Date: Nov 25, 2020

PLEASE NOTE that Project ECHO® Care of the Elderly case recommendations do not create or otherwise establish a provider-patient relationship between any ECHO Care of the Elderly Hub team member/presenters and any patient whose case is being presented in a Project ECHO® setting. All resources are posted in the COP website, under Care of the Elderly Resources "Mood Disorders". You must be logged in to view the resources.

Case Synopsis:

A 97-years-old male admitted to LTC with his wife who passed away a year ago. He was very dependent on his wife and she was the primary decision maker in the family. He has become more withdrawn, talks of wanting to die, he cries, talks about missing his wife and he sometimes resists care and wishes to be left alone. Has 4 daughters, 2 in Ontario –they would visit prior to COVID, however, due to their own health challenges and Covid, they have not been able to visit. He communicates with his daughters via tablet (with assistance). Past medical history is significant for ischemic heart disease, depression, osteoarthritis, and dementia. Current medications are Mirtazapine 30mg at bedtime and Trazodone 25mg as needed for agitation.

Questions:

1) Despite behavioural supports, attempts at social activity, one on one support, and trials of antidepressants, he remains vocal about wanting to die. He shouts it out and it leads to distress amongst staff who feel helpless to help him. Other residents express distress. How can staff best support him?
2) Is any pharmacologic intervention likely to be helpful?

Summary of Recommendations:

- Further assessment/work-up
    - Based on his risk factors for depression particularly the loss of independence, his wife, pain, cardiovascular disease and social isolation, he likely has a bereavement-related depression
    - Assess his capacity to consent to Medical Assistance in Dying to determine if his repeated request to die represents a valid wish
- Non-Pharmacological Interventions-likely will need to follow adjustments to pharmacotherapy first
    - Reminiscence therapy focusing on joyful past events, beloved cultural traditions, and people and places of interest
    - Virtual reality goggles (of his former cottage or scenery) or, more practically, photographs
    - Validating his sadness and giving him permission to exercise autonomy and control over his current circumstances
    - Other interventions include; finding reading materials on a subject he once was interested in or did and/or reading to him, referral to virtual senior groups, engaging him with other residents, and watching Ukrainian TV/YouTube videos
    - Organize a visit with a family member/friend or engage Ukrainian community to fund a "family mobile" outside the home
- Pharmacological Interventions for depression

- Pharmacotherapy can be started ahead of non-pharmacological interventions to address the depression initially
- Consider reducing but keeping low dose of Mirtazapine (e.g., 7.5 mg qhs) for sleep
- May consider a trial of Citalopram 2.5-7.5mg daily (can increase to a maximum of 10mg) or Escitalopram 5-10mg daily using a cross taper with Mirtazapine, as he has responded to this category of medication in the past **OR**
- Duloxetine 30mg daily for mood and concomitant chronic pain
- If these are ineffective, may consider augmentation with another antidepressant or an antipsychotic for agitated depression e.g., low dose Quetiapine being mindful of a prescribing cascade

- Depending on severity of dementia, there may be a role for a cholinesterase inhibitor to help with agitation if this has been ruled out to not be a manifestation of depression first
- Electroconvulsive Therapy (ECT) may also be indicated for severe refractory depression or severe depression with psychotic features