Periodically Screen Heart Patients for Depression

BY BRUCE JANCIN
Denver Bureau

NEW ORLEANS — Persistent comorbid anxiety and depression are common in patients with coronary heart disease, and they carry a greater mortality risk than either mood disturbance alone, according to a study in 2,325 patients.

"It's important to look for both anxiety and depression and really home in on patients who have symptoms of both," Lynn V. Doering, D.N.Sci., stressed in presenting the study results at the annual scientific sessions of the American Heart Association.

Persistence of the dual comorbid forms of dysphoria in patients with coronary heart disease (CHD) appears to be a key factor in the associated increased risk of all-cause mortality, added Dr. Doering of the University of California, Los Angeles.

"Anxiety and depression must be assessed periodically in patients with CHD," she said. "While it is important to identify and treat new symptoms, it is perhaps even more important to attend to persistent symptoms that are unremittent, especially with treatment."

She presented a secondary analysis of data from the PROMOTION trial, a multicenter randomized study of an educational nursing intervention designed to reduce prehospital delay to treatment of acute coronary syndrome in patients with known CHD. Her substudy focused on the 2,325 PROMOTION participants who completed mood evaluations at baseline and at 3 months, after which they were followed for a median of 22 months. Their mean age was 67 years, and 31% were women.

The brief mood assessment tools used were the Multiple Affect Adjective Checklist (MAACL) for depression and the six-item anxiety subscale of the Brief Symptom Inventory. Both are well-validated, reliable instruments, Dr. Doering said.

Nineteen percent of participants were classified as persistently depressed on the basis of MAACL scores of 11 or more at both time points. Another 16% were deemed persistently anxious, with Brief Symptom Inventory scores below 0.33 at baseline and again at 3 months. Persistent comorbid anxiety and depression were more common than either condition alone, affecting 26% of subjects. Only 39% of the CHD patients were free of persistent anxiety and/or depression.

"In other words, almost two-thirds of the sample had a persistent mood disorder," Dr. Doering observed.

A total of 63 deaths occurred during follow-up, for a 2.7% mortality rate, including 23 cardiac-related deaths.

Persistently distressed CHD patients tended to be younger, female, sedentary, and current smokers. They also were more likely to have diabetes, angina, a history of MI, and to not have attended cardiac rehabilitation.

In a multivariate Cox regression analysis adjusted for clinical and demographic variables and assignment to the intervention or control arm in the parent study, only three variables emerged as independent predictors of all-cause mortality: age, a history of MI, and the presence of persistent comorbid anxiety and depression.

Indeed, persistent comorbid anxiety and depression was the strongest predictor of mortality, with a 2.35-fold increased risk, even greater than that conferred by a prior MI. Neither persistent anxiety nor persistent depression alone was associated with increased mortality.

Future studies, she said, will focus on such key issues as the biobehavioral mechanisms involved in the link between persistent anxiety/depression and mortality, identification of subgroups at particularly high risk, optimal treatment options, and how to make treatments more acceptable to patients.

"I think it is important to screen, certainly the first time you see patients with CHD, and then periodically. What I was struck by in this study is you can't just do it once and say, 'OK, this patient is not depressed and not anxious.' You have to assess again and again because things change," Dr. Doering replied.

In screening for depression in clinical practice, she says she believes the nine-symptom Patient Health Questionnaire checklist (PHQ-9) is probably better than the MAACL. ■