

Menopausal Changes Linked to Depression

BY MARY ANN MOON
Contributing Writer

The “changing hormonal milieu” of menopause is strongly associated with new-onset major depression as well as depressive symptoms in women with no history of mood disturbance, reported Ellen W. Freeman, Ph.D., of the departments of ob.gyn. and psychiatry at the University of Pennsylvania, Philadelphia, and her associates in the Penn Ovarian Aging Study. Women are significantly more likely to develop a depressive disorder when their levels of estradiol fluctuate, levels of FSH and LH increase, and levels of inhibin B decrease, as happens during the transition to menopause. It appears that the hormonal changes characteristic of ovarian aging produce “destabilizing effects” that contribute to depression, the investigators said (Arch. Gen. Psychiatry 2006;63:375-82).

This finding should make a substantial contribution to what has been only “limited evidence” in the literature about mood symptoms in the perimenopausal years. “Whether mood symptoms increase in the perimenopausal years and whether the occurrence of depressed mood is independently associated with ovarian changes or is secondary to vasomotor or other bothersome symptoms” has been controversial, they noted.

Dr. Freeman and her associates examined the issue by assessing fluctuations in reproductive hormone levels in 231 premenopausal women aged 35-47 years at baseline who were followed for 8 years. During that interval, 43% of the women entered the transition to menopause. Hormone assays were conducted in 10 assessment periods, the first 6 at 8-month intervals. Blood samples were collected at the start of menstrual cycles. Depressive symptoms were assessed using the CES-D (Center for Epidemiological Studies-Depression) scale; either the PRIME-MD (Primary Care Evaluation of Mental Disorders) or the PHQ (Patient Health Questionnaire) was used to detect major depressive disorder. A total of 116 women (50%) were found to have depressive symptoms on the CES-D during follow-up. Of these, 16 women had depressive symptoms on two consecutive assessments

and 35 had them on three or more consecutive assessments.

Of the 231 women, 59 (26%) were found to have depressive disorders on the PRIME-MD or PHQ; 26 had major depressive disorder and 33 had other depressive disorders. Nine of the women had depressive disorders on two consecutive assessments and four had them on three or more consecutive assessments.

A total of 108 women (47%) showed no depressive symptoms on either measure, Dr. Freeman and her associates said.

Changes in individual women’s levels of FSH, LH, and inhibin B were significantly associated with depressive symptoms and with major depression. Similarly, variability in a woman’s mean levels of estradiol, FSH, and LH also



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DR. FREEMAN

were linked to depression and depressive symptoms. “On average, the women were 4.58 times more likely to have higher FSH levels ... 3 times more likely to have higher LH levels ... and 63% more likely to have lower inhibin B levels ... at the time of high [depression] scores,” compared with the time before high scores, the investigators said.

After the data were adjusted for several other depression risk factors, including change in employment status or marital status, the researchers found that a woman was, on average, more than five times “more likely to be in menopausal transition at the time of reporting high [depression] scores than she was before the onset of depressive symptoms.”

The “strongest risk factor for the new onset of diagnosed depressive disorders was the increased variability of estradiol (around the woman’s own mean levels) at the time of the diagnosed disorder,” Dr. Freeman and her associates said.

However, other health and demographic factors also significantly affected depression risk, “confirming ... the multifactorial nature of depressive symptoms.” These factors included hot flashes, body mass index, smoking status, and the presence or absence of PMS. ■

Depression and Anxiety Worsen Asthma in Preteens, Adolescents

BY JANE SALODOF
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Southwest Bureau

SAN FRANCISCO — Preteens and adolescents with asthma who were also depressed or anxious had asthma symptoms on significantly more days and were more prone to individual symptoms, according to a study presented at the annual meeting of the Pediatric Academic Societies.

Based on these findings, the investigators urged physicians to screen for anxiety and depressive disorders when young people have asthma symptoms that do not respond to medication.

“We conclude that youth with asthma and depressive disorders do have a higher symptom burden, and providers should consider screening for depression in youth with high symptom burden if they are not responding to medication or treatment as expected,” Dr. Laura Richardson said in a poster presentation.

The researchers surveyed by telephone 767 young people, 11-17 years of age, who had asthma and were enrolled in a staff-model health maintenance organization to assess the number of days of asthma symptoms each participant had experienced in the 2 weeks prior to a call and the incidence of individual symptoms.

A total of 125 respondents (16%) were found to have anxiety or depressive disorders, while

642 did not (84%). Nearly two-thirds of the depressed youth but fewer than half of the other respondents were female. Both groups were 14 years old on average, reported Dr. Richardson, a pediatrician specializing in adolescent medicine at the Univer-



‘Providers should consider screening for depression’ if kids are not responding to treatment.

DR. RICHARDSON

sity of Washington in Seattle.

Similar proportions of both groups met Health Plan Employer Data Information Set (HEDIS) asthma severity criteria: 69% of the depressed group and 70% of those who were not depressed. The depressed patients had higher Chronic Disease Scores, however (795 vs. 581).

“After controlling for asthma severity and other covariates, [we found that] youth with anxiety or depressive disorders had an average of 5.4 symptom days in the prior 2 weeks, compared to 3.5 days in those without anxiety or depressive disorders,” Dr. Richardson said.

The respondents with anxiety or depressive disorders also were significantly more likely than the other respondents to

report each of six asthma-specific symptoms (wheezing with a cold, cold that won’t go away, cough, wheezing without a cold, tightness in chest, and shortness of breath) and five less-specific symptoms (difficulty sleeping, stuffy nose/congestion, itchy eyes, skin rash, and headache).

In addition, the investigators charted a linear relationship between the number of symptoms of anxiety and depression and the number of asthma symptoms that the patients reported. “The more anxiety and depression you have, the more asthma you have,” Dr. Richardson said in an interview before her presentation at the meeting, which was sponsored by the American Pediatric Society, Society for Pediatric Research, Ambulatory Pediatric Association, and American Academy of Pediatrics. ■

Asthmatic Youths With Anxiety or Depression Have More Symptom Days

5.4 days

With anxiety and depressive disorders

3.5 days

Without anxiety and depressive disorders

Note: Based on survey of 767 asthma patients in the previous 2-week period.

Source: Dr. Richardson

ELSEVIER GLOBAL MEDICAL NEWS

Quick Screen Identifies Depression and Panic Disorder in Sports Medicine Clinic

MIAMI — Athletic patients with significant musculoskeletal pain should be screened for comorbid depression and panic disorder, according to study findings presented at the annual meeting of the American Medical Society for Sports Medicine.

In a study of 148 consecutively-treated athletic patients who presented to a sports medicine clinic with musculoskeletal complaints, the overall prevalence of a major depressive disorder was 6%; 7% had another form of depression.

Dr. William W. Dexter and his associates at the Maine Medical Center sports medicine program in Portland surveyed

participants using the Primary Care Evaluation of Mental Disorders (PRIME-MD) patient questionnaire.

Although these overall prevalence rates are similar to those in a general primary care practice, the prevalence of mood disorders was even higher among those patients who presented with pain severity scores of 6 or higher on a scale of 0-10, Dr. Dexter noted in an interview.

Overall, the prevalence of panic disorder was 17%.

Although the association between mood disorders and musculoskeletal pain has been documented in the literature, there are no data on the prevalence of

mental health disorders in a primary care sports medicine population. “In our clinic, we felt we were seeing a lot of musculoskeletal complaints in patients who had an undiagnosed or underdiagnosed mood disorder,” Dr. Dexter said.

If patients’ comorbid depression and/or panic disorder are not addressed, significant improvements in musculoskeletal pain are unlikely, he added.

“Many of the subjects in the study did not have a prior diagnosis of mood disorder,” Dr. Dexter said. They were identified through screening with the PRIME-MD tool.

—Damian McNamara