Drug treatment for depression in patients inside rehabilitation wards

EDITOR,—Shah and colleagues report on the prevalence of psychiatric disorders affecting elderly people institutionalised in a rehabilitation unit. They conclude that depression is common among older adults, it is a treatable condition, and that in cases where there are cognitive impairments associated with concomitant depression, the cognitive impairments are worsened by the depressive disorder. However, we cannot accept the elementary proposition of Shah et al about a drug trial with selective serotonin reuptake inhibitors (SSRIs) to elucidate the correct diagnosis when diagnostic doubts remain.

Depressive states in older patient groups have a tremendous clinical heterogeneity. Beside the depressive elderly patient without comorbid conditions, that will respond adequately to antidepressant drugs, a significant proportion of these patients is important and it is necessary to call attention to it, I believe that from the psychiatric perspective, the problem has been overestimated. Therefore, we cannot accept the elementary proposition of Shah et al about a drug trial with selective serotonin reuptake inhibitors (SSRIs) to elucidate the correct diagnosis when diagnostic doubts remain.

(1) Elderly depressed patients who may show greater cognitive deficits compared with age similar normal subjects. These patients also present (subcortical) dysfunction of learning and memory, comprising the so-called “depressive pseudodemodernia”, and may show reversible cognitive deficits after successful somatic treatment of depression.

(2) Patients who display cognitive deficits characterised by severe prefrontal dysfunction, with perseveration, psychomotor retardation, and long P300 latency.

(3) Patients who present features of dementia related to underlying vascular disease and neurological lesions, corresponding to the hypothesised “vascular depression”.

(4) Patients with late life onset of cognitive deficits, psychomotor retardation and limited depressive ideation, many of whom will have the apathy syndrome which frequently follows brain damage in caudate, putamen and thalamus, usually secondary to cerebrovascular or ischaemic diseases (and which was recognized by the previously mentioned third subgroup).

While SSRIs may be useful to the first subgroup, they are useless in the second and third groups, while in the fourth, dopamine agonists like bromocriptine are required. Hence, it is erroneous to generalise that “depressed elderly respond well to SSRIs” like Shah et al suggest. Moreover, Shah and colleagues also state that patients with dementia may become depressed, particularly if they have insight into their condition.

The frequent depressive symptoms found in these patients may be early manifestations of Alzheimer’s disease, in which case, cholinesterase inhibitor drugs instead of antidepressants are indicated. And what about the caution needed in the SSRI prescription because of their significant drug interactions resulting from interference with components of the hepatic P450 enzyme system? (where Shah and colleagues state that these drugs are apparently safe in the elderly, in spite of their frequent use of multiple medications). Drug treatments for every elderly disturbance, like for any other human complaint, must always be a careful skilled decision.

Incidentally, Shah and colleagues state that there are no biological diagnostic tests for depression. Besides the dexamethasone cortisol test, the brain dysfunction in the geriatric depressed and cognitively impaired patients suggests that the computer analysed, quantitative electroencephalographic record may help not only in the brain damage differential diagnosis but also in disclosing a depressive disease by showing the characteristic increased anterior alpha power and decreased coherence. Also functional magnetic resonance imaging can yield valuable diagnostic information by showing abnormal activation in the left medial prefrontal cortex and in the right anterior cingulate gyrus in depressive patients.

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The authors respond: Depression in the elderly has enormous heterogeneity, however it is very common, especially in those with concomitant physical illness. Its recognition in this area is important because of the effect it has on length of hospital stay and results of rehabilitation. Psychiatric intervention has been shown to increase recovery rate, reduce duration of stay, and reduce the need for residential care after discharge. Any additional drug treatment in the elderly must be considered with due risk of interactions and side effects: given appropriate care, the SSRIs have been used safely in this population for many years.

It is also accepted clinical practice to give a trial of antidepressants to patients with cognitive impairment if there is doubt as to whether the degree of depression may be causing/worsening the impairment. We know of no clinical service where functional magnetic resonance imaging or hypnagogic electroencephalography would be carried out as an alternative.

The dexamethasone suppression test is not accepted as a diagnostic tool in the elderly because of the high incidence of false positives.

If depressive illness does not respond to treatment, liaison psychiatry services should be involved. However, we would disagree strongly with the alternative suggestions given by Dr Vale.

Depression accompanying cerebrovascular changes can respond to antidepressants, and again a trial should be given. Depression as a prodromal feature of Alzheimer’s disease and multi-infarct dementia is well recognised as a diagnosis made with hindsight.

The cholinesterase inhibitors are not licensed as antidepressants, however, given the difficulty in many areas to obtain funding for their use in established Alzheimer’s disease are unlikely to become a treatment option for depression, nor is there any published evidence of efficacy in this area.

The dopamine agonist bromocriptine is again not licensed for use as an antidepressant and, other than a few anecdotal reports in the literature, is not recognised treatment alternative. Given the relative frailty of this population and risk of side effects including precipitating psychotic features, we would not recommend its use outside specialised neuropsychiatric facilities.

In summary, our paper reported a study carried out in a district general hospital rehabilitation service; results and conclusions are applicable to everyday clinical practice in such areas.


Medical urology

EDITOR,—We describe the last two years’ activity in our continence clinic as support for the thesis of Castleden and Duffin that a strong case can be made for the development of a speciality of medical urology.

In our area many community nurses have undergone training by the continuity advisers and are able to deal with simple lower urinary tract problems.

During the years 1998 and 1999 we saw 141 patients in the clinic (125 female). The age range was 19 to 96 years with a median of 70 years. The main sources of referral were...
BPH = benign prostatic hypertrophy.

All patients underwent a thorough clinical assessment including measurement of a flow rate and post-void residual (using bladder scanner) and the great majority of patients completed a frequency/volume chart. The average number of visits was 2.8 (range 1–8).

The medical speciality of urology (or urogynaecology) probably exists already but is not fully recognised. Our experience is that it has an important place in the management of lower urinary tract symptoms. Multidisciplinary working especially with continence advisers is imperative and also close links need to be maintained with surgical colleagues.

### Table 2 Outcomes in 141 patients

<table>
<thead>
<tr>
<th>Symptoms/Findings</th>
<th>Dry</th>
<th>Much improved (wet &lt;1/week)</th>
<th>Improved (on presenting symptom)</th>
<th>Frequency/nocturia improved</th>
<th>CIC</th>
<th>Lost to follow up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catheter advice</td>
<td>8</td>
<td>20</td>
<td>30</td>
<td>4</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>Faecal incontinence better</td>
<td>8</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>Containment</td>
<td>2</td>
<td>6</td>
<td>10</td>
<td>8</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>GSI</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>BPH</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
<td>13</td>
</tr>
</tbody>
</table>

Community based nurses: 56 referrals, general practitioners: 51, gynaecologists: eight, and consultant gynaecologists: eight, and consultant in rehabilitation medicine: seven.

The treatment offered to patients with overactive bladders included habit retraining, regular and prompted voiding, and antimuscarinic drugs (oxybutynin, tolterodine, and imipramine most commonly). Those with genuine stress incontinence (GSI) were taught to do pelvic floor exercises using digital assessment and a pessinometer. Vaginal cones were employed in a number of cases.

In those with voiding problems a few were treated with clean intermittent catheterisation (CIC) either done by the patient, a family member, or a district nurse. Fluid intake was adjusted according to responses. An afternoon diuretic was employed successfully in a number of patients with nocturnal polyuria. Constipation was treated with laxatives and/or enemas, urinary infections with antibiotics, and post-micturition dribble exercises were employed in the few with this problem. The outcomes in these patients are listed in table 2.

It was possible, therefore, to achieve relief of symptoms in the great majority of these patients. In those few in whom this was not possible appropriate advice about containment was given.

A very small number of these patients were referred for a surgical assessment, in fact a larger number was referred from the gynaecologists to this clinic.

Urinary incontinence remains one of the “giants of geriatrics” and as a consequence a number of gynaecologists run such clinics. The evidence base for useful conservative treatments for incontinence is growing, and their effectiveness should continue to increase with time. The co-morbidity seen in old age (as stated by Castleden and Duffin) also makes the geriatrician an appropriate physician to run such clinics.

The medical speciality of urology (or urogynaecology) probably exists already but is not fully recognised. Our experience is that it has an important place in the management of lower urinary tract symptoms. Multidisciplinary working especially with continence advisers is imperative and also close links need to be maintained with surgical colleagues.

### Table 1 Diagnoses on 141 patients

<table>
<thead>
<tr>
<th>Condition</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overactive bladder (unstable hyper-reflexia and low compliant bladder)</td>
<td>64</td>
</tr>
<tr>
<td>Nocturnal enuresis</td>
<td>8</td>
</tr>
<tr>
<td>Mixed (unstable and genuine stress incontinence (GSI))</td>
<td>26</td>
</tr>
<tr>
<td>Voiding problem (mostly neurogenic)</td>
<td>20</td>
</tr>
<tr>
<td>GSI</td>
<td>17</td>
</tr>
<tr>
<td>Excess fluid intake</td>
<td>10</td>
</tr>
<tr>
<td>Nocturnal polyuria</td>
<td>9</td>
</tr>
</tbody>
</table>

The nursery was almost closed down due to the local university have completed the clinical components of their degrees (doctorate and masters) in our nursery.

We strongly believe that increased motivation of registrars due to quick publications serving as quick reward for their hard work is the reason for our academic output. We are aware that case reports may not be counted as “research”, or serve as a marker of “academic quality” as long as they are not published in the “yellow pages”, they do provide us a very strong academic tool for motivating our registrars towards research.
is raised in patients who are on amiodarone and euthyroid. Therefore the triiodothyronine level is very much needed for making a diagnosis of AIH, which unfortunately has not been mentioned in the case. The question remains about the suppressed TSH. Is it surprising to have TSH suppressed in a 72 year old lady who is admitted to the hospital with a fall (and also who suffers from congestive cardiac failure)?

The authors did not provide us with the follow up. Was the patient treated as having AIH? Was there any improvement in the clinical status? Lastly, there was no mention of two types of AIH in the discussion. It is important to subtype a patient with AIH, as the treatment is different in the two types of AIH. Incidentally Loh has reviewed this topic in the same issue of the journal. In case the index patient had AIH, it would probably be type 2 where the main treatment option is corticosteroids and not antithyroid drugs.

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The authors respond:
I would like to thank Drs S and A Bhattacharyya for their interest and comments on the above case.

It is quite correct to highlight the point that a suppressed TSH does not necessarily equate to a hyperthyroid state and indeed it is worth stressing that the causes of a suppressed TSH are legion. In our article we did not include the triiodothyronine which has caused my colleagues to question the diagnosis. I would, however, caution against over-reliance on triiodothyronine values in this setting. Indeed, my colleagues also mention in their letter the excellent review article by Loh on amiodarone induced thyroid disorders, which appears in the same journal. According to Loh the triiodothyronine in AIH is unreliable and may be either high or normal. For the record the value of free triiodothyronine in the case described was 12.6 pmol/l (normal range 3.0–7.0).

The other criticism was that no information was available on the patient’s progress and follow up. After discussion with the endocrinologists this patient was treated with carbimazole starting at a dose of 20 mg daily for four weeks and then reduced to a maintenance dose of 10 mg daily. Amiodarone was discontinued. The patient continues to be reviewed on a regular basis and at present is on carbimazole 10 mg daily. She remains well and her last TSH was 2.83 mU/l.

DIARY

Falk Symposia

1–2 October 2000: Non-neoplastic diseases of the anorectum—an interdisciplinary approach (Freiburg, Germany)
3–4 October 2000: Immunosuppression in inflammatory bowel diseases—standards, news, and future trends (Freiburg, Germany)
12–13 October 2000: Biology of bile acids in health and disease (Den Haag, The Netherlands)
4 November 2000: Chronic inflammatory bowel diseases—progress and controversies at the turn of the century (Bucharest, Romania)

Royal College of Physicians of Edinburgh

7–8 October 2000: Stroke treatment and service delivery (consensus conference)
Details: Education, Audit, and Research Department, Royal College of Physicians of Edinburgh, 9 Queen Street, Edinburgh EH2 1JQ, UK (tel: +44 (0) 131 225 7324, fax: +44 (0) 131 220 4393, web site: www.rcpe.ac.uk).

Royal College of Physicians of Edinburgh/Scottish Intercollegiate Guidelines Network

3 November 2000: Symposium on clinical effectiveness, clinical guidelines and clinical standards
Details: Mrs Anne Fairbairn, Coordinator for Research and EBM, Royal College of Physicians of Edinburgh, 9 Queen Street, Edinburgh EH2 1JQ, UK (email: a.fairbairn@rcpe.ac.uk).

3rd Teupitz Colloquium

17–20 September 2000: Basic Research in Endocrine Dermatology
Details: Professor Dr Ch C Zouboulis, Department of Dermatology, University Medical Center Benjamin Franklin, Free University of Berlin, Hindenburgdamm 30, 12200 Berlin, Germany (tel: +49 30 84 45 28 08, fax: +49 30 84 45 42 62, email: zoubbere@zedat.fu-berlin.de).

St Mark’s Hospital & Academic Institute

16–18 October 2000: Frontiers in colorectal disease (lecture course)
Details: The Administrator, St Mark’s Academic Institute, St Mark’s Hospital, Northwick Park, Harrow, Middlesex HA1 3UJ (tel: +44 (0) 20 8235 4046/8, fax: +44 (0) 20 8235 4039, email: e.power@ic.ac.uk; web site: www.stmarkshospital.org.uk).