CASE REPORT

How Not to Miss a Case of Late-Life Depression in Primary Care: A Case Report

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ABSTRACT

Depression is the second most common geriatric issue affecting approximately 5% of the aging population worldwide. In Malaysia, there is reported 37% of late-life depression (LLD) in primary care settings. Late-life depression is a complex form of depression, which makes the diagnosis tougher. In this report, we reflect on the challenges in recognizing LLD, and the need for practice improvement in order to not miss the diagnosis. Mr. G, a 67-year-old man, presented with severe constipation and significant weight loss. Thorough investigations have been done in tertiary centre which included multiple scopes and scans, but the findings were inconclusive. Yet one issue was missed that had social withdrawal for the past 2 years since the Covid-19 pandemic started. He refused to leave his room and bathed only once a week. He had a depressed mood, reduced appetite, and increased somnolence. He looked cachectic and depressed clinically. He was IADL-partial-dependent. He scored 21/30, 6/15, and 21/27 for Mini mental state examination (MMSE), Geriatric Depression Scale (GDS), and Patient Health Questionnaire-9 (PHQ-9) respectively. Oral Sertraline was started, and the outcome was remarkably favorable. Mr. G could have been treated earlier if the depression had been diagnosed ahead. Missing out LLD is quite common, perhaps due to a lack of awareness among medical practitioners. We are focused on physical ailments compared to mental, and this needs to change for the betterment of care. It is important to screen every elderly patient for LLD. It might be challenging however simple instruments like Whooley and Geriatric Depression Scale (GDS) would do the betterment for the patient care.

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INTRODUCTION

The global population is ageing rapidly whereby the geriatric or elderly population over 60 years will nearly double from 12% to 22% between 2015 and 2050. This is an expected increase from 900 million to 2 billion people over the age of 60 according to the World Health Organization (WHO).

This special population faces special physical and mental health challenges which need to be addressed. Over 20% of adults aged 60 and above suffer from various mental and neurological disorders. The most common issues encountered worldwide are dementia and depression which affect approximately 5% and 7% of the aging population respectively.

In Malaysia, there is reported 37% of late-life depression (LLD) in the primary care setting alone. Late-life depression is not defined specifically in the DSM-5, and it is generally described as loss of interest or pleasure in nearly all activities, and experience of at least four additional symptoms which include changes in appetite, sleep, weight, and psychomotor activity. LLD is rather more complex with fewer major depressive symptoms and greater preoccupation with somatic and psychotic symptoms and misleading cognitive deficits. It is greatly associated with their underlying medical disorders which make the diagnosis tougher.

CASE REPORT

History of illness:

MR G, a 67 years old Indian gentleman has been complaining of constipation and excessive weight loss of almost 30kg over the past 2 years. Since early 2021, he has been visiting our clinic on multiple occasions to get his conditions sorted. He was then referred to the nearest tertiary center for further investigations and intervention.

In late 2022, during his routine follow-up appointment at our clinic, Mr G still complained of constipation as well as weight and appetite loss. His caregiver stressfully claimed that they had exhausted all the options provided to them by the tertiary centre. Mr G has gone through multiple oesophago-gastro-duodenoscopy (OGDS) and colonoscopy, multiple imaging procedures, and a number of blood investigations which all came back negative. He and his family members have eventually given up and right away defaulted the follow-up appointment by the hospital.

Upon further history, Mr G was already showing a decline in function over the past 2 years which was overshadowed by major health issues like constipation, loss of weight, and appetite. His problem started after quitting his job during the Covid-19 pandemic, whereby he experienced anhedonia, hypersomnia, and psychomotor retardation. He also claimed that he was worried as a circle of his friends had started to demise. His daily routine including personal hygiene and medication intake were monitored by his wife.

Past medical history:

Mr G was diagnosed with hypertension, dyslipidemia, and gouty arthritis for the past 20 years and his co-morbidities are pretty much under the radar. He has a reputed history of being compliant with his medication.

Social history:

Mr G was educated till lower secondary school with no significant history of trauma during his upbringing. He was then married to his current wife during his 20s and they would certainly have a blissful marriage and be blessed with 2 kids. He was hired as a driver, initially as a factory bus driver. Three years ago, he was driving kids to school, he was actually unhappy, and claimed to have been having a lower pay, which indirectly led to his resignation. Mr G has then been living with his son, daughter-in-law and kids. No significant rift is to be noted.

Personality history:

Mr G was described by his family as a quiet, humble, and hardworking person.

Substance use history:

The patient was a chronic alcoholic who started drinking at the age of 20 and was also an occasional smoker who smoked 1 to 2 sticks in between his drinking sessions. He compulsorily drank 1 to 2 bottles of beer daily after his back from work. However, since he quit his job, he has stopped drinking by all means and has also abruptly stopped his weekend drinking with his friends which he used to do.

Family history:

No known psychiatric disorder among family members.

Past psychiatric history:

No significant psychiatric history in the past.

General physical examination:

Mr G appeared cachectic upon examination.

Vital signs:

Bp: 109/70 mmHg	RR: 18 per minute
PR: 77 bpm	Current weight: 42kg
Spo2: 97% under room air	BMI: 15kg/m^2

Imaging and laboratory investigations:

Full blood count	Hb: 10gm/dl
Renal profile	Ure: 5.4, Sod: 141, Pot: 4.9, Cre: 90
Liver function	Alb: 30, Alp: 70, Alt: 32, Ast: 32
Sugar level (MOGTT)	6.4 (fasting) 7.9 (post-prandial)
Hba1c	5.3%
Uric acid	221
Ufeme	Normal
Thyroid function	TSH: 1.2, T4: 15.6
Infective screening	Hepatitis B, C, HIV, VDRL: Non reactive
CT Brain	cerebral atrophy with widened gyri and ventricles

Mental status examination (MSE):

Mr G dressed appropriately in a t-shirt but with poor hygiene. He was cooperative but not forthcoming and had poor eye contact. He showed no abnormal movement. His speech was coherent, with normal speed and rhythm, but low volume. He was in a low mood but looked calm and not anxious. He had no delusion or hallucination at review and had poor insight towards his condition.

Assessment of activities of daily living (ADL):

Mr G`s premorbid function was good, whereby he was independent in both his basic ADL and instrumental ADL. His current condition showed partial dependence on instrumental ADL. He depended on his wife for medication serving. He stopped using his phone and did not go out driving, shopping, or mingling around.

Mini mental state examination (MMSE):

MMSE domain	**Score**
Visuospatial	0/1
Language	7/8
Concentration	3/5
Working memory	3/3
Short term memory	3/3
Orientation to place	5/5
Orientation to time	0/5

Mr G scored 21/30 for his MMSE which suggested mild impairment and needed supervision, support, and assistance.

Geriatric depression scale (GDS):

Mr G showed 6 positive components out of 15 as shown below.

Do you prefer to stay at home rather than going out and doing new things?
Do you feel full energy?
Have you dropped many of your interests and activities?
Do you feel that your life is empty?
Are you in good spirits most of the time?
Do you often get bored?

Patient health questionnaire-9 (PHQ-9):

Mr G scored 21 out of 27 for PHQ-9 which indicated severe depression. His positive components for PHQ-9 are shown below.

Little interest or pleasure in doing things: 3
Feeling down, hopeless or depressed: 2
Trouble falling or staying asleep, or sleep to much: 3
Feeling tired or having little energy: 3
Poor appetite or overeating: 3
Feeling bad about yourself: 2
Trouble concentrating on things: 2
Moving or speaking so slowly or so fidgety: 2
Thoughts that you would have been better off dead: 0

Diagnosis and management:

Based on all the assessments and investigations done, Mr G was diagnosed with severe LLD. He was then started on treatment for depression as shown below in chronology.

08/09/22	Home visit and further assessment were done by our team. Mr G was started on oral Sertraline 25mg daily for 3 days and subsequently increased to 50mg daily for 2 weeks until review
22/09/22	Mr G defaulted on his appointment. Thus, a teleconsultation was done with his daughter-in-law. He only showed an improved appetite, but other symptoms still existed. Oral Sertraline was increased to 75mg daily.
06/10/22	A teleconsultation was once again made with his daughter-in-law as he defaulted another appointment. Mr G had a significant improvement in terms of appetite, whereby who once preferred eating only a soft diet like porridge, was then able to take in a more solid sort of diet including rice, Indian cuisines like string hoppers, and idlers. His oral Sertraline was optimized to 100mg daily.
20/12/22	Mr G came to the clinic on the appointment date with his family. He is very much satisfied with the improvement. He had a more regular sleeping pattern from 9 pm to 7 am and had started joining his wife in her walk and leaving the house to meet up with his friends. He complained of no more constipation. Upon examination, he looked cheerful, in good hygiene, and was forthcoming during the session. He gained weight from 42 kg to 48 kg. His PHQ-9 score improved to 10 (mild). His oral Sertraline was continued with the same dose.

DISCUSSION

An online survey conducted by the Malaysian Psychiatric Association and Malaysian Mental Health Association back in 2019 has revealed that more than 50% of mental health sufferers preferred talking to a friend regarding their suffering rather than seeking professional help, worrying about how it would impact their carrier prospect and also deeming how their family would react to it [1]. It is believed that mental health will take over the lead as the second most disease burden in Malaysia from 2030 onwards [2]. With the recent pandemic, multiple researches have shown a steep increase in the prevalence of depression between 29.4% in 2015 to 80.1% in 2022 [3].

As being said, since stigmatization has been playing an important role within the community, however, due to an increase in awareness, more citizens are coming forward to address their issues [3]. Formerly, mental health cases like depression and anxiety were commonly referred to tertiary centre causing patients to default or refuse treatment proportionately perhaps due to stigma and long waiting queues. Since treatment for these cases which make up more than half of the mental health burden has been officiated in primary care, we have seen a double fold in cases reported, which addresses the concern whereby the cases that we see is the tip of the iceberg to the entire issue [4]. Although we have been conditioned to screen young adults and middle-aged ones, Late-life depression which has not been defined in the DSM-5, is commonly overlooked perhaps due to poor awareness [5].

The term geriatric has been coined as medical care for older adults as being said, they are frail, and the process of aging comes a lot with physiological changes as well. Commonly, low mood or energy or uncommon presentations like forgetfulness and irritability will often be dismissed as aging [6]. Given multiple comorbidities that patient might suffer before the age of 65, we would tend to accommodate it more. On the other hand, LLD or geriatric depression may also mimic other neurological disorders like dementia or Parkinson disease which would make our diagnosis even tougher [7]. In the gist of the discussed patient, cases of depression in the elderly group is treatable but the diagnosis can be difficult since their symptoms overlap, thereby it is up to us as physicians to always consider mental health issues as one of the culprits likewise said depression and anxiety in all patients encountered [8].

Since it is common for patients above 65 to be diagnosed with neurological symptoms and complications, foremost a first glance of general examination and short history like mood, appetite, sleep, memory, and bowel habits is best to be done [9]. If positive, patients and their caretaker can be screened further with simple instruments like Whooley and GDS which come in handy [10].

CONCLUSION

Underdiagnosis of LLD is common, perhaps due to a lack of awareness among medical practitioners. The main implication is underdiagnosis and those affected with it are denied early treatment which is crucial to reduce the complications. We as medical practitioners are too focused on physical ailments compared to mental, and this practice needs to be changed first. Our knowledge and awareness of LLD need to be improved, and the step to screen the elderly for LLD needs to be taken seriously. These actions are extremely paramount to prevent our LLD patients from being denied the treatment they deserve and to ensure overall improvement in the quality of our care delivered.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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