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S15. Consequences of depression in the elderly

MAJOR DEPRESSION IN THE ELDERLY - HOW LONG SHOULD TREATMENT CONTINUE?

RJ Jacoby and AD Lunn (& 26 Co-workers from the Old Age Depression Interest Group). Section of Old Age Psychiatry, Oxford University, The Radcliffe Infirmary, Oxford OX2 6HE, UK.

Aim of Study: to determine how long elderly patients recovered from a major depression should continue to take medication. We identified 219 patients with major depression. After recovery 69 were recruited into a double-blind parallel group placebo controlled trial of the tricyclic antidepressant, dothiepin. Reasons for not entering the study were mainly insufficient recovery from the index episode of depression. A Cox regression model of survival analysis revealed that the active drug, dothiepin, reduced the relative risk of relapse by two and a half times. Prolonged index depressive illness trebled the relative risk of relapse. Stratification by sex showed a more favourable survival in males although numbers were small for such comparison. We concluded from this study that: 1. fewer elderly patients than expected recover so completely from major depression to be considered fit to enter such a double-blind placebo controlled trial; 2. patients should be recommended to continue treatment for at least two years, and perhaps longer or indefinitely after recovery from an index episode; 3. placebo controlled studies of continuation and maintenance therapy are no longer ethically justified.

ALTERATION OF AWARENESS OF TIME-PERSPECTIVE IN OLD AGE DEPRESSION

W. Stuhlmann

Rheinische- Landes und Hochschulklinik - Psychiatrische Klinik der Heinrich-Heine-Universität, Bergische Landstraße 2, D 40269 Düsseldorf

The awareness of time-perspective of elderly persons is of significant importance. If healthy elderly persons live more from their remembrance than from hope (ARISTOTELES), the more elderly depressive patients are aware of the changes of time in their life.
It seems not to be possible, to convert the kognitive structure of thoughts, as described by BECK, to the the cognitive changes in the depressive elderly patient.

In a pilot study, 23 depressive elderly patients, age above 65 years, and corresponding healthy controls, were investigated with a self-rating scale of time experience and a semantic differential of total life time. The results were correlated with the variables of the depressive syndrome.

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RISK OF DEMENTIA AFTER DEPRESSION IN THE ELDERLY

JP Clément, JM Léger
Service Hospitalo-Universitaire de Psychiatrie, Centre Hospitalier Esquirol, 15 rue du Dr Marcland, 87025 Limoges, France.

Depression in the elderly sets always problems of its treatment and of its prognosis. This disorder impairs old persons in their affects, in their body and in their cognitive functions. Risk of depression is often bound with objectal, material and physical loss. In 80 per cent of depression in old age, we can find life events during last year before the beginning of the disease. Intellectual decreasing with old age depression can let wander diagnosis to a starting dementia. This depressive "pseudo-dementia" has generally a good response with antidepressant treatment. Nevertheless, many studies have shown the risk to develop irreversible dementia during the 2 to 4 next years. This pejorative prognosis with emergence of well-codified cerebral injuries does yet call to mind a continuum between old age depression and dementia which frame two successive stages of delicate adaptation by a subject with an inefficiency facing environment requirements. According to old person personality means, there should have internal or external psychic events or stressing conditions which are able to involve an emotional distress whom severity should lie beyond possibility of depression to lead so far as to do organic disorganization with neurological changes. With loss condition whom bereavment elaboration may become impossible, there are relational rapprochements where the elder subject feels being in intrusion danger. Facing with these two life conditions with high psychopathological risk, it seems to be appropriate to take notice of biography and of previous personality features among old depressive subjects and those that become demented. The frequent depressive recurrence in the elderly and the less well known dementia risk have to do consider a rigorous and sustained treatment of every first depressive episode from a some aging threshold onwards.

LES TROUBLES BIPOLAIRES DANS L'ÂGE AVANCÉ. À PROPOS DE DEUX CAS DE CYCLES TRÈS RAPIDES

J. Wertheimer
Service Universitaire de Psychogériatrie de Lausanne, CH-1008 Prilly/Lausanne

L'évolution dans l'âge avancé des diverses formes évolutives de la dépression apparue dans l'âge adulte est assez bien connue. Selon C. Müller (1981), on constate une nette diminution de la fréquence des épisodes dépressifs ainsi que de l'intensité des symptômes. Le même auteur démontre que les anciens patients maniaques tendent soit à la rémission, soit à basculer vers une évolution maniaco-dépressive. La fréquence de l'épisode maniaque, sa durée et son intensité semblent diminuer, alors que la dépression devient plus fréquente et plus durable. Des travaux récents ne trouvent pas de différence claire quant à cette fréquence dans l'âge avancé, lors d'apparition de la maladie avant et après 65 ans. Le problème se complique lorsque l'on sait que les épisodes maniaques chez l'âgé peuvent être secondaires à une maladie physique, à un effet médicamenteux ou aussi être des conséquences paradoxales d'une perte (deuil). On connaît d'autre part mal la fréquence d'apparition et l'évolution avec le vieillissement des cycles bipolaires rapides, se succédant dans des intervalles de 3 à 6 mois. Des cycles très rapides existent aussi dans cette catégorie d'âge. Deux cas de femmes âgées sont décrits, caractérisés par une succession sans transition, à un rythme de quelques semaines, de phases hypomaniaques et dépressives. Ces troubles ont commencé dans la soixantaine et se prolongent sans modification au-delà de 80 ans. La fréquence des cycles ainsi que l'intensité des symptômes sont réfractaires aux thérapeutiques antidépressives et thymorégulatrices.

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