EDITORIAL COMMENT

Depression: Are We Ignoring an Important Comorbidity in Heart Failure?*

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Approximately 5 million Americans are currently living with heart failure (HF), and 550,000 new cases are diagnosed yearly (1,2). Patients with HF demonstrate a poor quality of life compared with patients who have other chronic diseases, scoring poorly on measures of physical function, emotional well-being, and overall social function (3,4). Studies have shown that patients with HF have high rates of depression compared with the general population; in addition, depression may confer a negative prognostic impact when present in HF patients, with an increased risk of both rehospitalization and mortality (5–12).

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In this issue of the Journal, Gottlieb et al. (13) report the results of a study investigating the prevalence of depression in a cohort of outpatients with HF. One hundred fifty-five patients were enrolled, and they completed assessments, including the Medical Outcomes Study Short Form, the Minnesota Living with Heart Failure Questionnaire, and the Beck Depression Inventory. The authors found that nearly one-half (48%) of the patients were depressed. Depressed patients tended to be younger, and women were more likely to be depressed than men; white men were more likely to be depressed than black men. Depressed patients scored significantly worse on quality of life measurements than patients who were not depressed.

This study is important because it extends our knowledge about the prevalence of depression in HF to the outpatient population. The authors should be commended for focusing on this population, about whom considerably less is known than the inpatient. Furthermore, given that patients spend the vast majority of their time away from the hospital and interact with medical providers primarily at clinic appointments, this represents a more real-world dataset than one composed entirely of inpatients. A limitation to this study, however, is that it is a cross-sectional glimpse; we have no information about the course of patients’ depression or cardiac health and no longitudinal data to correlate depression with prognosis.

In the past five years, eight studies have reported on the prevalence of depression in HF. Reported prevalence rates have ranged from 11% to 25% for outpatients and 35% to 70% for inpatients (5–12). In contrast, 5% to 10% of the general population meets the criteria for depression (14). The wide range of prevalence rates across studies of HF patients is likely due to the use of different diagnostic instruments and the inclusion of different patient populations in terms of age, gender, and disease severity. For example, depression may be more common in women with HF (5,10,11,15) and in patients with more severe disease or worse physical symptoms (6,14–16).

What remains largely conjecture, however, is why HF patients display such a markedly elevated prevalence of depression. Some researchers believe that the connection may lie in shared pathophysiology (for review, see reference 17). Neurohormonal activation (18), rhythm disturbances (19), inflammation (20), and hypercoagulability (21) may all play a role in the development, progression, and outcomes of HF. Interestingly, each of these pathologic states are also seen in depressed patients (22–25). This suggests that physiologic states brought on by depression might hasten the development of HF and worsen prognosis for established HF or that a single underlying factor might impact both depression and HF. Psychosocial factors may also contribute; for example, depression is associated with medical noncompliance, a higher prevalence of smoking, and lower levels of social support, each of which have been correlated with worse outcomes in HF (17).

It is even more unclear why patients with HF and depression are not more often treated for their depression. As Gottlieb et al. (13) point out, addressing depression in HF patients represents a prime opportunity to truly improve these patients’ quality of life. However, only 7% of the patients in this study were taking an antidepressant. Depression commonly goes undiagnosed; some research suggests that 30% to 50% of cases in the general population are never detected by a medical professional (26–29). Patients may be unwilling to disclose emotional distress to their physicians for fear of being stigmatized with the label of mental illness because they believe their feelings are part of their medical illness or because they don’t want a psychiatric diagnosis recorded in their medical record (29,30). Physicians may not address depression because they have not been adequately trained to recognize both typical and atypical depressive symptoms, because of time constraints in high-volume settings, or because they do not know how to best treat the condition. It is also important to recognize the difficulty inherent in diagnosing depression in the context of a disease with symptoms that mimic depression, particularly in the older population (31,32). Heart failure often is associated with fatigue, malaise, and insomnia (3), whereas depression is characterized by fatigue, insomnia, low mood,
loss of interest in usual activities, weight loss or gain, feelings of worthlessness, and decreased ability to concentrate (29,33). However, it is crucial that both clinicians and patients realize that the presence of major depression is not a standard part of living with HF. Although feeling upset about having a serious disease like HF may be nearly universal, major depression is not a normal reaction to illness and should be recognized as the disabling, chronic, and treatable condition that it is.

However, there remains a paucity of information regarding safe and efficacious treatment of depression in patients with HF. For example, the recent Enhancing Recovery in Coronary Heart Disease Patients (ENRICHD) trial showed that nonpharmacologic strategies in the treatment of depression in patients who suffered a myocardial infarction may not be efficacious (34), and the Montreal Heart Attack Readjustment trial (M-HART) suggested that nonpharmacologic treatment of stress in patients who suffered a myocardial infarction could even be harmful (35). Pharmacologic therapy remains controversial as well; tricyclic antidepressants are known to affect the cardiac system (36), whereas selective serotonin reuptake inhibitors have not been systematically studied in the HF population. The recent Sertraline AntiDepressant Heart Attack Randomized Trial (SADHART), a randomized trial of sertraline in depressed patients with acute coronary syndrome, demonstrated that the treatment of depression can be accomplished without increasing worrisome complications or cardiovascular events (37). Little is known, however, about treatment in patients with HF. The ongoing Sertraline AntiDepressant Heart Attack Randomized Trial in Heart Failure (SADHART–HF), funded by the National Institutes of Mental Health, will give clinicians important data regarding the safety and efficacy of pharmacologic treatment for depression in patients with HF.

The increased prevalence of depression seen in patients with HF is now well established. What remains is to determine why this is the case in the hopes of eventually being able to target treatment at the true root of the problem. In the meantime, HF patients should be screened for depression and treated when depression is found to be present. In this way, we can help improve patients’ quality of life and potentially improve long-term outcomes.

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