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ECT as a “therapeutic test” to differentiate pharmaco-resistant depression from dementia in the elderly: a pilot study

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Summary

Objectives. Traditionally, if depression is suspected in elderly patients with cognitive disorders, antidepressant therapy is administered during the first 3 months of diagnosis, in order to treat a comorbid depression that could ultimately compound cognitive impairments. However, antidepressants are only effective in 50 to 60% of such cases, and their use in elderly populations should be restricted due to their potential negative side effects. In order to offer an alternative treatment strategy, we describe several cases here where electroconvulsive therapy (ECT) was used as a “therapeutic test” for the presence of depression.

Methods. Eight patients with a diagnosis of « probable dementia; depression remains to be eliminated » were included in the present study. Following a negative “antidepressant test”, an “ECT test” was performed.

Results. Five patients recovered satisfactorily from depression and cognitive impairments. This improvement persisted for 14 months after the final ECT session.

Conclusions. Our results suggest that ECT could be used as a potential therapeutic test in elderly subjects with cognitive impairments when depression is suspected.

Keywords: ECT, pseudo-dementia, depression, cognitive impairments

Introduction

Depression and dementia are the most frequently occurring pathologies found in elderly individuals. These disorders can exert a highly negative impact on patients’ quality of life, autonomy and, most significantly, risk of mortality through suicide, which is significantly elevated in such populations [1]. By treating depression in elderly patients suffering from dementia, their quality of life can be significantly improved [2]. The daily challenge facing practitioners is to differentially diagnose depressed patients (who present with pseudo-dementia) from dementia, in order to propose an adapted treatment plan. However, in making such a differential diagnosis, depression is the most frequent cause of error. This is probably

due to masked forms of depression, and to the fact that a depressive state can be responsible for behavioural inhibition and attentional deficits, suggestive of cognitive deterioration.

The prevalence of depressive disorders in patients suffering from Alzheimer's disease varies between 15 to 50% [3-5] and its incidence in elderly patients without dementia is between 1 and 10% [6-8]. In a recent retrospective study, Klatka et al. [9] reported depression associated with Lewy body dementia in 50% of cases. The prevalence of depression in patients over 65 years of age is 15% in the general population [10] and 30% in retirement homes. Within the same patient cohort, dementia occurs in 5% of the general population and in 80% of those in retirement homes. Therefore, there is a high concordance between depression and dementia in elderly individuals and their aetiology is highly complex.

Several phenotypic parallels can be drawn between the two pathologies, with the result that it is often difficult to establish cause and effect in their aetiology and progression. However in clinical practice, priority should be given to treating and eliminating curable states, not identifying causal ones. To this end, many researchers have offered descriptive classification systems based on observations of disorder comorbidity in the elderly. For instance, the concept of 'pseudo-dementia depression' has been used as a key diagnostic variable by Wells [11] and for classification and treatment purposes by Feinberg & Goodman [12], in spite of controversy surrounding its use. However, Burke et al. [13] proposed abandoning the term 'pseudo-dementia depression' in favour of, 'potentially reversible cognitive disorder' ; while Saez-Fonseca et al. [14] consider the term to be of pragmatic use, regardless of empirical concerns, since it seems to be a strong predictor of dementia.

It is now acknowledged that elderly dementia patients can present with depressive symptoms or outright clinical depression. On the one hand, treating depression or depressive symptoms in such patients can significantly alleviate affective disorders and behavioural problems; on the other hand, it can rule out a potential confound of affective contributions to cognitive decline, facilitating the differential diagnosis of dementia versus depression. Therefore antidepressant treatments used as "therapeutic tests" help practitioners to make correct diagnoses, even if oft-neglected issues surrounding pharmaco-resistance are over-looked.

Indeed 30% of depressions remain resistant to antidepressant treatment regimens [15]. The most frequently used (and first availed of) antidepressants in elderly patients are Selective Serotonin Reuptake Inhibitors (SSRI's) [16, 17], Serotonin Norepinephrine Reuptake Inhibitors (NSRI's), and more rarely, Tricyclic antidepressants [18], or Monoamine Oxidase Inhibitors (MAOI's) [19, 20]. However, antidepressant side effects render them difficult to use in elderly subjects, particularly with respect to the Tricyclics (e.g. tachycardia, constipation, urinary retention, confusion and delirium). SSRI and NSRI antidepressants are clearly better tolerated than Tricyclics. Nevertheless, SSRI's and NSRI's may cause severe hyponatraemia in elderly subjects, probably due to inappropriate anti-diuretic hormone secretion (SIADH), or possible interactions at the level of cytochromes P450 with other medication [21].

Following negative responses to pharmacological reference treatments (due to intolerance to a given treatment or aggravation of the patient's state), ECT should be recommended for two reasons. Firstly, its efficacy in treating depression in the elderly has received very strong empirical support of late [22, 23]. Secondly, ECT permits assertion of whether observed cognitive deterioration in such patients is secondary or concomitant to the depression. In addition, ECT has been found to be a more efficacious treatment overall than antidepressants

in elderly subjects [15, 24, 25]. Therefore, the aim of the present study was to evaluate the usefulness of ECT in eliminating pharmaco-resistant depression in patients with pseudo-dementia.

Materials & Methods

Subjects and assessments

The study population included neurological in-patients referred to the University Hospital of Poitiers, France. During the entire study period (January to December 2006), 8 patients (5 females) were tested (mean age = 73.2 years; 66-80 years). After having received information about the purposes of the study and potential risks of ECT, all patients gave written consent for participation. The protocol was approved by the local ethics committee (CHU de Poitiers). At the time of recruitment, all patients suffered from probable dementia with a comorbid ICD-10 diagnosis of either moderate or severe depressive episodes. The eight patients had received a neurological diagnosis of 'probable dementia, depression remains to be eliminated'. Clinically, they all suffered from symptoms presenting as depression, including psychomotor agitation, inability to experience pleasure, sleep changes with insomnia and weight loss (4 to 8 kg over a six month period). All patients received an 'antidepressant therapeutic test' at appropriate doses for more than months, including SSRI's, and 4 patients additionally received Tricyclic antidepressants.

Since Tricyclics could not be administered in four patients due to adverse reactions (side effects), a diagnosis of pharmaco-resistant depression first needed to be eliminated before dementia could unproblematically be diagnosed. An anti-cholinesterase treatment was therefore prescribed for two patients, consisting of donepezil (10mg/day) and galantamine (12mg/day). In six patients, a history of psychiatric problems was found: Bipolar Disorder II (n=3) and Unipolar Depression (n=3). The other two patients showed no evidence of psychiatric history.

The Montgomery and Asberg Depression rating scale (MADRS 28.5±7.3) and the Mini-Mental State Examination (MMSE 26±3) were conducted prior to any ECT session. The MADRS and MMSE were repeated 3 months after the final ECT session. All patients were followed up for a period of time between 3 to 14 months after the last ECT session.

ECT was used as a diagnostic tool to confirm the diagnosis of depression. The eight patients who had not responded to standard pharmacotherapy and still suffered from depression associated with cognitive disorders underwent ECT sessions. Patients were treated using the Spectrum 5000 Q Stimulus Ultrabrief 200, from Mecta Corporation. The ECT monitoring and the ictal EEG parameters (e.g. regularity, post-ictal suppression) were manually rated by the same trained psychiatrist. Anaesthetic products used were propofol (1mg/kg) and succinylcholine (0.5 mg/kg). The titration method was available in all patients, and the recording of EEG on two stations by the ECT equipment permitted control of the quality of the shock (duration>25sec, sudden shock), signifying the efficacy of a session. The dose of a given delivered charge was 370 milicoulombs (128-792). All patients received two ECT sessions each a week, with a mean number of 12.7 (11-18). Six patients underwent ECT sessions on bilateral temporal position whereas two patients underwent ECT sessions on unilateral right temporal position.

All patients underwent a standard physical examination that included brain scan, an EEG and a TPHA-VDRL serology; these all returned as negative. Red blood cell folate and plasma vitamin B-12 were both measured at baseline. Functional SPECT imagery was not carried out.

Data Analyses

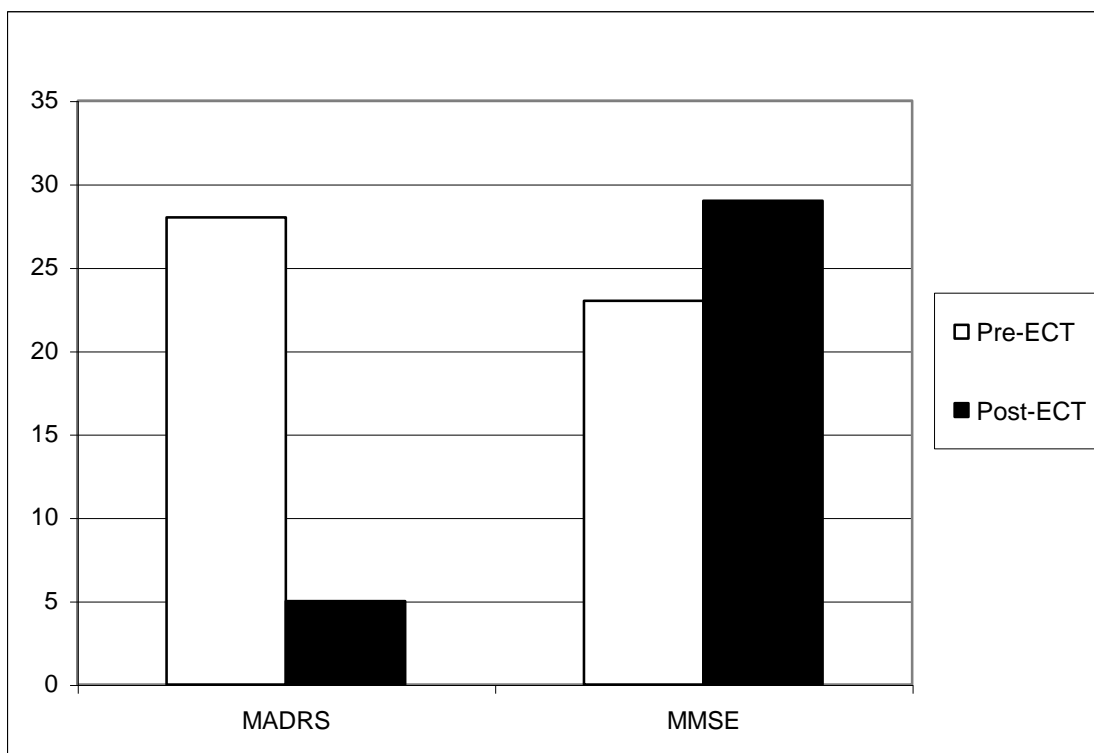
The significance of ‘general improvement’ (post-treatment versus pre-treatment) was tested by paired *t*-tests. Differences between groups on single, continuous variables were evaluated with *t*-tests or analysis of variance (ANOVA). Analyses were performed using SPSS version 10.0. The significance level was set at $p < 0.05$ for two-tailed tests.

Results

All patients responded positively to ECT treatment, with an overall recovery from depression (MADRS < 5, $p < 0.05$). The affective improvement persisted for 14 months after the final ECT session (Figure 1). The cognitive improvement measured by MMSE was not significant in all patients, being significant in only five (MMSE = 28, $p < 0.05$), while 3 patients still presented retrograde memory lacunae that persisted for 14 months after the end of ECT sessions (MMSE = 24). However, none of the patients showed evidence of cognitive deterioration that was more significant post-ECT versus pre-ECT, at either 3 or 14 months.

No significant side effects were observed due to participation in ECT sessions; although two patients did develop psychomotor agitation following a single session, necessitating sedation by midazolam (5mg). Another patient developed a delirium after the final ECT session, associated with cognitive decline as evaluated by the MMSE.

Figure 1. Comparison of mood (MADRS mean score) and cognitive changes (MMSE mean score) in patients (n=8) before and after ECT sessions.



Discussion

In this study, we reported the usefulness of ECT and its ability to distinguish between dementia and depression in elderly patients who suffer from resistant depression miming dementia. Depression was improved in a significant way for all patients (n=8). No significant variation of cognitive impairments was reported.

Depression and dementia occur frequently and are often comorbid in elderly patients. However no specific biological marker permits a confident, differential diagnosis of either one of these pathologies. A precise diagnosis of dementia (with Lewy bodies or Alzheimer's disease) can only be made through autopsy; no definitive marker exists to confirm the diagnosis of depression [26]. In elderly patients, depression and dementia share common clinical features, especially concerning cognitive impairments. Thus in order to aid diagnosis, an antidepressant test is usually performed. Yet antidepressants may be inefficient in treating presenting problems, or produce unwanted side effects in the elderly. The results of the present study suggest that ECT may be helpful in this regard, when antidepressant test results in such patients return negative.

Alternatively, some studies report the use of complementary examinations to provide evidence of diverse anomalies in subjects suffering from dementia or depression. In dementia the following techniques are often used: functional MRI, Monophotonic Emission Tomography (MPET or SPECT), and Positron Emission Tomography (PET). SPECT has a sensitivity of 89% in diagnosing Alzheimer's disease and a specificity of 80% [27]. In spite of this apparent efficacy, the scintigraphic profile of Alzheimer's disease is neither sensitive nor specific enough for two reasons. Firstly, approximately 25% of patients have abnormalities in predominantly anterior regions; secondly, this posterior hypometabolism can be observed in other pathologies. SPECT can provide other useful information [28], but cannot provide a differential diagnosis of depression or dementia.

The most investigated of the potential biological causes for depression is cortisol and the Hypothalamic–Pituitary–Adrenocortical (HPA) axis. Mannie et al. [29] reported that the level of salivary cortisol in the waking state (reflecting global HPA functioning) is increased in subjects from a depressive family. Other studies showed that the Dexamethasone Suppression Test [30-34] is perturbed in depressed subjects, and free urinary cortisol [35-38] is abnormally diminished in depressed subjects, while it is increased in subjects with dementia.

In terms of imaging, fMRI is more often used in depression research [39, 40] than Nuclear Magnetic Resonance imaging. Recognition of expressed joy is slower in depressed individuals, but antidepressant treatment normalised performance on this test, paralleled by an improvement in depressive symptomatology as evidenced by Hamilton's evaluation scale. Electroencephalography [41] can also bring informative elements to the diagnosis of depression through evaluation of cerebral activity. For instance, when depressed patients conduct a detection error task, EEG recordings show that they recruit more cerebral resources than normal subjects, complemented by the fact that they recognise their faults better than normal subjects. This 'auto-critic' faculty is exacerbated in melancholy which could lead to suicidal tendencies.

However, no definitive biological marker of depression exists, so the diagnosis of dementia or depression is based on a tableau of heterogeneous clinical and biological arguments. Nor is there a specific test for diagnosing depression, outside of clinical interview with the patient and their carers. Therefore in the majority of cases when depression associated with dementia

is suspected, antidepressant treatment is prescribed, but secondary effects and pharmaco-resistant forms limit their use.

ECT could act as an alternative, precise diagnostic tool to aid in distinguishing between depression and dementia. In our patients, ECT sessions resulted in disappearance of behavioural problems of psychomotor agitation and a global improvement in affective problems. Fourteen months after the final ECT session, the diagnosis of dementia was eliminated in 5 patients, and remained in 3 patients. In the latter group, the diagnosis of dementia and Alzheimer's disease was retained for two patients and Lewy body dementia for one patient.

Elsewhere, Bourgeois et al [42] reported 3 cases of dementia associated with depression that was significantly improved by ECT sessions - to such an extent that the diagnosis of dementia was eventually abandoned. These patients did not develop memory problems, anterograde or retrograde. Rasmussen et al. [43] reported 7 cases (5 males, 2 females) of Lewy body dementia associated with depression. Following ECT sessions, no changes in dementia symptoms were observed in these patients, but there was an overall improvement in affective problems. In a five year retrospective study (1991-1996), Rao et al. [44] reported 31 cases of 'dementia with depression', where a significant improvement of the affective state was found following ECT sessions. In this study, 55% of patients suffered from a vascular dementia, 13% from Alzheimer's disease and 32% from an uncertain aetiology. This significant improvement was measured on the affective plane by the MADRS, and on the cognitive plane by the MMSE, showing an improvement of 1.62 (non-significant improvement).

Patient Age and ECT

The age of patients was not a contra-indication for conducting ECT sessions, as confirmed by previous reports. In our study the average age was 73.5 years. It is 75.6 in Rao et al's study [44], with the eldest patient aged 97 years. Two other studies reported the age of patients as being 94 [39] and 96 [40] years. The risk of using ECT in the elderly relates to possible osteoarticular fractures caused by bone decalcification; however this is no longer a concern since the introduction of anaesthesia and curare products. Nowadays the principal risk to patients is cardiac complication. Cattani et al [41] reported that this risk increases after the 80th year of life. However, Burd et al [48] reported that patients aged less than 72 years showed significantly more asystole during ECT sessions relative to patients aged more than 77 years. Cardiac complications are not very frequent, and we have not witnessed them in our patients tested here. By contrast, they all tolerated ECT sessions well. Other studies confirm this trend [49, 50].

Anticholinesterasic

In the case of using ECT with patients treated by anti-cholinesterasics, medication should temporarily be suspended during ECT sessions, due to the potential adverse effects of prolonging succinylcholine action [51]. Anti-cholinesterasic medication can then be recommenced at the end of ECT treatment. Here we asked patients to stop taking anti-cholinesterasics one week before beginning ECT sessions. In contrast, Rasmussen et al [43] reported the absence of secondary effects in two patients under donepezil. They recommended conserving treatment during ECT if it proves efficacious in treating hallucinations (e.g. in Lewy body dementia), interrupting medication one day before the ECT session only.

Cognitive Problems Post-ECT

In this study, cognitive difficulties were totally reversed in 4 patients, slightly improved in two patients, and remained identical in the other two patients following ECT treatment. Memory was evaluated by the MMSE. Liang et al [52] reported the absence of aggravated cognitive problems after ECT in patients with dementia. Some studies supported the idea that pre-existing cognitive problems before ECT treatment can be aggravated by ECT sessions [47, 53]. Other studies [43, 44, 46] report an improvement in cognitive performance in patients measured by the MMSE post-ECT as compared to pre-ECT. Two randomised studies in elderly people [48, 49] reported the absence of significant cognitive problems after treatment by ECT, as measured by MMSE and by Folstein and Weschler's memory scale, independent of ECT method used (titration, moderated dose, elevated dose, unilateral ECT or bilateral ECT).

Generally speaking, the most frequently reported undesirable cognitive effects reported by patients are those of temporary memory problems [57]. These takes the form of an anterograde amnesia which progressively disappears, and a retrograde amnesia which can persist several weeks after completion of ECT treatment [58]. Freeman et al [59] and Frith et al [60] noted that post-ECT secondary cognitive effects disappear within an average of 72 days after the end of ECT sessions. Mid- and long-term cognitive effects can have a significant impact on memory performance. According to Squire [61], both implicit and procedural semantic memories are ordinarily preserved, whereas autobiographical and episodic memories are affected. Perturbations in remembering events that happened prior to the ECT sessions can be durable in certain patients, and can cover a period lasting from several hours to 2 years sometimes [62-67]. However, Vaughn McCall et al [68] reported that this mnemonic deficit does not have deleterious consequences on patients' quality of life. Although ECT perturbs the learning of events acquired just after treatment, the literature is unanimous in showing that this deficit is transitory, very often disappearing after several weeks.

ECT and Cerebral Structures

ECT does not produce cerebral tissue damage. A literature review by Devanand et al [69] concludes that no empirical evidence supports the notion that ECT causes cerebral lesions. No objective cerebral lesions were observed in patients who showed benefits from ECT treatment, as examined by post mortem autopsy or cerebral imaging. Agelink et al [70] reported the absence of deleterious effects on cerebral tissue in 14 patients by measuring neuronal specific enolase and protien S-100. Several post-ECT histological studies [71-74] on rat hippocampus show neurogenesis and the appearance of synaptic connections.

Strengths of this study

This is the first pilot study to address the question of the utility of ECT in order to rule out the depressive etiology miming dementia. Al the patients were given by a neurologist the diagnosis of "dementia; depression remains to be eliminated". All of them suffered from resistant depression to current antidepressant treatments. Therefore, ECT sessions were used as a therapeutic test which led to a significant improvement of depression with no side effect on cognitive abilities. Moreover, cognitive improvement was observed in 4 patients. This study demonstrates the usefulness of ECT as a "therapeutic test" for the presence of depression in the elderly, without leading to increased cognitive impairment.

Limitations of this study

However, results from this study must be interpreted with caution. Firstly, the small number of patients and the short-term follow-up (3 to 14 months) limit the conclusions that can be

drawn. Secondly, the cognitive assessment in the present study was restricted to the MMSE; a tool which provides a reliable global metric of performance, but not an extensive and precise evaluation of patient's individual cognitive status.

Future directions

Before any generalization of the reported results, more researches are needed especially based on a larger number of patients, more reliable assessment tools and longer period of time. If our results were to be confirmed, then the hypothesis that antidepressant treatments can be used as a "therapeutic test" to facilitate the differential diagnosis of dementia versus depression would be invalidated. Thus, ECT could sustain this "therapeutic test" part.

Conclusion

Antidepressants seem to function as potent "diagnostic" or "therapeutic" tests for treating depression in dementia patients; their potential in this regard may be far from realised [75]. However, the diagnostic 'weight' which antidepressants are granted is often exaggerated, and we believe it important to bear in mind that 30 to 40% of elderly patients do not respond to such treatments. Our results suggest that ECT represents a compelling alternative as "diagnostic test", especially for depressed elderly patients with cognitive problems who respond negatively to pharmacological treatments.

References

1. Suominen, K., E. Isometsa, and J. Lonnqvist, *Elderly suicide attempters with depression are often diagnosed only after the attempt*. Int J Geriatr Psychiatry, 2004. **19**(1): p. 35-40.
2. Moretti, R., et al., *Depression and Alzheimer's disease: symptom or comorbidity?* Am J Alzheimers Dis Other Demen, 2002. **17**(6): p. 338-44.
3. Rovner, B.W., et al., *Depression and Alzheimer's disease*. Am J Psychiatry, 1989. **146**(3): p. 350-3.
4. Migliorelli, R., et al., *Prevalence and correlates of dysthymia and major depression among patients with Alzheimer's disease*. Am J Psychiatry, 1995. **152**(1): p. 37-44.
5. Vida, S., et al., *Prevalence of depression in Alzheimer's disease and validity of Research Diagnostic Criteria*. J Geriatr Psychiatry Neurol, 1994. **7**(4): p. 238-44.
6. Henderson AS, J.A., MacKinnon A, Christensen H, Scott LR, Korten AE, Doyle C., *The prevalence of depressive disorders and the distribution of depressive symptoms in later life: a survey using Draft ICD-10 and DSM-III-R*. Psychol Med, 1993. **23**(3): p. 719-29.
7. Blazer D., *Depression in the elderly*. N Engl J Med., 1989. **19;320**(3):: p. 164-6.
8. Forsell Y, W.B., *Incidence of major depression in a very elderly population*. Int J Geriatr Psychiatry, 1999. **14**(5): p. 368-72.
9. Klatka LA, L.E., Schiffer RB, *Psychiatric features in diffuse Lewy body disease: a clinicopathologic study using Alzheimer's disease and Parkinson's disease comparison groups*. Neurology, 1996. **47**(5): p. 1148-52.
10. Macdonald, A.J., *ABC of mental health. Mental health in old age*. Bmj, 1997. **315**(7105): p. 413-7.
11. Wells CE., *Pseudodementia*. Am J Psychiatry, 1979. **136**(7): p. 895-900.
12. Feinberg, T. and B. Goodman, *Affective illness, dementia, and pseudodementia*. J Clin Psychiatry, 1984. **45**(3): p. 99-103.
13. Burke, D., A. Sengoz, and R. Schwartz, *Potentially reversible cognitive impairment in patients presenting to a memory disorders clinic*. J Clin Neurosci, 2000. **7**(2): p. 120-3.

14. Saez-Fonseca, J.A., L. Lee, and Z. Walker, *Long-term outcome of depressive pseudodementia in the elderly*. J Affect Disord, 2006.
15. Fava, M. and K.G. Davidson, *Definition and epidemiology of treatment-resistant depression*. Psychiatr Clin North Am, 1996. **19**(2): p. 179-200.
16. Nelson, J.C., *Diagnosing and treating depression in the elderly*. J Clin Psychiatry, 2001. **62 Suppl 24**: p. 18-22.
17. Mittmann, N., et al., *The efficacy, safety and tolerability of antidepressants in late life depression: a meta-analysis*. J Affect Disord, 1997. **46**(3): p. 191-217.
18. Lipsey, J.R., et al., *Nortriptyline treatment of post-stroke depression: a double-blind study*. Lancet, 1984. **1**(8372): p. 297-300.
19. Jenike, M.A., *The use of monoamine oxidase inhibitors in the treatment of elderly, depressed patients*. J Am Geriatr Soc, 1984. **32**(8): p. 571-5.
20. Jenike, M.A., *Monoamine oxidase inhibitors as treatment for depressed patients with primary degenerative dementia (Alzheimer's disease)*. Am J Psychiatry, 1985. **142**(6): p. 763-4.
21. Liu BA, M.N., Knowles SR, Shear NH., *Hyponatremia and the syndrome of inappropriate secretion of antidiuretic hormone associated with the use of selective serotonin reuptake inhibitors: a review of spontaneous reports*. CMAJ., 1996. **1;155**(5): p. 519-27.
22. van der Wurff, F.B., et al., *The efficacy and safety of ECT in depressed older adults: a literature review*. Int J Geriatr Psychiatry, 2003. **18**(10): p. 894-904.
23. Flint AJ, G.N., *Effective use of electroconvulsive therapy in late-life depression*. Can J Psychiatry., 2002. **47**(8): p. 734-41.
24. O'Connor, M.K., et al., *The influence of age on the response of major depression to electroconvulsive therapy: a C.O.R.E. Report*. Am J Geriatr Psychiatry, 2001. **9**(4): p. 382-90.
25. Flint, A.J. and S.L. Rifat, *The treatment of psychotic depression in later life: a comparison of pharmacotherapy and ECT*. Int J Geriatr Psychiatry, 1998. **13**(1): p. 23-8.
26. Oquendo MA, P.R., *What have we learned about the neurobiology of major depression?* Am J Psychiatry., 2007. **164**(4): p. 540-2.
27. Jobst KA, B.L., Shepstone BJ., *Accurate prediction of histologically confirmed Alzheimer's disease and the differential diagnosis of dementia: the use of NINCDS-ADRDA and DSM-III-R criteria, SPECT, X-ray CT, and Apo E4 in medial temporal lobe dementias*. Oxford Project to Investigate Memory and Aging. Int Psychogeriatr., 1998. **10**(3): p. 271-302.
28. Jagust, W., et al., *SPECT perfusion imaging in the diagnosis of Alzheimer's disease: a clinical-pathologic study*. Neurology, 2001. **56**(7): p. 950-6.
29. Mannie, Z.N., C.J. Harmer, and P.J. Cowen, *Increased waking salivary cortisol levels in young people at familial risk of depression*. Am J Psychiatry, 2007. **164**(4): p. 617-21.
30. Westrin, A., K. Frii, and L. Traskman-Bendz, *The dexamethasone suppression test and DSM-III-R diagnoses in suicide attempters*. Eur Psychiatry, 2003. **18**(7): p. 350-5.
31. Carroll, B.J., *The dexamethasone suppression test for melancholia*. Br J Psychiatry, 1982. **140**: p. 292-304.
32. Contreras, F., et al., *Hormonal differences between psychotic and non-psychotic melancholic depression*. J Affect Disord, 2006.
33. Fountoulakis, K.N., et al., *Are dexamethasone suppression test nonsuppression and thyroid dysfunction related to a family history of dementia in patients with major depression? An exploratory study*. Can J Psychiatry, 2005. **50**(6): p. 342-5.

34. Wamboldt, M.Z., N.H. Kalin, and S.J. Weiler, *Consistent reversal of abnormal DSTs after different antidepressant therapies in a patient with dementia*. Am J Psychiatry, 1985. **142**(1): p. 100-3.
35. Raskind, M., et al., *Dexamethasone suppression test and cortisol circadian rhythm in primary degenerative dementia*. Am J Psychiatry, 1982. **139**(11): p. 1468-71.
36. Azorin, J.M., et al., *Plasma levels of 3-methoxy-4-hydroxyphenylglycol in depressed patients compared with normal controls*. Neuropsychobiology, 1990. **23**(1): p. 18-24.
37. Azorin, J.M., et al., *[Diagnostic criteria of depressive pseudodementia]*. Encephale, 1990. **16**(1): p. 31-4.
38. McAllister, T.W., et al., *The dexamethasone suppression test in two patients with severe depressive pseudodementia*. Am J Psychiatry, 1982. **139**(4): p. 479-81.
39. Fossati, P., et al., *Distributed self in episodic memory: neural correlates of successful retrieval of self-encoded positive and negative personality traits*. Neuroimage, 2004. **22**(4): p. 1596-604.
40. Fu, C.H., et al., *Neural responses to happy facial expressions in major depression following antidepressant treatment*. Am J Psychiatry, 2007. **164**(4): p. 599-607.
41. Chiu, P.H. and P.J. Deldin, *Neural evidence for enhanced error detection in major depressive disorder*. Am J Psychiatry, 2007. **164**(4): p. 608-16.
42. Bourgeois, M., A. Hebert, and J. Maisondieu, *[Senile pseudo-demential convulsive-curable depressions]*. Ann Med Psychol (Paris), 1970. **128**(5): p. 751-9.
43. Rasmussen, K.G., Jr., et al., *Electroconvulsive therapy for patients with major depression and probable Lewy body dementia*. J Ect, 2003. **19**(2): p. 103-9.
44. Rao, V. and C.G. Lyketsos, *The benefits and risks of ECT for patients with primary dementia who also suffer from depression*. Int J Geriatr Psychiatry, 2000. **15**(8): p. 729-35.
45. Bernstein, I.C., *Anorexia nervosa, 94-year-old woman treated with electroshock*. Minn Med, 1972. **55**(6): p. 552-3.
46. Tomac, T.A., et al., *Safety and efficacy of electroconvulsive therapy in patients over age 85*. Am J Geriatr Psychiatry, 1997. **5**(2): p. 126-30.
47. Cattan, R.A., et al., *Electroconvulsive therapy in octogenarians*. J Am Geriatr Soc, 1990. **38**(7): p. 753-8.
48. Burd, J. and P. Kettl, *Incidence of asystole in electroconvulsive therapy in elderly patients*. Am J Geriatr Psychiatry, 1998. **6**(3): p. 203-11.
49. Gaspar, D. and L.A. Samarasinghe, *ECT in psychogeriatric practice--a study of risk factors, indications and outcome*. Compr Psychiatry, 1982. **23**(2): p. 170-5.
50. Weiner, R.D., *The role of electroconvulsive therapy in the treatment of depression in the elderly*. J Am Geriatr Soc, 1982. **30**(11): p. 710-2.
51. Folk, J.W., et al., *Anesthesia for electroconvulsive therapy: a review*. J Ect, 2000. **16**(2): p. 157-70.
52. Liang, R.A., R.W. Lam, and R.J. Ancill, *ECT in the treatment of mixed depression and dementia*. Br J Psychiatry, 1988. **152**: p. 281-4.
53. Kahn A., M.M., Hughes D, Bierut L., *Electroconvulsive therapy*. Psychiatr. Clin. North Am., 1993. **16**: p. 497-6513.
54. Abrams R., *Electroconvulsive Therapy*. Oxford University Press, 1988.
55. Fraser, R.M. and I.B. Glass, *Recovery from ECT in elderly patients*. Br J Psychiatry, 1978. **133**: p. 524-8.
56. Kellner, C.H., et al., *Weekly ECT in Geriatric Depression*. Convuls Ther, 1992. **8**(4): p. 245-252.

57. Peretti S., *Electroconvulsivothérapie et mémoire*. Masson ed. *Mémoire explicite, mémoire implicite et pathologies psychiatriques*. Pointe-à-Pitre: Congrès de Psychiatrie et de Neurologie de langue française., 1993.
58. Weiner, R.D., et al., *Effects of stimulus parameters on cognitive side effects*, in *Ann N Y Acad Sci*. 1986. p. 315-25.
59. Freeman, C.P., D. Weeks, and R.E. Kendell, *ECT: II: patients who complain*. *Br J Psychiatry*, 1980. **137**: p. 17-25.
60. Frith, C.D., et al., *Effects of ECT and depression on various aspects of memory*. *Br J Psychiatry*, 1983. **142**: p. 610-7.
61. Squire, L.R., *ECT and memory dysfunction*. In B. Lerer, R. D.,. 1984.
62. Sackeim, H., *The cognitive effects of electroconvulsive therapy*. Dans : Thal LJ, Moos WH, Gamzu E. *Cognitive disorders pathophysiology and treatment*. New York, N.Y :Marcel Dekker. 1992: p. 183-228.
63. Sackeim, H.A., et al., *Effects of stimulus intensity and electrode placement on the efficacy and cognitive effects of electroconvulsive therapy*. *N Engl J Med*, 1993. **328**(12): p. 839-46.
64. Steif, B.L., et al., *Effects of depression and ECT on anterograde memory*. *Biol Psychiatry*, 1986. **21**(10): p. 921-30.
65. Squire, L.R., P.C. Slater, and P.L. Miller, *Retrograde amnesia and bilateral electroconvulsive therapy. Long-term follow-up*. *Arch Gen Psychiatry*, 1981. **38**(1): p. 89-95.
66. Weiner, R.D., et al., *Effects of stimulus parameters on cognitive side effects*. *Ann N Y Acad Sci*, 1986. **462**: p. 315-25.
67. Peretti, C.S., et al., *Bilateral ECT and autobiographical memory of subjective experiences related to melancholia: a pilot study*. *J Affect Disord*, 1996. **41**(1): p. 9-15.
68. McCall, W.V., et al., *Health-related quality of life following ECT in a large community sample*. *J Affect Disord*, 2006. **90**(2-3): p. 269-74.
69. Devanand DP, D.A., Hutchinson ER, Bolwig TG, Sackeim HA., *Does ECT alter brain structure?* *Am J Psychiatry*., 1994. **151**(7): p. 957-70.
70. Agelink MW, A.J., Postert T, Wurzinger U, Zeit T, Klotz P, Przuntek H., *Relation between electroconvulsive therapy, cognitive side effects, neuron specific enolase, and protein S-100*. *J Neurol Neurosurg Psychiatry*. 2001, 2001. **71**(3): p. 394-6.
71. Scott, B.W., J.M. Wojtowicz, and W.M. Burnham, *Neurogenesis in the dentate gyrus of the rat following electroconvulsive shock seizures*. *Exp Neurol*, 2000. **165**(2): p. 231-6.
72. Madsen, T.M., et al., *Increased neurogenesis in a model of electroconvulsive therapy*. *Biol Psychiatry*, 2000. **47**(12): p. 1043-9.
73. Hellsten, J., et al., *Electroconvulsive seizures induce endothelial cell proliferation in adult rat hippocampus*. *Biol Psychiatry*, 2004. **55**(4): p. 420-7.
74. Hellsten, J., et al., *Electroconvulsive seizures induce angiogenesis in adult rat hippocampus*. *Biol Psychiatry*, 2005. **58**(11): p. 871-8.
75. Malauzat D, *Thérapeutiques biologiques de la dépression du sujet âgé*. Prid : les dépressions du sujet âgé, 1996: p. 95-112.