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· 综 述 ·

老年期抑郁障碍的临床特征及诊治进展

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[摘要] 老年期抑郁障碍(late life depression, LLD)已经成为老年人群常见的精神心理疾病。LLD 患者临床表现复杂多样, 且常伴有躯体疾病。临床应指导老年人群使用患者健康问卷-2(patient health questionnaire-2, PHQ-2)自评量表进行抑郁症状筛查, 结合躯体症状对筛查阳性人群进行综合评估, 并根据第 10 次修订国际疾病分类(international classification of diseases-10, ICD-10)诊断标准进行定性诊断, 为 LLD 患者的及时治疗奠定基础。心理治疗与药物治疗是该类患者的一线治疗方案, 极重度患者可进行电休克治疗, 同时应积极治疗躯体疾病和改善生活方式。本文主要针对 LLD 的临床特征、筛查和评估及诊治的研究进展进行综述, 为 LLD 的综合管理和防治提供参考。

[关键词] 老年期抑郁障碍; 临床特征; 筛查; 诊断; 治疗

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Research progress of clinical features and therapy of late life depression

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[Abstract] Late life depression (LLD) has become one of the most common mental and psychological diseases in the elderly. The clinical manifestations of LLD patients are complex and varied, and often accompanied by physical diseases. Clinicians should actively guide the elderly population to use the patient health questionnaire-2 (PHQ-2) self-rating scale to screen depressive symptoms, comprehensively evaluate the positive population combined with physical symptoms, and make definitive diagnosis according to the international classification of diseases-10 (ICD-10) diagnostic criteria, in order to offer the foundation for timely treatment of the LLD patients. Psychotherapy and drug therapy are first-line treatments for the patients, and the severe patients can be treated with electroconvulsive therapy. Meanwhile, the patients should focus on the treatment of physical illnesses and improvement of lifestyles. This article reviews the clinical features, screening, evaluation, diagnosis and therapy progress of LLD, and provides reference for the integrated management and prevention of LLD.

[Key Words] late life depression; clinical features; screening; diagnosis; therapy

老年期抑郁障碍(late life depression, LLD)是老年人群常见的精神心理疾病, 全球患病率为 2.8%~22.5%^[1]。我国 LLD 患病率为 3.02%~24.3%, 其中 32%~74.46% 的老年人有显著的抑郁症状^[1-3]。2015 年, 精神心理疾病已成为造成全球非致死性健康损害的第一大疾病^[4]; 预计 2020 年抑郁障碍将成为伤残调整生命年(disability-adjusted life years, DALYs)受损的第二大原因^[5]。然而, 文化多元性、地区经济发展不平衡性及个体因素使该病症状复杂化, 使其早期诊治较为困难^[6]。因此, 及时识别复杂的抑郁症状、综合评估躯体与

精神心理疾病并准确诊断是该病综合管理和防治的重要策略。

1 临床特征概述

LLD 包括老年期短暂性抑郁状态、早发型抑郁障碍(early onset depression, EOD)、迟发型抑郁障碍(late onset depression, LOD)、继发于躯体疾病或药物使用的抑郁障碍及卒中后抑郁障碍等, 各具有其临床特征^[7-9]。该病临床表现复杂多样, 基本特征为忧郁情绪或心境低落, 主要表现为悲伤、无望或泄气等^[10-12]。患者躯体不适主诉突出, 表现为以慢

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性疼痛为主的各种躯体不适,进行各种检查且治疗效果不佳。以躯体不适为主诉的“隐匿性抑郁”是其常见亚型。有精神病性症状(如妄想和幻觉)的抑郁障碍常见于老年人,老龄化心理、人格改变均与精神病性症状密切相关^[13]。抑郁障碍发作、精神病性症状是老年人自杀的高危因素,患者自杀观念频发,且牢固,自杀计划周密、成功率高^[14]。睡眠障碍既是抑郁障碍的危险因素,也是其主要症状,常见表现形式包括难以入睡、易醒、早醒或嗜睡。季节性抑郁障碍是特殊类型的抑郁障碍,指忧郁情绪或心境低落规律地发生于特定季节而在另一季节缓解^[12]。此外,约70%的患者至少并存1种疾病,如认知功能障碍、焦虑、痴呆等,使该病的治疗与管理复杂化^[15-17]。

2 筛查与评估

2016年,美国预防服务工作组和美国家庭医生学会建议对所有成年人进行抑郁障碍筛查,并强调筛查应在完整医疗保健体系的支持下进行,以确保后续诊断、治疗和随访的连续性^[18]。患者健康问

卷-2(patient health questionnaire-2,PHQ-2)包括2项内容(表1),易口头提问,适用于老年人群,但准确性较低,一般用于初步筛查。PHQ-2对识别抑郁障碍高危患者有效,敏感度为100%、特异度为77%^[19]。PHQ-2总分为6分,≥3分者为LLD阳性。筛查阴性且无相关抑郁症状和病史的人群不需进一步关注,阳性人群应继续完成患者健康问卷-9(patient health questionnaire-9,PHQ-9)。PHQ-9为自我筛查型量表(表2),由全科医师或护士指导患者完成,并对最终评分进行统计解读。PHQ-9敏感度为88%,特异度为88%,且各条目很好地对应美国精神疾病诊断与统计手册第4版(DSM-IV)的症状标准,有助于确定抑郁症状严重程度。其中,0~4分为无抑郁症状,5~9分为轻度抑郁障碍,10~14分为中度抑郁障碍,15~19分为中重度抑郁障碍,20~27分为重度抑郁障碍^[20-22]。此外,PHQ-9对伴有认知功能障碍的老年人群的筛查效果优于老年抑郁量表(geriatric depression scale,GDS)。因此,PHQ-9是LLD筛查、诊断与监测的可靠工具^[20]。

表1 患者健康问卷-2(PHQ-2)

最近2个星期里,您有多少时间受到以下任何问题的困扰?	完全不会	几天	一半以上的日子	几乎每天
1. 做事时觉得没意思或只有少许乐趣	0	1	2	3
2. 感到心情低落、沮丧或绝望	0	1	2	3
总分____= ____+ ____+ ____+ ____				

表2 患者健康问卷-9(PHQ-9)

最近2个星期里,您有多少时间受到以下任何问题的困扰?	完全不会	几天	一半以上的日子	几乎每天
1. 做事时觉得没意思或只有少许乐趣	0	1	2	3
2. 感到心情低落、沮丧或绝望	0	1	2	3
3. 入睡困难、很难熟睡或睡太多	0	1	2	3
4. 感觉疲劳或无精打采	0	1	2	3
5. 胃口不好或者吃的太多	0	1	2	3
6. 觉得自己很糟,或觉得自己很失败,或让自己或家人失望	0	1	2	3
7. 很难集中精神做事,例如看报或看电视	0	1	2	3
8. 动作或说话速度缓慢到别人可察觉到的程度? 或正好相反——您烦躁或坐立不安,动来动去的情况远比平常多	0	1	2	3
9. 有不如死掉或用某种方式伤害自己的念头	0	1	2	3
总分____= ____+ ____+ ____+ ____				

如果存在以上任何一个问题,这些问题在您工作、照顾家庭事务,或与他人相处上造成了多大的困难?
(1)毫无困难 (2)有点困难 (3)非常困难 (4)极度困难

筛查阳性者应进行抑郁障碍综合评估,其中症状评估最为重要,包括症状特点、持续时间及严重

程度等。LLD治疗和随访过程中,定期使用PHQ-9或汉密尔顿抑郁量表(hamilton depression scale,

HAMD)动态评估患者的症状变化和治疗反应^[23]。躯体疾病评估对协助诊断及指导治疗尤为重要,包括慢性疼痛、心脑血管疾病、风湿性疾病、恶性肿瘤及帕金森病等,同时评估药物使用情况以减少药物相互作用的不良反应。使用简易智力状态检查量表(mini mental state examination, MMSE)对确诊患者进行认知功能障碍筛查,及时发现视觉空间处理能力缺陷或记忆障碍等^[24]。神经心理学测试可用于 LLD 与老年痴呆的鉴别诊断,其中抑郁障碍急性期者应推迟至症状缓解后测试。全科医师应对患者进行自杀风险评估,询问自杀意念、计划及准备等,同时评估丧偶、搬迁等负性生活事件。精神专科医师协助全科医师对患者进行评估以便早期发现幻觉、妄想、精神运动性迟滞或激越等精神病性症状。另外应对患者进行实验室检查,包括血常规、肝功能、肾功能、血糖、甲状腺功能及维生素 B₁₂和叶酸水平等,必要时可进行颅脑 CT 或 MRI 等。

3 诊 断

抑郁障碍筛查后无定性诊断可导致假阳性诊断和过度治疗,故须遵循第 10 次修订国际疾病分类 10(international classification of diseases-10, ICD-10)诊断标准对筛查阳性者进行定性诊断。ICD-10 诊断标准(表 3)的症状标准包括核心症状和主要症状。核心症状为忧郁情绪或心境低落、兴趣缺失、精力减退;主要症状包括缺乏自信或自我评价过低、不合乎情理的内疚或自责、反复出现想死的念头或有自杀意向、思考困难或难以集中注意力、精神运动性迟滞或激越、睡眠障碍、引起体质量变化的食欲改变。在进行症状评估的同时,还需评估患者的社会功能受损情况及抑郁症状给患者带来的痛苦或不良后果的严重程度,然后结合症状持续时间作出抑郁障碍诊断。其中,LLD 的诊断标准为:≥60 岁+≥2 项核心症状+≥2 项主要症状,且已至少持续 2 周^[11-12,25]。

同时,应注意抑郁障碍亚型的诊断分类,主要包括以下 5 种:(1)轻度抑郁障碍,即符合上述抑郁障碍诊断标准,社会功能无损害或仅轻度损害;(2)中度抑郁障碍,介于轻重度之间者;(3)无精神病性症状的重度抑郁障碍,即符合上述抑郁障碍诊断标准,社会功能严重受损,但无幻觉、妄想、精神运动性迟滞或激越等精神病性症状;(4)有精神病性症状的重度抑郁障碍,即符合上述抑郁障碍诊断标

准,社会功能严重受损,伴有幻觉、妄想、精神运动性迟滞或激越等精神病性症状;(5)其他类型抑郁障碍。此外,应排除器质性精神障碍、精神活性物质和非成瘾性物质所致的抑郁障碍,伴有精神病性症状时还应与精神分裂症相鉴别。

ICD-10 抑郁障碍诊断标准与 DSM-IV 的区别在于:ICD-10 不包含亚临床抑郁障碍的诊断,而 DSM-IV 则强调亚临床抑郁障碍的重要性;抑郁障碍的 DSM-IV 诊断标准为≥1 项核心症状+≥4 项主要症状,且已至少持续 2 周,提示采用 ICD-10 能较 DSM-IV 筛查出更多的抑郁障碍患者^[12]。

表 3 ICD-10 抑郁障碍诊断标准

症状标准(*核心症状)
1. 忧郁情绪/心境低落*
2. 兴趣缺失*
3. 精力减退*
4. 缺乏自信或自我评价过低
5. 不合乎情理的内疚或自责
6. 反复出现想死的念头或有自杀意念
7. 思考困难或难以集中注意力
8. 精神运动性迟滞或激越
9. 睡眠障碍
10. 引起体质量变化的食欲改变
严重标准
社会功能受损,给本人造成痛苦或不良后果
病程标准
符合症状标准和严重标准的症状已至少持续 2 周
排除标准
排除器质性精神障碍、精神活性物质和非成瘾性物质所致的抑郁障碍

4 治 疗

4.1 心理治疗 心理治疗是 LLD 的一线治疗方案,具体实施取决于治疗方案的可及性和患者的偏好。其中,认知行为疗法(cognitive behavior therapy, CBT)和问题解决疗法(problem solving therapy, PST)是疗效显著的心理治疗方案。CBT 旨在帮助患者重新认识负面情绪,并促进患者参加社交活动和增加愉悦感。CBT 较一般治疗更能改善抑郁症状,但对合并躯体疾病或认知功能障碍患者的疗效较弱^[24-25]。计算机化的认知行为疗法(computerized cognitive behavioral therapy, CCBT)可有效改善抑郁症状,但不能给不善于使用

计算机的老年人带来明显获益^[26]。PST 着重于开发应对疾病的技能,以提高患者应对生活问题的能力。PST 比一般治疗更能有效改善抑郁症状,且能有效缓解合并认知功能障碍尤其是合并执行功能障碍 LLD 患者的症状(该类患者对抗抑郁药物反应性较差)^[27]。在合并认知功能障碍的 LLD 人群中,PST 的症状缓解率和致残改善率均高于支持治疗,且疗效至少维持 24 周^[28]。在进行高强度心理治疗的同时,应结合书籍、海报及网络资料等低强度心理治疗措施;而当心理治疗效果差或患者倾向其他治疗措施时,应及时调整治疗策略。此外,应鼓励患者积极参加体力活动和社交活动^[23]。

4.2 药物治疗 选择性 5-羟色胺再摄取抑制剂(SSRIs)是 LLD 患者的一线药物治疗方案。舍曲林、氟西汀和帕罗西汀较安慰剂能更有效地改善抑郁症状,治疗应答率和缓解率均优于安慰剂(应答率:35%~60% vs 26%~40%,缓解率:32%~44% vs 19%~26%)^[29-32]。临床试验未能直接证实西酞普兰与安慰剂治疗缓解率的差异,但事后分析显示西酞普兰能更有效地改善重度抑郁障碍患者的临床症状(35% vs 19%)^[33]。SSRIs 常见不良反应包括轻度恶心和头痛等^[34]。

5-羟色胺和去甲肾上腺素再摄取双重抑制剂(SNRIs)一般作为 LLD 的二线治疗方案。文拉法辛在临床实验中未显示出明显优势;度洛西汀在大规模临床试验中的治疗反应率和缓解率均优于安慰剂(反应率:37% vs 19%,缓解率:27% vs 15%)^[35]。回顾性研究^[35]证实,SSRIs 与 SNRIs 治疗 LLD 的临床疗效相似,但 SNRIs 更易引起不良反应。三环类抗抑郁药物(tricyclic antidepressants, TcAs)的疗效与 SSRIs 类似,但不良反应较大^[36],一般作为三线治疗方案。尽管安非他酮、米氮平和兴奋剂亦应用于 LLD 患者,但缺乏严格的循证依据支持^[37]。荟萃分析^[38]显示,针灸和中草药等治疗抑郁障碍的疗效不亚于 SSRIs,但仍待进一步验证。

4.3 电休克疗法(electroconvulsive therapy, ECT)

ECT 是极重度 LLD 患者最有效的治疗方法。ECT 的治疗缓解率为 70%~90%,但治疗后 6 个月内复发率为 40%~50%且疗效仍有待验证^[39]。ECT 安全性较高,禁忌症少,常见不良反应为发作后混合的顺行性和逆行性遗忘症。单侧电极放置技术可降低不良反应风险。经颅磁刺激

(transcranial magnetic stimulation, TMS)是治疗抑郁障碍的新方法,TMS 的治疗缓解率优于 ECT^[40]。但荟萃分析^[41-42]显示,ECT 较 TMS 具有更高的抑郁障碍治疗缓解率,且年轻患者的治疗反应更明显。

5 总结和展望

人口老龄化加剧、家庭结构变化及经济发展不平衡使国人面临着巨大的精神心理健康挑战。应熟悉 LLD 患者的临床特征、早期发现隐匿的抑郁症状、综合评估患者的健康状况及及时定性诊断等,以积极进行抗抑郁治疗。患者应及时接受心理治疗或抗抑郁药物治疗,极重度患者可接受 ECT 治疗。规范化治疗和综合管理不仅可改善患者的生活质量、降低自杀风险、提高健康水平,还可缓解医疗资源短缺的压力。我国目前已将抑郁障碍纳入慢性病范畴,强调社区卫生服务对该类患者治疗与管理的重要性。社区为基础的协作治疗模式是综合管理 LLD 有前景的方法之一,但仍需进一步研究证实其对该类患者的长期治疗效果。

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