Commentary

Depressive disorders rank among the most significant health problems in older adults. The consequences of both major and minor depression in older adults are severe and include diminished quality of life, functional decline, marked disability, increased service utilization, and high mortality from comorbid medical conditions.[1] Despite considerable interest, there is no consensus regarding the prevalence of depression in later life. The aim of this paper is to analyze the global epidemiological prevalence of geriatric depression in light of constrains which arise from the problems of objective measurement due to heterogeneous nature of diagnostic and assessment tools in clinical psychiatry. But let me congratulate the authors since in this updated meta-analysis authors left us with an inescapable impression by integrating last 50 years of community-based mental health studies consisting 75 original published studies and providing us striking understanding about the trend in the pattern of distribution of depressive disorders in the geriatric population across the globe in various continents for the very first time. This meta-analysis is special in its breadth and scope as it has entailed much higher number than the previously published meta-analysis by Chen R *et al*.,[2] Copeland JR *et al*.,[3] and Beekman AT *et al*.[4] The authors analyzed the data for a total of 487,275 elderly individuals of 60 years and above, and determined the median prevalence rate of depressive disorder in the world which was found to be 10.3% which was clearly suggestive to be in the lower range of overall prevalence (10-20%) observed by World Health Organization.[5] They have scrupulously excluded

unpublished and unanalyzed studies which made their analysis quite impressive and informative. There are couple of interesting consummate trailblazers came out of this meta-analysis as far as Indian population is concerned. First, compared to the global median prevalence rate of depressive disorders (10.3%), India has twice the number of elderly peoples suffering from depressive disorder which is surprisingly five times the rate seen in Asian continent (4.2%) and secondly authors meta-analysis observed 21.9% of median prevalence rate for Indian Population stand in the same stead as observed by Nandi *et al*.[6] way back in 1973. This speaks and reflects many dubious speculations such as weakness in the willingness of the Indian researchers to take up community prevalence studies since only four community studies were conducted in the geriatric population for screening depressive disorders and interestingly three out of four were exclusively carried out in South-India. Despite the increase in the longitivity, availability of better assessing instruments and the decrease in mortality rates, the median prevalence figure remained static. In contrast, this might suggests exquisitely balanced state with plateau phase in the trajectory of the course of time wherein India has been changing its own face marching from developing to developed country. As evident, rural Indians are inclined for getting migrated to the urban areas where the quality of provision of mental health services are comparatively easily available, peoples are becoming more aware about psychiatric disorders, and their acceptance of labeling as mental illness gradually seems to be fading, way the notion of grilling prejudices once enrooted in the pillars of society. In the aftermath of crisis, families began seeking psychiatrists help for the separated, helpless, and debilitated elderly who shares their despondencies to later. We might expect as well the change in the trend as far as prevalence of geriatric depression is concerned in coming few years as determined and predicted by a data rather than the agreement of the experts.

The most easily noted problem of contention in the past five decades of these epidemiological studies as noted in the meta-analysis was heterogeneous use of as many as more than 15 different assessment tools evolved and used over the period of time. I feel that epidemiology is an essential medical discipline and therefore exploits the concept of disease. Diseases are primarily categories. While for many diseases, what start off as categorical concept ends by revealing underlying continuities. The continuous distribution of depressive symptoms in elderly in a general population is obvious from the outset; however, there is little evidence for valid cut-off points and disease based approach must therefore be offset by robust skepticism. This reflects as I initially mentioned, that the categories beloved of epidemiologists should be treated as particularly tentative fictions. Such fictions may assist the progress of knowledge, but if we are to rely on them, they must be used consistently. In other words, those studies which have used the similar diagnostic evaluation scale only should have been considered by the author to reach out for uniformity so that discrepancies in the evaluation process can be reduced to an absolute minimum. Or a separate account of such categorical account if provided would have given us the insight as to whether the median prevalence rate in such instance differs or not. However, I perceive that there are many ways of assessment for depression in elderly which have the potential to create unstructured clinical judgment. The latter introduces variability into the process of case allocation and researchers must then decide how carefully the underlying diagnosis should be made as in nutshell the prevalence of depressive disorder in the geriatric population is not guaranteed to be set for all time. A strong tendency for chronic depression has been reported in the younger elderly. One of the major limitations of this analysis is exclusion of prospective follow-up longitudinal studies like Beekman *et al*.,[7] Haynie *et al*.,[8] and Palsson *et al*.[9] which are landmark in the epidemiology of geriatric depression, while the other limitation include inability of the authors to ensure whether the persistence of depression in the younger adult or younger elderly which is frequently extrapolated to the oldest old giving us the false values for prevalence.

To conclude this meta-analysis clearly backdrops the consolidated global and continental median prevalence rates for geriatric depression. As we know geriatric depression is often unrecognized because of many factors which include clinicians and patients attributing depressive symptoms to the aging process, older persons emphasize somatic symptoms and underreport depressed mood and finally, geriatric depression often occurs in the context of medical or neurological brain diseases whose symptoms are similar to the symptoms of depression.[10] Taken together with the results of the present meta-analysis, it is clear that more active case-finding is warranted, as treatment of depression in the oldest old is as potentially rewarding as in younger people.

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