

AHA: Screen Heart Disease Patients for Depression

BY SHARON WORCESTER
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Patients with heart disease are at increased risk of depression and should be screened routinely, and referred and treated as necessary for the condition, a new science advisory from the American Heart Association states.

Depression has been shown in numerous studies to have profound adverse effects on prognosis and quality of life in heart disease patients. Findings from more than 60 prospective studies, several major review articles, and more than 100 additional narrative reviews of the literature have demonstrated links between depression and cardiovascular morbidity and mortality, according to the advisory, which was published online last month by the Prevention Committee of the American Heart Association Cardiovascular Nursing Council, Clinical Cardiology Council, Epidemiology and Prevention Council, and Interdisciplinary Council on Quality of Care and Outcome Research.

It has been shown that depression is about three times more common in acute myocardial infarction patients than it is in the general community, and in-hospital assessments indicate that up to 20% of patients with myocardial infarction meet the criteria for major depression. An even greater proportion exhibits depressive symptoms, Judith H.K. Lichtman, Ph.D., cochair of the committee, and her colleagues wrote (*Circulation* 2008 Sept. 29 [doi:10.1161/circulationaha.108.190769]).

Furthermore, the 12-month prevalence of major depression in patients with cardiac disease was 9.3%, compared with 4.8% in those with no comorbid medical illness, in nearly 40,000 participants in a recent National Health Interview Survey.

"There is general consensus that de-

pression remains associated with at least a doubling in risk of cardiac events over the subsequent 1-2 years after an MI," the authors wrote. Both biological factors—such as human platelet antigen dysfunction, impaired vascular function, and reduced heart rate variability—and behavioral and/or social mechanisms—such as diet, exercise, medication adherence, tobacco use, social isolation, and chronic life stress—have been suggested as possible links between depression and heart disease.

"Although the specific behavioral and biological processes remain unclear, the alteration of these processes is associated with depressive symptoms, consistently in a direction that increases cardiovascular risk," wrote the committee, adding that depression is associated with decreased compliance with medications; reduced chances of successful modification of other cardiac risk factors and participation in cardiac rehabilitation; higher health care utilization and cost; and greatly reduced quality of life.

"Thus, whether depression impacts cardiac outcomes directly or indirectly, the need to screen and treat depression is imperative," they wrote.

The committee advised the following:

- ▶ Routine screening for depression in heart disease patients in a variety of settings, including the doctor's office, hospital, clinic, and cardiac rehabilitation center. At a minimum, administration of the Patient Health Questionnaire (PHQ-2), a two-item assessment of depression that addresses loss of interest or pleasure in normal activities, and feelings of depression and hopelessness, is advised.

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- ▶ Administration of PHQ-9, an expanded version of the PHQ-2, to those who answer "yes" to one or both of the PHQ-2 items. The PHQ-9 assesses additional symptoms of depression, such as altered sleep patterns, fatigue, changes in appetite, and feelings of failure. In addition to yielding a provisional depression diagnosis, it provides a severity score that can be useful for guiding treatment and for patient monitoring. The tool has been shown to have "reasonable" sensitivity and specificity for those with heart disease, according to the advisory.

- ▶ Follow-up assessment during a subsequent visit in patients with mild symptoms.

- ▶ A review of the responses with those patients who had high depression scores.

- ▶ Referral for more comprehensive eval-

uation by a qualified professional in those with a PHQ-9 score of 10 or higher (out of a possible 27).

- ▶ Evaluation for other mental disorders, such as anxiety, in those who meet criteria for a more comprehensive evaluation.

- ▶ Careful monitoring for adherence to medical care, drug efficacy, and safety (with respect to both cardiovascular disease and mental health).

- ▶ Coordination of care among health care providers.

"Cardiologists should take depression into account in the management of [heart disease], regardless of whether they treat the depression or refer the patient to a health care provider who is qualified in the assessment and treatment of depression, which often may be the patient's primary care provider," the committee wrote.

Depression can occur before and con-

tinue after an acute cardiac event and should not be ignored based on the premise that it is a "normal" reaction to a stressful life event, the authors wrote.

They explained that although there is no direct evidence that depression screening improves outcomes in heart disease patients, there is plenty of evidence that the presence of depression is linked with increased morbidity and mortality, poorer risk factor modifications, lower rates of rehabilitation, and reduced quality of life.

"Therefore, it is important to assess depression in cardiac patients with the goal of targeting those most in need of treatment and support services," the committee concluded.

The advisory also includes an overview of treatment options for depression, including antidepressant drugs, cognitive behavioral therapy, lifestyle modifications, and combinations of these options.

Data suggest that treatment with SSRIs soon after acute MI is safe and effective. First-line treatments are sertraline and citalopram; among contraindicated treatments are tricyclic antidepressants and monamine oxidase inhibitors, which have cardiotoxic side effects, the advisory states.

Cognitive behavioral therapy can also be of benefit, and may be an alternative for those who cannot or will not tolerate pharmacologic therapy. In some patients, a combination of pharmacologic and psychotherapy works best. Depending on cardiac status and exercise capacity, patients might also benefit from aerobic exercise and cardiac rehabilitation alone or in combination with other treatments, but individual assessment is necessary for determining the appropriate approach.

In a written statement from the AHA, Dr. Lichtman stressed that "you can't treat the heart in isolation from the patient's mental health." ■

Symptoms Can Persist Despite Long-Term SSRI Treatment

BY MICHELE G.
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BARCELONA — Despite long-term treatment with selective serotonin reuptake inhibitors, many depressed patients cared for by primary care physicians continue to experience symptoms that affect their daily lives, according to a survey conducted in the United Kingdom.

Only a minority of these patients were satisfied with their current sleep, while 52% reported moderate-severe anxiety and 37% moderate-severe depression, although most had been on treatment for 6 months to more than 1 year, Dr. Alan G. Wade wrote in a poster presented at the annual congress of the European College of Neuropsychopharmacology.

"If patients are to have a good quality of life with the maximum possibility of remaining free from

subsequent episodes of depression, it's important that treatment results in patients who are in remission with a minimal number of symptoms," wrote Dr. Wade, a founder of Patients Direct in Glasgow, Scotland. "But despite long-term SSRI treatment, few of these patients were in true remission."

Patients Direct operates in tandem with the Robertson Centre for Biostatistics at the University of Glasgow. The company obtains postmarketing drug data by direct patient survey and supplies this information to health care providers, the pharmaceutical industry, and other interested groups, according to the company Web site. Dr. Wade's analysis was based on surveys completed by 256 patients in western Scotland whose general practitioners were treating them for depression with SSRIs.

Prescribing information was obtained from a large regional

database, and each patient filled out a questionnaire about treatment. The survey included the Hospital Anxiety and Depression Scale (HADS), and specific questions about sleep. The group was primarily composed of women (79%). Most of the patients (190) were aged 36-70 years, with the remainder aged 18-35 years. The primary indication for SSRI was depression (80%). Other indications were anxiety and pain.

Length of treatment varied, with 56% having taken the drugs for more than a year; 13% for 7-12 months; 18% for 4-6 months; and 12% for 1-3 months. The rest had been on an SSRI for a month or less. Most (90%) said that they took the medication as directed.

HADS scores showed that depression and anxiety persisted in many patients, despite the medication. Fewer than half (42%) scored "normal" on the scale; 21% reported minor symptoms.

Among the participants, 20% reported moderate depression, while 17% reported severe depression.

Symptoms of anxiety did not respond even that well to the medication. Just 20% of patients had normal scores on the HADS anxiety subscale. Mild symptoms occurred in 22%, moderate symptoms in 23%, and severe symptoms in 29%.

About a third of patients complained of poor sleep—32% felt their sleep problems were so severe that others could notice them, and 29% said the sleep issues interfered with their daily life and were a source of significant distress. This finding was significantly associated with higher depression and anxiety scores.

Most patients with sleep problems (62%) never mentioned the issue to their general practitioner, although of those who did, 51% got a prescription for a sleep

aid. However, more than half of those who received a hypnotic prescription ended up taking it for longer than the recommended 4-week period.

"The long-term use of hypnotics presents its own problems," Dr. Wade pointed out, "but there is some evidence that addressing sleep as a symptom of depression can provide benefit."

He noted that the survey results are similar to findings in a recent paper addressing remission in depression. The review found that many patients treated for depression report residual symptoms despite apparently successful treatment (*Psychol. Med.* 2007;37:307-17).

Dr. Wade's study was sponsored by an unrestricted educational grant from Servier Laboratories Ltd., a European company that is developing a new antidepressant, agomelatine, for the U.S. market. ■