Depression in dementia – a frequent comorbidity

DEPRESSION IS ONE of the most frequent comorbid psychiatric disorders in Alzheimer’s disease (AD) and other dementias. It is associated with poorer quality of life, greater disability in activities of daily living, a faster cognitive decline, a high rate of nursing home placement, increased mortality and a higher frequency of depression and burden in caregivers. Depression in AD affects as many as 50% of patients and is markedly underdiagnosed. Patients with subcortical dementias, including vascular dementia and Parkinson’s disease are more prone to depression than patients with AD. There are also suggestions that a positive family history and previous personal history of depression each confer increased risk for depression in AD. Most of these patients with depression are either not treated or are on sub-clinical doses of antidepressants.

Depression and cognitive impairment may occur together by chance. Patients with depression may exhibit cognitive deficits including depressive pseudodementia. Depression may also precede the onset of dementia either as an early presentation of incipient dementia or may even constitute a risk factor for dementia. As subjects progress to dementia, they tend to exhibit fewer affective symptoms, more agitation and psychomotor slowing. Depressive symptoms and major depressive illness in dementia require careful definition due to overlap with features of personality changes and cognitive impairment, especially frontal lobe features (see Table 1).

Unlike classic depression, depression in the context of dementia may result from anatomic damage to the brain and may not present in the typical way.

An American-based collaborative study compared a group of elderly Alzheimer’s patients with neurologically healthy elderly subjects and had some interesting findings. The lifetime prevalence of depression in AD patients was significantly higher than in non-demented elderly subjects. During their most recent depressive episode, patients with Alzheimer’s disease were significantly more likely to report reduced concentration or indecisiveness and less likely to have sleep disturbances (insomnia/hypersomnia) and feelings of worthlessness or excessive guilt. Recurrent thoughts of death or suicidal ideation also tended to be less common among AD patients. Both cognitive impairment and reduced frequency of feelings of worthlessness may have contributed to the reduced frequency of suicidal ideation.

Also, none of the elderly control subjects developed psychotic symptoms during their major depressive episodes compared to nearly one-third of AD subjects who experienced delusions or hallucinations.

Among patients with AD, ranging from mild, moderate and severe cognitive impairment, a trend toward increased frequency of psychomotor agitation/retardation and fatigue/loss of energy was noted for the most cognitively impaired patients. Psychotic symptoms also increased with increasing cognitive impairment.

Several studies have also found that depression is more prevalent and severe in vascular cognitive impairment (VCI) compared to AD. Psychomotor slowing and apathy are also more severe in VCI. Neurological abnormalities such as extrapyramidal signs and grasp reflexes predict the severity of the depression in both vascular and Alzheimer-type dementia.

Patients with VCI have been described to have more severe behavioural retardation, depression and anxiety than those with AD when the groups have similar levels of cognitive impairment. This probably reflects the contrasting brain regions typically involved in the two disorders.

Self-rated and interviewer-rated scales are available for measuring depression in dementia. They however, become less accurate as cognitive impairment increases and insight decreases because good attention, concentration, memory and judgement are required for their completion. To overcome this problem, some instruments have been designed to measure depression in dementia using collateral sources of information in addition to clinical examination. These include the Depressive Signs Scale (DSS), the Cornell Scale and Depression in Dementia Mood Scale (DDMS).

Early detection and treatment cannot be overemphasised as it would enhance optimisation of the adaptive functions and quality of life of these patients. The identification of depression existing with AD is difficult in the absence of clear affective symptoms, since the cognitive, psychomotor...
Features distinguishing pseudodementia from dementia

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<thead>
<tr>
<th>History</th>
<th>Pseudodementia</th>
<th>Dementia</th>
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<tbody>
<tr>
<td>Onset and decline</td>
<td>Often and rapid with an identifiable trigger factor or life event</td>
<td>Vague, insidious onset. Often no obvious precipitant.</td>
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<tr>
<td>Symptoms</td>
<td>Symptoms become obvious early on</td>
<td>Symptoms may go unnoticed for years.</td>
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<td>Mental state</td>
<td>Patients distressed/unhappy</td>
<td>Patient often unaware or attempts to hide problems.</td>
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<td>Variability in cognitive performance. 'Don’t know' answers.</td>
<td>Confusion often worse in the evening.</td>
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Table 1

References