Case #1

An 86-year-old white male presents to his cardiac rehab appointment. During the visit, he discloses to his therapist that he has been feeling depressed since he was diagnosed with pancreatic cancer 4 months ago. He is following with oncology and receiving chemotherapy for this, which has been physically taxing for him. He reports symptoms of fatigue and apathy most days. He lives alone in a single level home in Norwood, and rarely leaves since his wife died in 2010, "She was the social butterfly, I am more of a wallflower." In addition to pancreatic cancer and heart disease, his medical history also includes peripheral vascular disease, restless leg syndrome, chronic low back pain (which is poorly controlled), chronic kidney disease (CKD stage 3a), and depression (which was successfully treated with pharmacologic therapy in the past).

A. Describe the risk factors that predispose this patient to LLD (late life depression).
Terminal illness, chronic disease, widowhood, social isolation, chronic pain

B. What are this patient's risk factors for suicide?
Age, race, terminal disease, chronic disease, isolation & widowhood

C. What questions would you ask to ensure that this patient is safe at home?
Ask about current thoughts of suicidality, details of depression history, any prior attempts, family history of suicide, firearms in the home, support system, etc.

D. Does this patient meet criteria for a LLD syndrome diagnosis? How would you go about determining this? Which screening tools might you implement? What follow up interview questions would you ask?

You would need to use a screening tool to identify depression. Most accessible and frequently used would be the PHQ2/9, which would be appropriate given absence of cognitive impairment. IF screening tool flags positive, would ask interview questions to clarify SIGECAPS. If the patient has had 2 weeks of >/=5 of the listed symptoms (handout, page #3), symptoms are affecting pt's daily function, and can not be attributed to another medical illness (re: hypothyroidism, etc.), the patient meets criteria for Major Depressive Disorder (MDD). Note that patients can have clinically relevant depression, but NOT meet the criteria for diagnosis of MDD or other depressive syndromes recognized by the DSM. If the patient has between 2-4 of the listed symptoms (handout page #6) for two weeks, symptoms are affecting his life, and can not be explained by an alternative etiology, the patient meets criteria for Minor Depressive Disorder, which is the most common form of depression amongst geriatric patients. Patients with minor depression have similarly high suicide, morbidity, and mortality risk associated with their depressive illness. Despite the fact that this syndrome is no longer recognized by the DSM, it remains clinically relevant to geriatric mental health in clinical practice.

E. Describe your follow up plan.

Would start an SSRI (likely Lexepro or Sertraline), arrange therapy, connect with PCP to implement collaborative care. Could consider group therapy for cancer patients. Could consider a specialized psychologist or SW counselor with cancer treatment experience.

Case #2

A 75-year-old woman presents to the Family Medicine clinic's behavioral health social worker after being referred by one of the resident physicians for "mood problems." In conversation with you, she reveals that she has been depressed and unable to experience pleasure for the past 4 months. Her appetite is poor. On chart review you notice that she has lost 8 lbs. since her well woman visit with her PCP 6 months ago. She reports that she is not motivated to go outside and walk like she has in the past. She is apathetic about bathing and cleanliness around the home, which she previously kept extremely tidy. Additionally, she reports feeling more forgetful in daily life. When probed, she reluctantly admits to getting lost returning from a recent church volunteer outing. Additionally, she reports missing paying her water and electricity bills twice in the past 6 months.

A. Which screening tool would you use to rule out depression in this patient?

While any of the screening tools would be appropriate, the Cornell Depression Scale is an excellent choice for patients with mood complaints who also present with symptoms of cognitive impairment. The Cornell scale is well suited for this cohort because it uses information from a secondary reporter who may be better equipped to give a more accurate and insightful history, as this is often challenging for patients with executive dysfunction to do alone.

B. Would you screen for cognitive impairment at this time? If positive, how might you open a conversation with the referring physician to best advocate for this patient?

Absolutely! This patient should definitely be screened for a cognitive impairment. If positive, a thorough psychiatric history should be obtained, as well as family history of psychiatric and neurocognitive disease. In conversation with the PCP, you should gauge their level of comfort working up dementia, and if appropriate suggest referral to a geriatric medicine specialist or behavioral neurologist. It would be appropriate to advocate for high quality neuroimaging (MRI brain), metabolic tests, and a neuropsychology evaluation (the latter especially given the patient's mood complaints). This will help identify reversible causes of dementia and detect deficit patterns specific to individual dementia syndromes. Depending upon accessibility and patient preference, referral to check for biomarkers such as tau protein and Lewy bodies in the CSF or plasma would also be reasonable. This can help with anticipatory guidance, structuring individualized treatment plans, and implementing disease mitigating practices in the patient's daily life. Lastly, today we discussed the link between LLD and dementia, how this can be an initial symptom of neurocognitive disease, and is no longer considered to be a separate illness. It would be appropriate to share this information with the PCP to facilitate well informed anticipatory guidance.

C. Describe your initial approach to her treatment How might you implement the collaborative care approach in the treatment plan?

As outlined above, you would want to maintain an open dialogue with the PCP, gauge their level of comfort managing dementia and mental health concerns, and suggest referrals to specialists when appropriate. A behavioral health social worker can help with counseling the patient and family, checking in with the patient and family along their treatment journey, and recommending community resources about which the PCP may not know!

D. Do you have any experience applying the collaborative care approach to the treatment of patients with cognitive impairment in the primary care setting?If so, please share any pearls you may have!
Audience sharing time!

E. Which medications, if any, would be best to treat this patient? Which should be avoided?

The best medications to start for this patient would be an SSRI such as Lexepro or Sertraline. If the patient fails to respond to treatment with an SSRI alone, this is highly indicative of underlying neurocognitive disease: neurocognitive screening and workup should be done in collaboration with the PCP and the family should be given appropriate anticipatory guidance, prognostication. Ideally, one would prefer to avoid TCA's and some of the psychiatric medications with more cardiovascular risk and anticholinergic burden.

F. Describe your follow up plan.

Would start medication for mood and send dementia workup. Patients should follow up with the PCP and behavioral health social worker in two weeks to discuss results of testing. LSW can provide resources and discuss follow up plans for therapy, family support resources at that time as well. It is absolutely vital to maintain open communication between the entire care team for this patient to get the best treatment possible (re: collaborative care).

A 65-year-old man with a history of atrial fibrillation is admitted to the skilled nursing facility where you work following a left middle cerebral artery stroke. His residual unilateral weakness and dysarthria improved following two weeks of therapy. Prior to this event, he lived independently in a two-story home in Clifton. He is a widowed, newly retired Cincinnati Public School teacher. He hopes to return home with the support of his adult daughter, who plans to stay with him for the next two months. In speaking with you while coordinating his discharge, he mentions difficulty with memory and word finding issues that began after the stroke but have not improved with rehab. Additionally, he reports symptoms of decreased appetite, difficulty sleeping, hopelessness, and irritability. He has been an avid reader his entire life, but now feels he can not follow a story and has no interest in starting a new book. Home PT/OT are scheduled to follow him at home once discharged, but he feels apathetic about working with them, "I just don't see how it will make a difference."
Score on the Montreal Cognitive Assessment 21/30. Laboratory findings are unremarkable.

A. For which LLD syndrome is this patient most at risk of developing?

This patient had a left sided middle cerebral artery stroke. The tributaries of the left middle cerebral artery provide blood flow to the left dorsolateral prefrontal cortex, where the patient's cognitive control network is housed. Strokes that affect this region of the brain are particularly at high risk for developing Post Stroke Depression.

Post stroke depression is under-diagnosed and under-treated. Many psychiatrists believe that patients should be started on an SSRI immediately after a stroke as preemptive treatment for this disease.

B. Describe ways in which treatment of this particular syndrome differs from treatment of other forms of LLD?

Post stroke depression is uniquely complicated to treat in that it often does not respond to SSRI alone. Patients with this disease fare significantly better when a therapy arm of treatment is implemented. Additionally, it is not uncommon for patients to respond better to tricyclics or atypical antidepressant medications than an SSRI or SNRI. Implementing a methylphenidate (Ritalin) + SSRI combo can be highly effective in treating apathy associated with post stroke depression. Problem based therapy, cognitive behavioral therapy, and computerized cognitive training are also extremely effective treatments for this disease.

C. Describe your approach to treatment.

This patient should be started on an antidepressant medication and a therapy method should be chosen and started immediately. The above approaches to therapy would be evidence based and appropriate to start. This patient would also especially benefit from aerobic exercise (as is able, given neurologic deficits). This could be worked into a behavioral activation therapy plan and implemented in tandem with any of those listed above. Additionally, it is important to make sure that this patient continues to socialize and engage with others as this can mitigate severity and slow progression of cognitive deficits.