Depression screening does not impact quality of life after heart attack

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After suffering a heart attack or unstable angina (chest pain caused by blocked arteries), patients who were systematically screened for depression and referred for treatment when appropriate did not show a significant improvement in quality of life compared with those who received no depression screening, according to research presented at the American College of Cardiology's 68th Annual Scientific Session.

Experts have identified depression as a risk factor for heart disease. Previous studies estimate that at least 1 in 5 patients with acute coronary syndromes also have symptoms of depression, and there is evidence that depression after a cardiac event can dramatically raise the risk of subsequent heart problems and death for any reason. The new trial suggests using currently available questionnaires to screen patients for depression after a heart attack or unstable angina is not an effective way to reduce the toll depression takes on patients' quality of life. However, the findings leave open the possibility that other ways of addressing depression could be more effective, according to researchers.

"Based on this study and the best evidence we have, we don't see a justification for putting large amounts of resources into universal, systematic depression screening for these patients," said Ian Matthew Kronish, MD, Florence Irving Associate Professor of Medicine at Columbia University Medical Center and the study's lead author. "However, that doesn't mean physicians shouldn't be on the lookout for signs of depression or that, if they notice it, they should ignore it. Depression still has a major impact on patients' quality of life and

prognosis overall, and if physicians do find it, they should absolutely try to address it with treatments that can reduce the depressive symptoms."

Researchers enrolled just over 1,500 patients hospitalized within the previous two to 12 months for acute coronary syndromes, a group of conditions that includes heart attacks and unstable angina, at four U.S. medical centers. Patients were randomly assigned to three groups. The first group received no depression screening. The other patients were asked to complete the eight-item Patient Health Questionnaire, a questionnaire designed to identify depression. For half of these patients, a positive screen resulted in notification of both the patient and his or her primary care provider, along with an invitation to participate in depression care. For the other half, a positive screen resulted only in notification of the patient and the patient's primary care provider, leaving the provider to determine next steps regarding depression treatment.

Overall the study identified depression in about 7 percent of patients screened. This is somewhat lower than seen in previous studies that found major depression affects about 10 percent of acute coronary syndrome patients. This was due, in part, to the fact that people who were already being treated for depression and those with a history of depression were excluded from the study, Kronish said. Also, depressive symptoms were assessed at least two months after the acute coronary syndrome; depressive symptoms that are elevated immediately after acute coronary syndromes often go away without depression treatment.

The researchers followed participants for 18 months and assessed changes in their quality of life based on quality-adjusted life years (QALYs), the trial's primary endpoint. QALYs capture the degree to which a person's life is detrimentally affected by physical or mental disability over time, with one point representing one year of perfect health and zero points representing death. No significant difference was

found between the three study groups, with all three groups having a very small decline in QALYs (a drop of 0.03 to 0.04 points, on average) over 18 months.

In addition, no significant difference was found between the groups in terms of participants' cumulative number of depression-free days, which ranged from 339 to 351 for the 18-month period. There was also no significant difference in terms of depressive symptoms at nine months, reported side effects of antidepressants, or rates of death or bleeding.

Within the group of patients who received the most extensive intervention—notification of a positive screen plus an invitation to participate in depression care, which was offered at no cost—about a quarter of patients declined depression treatment from study providers. Those who accepted the invitation received medications, phone-based psychotherapy sessions or a combination of both, depending on the patient's preferences—a therapy approach found to be effective in other trials. Although the trial did not show a significant benefit in this approach to screening these patients over other groups in the trial, Kronish said that further study is warranted to identify effective ways to address depression and its associated risks in those suffering acute coronary syndromes.

"We hope this isn't the final word on this question and that others will look into different ways to identify heart attack survivors who could benefit from depression treatment," Kronish said. "In addition, we need to think about how we can improve our depression treatments to have a bigger benefit, which could make screening more worthwhile."

Besides exploring different approaches to screening for and treating depression, Kronish added that it might be helpful to better educate patients about the impact of depressive symptoms on heart health, which could potentially improve patients' engagement in their care and increase

the effectiveness of depression treatment.

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