Consensus of the SEPG on depression in the elderly

M. Martín-Carrasco[1]
L. Agüera-Ortiz[2]
L. Caballero-Martínez[3]
J. Cervilla-Ballesteros[4]
J.M. Menchón-Magriñá[5]
A.L. Montejo-González[6]
A. Moríñigo-Dominguez[7]
F. Caballero-Martínez[8]

[1]Clínica Psiquiátrica Padre Menni Pamplona
[2]Hospital Universitario 12 de Octubre Madrid
[3]Hospital Universitario Puerta de Hierro Majadahonda (Madrid)
[4]CIBERSAM Hospital Universitario San Cecilo. Granada
[5]Hospital Universitario de Bellvitge Hospitalet de Llobregat Barcelona
[6]Hospital Universitario Salamanca
[7]Departamento de psiquiatria Universidad de Sevilla
[8]Unidad de investigación Dirección Académica de Medicina Universidad Francisco de Vitoria Madrid

Background. The limitation of clinical-epidemiological know-how and evidence regarding therapeutic efficiency in depression among the elderly and extremely elderly patients has given rise to an excessive variety of practices in clinical care of these patients in the Spanish health system. The Spanish Society of Psychogeriatrics (SEPG) has raised the question of the need to unify criteria through a structured approach based on professional consensus.

Objectives. To develop an expert consensus of clinical recommendations to improve the clinical treatment of depression in elderly patients in Spain, sponsored by the Spanish Society of Psychogeriatrics (SEPG).

Methods. Modified Delphi Consensus, in two rounds. The study was conducted in four phases: 1) constitution of a Scientific Committee, project promoter and responsible for bibliographic review and formulation of recommendations for discussion 2) constitution of a multicenter Panel of Experts with representatives from this specialist field 3) postal survey comprised of two rounds, with interim processing of opinions and a report for the experts and 4) discussion of results during an on-site meeting of the Scientific Committee.

Results. The survey evaluation was completed by 61 experts consulted, in two rounds. In the first round, consensus was reached in 39 of the 54 questions analyzed. Following interaction by the panel, this consensus was increased to a total of 46 survey items (85% of the proposed contents). It was impossible to obtain a sufficiently unanimous consensus on the remaining 8 questions, either due to differences of opinion among the professionals or a lack of established criterion in most of the experts.

Conclusions. A full list of criteria and clinical recommendations for the purpose of rationalizing the treatment of depression in elderly patients and reducing excessive variability in clinical practice is presented. The recommendations are qualified in accordance with the degree of consensus of the professionals endorsing them and can be considered valid until new scientific information becomes available that justifies their review.

Key words:
Depression, elderly, consensus, psychiatry

Actas Esp Psiquiatr 2011;39(1):20-31

Consenso de la SEPG sobre la depresión en el anciano

Antecedentes. La limitación del conocimiento clínico-epidemiológico y de la evidencia sobre efectividad terapéutica en la depresión en los pacientes ancianos y muy ancianos genera una excesiva variabilidad de prácticas en la atención clínica a estos pacientes en nuestro sistema sanitario. La Sociedad Española de Psicogeriatría (SEPG) se plantea la necesidad de unificar criterios mediante un método estructurado de consenso profesional.

Objetivos. Desarrollar un consenso experto de recomendaciones clínicas para optimizar el abordaje clínico de la depresión en el paciente anciano en España, bajo auspicio de la Sociedad Española de Psicogeriatría (SEPG).

Métodos. Consenso Delphi modificado en dos rondas. El estudio se efectuó en cuatro fases: 1) constitución de un comité científico, impulsor del proyecto y responsable de la revisión bibliográfica y de la formulación de las recomendaciones a debate; 2) constitución de un panel experto multicéntrico con representantes de la especialidad; 3) encuesta postal en dos rondas con procesamiento intermedio de opiniones e informe a los panelistas; y 4) discusión de resultados en sesión presencial del comité científico.

Correspondence:
Manuel Martín Carrasco
Clínica Psiquiátrica Padre Menni
Avda. Marcelo Celayeta, 10
31014 Pamplona (Navarra)
E-mail: manuelmartin@intersep.org

Resultados. 61 expertos consultados completaron las dos rondas de evaluación del cuestionario. En la primera ronda se logran consensuar 39 de las 54 cuestiones analizadas. Tras la interacción del panel se aumenta el consenso hasta un total de 46 ítems de la encuesta (85% de los contenidos propuestos). En las 8 cuestiones restantes no se consigue un consenso suficientemente unánime, bien por disparidad de opiniones entre los profesionales, bien por falta de criterio establecido en la mayoría de los expertos.

Conclusiones. Se presenta un amplio listado de criterios profesionales y recomendaciones clínicas que pretenden racionalizar el manejo de la depresión en el paciente anciano y reducir el exceso de variabilidad en la práctica clínica. Las recomendaciones se cualifican según el grado de acuerdo profesional en que se sustentan y pueden considerarse vigentes hasta la aparición de nueva información científica que justifique su revisión.

Palabras claves:
depresión, anciano, consenso, psiquiatría

INTRODUCTION

Experimental clinical research in psychiatry has intrinsic methodological problems that specifically condition the design quality and limit the validity of many of the studies published (adaptation of the criteria and of the diagnostic instruments used in the recruitment and classification of the study subjects, availability of well-validated clinical evaluation scales that are sufficiently sensitive to change, complexity to standardize and mask the tested interventions, especially if they are psychotherapeutic procedures, ethical restriction for the obtaining of a valid consent from the patient with a mental disorder, etc.).

These problems at least partially explain the frequent bibliographic controversies on the effectiveness of the psychopharmaceuticals and the variability of professional criterion and clinical habits in the use of these substances, both between psychiatrists as well as in other medical specialities.[1]

In the specific case of the geriatric populations and depression, the frequent specific exclusion of the elderly in pharmacotherapeutic clinical trials with antidepressants and the practical non-existence of information available referring to the very elderly depressed subpopulation is also a reason why the psychiatrist has to continuously make clinical decisions under high uncertainty conditions. These decisions are usually made with information extrapolated from non-geriatric population studies, together with the previous personal experience of each professional.

With this project, the Sociedad Española de Psicogeriatría (SEPG) (Spanish Society of Psychogeriatrics) has aimed to obtain a consensus on a proposal for professional criteria and clinical recommendations that will facilitate the management of the clinical uncertainty in the treatment of the elderly patients with depressive disorders. For this reason, the expert criterion of professionals who have special interest and dedication to the management of these patients was requested and analyzed, attempting to elucidate the scientific controversies by means of the best tests available and the clinical experience accumulated by the professionals with greater dedication to this problem in our country.

For this reason, under the institutional impulse and supervision of the scientific society, a meeting of an expert multicenter panel was organized, formed by psychiatrists within the clinical and academic setting, experts of renowned prestige because of their previous trajectory in the field of depression and psychogeriatrics. The participants in this project evaluated, compared and reached a consensus on their professional opinions on the extensive battery of questions regarding depression in the elderly, object of different grades of professional debate. To unify their criterion, they were asked to consider the known and available scientific evidence as well as their own personal clinical-epidemiologic cohort experience on each question.

This project has been carried out using a reliable procedure of expert consensus which has a long tradition of use in biomedicine, as is the two-round modified Delphi technique.[2] This method makes it possible for the participants to know the previous opinions of all the participants and to bring their divergent positions closer together, avoiding the difficulties and disadvantages of having discussion procedures with the members physically present (such as the need for physical traveling, the long duration of the deliberations, the frequent blockage of negotiation, the uncontrolled biases in the influence of the leaders, then nonconfidential interaction between the panelists, etc.).

The present study collects the final conclusions obtained from the consensus procedure, that the SEPG subjected to the consideration of the psychiatric group and of the remaining clinical community involved in the usual care to the elderly patient (primary care, geriatrics, neurology, palliative cares, home care services, and residential cares, etc.). This is done with the confidence that the proposal will help to unify the clinical decisions in the diagnosis and treatment of the elderly patients with depressive disorders

and reduce the unjustified variability of practices in the approach to this important problem.

MATERIAL AND METHODS

The present study has used the modified Delphi method, a non-on-site technique originally developed in the RAND Corporation (Santa Monica, California) by Helmer and Dalkey[2] to achieve consensus of a heterogeneous group of experts on the subject of interest subjected to a variability of criterion or professional controversy. To do so, the individual and anonymous opinion was requested from each expert by means of response to a written survey. The individual repetition of a second round of the survey on the questions that did not receive consensus in the first attempt, informing the participants of the results obtained by the group with the first questionnaire, allowed for the reconsideration and approach of the divergent positions, achieving the maximum possible consensus in the group. The dispersion grade in the responses was statistically analyzed to determine in which questions consensus was achieved by the expert panel, either by agreement or disagreement with the subjects proposed in the survey.

The project was carried out in four phases: 1) Constitution of a scientific committee, at the proposal of the SEPG, that was responsible for the preliminary bibliographic review and the formulation of the items on the survey; 2) selection of an expert panel of specialists in psychiatry with special interest and/or experience in the treatment of depression in elderly patients; 3) written survey (via e-mail) in two rounds with interim processing of opinions and report to the panelist; and 4) compiling, final analysis of results and discussion of conclusions in an on-site face-to-face session with the scientific committee.

The scientific steering committee of the project, after a bibliographic review of the subject performed independently by each one of its components, initiated the task of elaborating the questionnaire based on an initial free proposal of the contents provided by each member. After a process of review and subject grouping, carried out by 2 external consultants, a first draft was elaborated of the survey and was then distributed for review by the committee on 3 occasions. The formulation of each item in the final version of the survey was decided unanimously or, if this was not possible, by a simple consensus of the committee members (approval by the simple majority, without express veto by any member).

The final questionnaire was made up of 54 questions **(table 1)**, grouped into the following subject areas: epidemiology and etiopathogeny of depression in the elderly (8 items), clinical characteristics (7 items), diagnosis (4 items), prognosis (3 items), treatment (20 items), management of special situations and comorbidity in depressed elderly (9 items) and criteria on the professional competence necessary to a protest depression in the elderly (3 items).

Each item of the questionnaire was formulated as a statement (affirmative or negative) that collected a professional criterion or a clinical recommendation on any aspect of interest or controversy in the approach to depression in the elderly (especially on the unique aspects that differentiate it from the non-depressed elderly population). The bibliographic material used by each committee member in the writing of their proposals was also collected, in order to put it at the disposition of the subsequently surveyed expert panel. [3-13]

To score the survey, a single type of evaluation scale was used in all the questions, the five-categories ordinal type Likert response described by linguistic and numeric scores qualifiers: 1 = totally agree with the item, 2 = moderately agree, 3 = neither agree nor disagree (I have no defined criteria), 4 = moderately disagree, 5 = totally disagree with the item. After each question, the survey offered the possibility of adding free observations to the panelists and it was completed with a final section for the supplying of new proposals of items.

The expert panel was formed under the direction of the scientific committee by the selection of a multicentric group of psychiatrists with clinical experience and specific professional recognition in the approach to depression in the elderly patient, both in the psychogeriatrics and general psychiatry setting. For their identification, a "snowball" strategy was used, based on the professional contacts of the committee members, who proposed, in turn, new candidates within their professional setting, of prestige in this area. Finally, 63 psychiatrists from most of the regional Spanish communities were sent a letter inviting them, 61 panelists agreeing to participate.

The project field work was carried out for six weeks, between the months of April and June 2008, using e-mail as the pathway to distribute and collect the forms.

The analysis of the surveys and interpretation of the results were done as follows: the responses of the panel in the first round of the questionnaire were described by calculation of the average values of the scores of each item and their corresponding 95% confidence interval (95% CI), considering those items in which the upper limit of the 95% CI was less than 3 (agreement of the panel with the statement) and in which the lower limit of the 95% CI was superior to 3 (disagreement with the statement) as having a consensus. The remaining items in which the 95% CI included the value of 3 were selected to be proposed for reconsideration of the panel in the second Delphi round.

Table 1 Results after 2 rounds of the Delphi survey. For each item, the grade and direction of the consensus are indicated with the average group score on the scales 1-5 (1 = Totally agree, 2 = Agree, 3 = Neither agree nor disagree, 4 = Disagree, 5 = Totally disagree).

	Mean	LL-CI	UP-CI	% against
EPIDEMIOLOGY AND ETIOPATHOGENY OF DEPRESSION IN THE ELDERLY				
1. Major depression is more frequent in the elderly than in the younger adult.	2.52	2.27	2.77	(*) No consensus
2. The role of the genetic and family factors is more important in the depression of the elderly, the more advanced the initiation age of the depression of the elderly person.	3.92	3.70	4.15	5.9
3. Degenerative processes play an important role in the etiology of depression in the elderly.	1.74	1.56	1.91	1.9
4. Psychosocial stress factors, for example, mourning, loneliness, poverty play an important role as a precipitant of depression in the elderly.	1.39	1.24	1.53	0
5. Entry into a Residence for the Elderly frequently determines the appearance of depression.	2.19	1.92	2.46	11.5
6. Somatic comorbidity, especially cardiovascular, painful or incapacitating type conditions, are frequently associated to depression in the elderly.	1.46	1.31	1.62	0
7. The concept of vascular depression has clear clinical utility.	2.55	2.28	2.82	(*) No consensus
8. The concept of depressive pseudodementia is useful in the clinical practice	2.38	2.08	2.67	17.8
CLINICAL CHARACTERISTICS OF DEPRESSION IN THE ELDERLY				
9. Delusional depression is more frequent in the elderly than in the young adult.	1.75	1.55	1.96	5.7
10. Depression with melancholy is less frequent in the elderly than in the young adult.	3.66	3.39	3.94	17
11. Dysthymia is equally frequent in the elderly and in the younger populations.	3.51	3.26	3.76	20.8
12. The elderly tend to have subclinical depression with less frequency than young adults.	3.60	3.26	3.95	20.7
13. Somatic complaints are a more frequent symptom in the depression of the elderly than in the younger subjects.	1.44	1.30	1.59	0
14. Clinical studies should differentiate between elderly persons and very elderly (older than 80 years) because the causes of the depression and/or their clinical expression is different between these 2 groups.	1.93	1.66	2.19	9.3
15. Executive dysfunction is the most important cognitive alteration in the depression of the elderly.	2.39	2.18	2.61	16.1
DIAGNOSES OF DEPRESSION IN THE ELDERLY				
16. In the diagnosis of depression in the elderly, it is essential to perform a cognitive evaluation of the patient.	1.37	1.18	1.56	3.7
17. In all depression of onset in the elderly, it is necessary to perform at least one basic analytic study.	1.23	1.08	1.38	1.9
18. In all depression of onset in the elderly, it is necessary to perform a neuroimaging study (as for example, brain CT scan).	2.28	1.96	2.60	22.2
19. DSM/ICD standard diagnostic criteria are useful to diagnose depression in the elderly.	3.21	2.95	3.48	(*) No consensus
PROGNOSES OF DEPRESSION IN THE ELDERLY				
20. Patients over 60 years respond worse to pharmacological treatments with antidepressants than the rest of the ages.	3.15	2.86	3.45	(*) No consensus
21. Elderly age is a risk factor for consumed suicide in patients with depression	1.87	1.53	2.21	15.4

Table 1 Continuation

22. Evolution to dementia is a frequent complication of depression, especially in pictures with significant cognitive impairment.	2.15	1.83	2.48	15.4
TRATAMIENTO DE LA DEPRESIÓN EN ANCIANOS				
	Mean	**LL-CI**	**UP-CI**	**% against**
23. SSRI antidepressants are first-line treatment drugs of major depression in the elderly.	2.00	1.78	2.22	7.4
24. SSRNI antidepressants are drugs of the first line in the treatment of major depression in the elderly.	2.17	1.94	2.39	11.1
25. Tricyclic antidepressants are first-line treatment drugs of major depression in the elderly.	4.31	4.12	4.51	1.9
26. Other antidepressants are first-line treatment drugs of depression in the elderly (if "Total agreement" or "Agreement" is chosen in this item, specify the antidepressant agent).	3.55	3.33	3.76	9.1
27. The SSRNI drugs achieve greater efficacy in the treatment of depression in the elderly compared with the SSRIs.	2.62	2.36	2.88	(*) No consensus
28. Dopaminergic agonists have an outstanding role in the treatment of depression in the elderly.	2.38	2.08	2.67	21.4
29. The recent introduction of drugs such as duloxetine or bupropion may improve therapeutic response of depression in the elderly.	2.02	1.82	2.21	3.7
30. The clinical and biological information available, including the results of the controlled clinical trials (CCTs), make it possible to provide a selective therapeutic indication of antidepressants in the elderly.	2.96	2.68	3.25	(*) No consensus
31. In general, it is not necessary to make an initial dose adjustment to treat the depression of the elderly with antidepressant drugs.	3.83	3.57	4.10	11.2
32. In the case of resistance or insufficient response to an antidepressant drug in elderly patients, the maximum recommended dose for each agent should be increased.	2.20	1.95	2.45	13.3
33. In the case of resistance or insufficient response with a single antidepressant drug, the association of antidepressants is an adequate option in elderly patients.	2.09	1.80	2.38	15.6
34. In the case of resistance or insufficient response to an SSRI in the elderly, it is adequate to change the treatment to a dual antidepressant.	1.82	1.65	2.00	2.2
35. The most frequent cause of lack of efficacy of antidepressants is the administration of an inadequate dose.	2.40	2.16	2.65	19.0
36. Antidepressant-induced sexual dysfunction is not a problem in the elderly who are sexually active.	3.96	3.73	4.20	7.5
37. In the depression of the elderly, concomitant treatments such as benzodiazepinic hypnotics and anxiolytics can be used without taking any special precaution.	4.26	4.02	4.50	5.6
38. Psychotherapy may be especially useful when there are psychosocial factors identified in the origin or maintenance of the depression.	1.87	1.73	2.01	0
39. Psychotherapy may be especially useful when the drugs have little efficacy or are poorly tolerated.	2.96	2.68	3.24	(*) No consensus
40. Physical exercise improves depression in the geriatric patients.	2.02	1.84	2.20	1.9
41. Electroconvulsive therapy is indicated in the elderly with refractory depression or serious risk of suicide.	1.66	1.53	1.79	0
42. Electroconvulsive therapy cannot be used as maintenance treatment due to its risks.	3.63	3.33	3.93	16.3
MANAGEMENT OF SPECIAL SITUATIONS AND OF COMORBIDITY IN THE DEPRESSED ELDERLY SUBJECTS				
	Mean	**LL-CI**	**UP-CI**	**% against**
43. In the case of doubt between depression and depressive pseudodementia, treatment should never be initiated and it should be waited until a definitive diagnosis is established.	4.24	3.94	4.55	9.3

Table 1 Continuation

44. Depression accompanied by significant cognitive alterations indicates greater severity, with slower and more difficult recovery.	2.00	1.74	2.26	11.2
45. It is not necessary to have a specific way of treating depression that complicates the course of dementia (for example, Alzheimer's disease).	4.13	3.84	4.43	11.3
46. Vascular depressions respond worse to standard antidepressant treatment.	1.98	1.71	2.25	8.9
47. The specific case of psychotic depressions requires treatment with associated antidepressants and antipsychotics, if not electroconvulsive therapy.	1.54	1.30	1.77	3.7
48. In case of several previous depressive episodes, maintenance treatment with an indefinite duration is recommended.	1.33	1.19	1.47	0
49. In case of resistance or insufficient response with a single antidepressant drug, addition of lithium salts is an adequate option in elderly patients.	3.51	3.27	3.75	21.3
50. In depression associated to Parkinson's disease, SSRIs are not agents of first choice due to the possible deterioration of the Parkinsonian symptoms.	2.93	2.66	3.20	(*) No consensus
51. In elderly patients who take anticoagulants, it is not necessary to adopt special precautions when prescribing an antidepressant.	3.91	3.67	4.15	9.1
SOME CRITERIA ON THE PROFESSIONAL CAPACITY TO APPROACH DEPRESSION IN THE ELDERLY				
	Mean	**LL-CI**	**UP-CI**	**% against**
52. Most of the depressions in the elderly can be diagnosed and treated in Primary Care.	2.50	2.28	2.75	25.0
53. The current approach to the depressed elderly in Primary Care is frequently inappropriate.	2.26	2.00	2.52	14.9
54. The psychiatrist requires specific training to approach with competence the depressive disorders in the elderly.	2.20	1.98	2.42	13.0

(*) Item in which consensus does not exist according to the statistical criteria proposed.
LL-CI and UL-CI: lower and upper limit, respectively of the 95% confidence interval of the average.
% against: percentage of panelists with opinions contrary to the group consensus achieved ∑ of options 4 and 5 in case of group agreement, ∑ of options 1 and 2 in case of group disagreement).

The questions that were not answered because the panelist considered him/herself as not competent in the material analyzed were managed as data lost for statistical effects. After this, the panelists were informed of the distribution of the responses obtained in the first round for each item for which a consensus was not reached by the corresponding bar graph (with the percentage of responders to each response category). In addition, the free comments and clarifications made by the panelists were distributed anonymously.

After the second round of survey, identical criteria were applied to discriminate the finally agreed upon items from those in which it was not possible to achieve a consensus of the panel. For comparison, the greater the extreme of the average scores of one item (closest to one or to 5), the more manifest the consensus achieved is considered to be, in either the agreement or disagreement, respectively, on the proposal considered. The narrower the confidence interval, the greater the unanimity of opinion existing in the group. The items where no consensus was achieved after completing the process described were analyzed descriptively to distinguish those in which there were extremely different opinions among the panelists from those in which most of the group expressed that they had no definitive criterion on them (vote = 3).

Although this methodology of analysis was widely disseminated in previous studies,[14-16] the low resulting consensus with other alternative and stricter statistical criteria used by other authors in studies with similar evaluation scales was verified,[17-19] that is, variation coefficient less than 0.3, average of the scores less than 2.5 or greater than 3.5, some of the percentages of the extreme values (1+2 or 4+5) superior to 70% of the responses (respectively, for the agreement and disagreement), medium different from the central point (3).

RESULTS

The 61 experts consulted completed the two evaluation rounds. In the first round of the survey, 39 of the 54 questions analyzed had a consensus according to the preestablished evaluation criteria (27 of them in terms of group agreement

with the questions proposed and 12 in terms of group disagreement). Of the 15 remaining items proposed for reconsideration of the experts in the second round, it was possible to reach a consensus in 7 more (5 of them in group agreement with the item considered and 2 in terms of unanimous group disagreement with the item considered).

Globally considered, the panel achieved sufficient consensus in 85.18% of the contents proposed. In 8 items (14.81% of the questionnaire), sufficient unanimity of the criterion in the panel was not achieved, either because of differences of professional opinion, or due to lack of criterion established in most of the experts.

Table 1 shows the global results with their corresponding statistics, specifying the distribution of opinions of the panelists in each case (% who accept or reject the content of the item). The interpretation of the achieved or failed consensus (shown in the last column of table 1) was made requiring all the previously described statistical criteria in each case. It is pointed out that, according to the specifications of the technique, part of the items were written negatively. This should be carefully considered when evaluating the orientation of the group opinion (agreement or disagreement) with each recommendation evaluated. Table 2 collects the items with consensus and non-consensus synoptically.

DISCUSSION

In general terms, in spite of the limited evidence available on many of the subjects being considered by the panel, the professional criterion of the experts participating in this project is quite uniform, it having been possible to achieve the desired consensus in more than four fifths of the questions evaluated.

On the epidemiology of the problem, there is no unanimous opinion, although there was a majority in the opinion on whether major depression is more frequent in the elderly than in the younger adult. Neither the limited epidemiological data available (even more deficient in our setting) nor the personal experience of the clinicians (who attend to biased populations coming from referrals of patients by other physicians) are reliable sources of information in this regards.

Regarding the etiopathogeny of depression with onset in the elderly, although the panel gives less importance to the genetic factors than in the adult-young age, the genes mediating neurodegeneration may confer a risk of depression. In this sense, some depressive syndromes of the elderly, above all in the less productive or apathic subjects, seem to be associated to neurodegenerative pictures, particularly those that imply disruption of the frontal-subcortical circuits. Another pathogenic hypothesis derived from the frequent comorbidity between pain and depression in the elderly identified by the experts would be the shared dysfunction of the nervous pathways of the transmission of pain and of the emotional zones in both conditions.

There is extensive professional consensus on the participation of psychosocial factors (mourning, loneliness, poverty, etc.) as precipitants of depression in the elderly. Furthermore, admission to a geriatric residence is identified as a clearly associated factor to the appearance of depression, although doubts persist on whether this relationship is due to a psychological reaction to a new setting or if, on the contrary, the patients who need institutional cares may suffer other determining disorders of depression, although admission to a residence for the elderly does not mediate.

Without reaching full consensus, the majority of the expert panel considers that the concept of "vascular depression" is of clinical utility (less than one fourth of them doubt it). Perhaps the specialist most familiarized with the psychogeriatric literature follow the evolution of this concept more closely (of recent introduction and not exempt of controversy) and its possible application to the daily clinical work.

Regarding the concept of "depressive pseudodementia," of 25 years of antiquity, the experts considered it to have clear clinical utility, especially among non-psychiatric physicians (general practitioners and neurologists), as an alert to the possibility that the cognitive symptoms inherent to depression of the elderly could be confused and produce false positives in the diagnosis of dementia. However, the terminological inaccuracy of the prefix "pseudo," that should not be maintained once the diagnosis of depression is made, considering the operative criteria, can be criticized. Furthermore, the concept affects a restrictive and unreal dimension/depression diagnostic duality since there are other disorders that can be confused with dementia, such as "hysterical pseudodementia."

Regarding the clinical expression per se of geriatric depression, the delusional form is considered to be more frequent than in the young adult. In the same sense, the panel rejected that severe and melancholic depressions are less frequent in the elderly, although there does not seem to be clear epidemiological evidence in this regards. There is also unanimous disagreement that subclinical depression is a less prevalent disorder in the elderly (among whom, in addition, it seems to cause greater impact on quality of life than that seen in the younger populations) and that dysthymia is as frequent in the elderly population as in the previous stages of life. These criteria may depend on associating the concept of dysthymia to depression in the young and to personality maladaptations, while in the elderly, the dysthymic course pictures are seen as minor depressions or adaptive disorders.

Table 2 Items with consensus and without consensus

A. EPIDEMIOLOGY AND ETIOPATHOGENY OF DEPRESSION IN THE ELDERLY

CONSENSUS

Factors involved in the etiology of depression in the elderly are considered to be:
- Degenerative processes.
- Somatic comorbidity, above all cardiovascular, painful or incapacitating disorder.
- The circumstances of psychosocial stress –mourning, loneliness, poverty, etc., especially, admission to geriatrics facility, as precipitants.

Genetic condition is not a determinant factor of depression of the elderly, especially if the onset is in advanced ages.
"Depressive pseudodementia" is a concept of utility in the clinical practice.

NO CONSENSUS

The prevalence of major depression is greater in the elderly than in the young adult.
"Vascular depression" is a concept of utility in the clinical practice.

B. CLINICAL CHARACTERISTICS OF DEPRESSION IN THE ELDERLY

CONSENSUS

It is considered that the clinical characteristics of depression that are more frequent in the elderly than in the young adult are:
- Delusional depression.
- Depression with melancholy.
- Subclinical depression.
- Presentation by somatic symptoms.
- Executive dysfunction as cognitive alteration.

On the contrary, dysthymia is considered to be a less frequent disorder in the elderly population.
The clinical investigation should separate the elderly and very elderly populations (> 80 years) because of their etiological and symptomatic specific features.

C. DIAGNOSIS OF DEPRESSION IN THE ELDERLY

CONSENSUS

In the diagnoses of depression in the elderly, it is essential to carry out:
- Cognitive evaluation.
- Basic analysis.
- A neuroimaging study (e.g., brain CT scan).

NO CONSENSUS

The DSM/ICD standard diagnostic criteria are useful for the diagnoses of depression in the elderly.

D. PROGNOSES OF DEPRESSION IN THE ELDERLY

CONSENSUS

Elderly age is a risk factor for consumed suicide.
Evolution to dementia is a frequent complication of depression, especially if there is significant cognitive involvement.

NO CONSENSUS

Elderly patients (over 60 years) respond worse to treatment with antidepressants than other ages.

Table 2 Continuation

E. TREATMENT OF DEPRESSION IN THE ELDERLY

CONSENSUS

SSRI and SSRNI are considered first line antidepressant alternatives in the elderly, but not the tricyclics or other agents, although the dopaminergic agonists have an outstanding role.

New agents such as duloxetine or bupropion can improve the therapeutic response of depression in the elderly.

An initial dose adjustment of the antidepressants in the elderly is recommended.

In case of resistance or insufficient response to an antidepressant drug in the elderly, the following can be done:

- Reach the maximum recommended dose for each agent (insufficient doses are the most frequent cause of inefficacy).
- Associate a second antidepressant agent if the monotherapy fails.
- Substitute the first agent, if it was an SSRI, for a dual antidepressant.

In the depressed elderly, special precaution is required with:

- The concomitant use of benzodiazepinic hypnotics or anxiolytics.
- Possible sexual dysfunction due to antidepressants in sexually active elderly.

Useful therapeutic alternatives in depression of the elderly are:

- Psychotherapy, especially if there are identified psychosocial factors.
- Physical exercise.
- Electroconvulsive therapy when there is refractory depression or severe risk of suicide, even useful as maintenance treatment.

NO CONSENSUS

SSRNI drugs are more effective than the SSRI in the depression of the elderly.

There is sufficient clinical and biological information to make a selective therapeutic indication of antidepressants in the elderly.

Psychotherapy is especially useful when pharmacological treatment fails.

F. MANAGEMENT OF SPECIAL SITUATIONS AND COMORBIDITY IN DEPRESSED ELDERLY

CONSENSUS

Depression that complicates the course of a dementia and the cases of diagnostic doubt between both conditions should be treated with antidepressants.

The following are unfavorable prognostic factors in depression of the elderly:

- Significant cognitive alterations (more difficult recovery).
- Vascular depressions (worse response to antidepressant treatment).
- Psychotic depressions (they require association of antidepressants antipsychotics or ECT.
- Background of several previous depressive episodes (they require indefinite maintenance treatment).

In case of resistance or insufficient response to antidepressant monotherapy, lithium salts are not a reasonable option in the elderly.

When anticoagulation drugs are taken, precaution is required when using antidepressant drugs.

NO CONSENSUS

In Parkinson-associated depression, SSRI are not agents of first choice due to the possible worsening of the Parkinsonian symptoms.

G. SOME CRITERIA ON PROFESSIONAL COMPETENCE TO APPROACH DEPRESSION IN THE ELDERLY

CONSENSUS

Most of the depressions in the elderly can be diagnosed and treated in primary care, although the current approach is frequently inappropriate.

The psychiatrist also requires specific training to competently approach depressive disorders in the elderly.

One criterion clearly shared by the experts is that depression in the elderly is typically manifested with somatic complaints. Furthermore, it is considered that depression in very elderly persons (over 80 years) is a different picture in its expression and/or causes, so that it is estimated to be necessary to include this subpopulation specifically in the clinical studies on depression in order to generate knowledge about it.

Executive dysfunction is evaluated as the most important cognitive alteration of depression of the elderly. Furthermore, its presence is related with worse prognosis and less response to treatment. Thus, it is convenient to explore the depression specifically, an action that is not often routinely performed. Although the involvement of attentional or memory processes is also common in geriatric depressive conditions, the executive deficit due to frontal and prefrontal subcortical circuit affectation is especially characteristic in late-onset geriatric depression.

Regarding the diagnosis, there is wide expert consensus on the utility of carrying out a systematic cognitive evaluation within the diagnostic protocol of depression of the elderly. Scientific literature and clinical experience support the convenience of this action, because of its diagnostic and prognostic implications. The evaluation helps to make the differential diagnosis between depression and dementia and to establish the baseline cognitive functioning of the patients at the point in time (in relationship to whether the subsequent evaluation shows improvement/stability/deterioration during the evolution of the depression, it would represent an alarm for possible evolution towards dementia). The extension of the cognitive evaluation, adapted to each specific case, should include at least one standard screening test, such as the mini-mental state cognitive examination.

Furthermore, it is recommended to investigate the physical condition of the depressed elderly patients using a basic analysis that provides information both to rule out underlying organic factors as well as to choose the treatments that could be established. The panel also advises performing a neuroimaging study (for example, brain CT scan) as part of the routine study, an action only rejected by one-fifth of those surveyed. Factors such as economic cost or difficulties of access to the test may influence this opinion contrary to that of the majority.

The panel did not achieve consensus on their criterion on the diagnostic utility of the DSM/ICD for the detection of depression of the elderly. Against these classifications, the underdiagnosis induced by the syndrome in the elderly, among whom the depressive manifestations are frequently atypical, has been criticized. The need to adapt these criteria for one or more subtypes of late depression, as those already existing for depression and Alzheimer's disease, seems clear.

On the specific prognostic features of depression in the elderly, there is no clear consensus regarding whether elderly patients respond worse to antidepressant pharmacological treatments than the remaining ages (50% of the panelists have a contrary opinion). The scarcity of specific clinical trials for the elderly population explains the variability of the expert criterion, based fundamentally on personal experience. However, what is accepted is that consumed suicide is more frequent in the depressed elderly subject, especially if pain and depression are associated. Equally, it is accepted that it is likely that depressions in the elderly may evolve frequently towards dementia, above all when there is cognitive impairment.

Regarding pharmacological treatment of depression in the elderly, both the SSRI type antidepressants as well as the SSRNIs are recommended as first line drugs in the treatment of depressions in the elderly. This is not true regarding tricyclic antidepressants or other specific agents. Although the opinion of the majority of the panel is that the SSRNIs are more effective than the SSRIs in the treatment of the depressed elderly patients and that antidepressant drugs with dopaminergic action have a role in the treatment of geriatric depressions, both criteria do not achieve a manifest consensus. However, the recent introduction of dual antidepressants such as duloxetine (serotonergic and noradrenergic action) and bupropion (dopaminergic and noradrenergic action) is considered by the panel to be an important factor to improve the therapeutic response of depression in the elderly.

In general, the experts considered that there must be an initial dose adjustment when antidepressants are used to treat depression in an elderly subject. However, if the therapeutic response is insufficient, the recommendation is made to reach the maximum recommended dose for each substance, since the administration of inadequate doses is the most frequent cause of lack of efficacy. If the expected response is not achieved with the drug, then its association with another antidepressant is considered to be a valid option, also in the case of the elderly patient. If the resistance occurs with an SSRI agent, the panel considers it to be good praxis to treat the therapeutic change to a dual agent.

Contrary to the usual criteria, the experts reject that antidepressant induced sexual dysfunction is not an important problem in the elderly patients, many of whom are sexually active, since it affects their quality of life and therapeutic compliance. Equally, they show their disagreement that the association of hypnotics and benzodiazepines with antidepressants is exempt of specific risks in the elderly patient.

It is recommended to consider psychotherapy in the treatment of depression in the elderly, especially when

there are psychosocial factors identified in its origin or maintenance as well as evaluating the express prescription of physical exercise, since this may clearly improve the symptoms of geriatric depression. The panel divides its opinion on the utility of psychotherapy as an alternative in patients in whom a previous pharmacological therapeutic attempt has failed.

Finally, electroconvulsive therapy (ECT) is considered to be indicated in elderly patients who do not respond to standard treatments, and it may even be used as a maintenance treatment, if necessary.

Regarding the management of the frequent situation of the comorbidity characteristic of the depressed elderly subjects, even when there are reasonable doubts in the differential diagnosis between depression and dementia with depressive symptoms, it is recommended to specifically treat the depressive symptoms. Furthermore, it is necessary to treat the depression that complicates the course of dementia. In general, the experts consider that the presence of important cognitive impairments in a depression in the geriatric age implies greater severity and worse prognoses.

There is a majority opinion regarding the criteria of the experts that vascular depressions respond worse to the usual antidepressant treatments, that psychotic depression of the elderly generally requires treatment with associated antidepressants and antipsychotics (and eventually ECT) and that recurrent depressions with several previous episodes in an older patient legitimize the decision to consider an indefinite duration for the maintenance treatment. The association of antidepressants or the change of SSRI to dual treatment also are considered adequate regimes in case of insufficient therapeutic response.

On the contrary, the panel has expressed that it is against considering the association of lithium salts to antidepressants in cases of resistant depression in the elderly as a widely indicated option and reminds that special precautions should be taken (e.g. dose adjustment, close monitoring) in elderly patients with anticoagulant treatment in whom antidepressants need to be prescribed. The management of depression associated to Parkinson's disease is a question in which there is great difference of expert criterion. Half of the panelists were in favor of or against the use of SSRI due to the possible deterioration of the Parkinsonian symptoms.

Finally, although the panel considers that the management of depression of the elderly subject is perfectly assumable in the Primary health-care centers, it also stands out that the therapeutic approach of most of these patients is inappropriate. In the opinion of the experts, psychiatrists also do not escape the need for specific training in psychogeriatrics to improve their competence in the treatment of depression of the elderly.

In conclusion, experts in geriatric depression have shown a high grade of unanimity in the approval or rejection of most of the contents subjected to their consideration. The professional criteria in which consensus has been reached in this project, in the absence of new evidence that contradicts them, may be considered sufficient justification of clinical recommendations supported by the unanimous professional criterion of the Spanish experts and should come from the systematic application in the usual practice to reduce the unjustified variability of the practices in the treatment of depression of the elderly.

The items in which consensus was not reached in this project make it possible to show some aspects of the practice in which there is greater disagreement of opinion between the expert professionals. In these questions, possible needs for research have been identified and this would provide responses that are still not available at present.

ACKNOWLEDGMENTS

To the panelists surveyed, for their participation as experts in the Delphi survey.

Baca, Enrique
Brenilla, Julio
Bousoño, Manuel
Bulbena, Antonio
Catalán, Rosa
Claver, Dolores
De Azpiazu, Pilar
De Blas, José
De Dios, Consuelo
De la Fe, Inmaculada
De la Gándara, Jesús
Fernández, Olga
Franco, Blanca
Franco, Manuel
Galindo, Alfredo
Gamo, Beatriz
García Balado, Beatriz
García López, Aurelio
García Mellado, Juan
García Montañes, Bianca
García Parajua, Pedro
García Santos, Luis María
Giner, Lucas
González, Víctor
Gómez del Barrio, Andrés
Guerro, Delio
Gurpegui, Manuel
Iglesias, Celso
Mateos, Raimundo
Martín, Tomás
Mirón, Eduardo
Monforte, Jesús
Navarro, Rafael
Olivera, Javier
Osorio, Ricardo
Otero, José
Pascual, Jesús
Pelegrín, Carmelo
Pérez, Francisco
Pla, Jorge
Pérez Bravo, Avelina
Pérez Solá, Víctor
Pozo, Jorge
Pujol, Joaquín
Ramos, Isabel
Roca, Ernesto
Roca, Miquel
Rojo, José Emilio
Ros, Salvador
Royuela, Ángel
Ruiz, Óscar
Ruiz, Francisco
Sánchez Pérez, Manuel
Sánchez Sevilla, Juan
Sanjuán, Julio
Sanz, Olga
Sáez, Cristina
Seguí Montesinos, Joan
Soto, Antonio
Taboada, Óscar
Urretavizcaya, Miquel

To the L5 group of the Clinical-Epidemiological Research Unit, for their help to the scientific committee in the tasks of designing the project, statistical analyses and writing of the draft of this original.

CONFLICT OF INTERESTS

SEPG has developed the present project with the financial help of Lilly pharmaceutical company (Laboratorios Lilly) for the development of the study surveys. The financial backer has not participated in the design, data analysis or writing of the present article.

REFERENCES

1. Pincus HA, Tanielian TL, Marcus SC, Olfson M, Zarin DA, Thompson J, Magno Zito J. Prescribing trends in psychotropic medications: primary care, psychiatry, and other medical specialties. JAMA 1998;280:132-3.
2. Dalkey N, Brown B, Cochran S. The Delphi Method, III: Use of Self Ratings to Improve Group Estimates. Santa Monica, Calif: Rand Corp; November 1969. Publication RM-6115-PR.
3. Alexopoulos GS. Depression in the elderly. Lancet 2005;365:1961-70.
4. Baldwin RC. Recent understandings in geriatric affective disorder. Curr Opin Psychiatry 2007;20:539-43.
5. Berra C, Torta R. Therapeutic rationale of antidepressant use in the elderly. Arch Gerontol Geriatr 2007;44:83-90. Review. PMID: 17317438.
6. Buckley MR, Lachman VD. Depression in older patients: recognition and treatment. JAAPA 2007;20(8):34-41. Review. PMID: 17847649.
7. Charney DS, Reynolds CF, Lewis L, et al. Depression and bipolar support alliance consensus statement on the unmet needs in diagnosis and treatment of mood disorders in late life. Archives of General Psychiatry 2003;60:664-72.
8. Copeland JRM. Prevalence and risk factors on depression in the elderly: A European research project. European Psychiatry 2004;19:6S-7S.
9. Das B, Greenspan M, Muralee S, Choe CJ, Tampi RR. Late-life depression: A review. Clinical Geriatrics 2007;15:35-44.
10. Mottram P, et al. Antidepressants for depressed elderly. Cochrane Database of Systematics Reviews. 2007(2).
11. Schultz S. Depression in the older adult: the challenge of medical comorbidity. Am J Psychiatry 2007;164:847-8.
12. Unützer J. Clinical practice. Late-life depression. N Engl J Med 2007;357:2269-76. Review. PMID: 18046030.
13. Vannoy SD, Duberstein P, Cukrowicz K, Lin E, Fan MY, Unützer J. The relationship between suicide ideation and late-life depression. Am J Geriatr Psychiatry 2007;15:1024-33.
14. Figueras J, López J, Medrano C, et al. Consenso multidisciplinar español sobre la profilaxis de la infección respiratoria pediátrica por virus respiratorio sincitial. An Pediatr (Barc) 2008;69(1):63-71.
15. Beers MH. Explicit criteria for determining potentially inappropriate medication use by the elderly. Arch Intern Med 1997;157:1531-6.
16. Fick DM, Cooper JW, Wade WE, Waller JL, Maclean JR, Beers MH. Updating the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. Results of a US Consensus Panel of Experts. Arch Intern Med 2003;163:2716-24.
17. Almansa C, Rey E, Bolaños E, Palma M, Álvarez A, Díaz-Rubio M. Opinión de los médicos españoles sobre el síndrome de intestino irritable: resultados de un estudio utilizando el método Delphi. Rev Esp Enferm Dig 2007;99:210-7.
18. Dago A, Arcos P, Álvarez de Toledo F, Baena MI, Martínez J, Gorostiza I. Indicadores de riesgo de morbilidad prevenible causada por medicamentos. Gac Sanit 2007;21:29-36.
19. Holey EA, Feeley JL, Dixon J, Whittaker VJ. An exploration of the use of simple statistics to measure consensus and stability in Delphi studies. BMC Med Res Methodol 2007;7:52.