Primary Care Falling Short in Treating Depression

BY DOUG BRUNK
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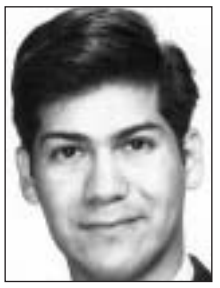
SAN DIEGO — Results from two studies presented during poster sessions at the annual meeting of the American Association for Geriatric Psychiatry paint a bleak picture of how primary care physicians are treating late-life depression.

Even though depression treatment guidelines have been available from the Agency for Healthcare Research and Quality (AHRQ) and other groups for more than a decade, only about one-quarter of physicians are using them in practice.

"Dissemination of guidelines is still a significant problem. Identifying depression is not enough," Randall Espinoza, M.D., told this newspaper. "In terms of managing depression, we need to reach an extra level of surveillance. We have to do a better job."

In one of the largest studies of its kind, Dr. Espinoza and his associates analyzed data from 895 patients in the "usual care" arm of Project IMPACT (Improving Mood: Promoting Access to Collaborative Treatment), a randomized, controlled trial of collaborative care management for late-life depression. The mean age of patients was 71 years, and the trial took place in 18 primary care practices in five states. (Patients in the intervention arm were assigned a care manager to provide medication support or counseling.)

Of the 895 patients in the usual care arm, 52% had both dysthymia and major depression, 32% had dysthymia only, and 16% had major depression only, reported Dr. Espinoza of the department of psychiatry and biobehavioral sciences at the University of California, Los Angeles, Neuropsychiatric Institute. Nearly 70% reported two or more prior episodes of depression at baseline, and fewer than half were receiving depression treatment at the time of study enrollment.



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"Only 28% had received guideline-concordant depression care during the 3 months prior to baseline," he said. "Over 6 months, the modal experience was that patients experienced no change in depression treatment despite persistent depression symptoms."

Of those who were not on an antidepressant at baseline, 73% did not receive one during the following 6 months, and 68% of patients who were on a selective serotonin reuptake inhibitor (SSRI) remained on the same type of medication.

At 6 months, only one-third of the sample showed significant improvement or remission of depressive symptoms.

Patients who were prescribed medications other than SSRIs were significantly more likely to improve but not more likely to achieve remission, Dr. Espinoza noted. Patients with dysthymia were less likely to improve or to achieve remission.

"So if you identify somebody in primary care who is chronically depressed, you may want to get them to a mental health specialist sooner, rather than later, or increase your surveillance and change medication sooner, rather than later," he said.

The study was funded by the American Federation for Aging Research, the U.S. Department of Health and Human Services, the John A. Hartford Foundation, and the California HealthCare Foundation.

In another trial, Patrick Raue, Ph.D., and his associates examined the practices of physicians enrolled in the "usual care" arm of the Prevention of Suicide in the Elderly Project (PROSPECT). (In the intervention arm, a social worker, psychologist, or nurse provided care management to patients in the form of antidepressant treatment, psychotherapy, or both.)

Dr. Raue and his associates sought to discover whether physicians started antidepressant treatment after being informed of a diagnosis of major or minor depression in their patients and after being educated about the 1993 AHRQ guidelines for detection, diagnosis, and treatment of depression in primary care.

The investigators reviewed the charts of 107 patients with a mean age of 72 years in seven primary care practices in New York, Philadelphia, and Pittsburgh who met Structured Clinical Interview for DSM-III-R criteria for major or minor depression. They studied information on physician visits and antidepressant prescriptions for a 2-month period after physicians were informed of a depression diagnosis.

Physicians met or spoke by phone with only 30 patients (28%) within 2 months of being informed of a depression diagnosis, reported Dr. Raue of the department of psychiatry at Cornell University, New York.

Among these 30 patients, physicians began a new antidepressant in 13 cases, increased the dose in 6, decreased the dose in 1, and discontinued treatment in 6.

"I think it's particularly striking that 10 years after more clear guidelines for prescribing antidepressants, we're still finding that physicians in primary care aren't doing such a great job, even with being told that their patients are suffering from depression," Dr. Raue told this newspaper. "There's very little follow-up. It's striking that these findings continue in the face of more educational efforts and more appropriate guidelines" for treating late-life depression.

The National Institute of Mental Health funded the study. ■

In Small Trial, Donepezil Safe and Effective for African Americans

SAN DIEGO — Donepezil is safe and effective in African Americans with mild to moderate Alzheimer's disease, a 12-week open-label study demonstrated.

The finding is important because African Americans are underrepresented in clinical trials even though they have a higher risk of developing Alzheimer's disease, compared with whites, Patrick Griffith, M.D., said during a poster session at the annual meeting of the American Association for Geriatric Psychiatry.

In addition, this is the first Alzheimer's trial to use the Fuld Object Memory Evaluation (FOME), which is thought to provide a culturally unbiased evaluation of memory. "The test has been validated in African Americans, and it operates independent of educational level or [social background]," Dr. Griffith, chief of the division of neurology at Morehouse School of Medicine, Atlanta, said in an interview. "It relies on touch and vision. We may have a measuring tool for future clinical trials that will avoid previous reports of educational or cultural bias."

He added that the FOME was designed for elders who may have problems with hearing or attention.

Dr. Griffith and his associates enrolled 125 community-dwelling African Americans aged 51-98 from 30 sites in the United States with a clinical diagnosis of mild to moderate Alzheimer's disease and Mini-Mental State Examination (MMSE) scores of 10-26. The patients received donepezil (Aricept) 5 mg/day at the conclusion of their baseline visit; the dose was increased to 10 mg/day after 4 weeks—according to clinician judgment.

At weeks 4, 8, and 12, the investigators administered the FOME, the MMSE, and the Clinician Interview-Based Impression of Change with Caregiver Input (CIBIC-plus).

From baseline to week 12, patients demonstrated significant improvement on the FOME storage and retrieval scores, the MMSE scores, and the CIBIC-plus scores.

The most common treatment-emergent adverse events were diarrhea, hypertension, and urinary tract infection, and the incidences were similar to those reported previously in patients with mild to moderate Alzheimer's. Lab results were unremarkable.

Pfizer Inc., which manufactures donepezil, supported the study.

—Doug Brunk