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Depression in Older Adults With Heart Failure

We read with great interest the study by Gottlieb et al. (1), which examined an important area in heart failure (HF) management: depression. The investigators observed that for every 10 years above the mean age (64 years), “the likelihood of exhibiting depressive symptoms decreased by 26%.” This is surprising as depression is rather common in old age. About 20% of the U.S. population 65 years and older suffer from depression, compared with 7% in younger adults (2,3).

Many of these older adults suffer from subsyndromal or atypical depression, which is much more common in old age, more difficult to diagnose, and is as distressing and disabling as major depression (2–4). The vast majority of HF patients are 65 years or older, many have preserved systolic function, and they receive care from generalist physicians in nonacademic settings. The results of this interesting study of depression in relatively younger male HF patient with systolic dysfunction receiving care from a cardiology clinic in an academic setting may not be generalizable to most HF patients.

Focusing on “relatively young” patients may not be the most efficient way to screen depression in HF, and certainly not in older adults. In addition, use of the Geriatric Depression Scale, instead of the Structured Clinical Interview described in the *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition—Revised (*DSM-III-R*) or other diagnostic tools such as Beck Depression Inventory, is more likely to identify depression in older adults (5).

Finally, care settings also likely have significant implications for appropriate diagnosis and management of depression in older adults with HF. Older adults with HF should preferably receive primary care from a generalist physician, in consultation with a cardiologist (6). The American College of Cardiology/American Heart Association guidelines for chronic HF has identified this collaborative model as the most preferred model for HF management (7).

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Influence of Age, Gender, and Race on Depression in Heart Failure Patients

We applaud Gottlieb and colleagues for devoting attention to depression and quality of life in heart failure (HF) patients (1). We are concerned, however, with the investigators' use of: 1) the Beck Depression Inventory (BDI) (2) as a sole measure of depression, and 2) the Medical Outcomes Study, Short Form Health Survey-36 (SF-36) (3) as a measure of quality of life in HF patients.

Although there is precedent for using the BDI to screen for depression in HF patients (4,5), we are concerned that the BDI may be inadequate as a single index of depression in this medically ill population. Because the BDI was not designed to diagnose or assess depression in medically ill patient samples, fully one-third of the scale's items are somatic in focus, assessing fatigue, appetite, libido, sleep habits, somatic worry, functional ability, and weight change—all symptoms consistent with HF. Previous studies of major depression in HF have used the BDI as a screening instrument before using a diagnostic interview such as the Diagnostic Interview Survey (DIS) (6) to diagnose major depression (4,5). Without a diagnostic interview for depression and/or a concurrent, nonsomatic measure of depression (e.g., the Hospital Anxiety and Depression Scale) (7), using only the BDI to assess depression poses a potential threat to construct validity in these symptomatic HF patients. In their study, Gottlieb et al. (1) further operationalized depression as a BDI score ≥ 10 . Whereas Beck et al. (2) categorize BDI scores of 4 to 10 as normal, and scores of 11 to 16 as indicative of mild depression, these cut-off points represent norms established in a nonmedically ill population. Thus, classifying stage II to IV HF patients with BDI scores ≥ 10 as depressed, in the absence of a secondary diagnostic or nonsomatic measure of depression, may potentially serve to overestimate the prevalence of depression in this, by definition, symptomatic sample.