Depressed Mood, RA Disease Activity Linked

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FROM ANNALS OF THE RHEUMATIC DISEASES

In patients with rheumatoid arthritis, higher disease activity scores were associated with more severe depression, both when measured at the same time and when measured 6 months apart, suggesting that the impact the two factors have on each other persists over time.

Similarly, depression predicted increased disease activity later.

The findings, while not necessarily causal, "support the notion that in patients with more severe depressed mood, disease activity is probably greater, not only at the same time but also several months later, and that in patients with more swollen and painful joints, psychological distress is probably greater at the same time and later on," wrote Dr. Cécile L. Overman of Utrecht (the Netherlands) University, and associates (Ann. Rheum. Dis. 2011 Sept. 14 [doi:10.1136/annrheumdis-2011-200338]).

Dr. Overman of the department of clinical and health psychology at Utrecht University looked at 545 patients with a recent diagnosis of rheumatoid arthritis (RA) recruited between 1990 and 2002 in the Utrecht region. The patients were enrolled in a prospective drug trial at the time.

Patients with comorbid psychiatric disorders or drug use were excluded from the study.

Psychological distress was assessed at baseline, before randomization, and then annually for 5 years using the Impact of Rheumatic Diseases on General Health and Lifestyle (IRGL) questionnaire.

The anxiety portion of IRGL consists of 10 items (scored from 10 to 40) derived from the Spielberger state-trait anxiety inventory; the depressed mood scale consists of six items (scored from 0 to 24).

Disease activity according to erythrocyte sedimentation rate (ESR) and the Thompson articular index was assessed at baseline, every 3 months for the first 2 years, and every 6 months for the next 3 years.

At baseline, the authors found that 45% of patients had a depressed mood according to the IRGL scale, while 36% had anxiety.

Also at baseline, the mean Thompson joint index was 146.0, while the mean ESR was 41.1 mm/hr.

Overall, these high levels of both disease activity and psychological distress decreased sharply in the first year, and continued to decrease over the course of the study, reported the authors, although 26% of patients still had depressed mood after 5 years and 23% reported anxiety.

However, looking prospectively, the authors found that that scores exceeding zero on the depressed mood scale were associated with a higher Thompson joint score ($P = .03$) and a higher ESR ($P = .04$) 6 months later.

Similarly, a higher Thompson joint score was associated with higher levels of depressed mood ($P = .03$) and anxiety ($P = .02$) at assessments occurring 6 months afterward.

On the other hand, elevated anxiety scores were not associated with higher disease activity later on.

"Our data do not support the notion that psychological stress may cause disease flares," despite "weak" evidence that stress may exacerbate disease activity, they wrote. Nor did elevated ESR levels predict psychological distress down the line.

The authors did admit to several weaknesses in their study. For one, "we used existing data with relatively long intervals between assessments," wrote Dr. Overman. "More frequent monitoring, for example, every 3 months during 5 years, will increase the chance of finding disease flares and substantial mood changes."

Additionally, ESR levels and the Thompson joint index are not the only measurements of disease activity available. The authors pointed out that their findings "do not generalize to cytokine and hypothalamic-pituitary-adrenal axis functioning," for example.

The authors disclosed no individual conflicts of interest in regard to this study, which was funded by grants from Utrecht University and the Dutch Arthritis Association. ■