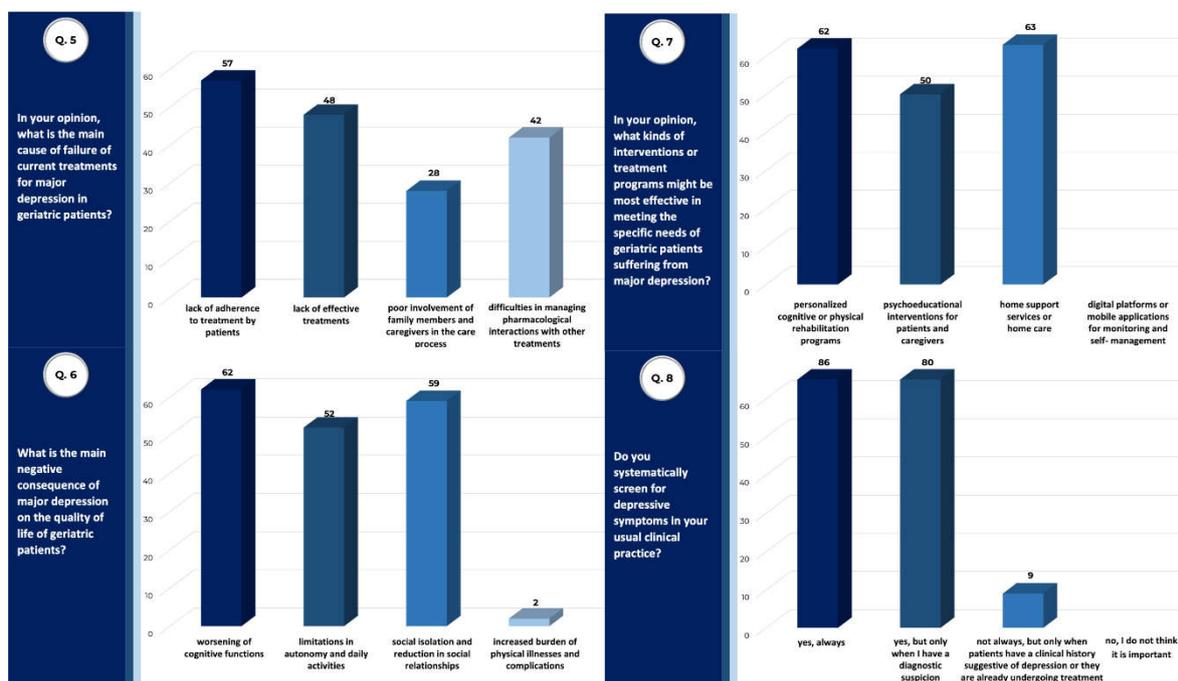


Figure 2. Answers to queries 5, 6, 7 and 8 of the questionnaire submitted to SIGG members, relative to results described. Raw data are reported (tot. surveyed physicians =175).

Almost all respondents declared to systematically screen geriatric patients for depressive symptoms, mostly by using the Geriatric Depression Scale (GDS) as a standardized tool [24]. However, respondents declared to avail themselves of a psychiatric consultation mainly in the event of suicidal ideation shown by patients (33.14%), or when patients need a complex undertaking by mental health services (26.3%) (Figure 3).

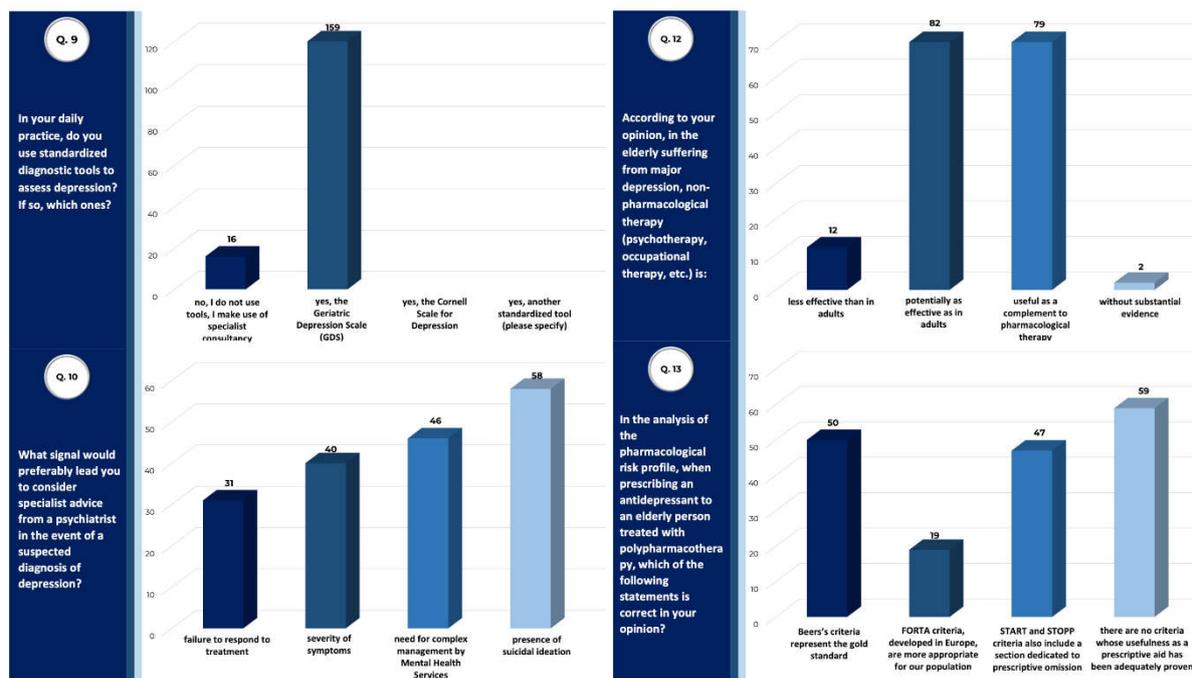


Figure 3. Answers to queries 9, 10, 12 and 13 of the questionnaire submitted to SIGG members, relative to results described. Raw data are reported (tot. surveyed physicians =175).

When choosing a therapeutic strategy, most of surveyed physicians (45.14%) agreed that non-pharmacological treatments should be proposed as a completion of pharmacological treatments, due to their well-known combined efficacy, comparable to that in adult population (46.85%). Regarding the use of pharmacological treatments, the responders agreed on the use of specific guidelines of treatment, such as the Beers's criteria, the Screening Tool of Older Person's Prescriptions (STOPP) criteria, the Screening Tool to Alert doctors to the Right Treatment (START) criteria, and the Fit FOR The Aged (FORTA) list [25] (Figure 3). Antidepressant drugs could be used cautiously to treat behavioral disorders in geriatric patients (98.85%), but surveyed physicians agreed that the so-called anticholinergic drug load [26] should be considered when prescribing antidepressants in poly-treated elderly patients (66.3%). Indeed, the responders also agreed (76.6%) that elderly patients with depression preferentially manifest cognitive symptoms, as compared to depressed adult patients (Figure 4).

The most part of physicians (42.85%) believed that, in case of treatment-resistant geriatric depression, a switch to a different antidepressant drug should be considered, and then a combined psychotherapeutic (cognitive-behavioral therapy) approach should be initiated (21.7%). The duration of antidepressant pharmacological treatment should be prolonged, due to the higher risk of relapses in older patients as compared to adults (55.4%) (Figure 5).

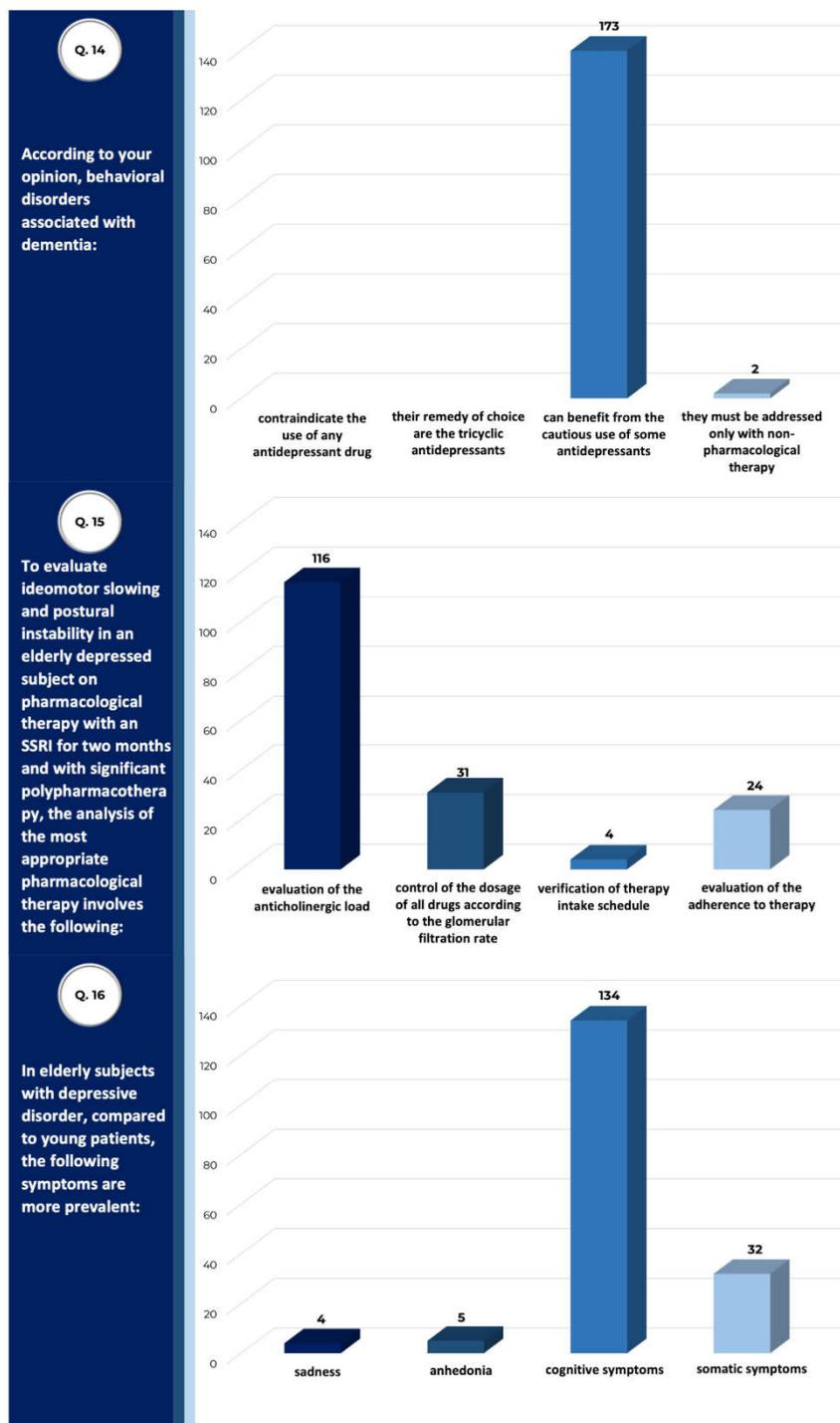


Figure 4. Answers to queries 14, 15 and 16 of the questionnaire submitted to SIGG members, relative to results described. Raw data are reported (tot. surveyed physicians =175).

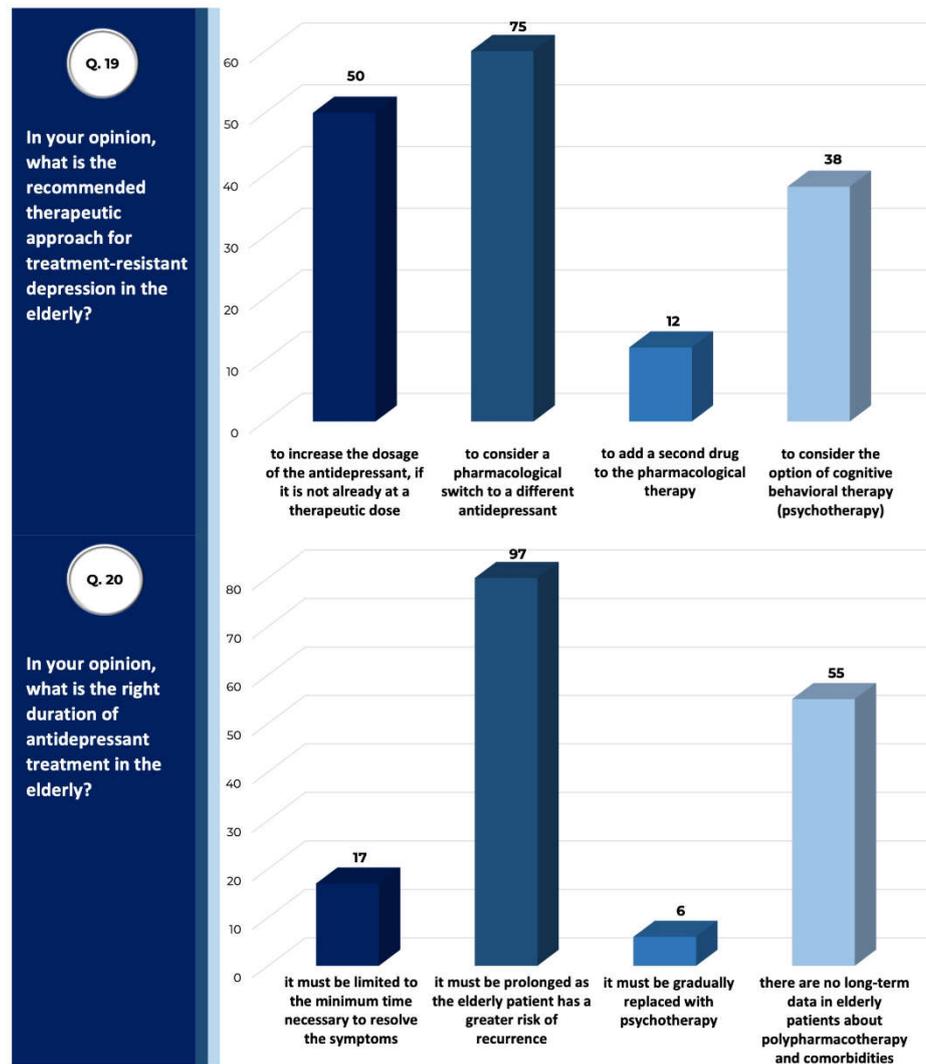


Figure 5. Answers to queries 19 and 20 of the questionnaire submitted to SIGG members, relative to results described. Raw data are reported (tot. surveyed physicians =175).

Discussion

To the best of our knowledge, this is the first survey on an Italian sample to specifically analyze the opinion of expert physicians on geriatric depression. The experts of SIGG were asked to give their opinion on diverse clinical problems and unmet needs regarding their experience with patients suffering from geriatric depression. According to the results, Italian geriatrics-working physicians very often deal with older patients diagnosed with depression, which show unsatisfied care needs. Principally, physicians agreed that the main challenge in elderly depressed patients is the high prevalence of medical comorbidities, often chronic diseases. As abovementioned, several studies, indeed, demonstrated that depression is often associated to comorbid medical illnesses in elderly patients, these comorbidities increasing synergistically the odds of disability in basic and instrumental activities of daily living, as well as interactively worsening the quality of life of affected patients [27]. Therefore, a combined treatment taking into account the multimorbidity may be helpful to increase effectiveness of treatments in elderly depressed patients [28] Moreover, recently some authors have envisioned the possibility of review “old” psychopharmacotherapies, such as trazodone, in the light of their safe and effective use in older multimorbid patients, based on the scarce pharmacodynamic and pharmacokinetic interactions, the rapidity of actions, and the efficacy in complex cotreatment contexts [29]. According to this view, a multidisciplinary approach to treat

depression in elderly population has been increasingly considered a better strategy as compared to non-integrated protocols, since it emphasizes the collaboration amongst different professionals (i.e., general practitioners, psychiatrists, psychologists, neurologists, geriatricians, nurses, and others) and provides a more feasible success against the multiple challenges of older people depression [30]. This vision is completely embraced by physicians that responded to this survey, which agreed that a multidisciplinary approach to the treatment of depression in older people may represent an advantage in overcoming difficulties such as the lack of compliance to therapy, the choice of effective and safe pharmacological treatments, as well as the management of polypharmacy-related interactions.

Responders also agreed that stigma may represent a main obstacle to a correct treatment approach to older people depression. Indeed, negative attitudes toward older people, such as prejudices, ageism, stereotypes, underestimation, may significantly impair the right complex vision of depression in the elderly, thus discriminating the provision of combined physical and mental health services to these patients [31]. Specific multidisciplinary programs, as well as aimed research about the issue, may help to avoid the stigmatization of care for older people with comorbid physical problems [32]. Home support and psychoeducational programs for both patients and caregivers may also help to avoid stigmatic attributions by caregivers, which impair the effectiveness of treatments and, in turn, favor the onset of caregivers' stress-related burden [33].

A large percentage of responders of this survey agreed on the use of validated tool, such as the GDS to correctly diagnose depression in older people. Indeed, several studies have demonstrated the high sensitivity and specificity of GDS for detecting depression in the elderly [34]. Standardized evaluation scales represent useful tools also to avoid misdiagnosis of depression in older people, which are often underdiagnosed (and then undertreated) due to the multiple comorbidities which may mask depressive symptoms, or even to stigmatic attribution such as that depression may be part of growing old [35]. Moreover, consultation with specialized physicians, such as psychiatrists, may improve the effectiveness of diagnosis and treatment management, particularly in case of complex situations which should be taken in charge by mental health services, such as the emerging of suicidal thoughts or intentions [36]. Indeed, untreated depression, due to misdiagnosis or underestimation, has been demonstrated to worsen the quality of life of older patients, as well as to increase the odds of developing a neurocognitive disorder [37]. To meet these increasing needs in geriatric depression, in some countries a specialized figure of Geriatric Psychiatrist is emerging [38].

The majority of surveyed physicians claimed that pharmacological treatments are essential to avoid the progression of depressive symptoms in older people, and to prevent cognitive decline in these patients. However, pharmacological treatments should be combined with non-pharmacological interventions to maximize the effectiveness. This is in agreement with consistent evidence on the favorable effect of non-pharmacological interventions in support of pharmacological treatments in elderly depressed patients to improve the outcomes, to reduce the progression of cognitive deterioration, and also to reduce dosages of the drugs used, as well as to avoid multiple psychopharmacological combinations (with a heightened risk of side effects) [39–41]. Although antidepressants are essential for the treatment, most of the responders agreed that these drugs should be prescribed to older people following validated criteria to reduce over-prescription, side effects, and to optimize the effectiveness of treatment. Beers, START, STOPP, FORTA criteria have been all developed to improve pharmacotherapy in older patients, and have been demonstrated to be useful to maximize treatments efficacy and minimize unwanted side effects [17,18,42–45]. Moreover, when prescribing antidepressant drugs to older people, their anticholinergic properties should be considered. Indeed, many drugs used by older people to treat common conditions (i.e., allergy, overactive bladder, anxiety) have anticholinergic properties, which have been directly correlated to worsening in cognition, drowsiness, falls and constipation [46]. The so-called anticholinergic burden has been demonstrated to worsen the daily abilities of elderly depressed patients, as well as to promote their cognitive deterioration [47–50]. Thus, when prescribed, antidepressants possibly lacking anticholinergic properties should be preferred. According to this view, some antidepressant drugs with anxiolytic/antidepressant properties, such as trazodone, have been envisioned as first-

choice treatment in behavioral manifestations of older depressed patients [51], due to the lack of anticholinergic effects, the primary effects on sleep architecture [52], and the important pro-cognitive and anti-deteriorative effects [53] Supported by literature data, the surveyed physicians agreed on a long-lasting duration of antidepressant treatment in older people, in order to avoid relapses [54], as well as on the support of cognitive-behavioral therapy in partially effective treatments, in order to maximize the efficacy [55].

Conclusions and Limitations

Geriatric depression may represent a hard challenge for physicians, due to the high rates of misdiagnosis and undertreatment, to the difficult management of comorbidities, as well as to the development of an effective treatment strategy. The present survey represents a first attempt to collect the experiences of geriatrics-expert physicians in order to provide useful insights on the unmet needs in the treatment of late-life depression. The small sample may represent a limitation, but the results may serve as stimulus to further research and debate on the treatment of elderly depression, to develop better and better strategies which may avoid underdiagnosis and help to bypass stigmatization and to improve the outcomes of older patients.

Authors contribution: UA and GM developed the original idea; RAI, AC, AP and MZ developed the questionnaire, which was discussed and revised by all the authors; CT wrote the first and the last draft of the manuscript; all the authors equally contributed to the conception, the writing, and the revisions of the paper.

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