Pain Improved in 44% vs. 9%

Antidepressants *from page 1*

months or longer despite two analgesics and also had moderately severe depression (Patient Health Questionnaire–9 score of 10 or greater).

Patients randomized to the intervention received six contacts—three in person and three by phone—from study nurse care managers over a 12-week period.

Antidepressants were started in the first week, with assessments of adherence, side effects, and appropriate dose and/or medication adjustments made in subsequent weeks. Depression response was assessed at weeks 3 and 12.

'Additional strategies to comanage pain may be needed to further improve pain outcomes.'

DR. BAIR

The serotonin norepinephrine reuptake inhibitor (SNRI) venlafaxine (75-225 mg/day) was the first-choice treatment because the SNRIs have been found comparable in depression outcomes to the selective serotonin reuptake inhibitors (SSRIs) while also showing some preliminary evidence for potential efficacy in pain reduction, said Dr. Bair of the VA Center on Implementing Evidence-Based Practice at the Richard L. Roudebush VA Medical Center, Indianapolis.

Patients who did not respond to or could not tolerate the SNRI were given an SSRI (fluoxetine, sertraline, or citalopram). If neither an SNRI nor an SSRI were effective, bupropion or mirtazapine was used.

All of the antidepressants used in the study were part of the participating hospital formularies and came in generic form, noted Dr. Bair, who is also with the division of general internal medicine and geriatrics at the University of Indiana, Indianpolis.

Patients randomized to the control group were simply informed that they had depressive symptoms and advised to seek advice about treatment. No attempts were made to influence pain or depression management unless there was a psychiatric emergency such as suicidal ideation.

The 123 intervention patients did not differ from the 127 controls in baseline characteristics such as age (mean 56 years for the overall sample), gender (53% women), race (60% white, 36% black), employment status (26% employed/31% not working/43% retired), location of pain (60% back, 40% hip/leg), or baseline treatments (45% opioids, 36% antidepressants).

The patients in both groups were also similar on baseline pain and depression measures. The number of disability days in the past 3 months was 34.9 for the intervention group and 38.0 for the controls.

Overall, 59% were seen in university clinics and 41% in the VA clinic.

At baseline, mean scores on the Hopkins Symptom Checklist depression scale (HSCL-20) were 1.83 for the intervention group and 1.84 for usual care (on a scale of 0-4 with higher scores representing more severe depression). Major depression was present in 73% of the intervention group and 76% of controls.

At 3 months there was an absolute difference of 0.65 in HSCL-20 between the two groups, at that point numbering 113 intervention patients and 119 controls. The effect size was large (0.99), with most of the effect already seen at 1 month (118 intervention/112 controls), Dr. Bair reported.

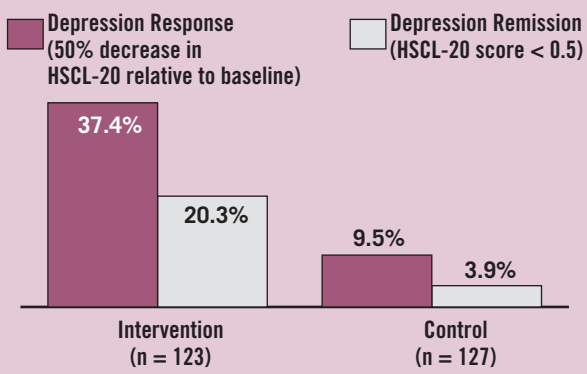
Rates of remission of depression, defined as an HSCL-20 score of less than 0.5, and rates of response, defined as a 50% decrease in HSCL-20 relative to baseline, were significantly greater at both 1 and 3 months in the intervention group, compared with the controls. At 3 months, 37.4% of the intervention patients had responded to treatment, compared with 9.5% of controls, and 20.3% of the intervention group experienced remission, versus just 3.9% of the control group. As a result, the proportion of patients meeting the criteria for major depression was significantly lower in the intervention group (46% vs. 75%).

Intervention patients were also much more likely to report improvement in pain at 3 months, with 44% vs. 9% of controls saying their pain was better, while just 5% of the intervention group, compared with 17% of controls, said their pain was worse. The intervention group reported 8.3 fewer pain-related disability days in the previous 3 months than did the controls. The effect size for pain was moderate, at 0.43 for severity and 0.35 for disability.

Intervention patients also reported improved secondary outcomes such as lower rates of anxiety and better health-related quality of life, Dr. Bair said.

"In the future, additional strategies to comanage pain may be needed to further improve pain outcomes and possibly depression response rates," Dr. Bair concluded. ■

Patients With Comorbid Depression and Pain Improve With Optimal Antidepressant Intervention



Note: Based on Hopkins Symptom Checklist depression scale score and 3-month follow-up.

Source: Dr. Bair

Self-Report Tool Tops Common Screens for Elderly Depression

BY HEIDI SPLETE
Senior Writer

WASHINGTON — A nine-item questionnaire of self-reported symptoms was more reliable and efficient than the widely used Geriatric Depression Scale and the Minimum Data Set 2.0 scale at assessing mood disorders in nursing home patients, according to a study in 71 facilities across eight states.

Accurate detection of mood disorders in the long-term care population remains a constant challenge, said Dr. Debra Saliba, a geriatrician at the University of California, Los Angeles, and director of the Borun Center for Gerontological Research there. She reported the results at the annual meeting of the American Geriatrics Society.

The questionnaire did not lead to more patients being classified as depressed and was more accurate and took less time than the more widely used tools.

Identifying depression in nursing home patients is important, she emphasized, because the condition is associated with poor functional status; increased perception of pain; stress; suicide; and more need for medical services. "In fact, a disproportionate number of successful suicides occur in people over the age of 65," said Dr. Saliba.

Treating depression can be effective in reducing poor outcomes in long-term care residents, but depression often goes unnoticed in this population. Several screening tools for mood disorders are in use, but they haven't been compared with one another or to any validated psychiatric-assessment tool, said Dr. Saliba.

The new study compared the effectiveness of the nine-item Patient Health Questionnaire (PHQ-9), the Geriatric Depression Scale (GDS), Minimum Data Set version 2.0 (MDS 2.0) assessment by staff, and one of two validated tools for identifying mood disorders in a long-term care population.

The GDS was designed for older adults and has become a geriatric standard; this study used the newer version of the test, which is made up of 15 yes/no questions. But studies have suggested that the test may be overly influenced by somatic symptoms when individuals answer questions such as, "Have you stopped many of your activities and interests?" without being able to elaborate.

By contrast, PHQ-9 questions prompt open-ended responses to topics including sleep problems, feeling bad about oneself, and having trouble concentrating. The tool may be administered either as a self-reported survey or as part of an interview. The MDS 2.0 observer-rated scale avoids an interview or self-report.

"Some people have said that the PHQ-9 is too symptom driven or too complicated," Dr. Saliba said, leading to questions of the survey's validity for assessing mood disorders in frail old people.

The investigators selected 418 nursing home residents scheduled to receive mandatory MDS 2.0 assessments. Nearly half the study participants were older than 85 years.

In addition to the MDS 2.0 assessment for each resident, one nurse administered the PHQ-9 and GDS, and a second nurse administered either the modified Schedule for Affective Disorders and Schizophrenia (mSADS) or the Cornell Scale for Depression.

The Cornell tool was used for residents whose cognition was too low to allow assessment by mSADS, but both of these tests are validated, "gold standard" tools, said Dr. Saliba.

About 80% of study participants were assessed by at least one of the screening tools as well as one of the validated tools. Overall, the GDS screen found 41% of residents with probable depression, PHQ-9 found 42%, and MDS 2.0 found 17%.

When the investigators used a measure of agreement adjusted for chance (kappa scores), the PHQ-9 had significantly higher agreement with the validated standard than either the GDS or the MDS 2.0 did. In fact, the MDS 2.0 assessment was less accurate than if the results had happened by chance, Dr. Saliba said.

"Contrary to the expectations of many, the PHQ-9 did not lead to more classification with depression," she said.

Not only was the PHQ-9 tool more accurate than the GDS screen, but it also took less time to complete: 4.9 minutes for the PHQ-9 vs. 11.4 minutes for the GDS.

Most of the residents, including the large number with cognitive impairment, could complete the PHQ-9, said Dr. Saliba. The findings suggest that standardized mood assessment of older adults could be performed more effectively with the PHQ-9 than with the GDS or MDS 2.0, although more research is needed to confirm the results.

"We hadn't expected it to be quite so favorable for PHQ-9," she said. "But it is often difficult for older adults to reduce their life experiences to yes or no questions." ■