Depression, Anxiety Take Toll on Cardiac Rehab

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WASHINGTON — Depressed or anxious patients who are referred to cardiac rehabilitation programs are significantly more likely to comply poorly or have a poorer outcome than are patients without the conditions, Angele McGrady, Ph.D., reported at the annual meeting of the Society of Behavioral Medicine.

Because of this, patients who are referred to cardiac rehabilitation programs "need to be quickly screened for depression and anxiety prior to entering rehabilitation, said Dr. McGrady, professor of psychiatry at the University of Toledo (Ohio).

Depression is a known risk factor for the development and worsening of coronary heart disease (Psychosom. Med. 2005;67[suppl. 1]:S19-S25).

Anxiety also may be a risk factor for CHD. Recent research has associated high levels of phobic anxiety with an increased risk of a fatal cardiac event (Circulation 2005;111:480-7).

At the University of Toledo Medical Center, patients who have angina or chronic heart failure, or who have had a myocardial infarction or coronary artery bypass graft (CABG), get referred to the cardiac rehabilitation program. Such programs are known to be effective in reducing mortality. But in order for patients to benefit, they must complete the full program of exercise, stress management, and nutritional counseling, Dr. McGrady said.

The only chance to catch the nearly 20% of patients who dropped out before starting the actual rehab was at the psychological assessment.

In the rehabilitation program, patients are first psychologically assessed using the Beck Depression Inventory, the Beck Anxiety Inventory, and the SF-36 quality of life measure. A week later, patients come back for a walk test (number of feet walked in a certain period of time).

Over the next 6 months, the patients attend 36 sessions that are largely exercise based; these sessions also include stress management, smoking cessation, and lifestyle counseling, such as nutritional assessment and recommendations for improving nutrition. At the end of 6 months, psychological and physical tests are repeated.

Of 380 consecutive patients who were referred to the medical center over a period of about 2 years, exactly half completed the full rehabilitation program. Other centers have reported dropout rates at cardiac rehabilitation centers ranging from 20% to 65%, she said.

The overall sample had an average age of 61 years; most patients were males (63%) and white (79%). Completers tended to have a higher average age (63 years vs. 59 years) and were more often male (67% vs. 60%) than were noncompleters.

On entry to the rehabilitation program, the 190 patients who completed the program had a significantly lower mean Beck Depression Inventory score than did the 190 noncompleters (8.6 vs. 11.7). The completers also reported a significantly higher initial quality of life than did noncompleters in physical (39.2 vs. 35.7) and mental health (47.6 vs. 43.4).

Beck Anxiety Inventory scores were significantly lower among the completers than in a group of 68 early dropout patients who did not come back at week 2 for the walk test and did not begin the program.

This means that the only chance to catch the nearly 20% of patients who dropped out early, before even starting the actual rehabilitation process, was at the time of the psychological assessment. Early interventions at this point could improve adherence to the program and subsequent outcomes, Dr. McGrady said.

According to the diagnostic category of patients, those who had myocardial infarction, angina, or heart failure had significantly higher anxiety scores than did patients who underwent CABG. Heart failure patients also had significantly higher depression scores than did those who underwent CABG.

No significant differences between patients in different diagnostic categories were found on walk tests or in the patients' perceptions of physical health. ■