Gruppo di ricerca geriatrica

Venerdì 21 settembre 2007

Depressione e Malattie Somatiche, etc.

Renzo ROZZINI

Prevalenza di depressione, rilevata attraverso l'impiego di diverse scale, in alcuni studi epidemiologici del GRG

		Depressione			
	n	assente	moderata	severa	età
Nel territorio:					
Brescia (1986)*	1201	66.2	27.5	6.3	70-75
Ospitaletto (1992)**	549	73.5	23.1	3.4	>70
Tirano (1993)**	183	75.8	17.0	7.1	>60
Coccaglio (1995)***	390	64.6	30.0	5.4	>70
In ambulatorio medico:					
PEQOL (1992)#	462	60.4	23.8	15.8	>75
In RSA:					
PROLOGUS (1994)***	178	37.2	21.5	41.3	>70
In Ospedale:					
GERU (1996)***	998	39.9	24.3	35.8	>65
ACE (2003)**	3015	59.2	29.7	11.1	>65
UCSI (2006)**	1370	66.1	26.6	7.4	>65

**BDI; **GDS (short form); ***GDS (complete form); #BSI.*

Epidemiology

1–4% of the general elderly population has major depression, equivalent to an incidence of 0·15% per year. Twice as many women as men are affected. Both the prevalence and the incidence of major depression double after age 70–85 years. Similarly, the number of elderly people with bipolar disorder is increasing, because the absolute number of old people is rising and, possibly, because the proportion of elderly individuals with this illness is increasing. Minor depression has a prevalence of 4–10%. Dysthymic disorder, characterised by low-intensity symptoms of depression that last 2 years or longer, occurs in about 2% of elderly people.

A very old person is particularly prone to significant symptoms of depression. An increase in disability and cognitive impairment, a fall in socioeconomic status, and the high proportion of women who survive their partner's death might explain this pattern.

Alexopoulos, Lancet 2005; 365:1961-1970

La diagnosi di depressione

Is depression overdiagnosed?

Gordon Parker scientia professor School of Psychiatry, University of New South Wales, Randwick NSW 2031, Australia **g.parker@unsw.edu.au**

YES It is normal to feel depressed. In our study of 242 teachers, the 1978 baseline question-

blue …down in the dumps." Criterion B (mandating four of eight listed items) could be met by appetite change, sleep disturbance, drop in libido, and fatigue. Trials confirmed the low reliability of these criteria,[4] and studies showed variable

Does overdiagnosis matter?

Does current looseness matter if a low diagnostic threshold destigmatises depression, encouraging people to seek help? After all, breast screening programmes may lead to detecting more malignant lumps. However,

Meta-analyses show striking gradients favouring antidepressant drugs over placebo for melancholic depression. Yet trials in major depression show minimal differences between antidepressant drugs, evidence based psychotherapies, and placebo. The benefit of treatment for minor and subsyndromal depression is even more unclear. Extrapolating management of the more severe biological conditions to minor symptom states reflects marketing prowess rather than evidence. Depression will remain a non-specific "catch all" diagnosis until common sense prevails.

As American journalist Ed Murrow said: "Anyone who isn't confused doesn't really understand the situation."

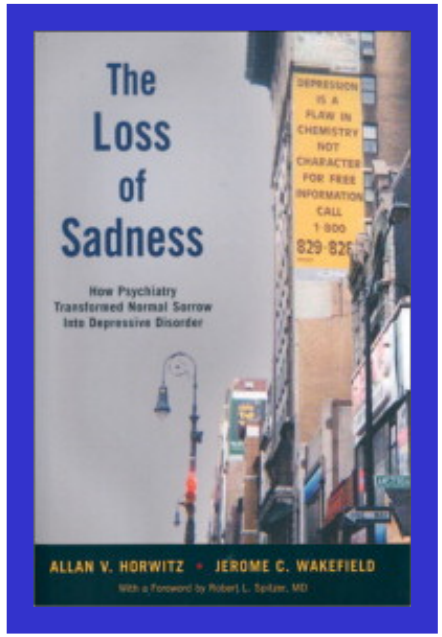
Is depression overdiagnosed?

Ian Hickie executive director, Brain and Mind Research Institute, University of Sydney, Camperdown NSW 2050, Sydney, Australia **ianh@med.usyd.edu.au**

NO It is appropriate for the wider community to ask if the benefit of increased treatment of depres- of mental hospital environments. Without diagnosis of these conditions, we would still distance ourselves, our families, and our communities from the benefits of receiving mental health care.

The promotion of safer antidepressants in antidepressants. In fact, substantive personal, demographic, geographical, professional, training, and health system barriers remain in place. The net result is that diagnosis of major depression is largely restricted to people with severe or persistent disorders,

It is appropriate for the wider community to ask if the benefit of increased treatment of depression over the past 15 years has outweighed any harm. If increased treatment has led to demonstrable benefits, and is cost effective, then depression is not being overdiagnosed. From a health and economic perspective, we can give a clear answer—more adults are alive and well, and we can easily afford to treat more. Increased treatment of depression reduces suicides and increases productivity. The provision of appropriate medical and psychological care is also cost effective.



Allan Horwitz and Jerome Wakefield's important book, *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder*, is part of a gathering blowback against the pathologisation and medicalisation of the ordinary human condition of sadness after loss.

There are many things in life to make one feel sad. Losses abound. Relationships go to pieces. People get sacked from a decent job. Career fail. Aesthetic or moral projects are checked. Families fall down the class and status ladder. A myriad of disappointments can demoralize and defeat any of us.

And, as we age, we sense death coming. Researchers and clinicians (even the general public) have come to use the euphemism "stress" to stand for the routine and extraordinary dangers that each of us experience. These run from financial crisis to health catastrophes; from serious accidents to disabling chronic disorders; and, especially among the truly poor, from incidental to structural violence. In most societies the popular culture's wisdom makes the point that life is difficult, uncertain, and only poorly predicted or controlled.

For thousands of years of recorded medical history, it is well documented that physicians understood that symptoms cannot be interpreted outside of the actual context of the patient's life. No master clinician, in the past, would confuse depressive disorder with normal grief, unless the symptoms of grief lasted such a disproportionately long time and were dangerously dysfunctional to the patient and his or her world as to indicate pathology. Horwitz and Wakefield suggest that the same professional common sense informed the diagnostic systems from Hippocrates and Galen to pre-1980 medicine in the West for other losses from jobs and status to lovers.

Then came the cultural revolution of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (*DSM-III*, 1980). To improve clinical reliability, *DSM-III* simply added up symptoms. With the exception of bereavement—which the latest version (*DSM-IV*) grudgingly regards as normally lasting 2 months—*DSM-III* recognized no contextual events, besides other diseases, that might qualify the depressive syndrome as a normal response to serious life events. A modern Romeo might experience sadness after the break-up of a consuming love affair and would have several weeks or a month of sadness, sleeplessness, exhaustion, difficulty concentrating on his work, agitation, and lack of interest in eating and other previously valued things. In the *DSM-III*, the symptom count would easily make the cut off for depressive disorder, never mind the obvious social source of the problem or even the fact that, left to his own devices, our young man might no longer experience symptoms as he got over his loss and found a new love.

Is replacing the medicalisation of depression with the biologisation of sadness a useful trade-off?

I modelli interpretativi

“Ci vuole tempo perché le strutture arrugginite di un edificio crollino, ma la ruggine polverizza, giorno dopo giorno la materia, l’assottiglia, la snerva. Il cedimento, per quanto brusco, non è che il risultato cumulativo di un lento progresso di degrado, malgrado resti un evento drammatico a sè stante. Passa molto tempo tra la prima pioggia e il momento in cui la ruggine inizia a corrodere una travedi ferro. Talvolta il processo coinvolge punti nevralgici, tanto che il crollo appare totale; più spesso si tratta solo di un evento parziale: collassa una sezione, che provoca il cedimento di un’altra, con un’allarmante alterazione di tutti gli equilibri.
La depressione maggiore è invece contraddistinta da fasi di crisi profonda. Se immaginiamo un’anima di ferro logorata dal dolore e corrosa dal disturbo depressivo minore, potremmo paragonare la depressione maggiore a un vero e proprio cedimento strutturale”.

Il demone di mezzogiorno, Solomon A., 2002

The elderly are at high risk for depression because they are more likely than younger people to have experienced illness, death of loved ones, impaired function and loss of independence. The cumulative effect of negative life experiences may be overwhelming to an older person.

Fattori precipitanti una malattia depressiva o eventi che inducono una “ragionevole” risposta maladattativa?

Qual’è il loro significato clinico?

Depression, chronic diseases, and decrements in health: results from the World Health Surveys

Saba Moussavi, Somnath Chatterji, Emese Verdes, Ajay Tandon, Vikram Patel, Bedirhan Ustun

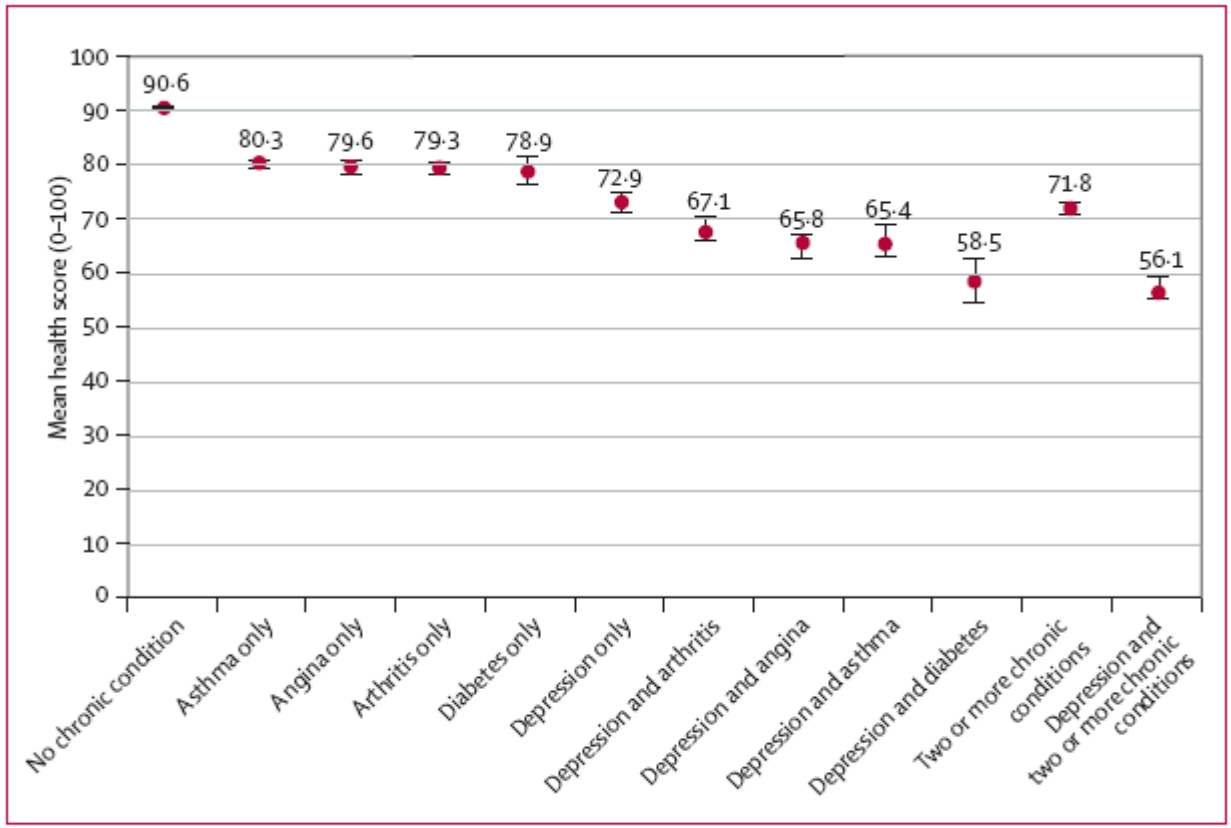


Figure: **Global mean health by disease status**
Data from WHS 2003.

Lancet 2007; 370: 851–58

Depressione e mortalità

Article

Medical Illness, Past Depression, and Present Depression: A Predictive Triad for In-Hospital Mortality

Stephanie von Ammon Cavanaugh, M.D.

Leticia M. Furlanetto, M.D., Ph.D.

Steven D. Creech, M.S.

Lynda H. Powell, Ph.D.

Objective: The authors' objectives were to determine 1) whether major depressive disorder diagnosed according to DSM-IV criteria modified for the medically ill predicted in-hospital mortality better than major depressive disorder diagnosed according to inclusive DSM-IV criteria and 2) whether a history of depression and current depression predicted mortality independent of severity of physical illness.

Method: Of 392 consecutive medical inpatients, 241 were interviewed within the first 3 days of admission and 151 were excluded from the study. Chart review and a clinical interview that included the Schedule for Affective Disorders and Schizophrenia were used to determine demographic variables, past psychiatric history, psychiatric diagnoses, and illness measures. Diagnoses included major depressive disorder and minor depression diagnosed according to DSM-IV criteria that included all symptoms regardless of etiology and according to criteria modified for the medically ill (hopelessness, depression, or anhedonia were used as the qualifying affective symptoms; depressive symptoms were eliminated if easily explained by medical illness, treatments, or hospitalization). The Charlson combined age-comorbidity index was used to measure severity of illness.

Results: A diagnosis of major depressive disorder based on criteria modified for patients with medical illness better predicted mortality than a diagnosis based on inclusive criteria. A past history of depression and the Charlson combined age-comorbidity index predicted in-hospital mortality, but demographic variables, pain, discomfort, length of stay, medical diagnoses, and minor depression did not. In the final multivariate logistic regression model, the Charlson combined age-comorbidity index, a modified diagnosis of major depressive disorder, and a history of depression were independent predictors of in-hospital death.

Conclusions: Severity of medical illness, a diagnosis of major depressive disorder based on modified criteria, and a past history of depression independently predicted in-hospital mortality in medical inpatients.

(Am J Psychiatry 2001; 158:43–48)

Annals of Internal Medicine | ARTICLE

Outcomes of Minor and Subsyndromal Depression among Elderly Patients in Primary Care Settings

Jeffrey M. Lyness, MD; Moonseong Heo, PhD; Catherine J. Datto, MD, MS; Thomas R. Ten Have, PhD; Ira R. Katz, MD, PhD; Rebecca Drayer, MD; Charles F. Reynolds III, MD; George S. Alexopoulos, MD; and Martha L. Bruce, PhD, MPH*

Background: Although depressive conditions in later life are a major public health problem, the outcomes of minor and subsyndromal depression are largely unknown.

Objective: To compare outcomes among patients with minor and subsyndromal depression, major depression, and no depression, and to examine putative outcome predictors.

Design: Cohort study.

Setting: Patients from primary care practices in greater New York City, and Philadelphia and Pittsburgh, Pennsylvania.

Patients: 622 patients who were at least 60 years of age and presented for treatment in primary care practices that provided usual care in a randomized, controlled trial of suicide prevention. Of the 441 (70.9%) patients who completed 1 year of follow-up, 122 had major depression, 205 had minor or subsyndromal depression, and 114 did not have depression at baseline.

Measurements: One year after a baseline evaluation, data were collected by using the following tools: Hamilton Depression Rating Scale, the depressive disorders section of the Structured Clinical Interview for DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders*, fourth edition), Charlson Comorbidity Index, Multilevel Assessment Instrument for measuring instrumental activities of daily living, Physical Component Summary of the Medical Outcomes Study Short Form-36, and Duke Social Support Index.

Results: Patients with minor or subsyndromal depression had intermediate depressive and functional outcomes. Mean adjusted 1-year Hamilton depression score was 10.9 (95% CI, 9.6 to 12.2) for those with initial major depression, 7.0 (CI, 5.9 to 8.1) for those with minor or subsyndromal depression, and 2.9 (CI, 1.6 to 4.2) for those without depression ($P < 0.001$ for each paired comparison). Compared with patients who were not depressed, those who had minor or subsyndromal depression had a 5.5-fold risk (CI, 3.1-fold to 10.0-fold) for major depression at 1 year after controlling for demographic characteristics ($P < 0.001$). Cerebrovascular risk factors were not associated with a diagnosis of depression at 1 year after controlling for overall medical burden. Initial medical burden, self-rated health, and subjective social support were significant independent predictors of depression outcome.

Limitations: Participants received care at practices that had personnel who had been given enhanced education about depression treatment; 29.1% of participants withdrew from the study before completing 1 year of follow-up.

Conclusions: The intermediate outcomes of minor and subsyndromal depression demonstrate the clinical significance of these conditions and suggest that they are part of a spectrum of depressive illness. Greater medical burden, poor subjective health status, and poorer subjective social support confer a higher risk for poor outcome.

Ann Intern Med. 2006;144:496-504. www.annals.org

For author affiliations, see end of text.

*Additional information regarding the authors' roles as study coordinators is available in the Appendix.

Crude and adjusted associations of GDS score with 60-month mortality in a community-dwelling population aged 70 and over.

	n/deaths	*RR*[a]	*95% C.I.*	*RR*[b]	*95% C.I.*
GDS					
0-2	227/35	1.0		1.0	
3-5	159/41	1.7	1.1-2.8	1.5	0.9-2.4
6-15	136/53	3.0	1.9-4.6	1.9	1.2-3.1
			p<0.0001 [a]		*p<0.005* [b]

A: crude analysis.
B: adjusted for age, gender, education (years of schooling), cognitive status (MMSE), number of diseases, disability (BADL).

(Rozzini et al., Arch. Int. Med., 2000)

ORIGINAL INVESTIGATION

Relationship of Depression to Death or Hospitalization in Patients With Heart Failure

Andrew Sherwood, PhD; James A. Blumenthal, PhD; Ranak Trivedi, PhD; Kristy S. Johnson, MPH; Christopher M. O'Connor, MD; Kirkwood F. Adams, Jr, MD; Carla Sueta Dupree, MD; Robert A. Waugh, MD; Daniel R. Bensimhon, MD; Laura Gaulden, MS; Robert H. Christenson, PhD; Gary G. Koch, PhD; Alan L. Hinderliter, MD

Arch Intern Med. 2007;167:367-373

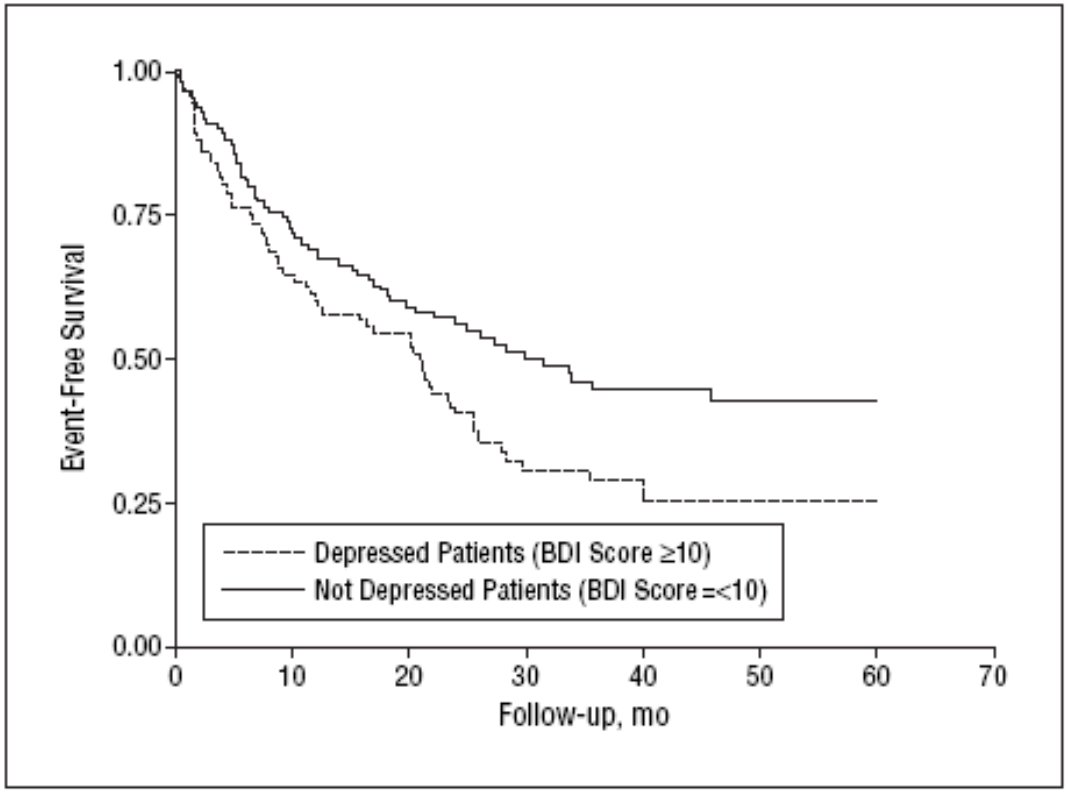


Figure. Kaplan-Meier curves indicate the composite end point of death or hospitalization because of cardiovascular disease in 94 patients with heart failure (HF) with clinically significant symptoms of depression (BDI score ≥10) compared with 110 patients with HF without depression (BDI score <10). Note: $P = .02$ comparing patients with and without depression, based on proportional hazards models including adjustment for age, HF etiology, left ventricular ejection fraction, *N*-terminal pro–B-type natriuretic peptide, and antidepressant medication use. BDI indicates Beck Depression Inventory.

Arch Intern Med. 2007;167:367-373

Table 2. Cox Proportional Hazards Regression Analyses for Death and Hospitalizations Because of Cardiovascular Disease

	Deaths or Hospitalizations (n = 120)		All-Cause Deaths or Hospitalizations (n = 145)		Deaths (n = 54)	
Variable*	HR (95% CI)	*P* Value	HR (95% CI)	*P* Value	HR (95% CI)	*P* Value
Age/10 y†	1.11 (0.94-1.32)	.22	1.18 (1.00-1.39)	.045	0.92 (0.71-1.18)	.49
HF etiology	1.05 (0.71-1.55)	.82	0.90 (0.64-1.28)	.57	1.37 (0.75-2.52)	.31
LVEF, %	0.99 (0.97-1.01)	.27	0.99 (0.98-1.01)	.60	0.97 (0.94-1.00)	.06
NT-ProBNP/1000 pg/mL	1.28 (1.16-1.42)	<.001	1.23 (1.12-1.35)	<.001	1.42 (1.24-1.64)	<.001
BDI score	1.06 (1.03-1.09)	<.001	1.06 (1.03-1.09)	<.001	1.05 (1.00-1.10)	.06
Antidepressant medication	1.75 (1.14-2.68)	.01	1.57 (1.06-2.34)	.02	1.79 (0.96-3.34)	.07

Abbreviations: BDI, Beck Depression Inventory; CI, confidence interval; HF, heart failure; HR, hazard ratio; LVEF, left ventricular ejection fraction; NT-proBNP, *N*-terminal pro–B-type natriuretic peptide.

*Values for each variable in the model are adjusted for all other variables in the model.

†Age divided by 10 indicates the heart rate values associated with age reflect a decade.

Arch Intern Med. 2007;167:367-373

Conclusions: Symptoms of depression were associated with an adverse prognosis in patients with HF after controlling for HF severity. The unexpected association of antidepressant medications with worse clinical outcome suggests that patients with HF requiring an antidepressant medication may need to be monitored more closely.

Arch Intern Med. 2007;167:367-373

Depressione e outcome in pazienti anziani con scompenso cardiaco

Depression and major outcomes in older patients with heart failure

Renzo Rozzini, MD, Tony Sabatini, MD, Giovanni B. Frisoni, MD, Marco Trabucchi, MD
Arch Int Med, 2002; 162:362-363

In our study, 6-month mortality was 8%, and the rate of rehospitalization was 29%. Mortality in patients with neither HF nor depression was 4%; in patients without HF and with depression, 7%; in patients with HF and without depression, 15%; and in those with both HF and depression, 21% (differential survival on log rank test, P<.01).
In the same groups, the rate of rehospitalization was 35%, 38%, 44%, and 67%, respectively (chi- square test, P<.01).

Association of groups of risk with 6-month mortality in hospitalized elderly patients

		A		B	
	N/events	RR	95% C.I.	RR	95% C.I.
No HF and no depression	353/14	1.0	Ref.	1.0	Ref.
No HF and yes depression	361/23	1.9	0.9-4.0	1.8	0.8-4.3
Yes HF and no depression	47/7	3.2	1.0-10.3	3.1	1.0-10.4
Yes HF and yes depression	39/8	6.9	2.6-18.3	5.8	2.1-16.6
Disability in BADL	143/22	2.8	1.6-4.9	2.2	1.1-4.6
Serum albumin (<3.5 g/dl)	112/16	2.4	1.3-4.4	2.0	0.9-4.1
APACHE (APS score >5)	76/14	3.3	1.7-6.2	2.3	1.1-5.0

A: crude analysis. B: adjusted for potential confounders (disability, serum albumin, and APACHE)
RR: risk ratio. C.I.: confidence interval.
Variables failing to qualify for entering the multivariate regression model were: age, male gender, cognitive impairment, anemia (Hem<8g/dl), diabetes mellitus, COPD, and GI diseases.

Rozzini R, Sabatini T, Frisoni GB, Trabucchi M. Arch Intern Med (2002).

Depression and Negative Outcomes in Patients With Heart Failure

The rate or rehospitalization in patients without HF and depression was 35%; in patients without HF and with depression was 38%; in patients with HF and without depression was 44%; and in those with HF and with depression was 67% (chi-square test: $p<0.01$).

R.Rozzini & M.Trabucchi. Arch Intern Med, 2003

ORIGINAL INVESTIGATION

Depressive Symptoms and Chronic Obstructive Pulmonary Disease

Effect on Mortality, Hospital Readmission, Symptom Burden, Functional Status, and Quality of Life

Tze-Pin Ng, MD; Mathew Niti, PhD; Wan-Cheng Tan, MD; Zhenying Cao, MSc; Kian-Chung Ong, MMed(IntMed); Philip Eng, MMed(IntMed)

Conclusions: Comorbid depressive symptoms in patients with COPD are associated with poorer survival, longer hospitalization stay, persistent smoking, increased symptom burden, and poorer physical and social functioning. Interventions that reduce depressive symptoms may potentially affect COPD outcomes.

Arch Intern Med. 2007;167:60-67

Association Based on Cox Regression Analysis of Groups of Risk With 12-Month Mortality in 621 Hospitalized Elderly Patients

	Total/events	RR (a)	95%CI	RR (b)	95%CI
No COPD and no depression	95/6	1.0	ref.	1.0	ref.
No COPD and yes depression	422/66	2.2	1.1-5.9	2.2	1.0-5.3
Yes COPD and no depression	21/5	4.1	1.2-13.4	4.0	1.2-13.3
Yes COPD and yes depression	83/28	6.4	2.6-15.4	4.9	2.0-12.0
Sex (males)	188/42	1.7	1.1-2.6	*1.5*	*1.0-2.4*
Age>80	337/55	1.1	0.7-1.7	1.1	0.9-4.6
Education (<5 yrs)	127/26	1.3	0.8-2.2	1.1	0.9-1.4
Dementia	172/46	2.4	1.6-3.7	1.9	1.3-2.9
Charlson Index >3	173/47	2.5	1.6-3.9	1.0	0.7.15
Disability in BADL	335/66	1.5	1.1-2.4	1.2	1.1-1.3
Malnutrition	191/63	2.5	1.6-3.9	1.6	1.1-3.2

Journal of Gerontology: MEDICAL SCIENCES
2006, Vol. 61A, No. 9, 975–981

Does Depression in Older Medical Inpatients Predict Mortality?

Jane McCusker,[1,2] Martin Cole,[3,4] Antonio Ciampi,[2] Eric Latimer,[4,5] Sylvia Windholz,[6,7] and Eric Belzile[1]

Departments of [1]Clinical Epidemiology and Community Studies and [3]Psychiatry, St. Mary's Hospital, Montreal, Quebec, Canada.
Departments of [2]Epidemiology, Biostatistics, and Occupational Health, [4]Psychiatry, and [7]Family Medicine, McGill University, Montreal, Quebec, Canada.
[5]Services, Policy and Population Health Research Theme, Douglas Hospital Research Centre, Montreal, Quebec, Canada.
[6]Division of Geriatric Medicine, Sir Mortimer B. Davis Jewish General Hospital, Montreal, Quebec, Canada.

Background. Previous studies of the effect of depression on mortality among older medical inpatients have yielded inconsistent results. We examined the effects on mortality of both a diagnosis of depression at hospital admission and a history of previous depression, taking into account potential sources of bias (sample selection and confounding).

Methods. Medical inpatients aged 65+ with at most mild cognitive impairment were recruited at two Montreal hospitals and were screened for depression. All those with a diagnosis of major or minor depression (*Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* [DSM-IV] criteria) and a random sample of nondepressed patients were invited to participate. Baseline data included: history of previous depression, severity of physical illness, co-morbidity, and health services utilization. Cox proportional hazards methods were used to analyze survival during the 16- to 52-month follow-up period.

Results. Five hundred patients were enrolled; 116 (23.2%) had a history of previous depression. After adjustment for demographic factors, physical illness, cognitive impairment, and prior service utilization, the only depression group with significantly different mortality was patients with both current major depression and a history of depression, who had lower mortality than all other patient groups (hazard ratio 0.42; 95% confidence interval: 0.25, 0.70).

Conclusions. Among patients with no history of depression, a diagnosis of depression was not associated with mortality after adjustment for confounding by physical illness and other factors. Coincident major depression and history of depression was associated with decreased mortality.

Characteristics of hospitalized elderly patients according to their mood status: No Depression, Major and Minor Depression.

	Total N=1234 Mean (±SD)	No Depres N=564 Mean (±SD)	Major Depres N=164 Mean (±SD)	P*	Minor Depres N=506 Mean (±SD)	P**	P***
Age (years)	78.8 (±7.4)	77.4 (±7.7)	77.0 (±6.9)	.223	79.5 (±7.0)	.000	.000
Gender (female) n (%)	832 (67.4)	323 (57.3)	143 (87.2)	.000	366 (72.3)	.000	.000
MMSE score	25.2 (±3.9)	25.8 (±3.9)	25.6 (±3.8)	.821	24.3 (±4.1)	.000	.001
GDS score	5.1 (±3.5)	2.2(±1.3)	8.0 (±3.9)	.000	7.4 (±2.5)	.000	.050
Living alonen (%)	385 (31.7)	152 (27.4)	74 (45.7)	.001	159 (31.9)	.800	.008
Barthel Idx (prior hosp)	88.8 (±17.3)	92.2 (±14.2)	90.3 (±14.2)	.170	84.5 (±20.1)	.000	.003
Barthel Idx (at adm)	81.0 (±24.5)	84.1 (±23.7)	86.1 (±18.8)	.360	75.9 (±26.1)	.000	.000
Barthel Idx (at disch)	84.1 (±22.3)	88.1 (±19.7)	87.8 (±16.6)	.665	78.4 (±25.1)	.000	.000
IADLs lost (prior hosp)	2.5 (±2.5)	1.9 (±2.3)	2.6 (±2.3)	.004	3.1 (±2.6)	.000	.103
Charlson Index	2.5 (±2.3)	2.5 (±2.3)	1.7 (±1.9)	.001	2.6 (±2.3)	.234	.000
APACHE II score	7.9 (±4.3)	8.1 (±4.6)	6.6 (±3.0)	.004	8.1 (±4.3)	.608	.007
APACHE II-APS score	1.8 (±2.6)	2.0 (±2.7)	1.2 (±1.9)	.030	1.9 (±2.6)	.684	.050
Serum Albumin (g/dl)	4.0 (±0.8)	4.0 (±0.7)	4.1 (±0.6)	.026	4.1 (±0.9)	.495	.192
6-month mortality n (%)	174 (14.1)	74 (13.1)	12 (7.3)	.048	88 (17.4)	.226	.026

(Rozzini et al., J Gerontol., 2007)

Chi soffre di più?

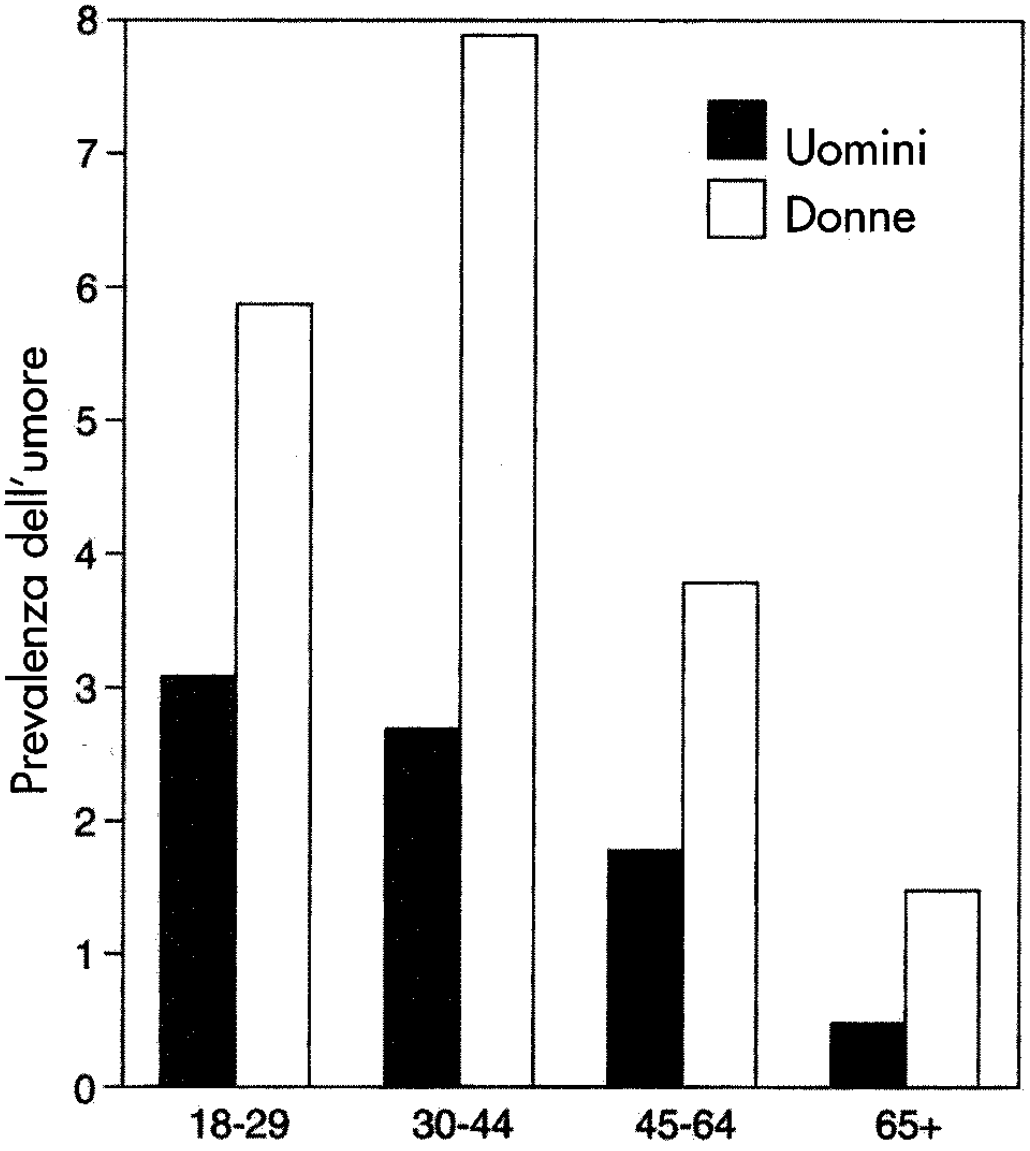
Quando è indicato il trattamento farmacologico?

Dobbiamo sempre prescrivere farmaci antidepressivi nei pazienti affetti da malattia fisica (ad es. scompenso cardiaco) tenuto conto che la depressione peggiora il decorso della malattia?

Il problema è chiarire se la depressione sia una comorbilità, la cui rilevanza potrebbe essere smascherata da una malattia fisica, oppure una condizione psicologica indicatore di fragilità spia di un'incapacità a far fronte ad un evento stressante.
Nel primo caso il trattamento farmacologico potrebbe essere efficace, nel secondo, inutile o negativo.

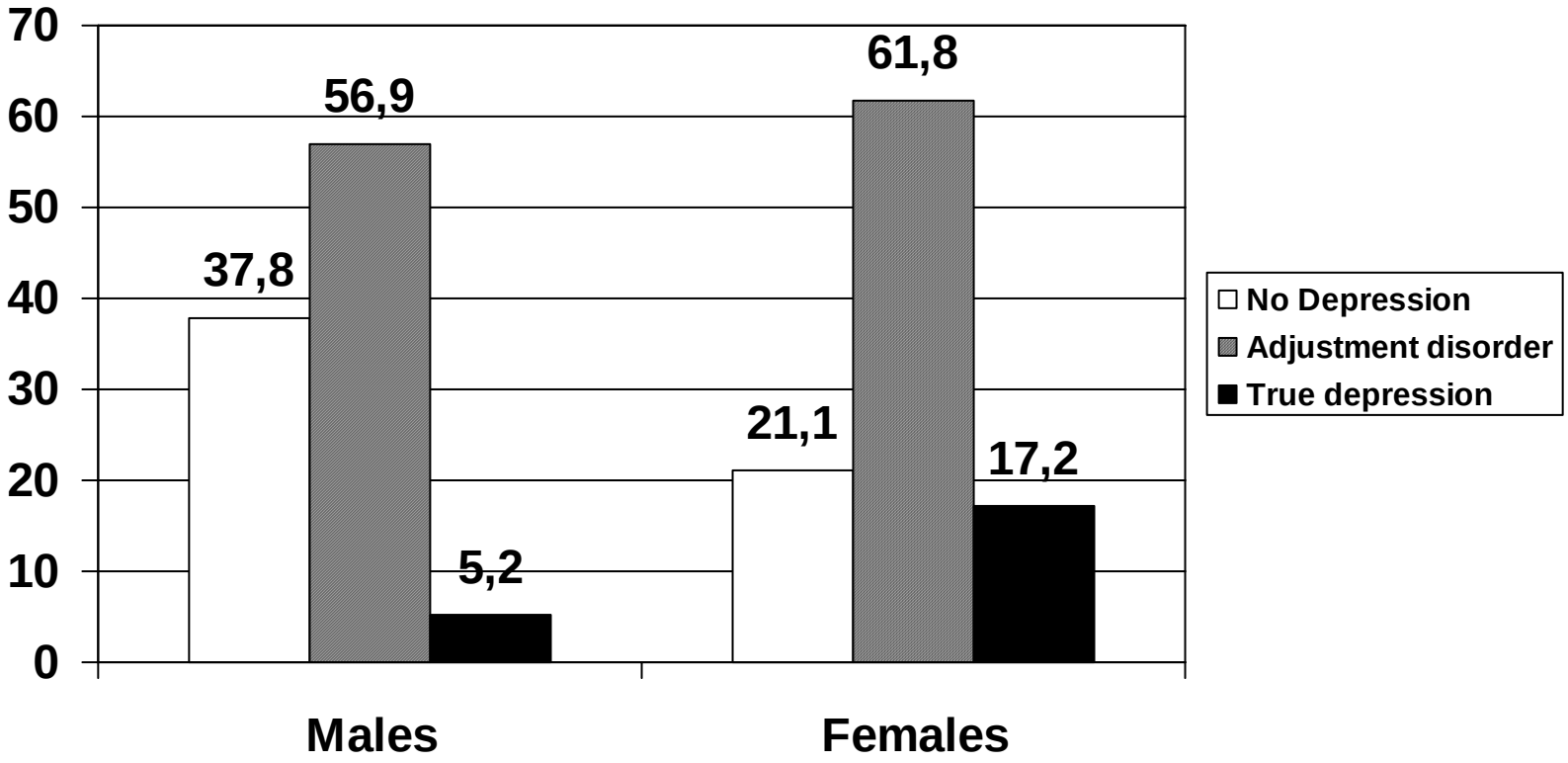
Renzo Rozzini & Marco Trabucchi, Arch Int Med, 2003; 163:498-499

Depressione e genere

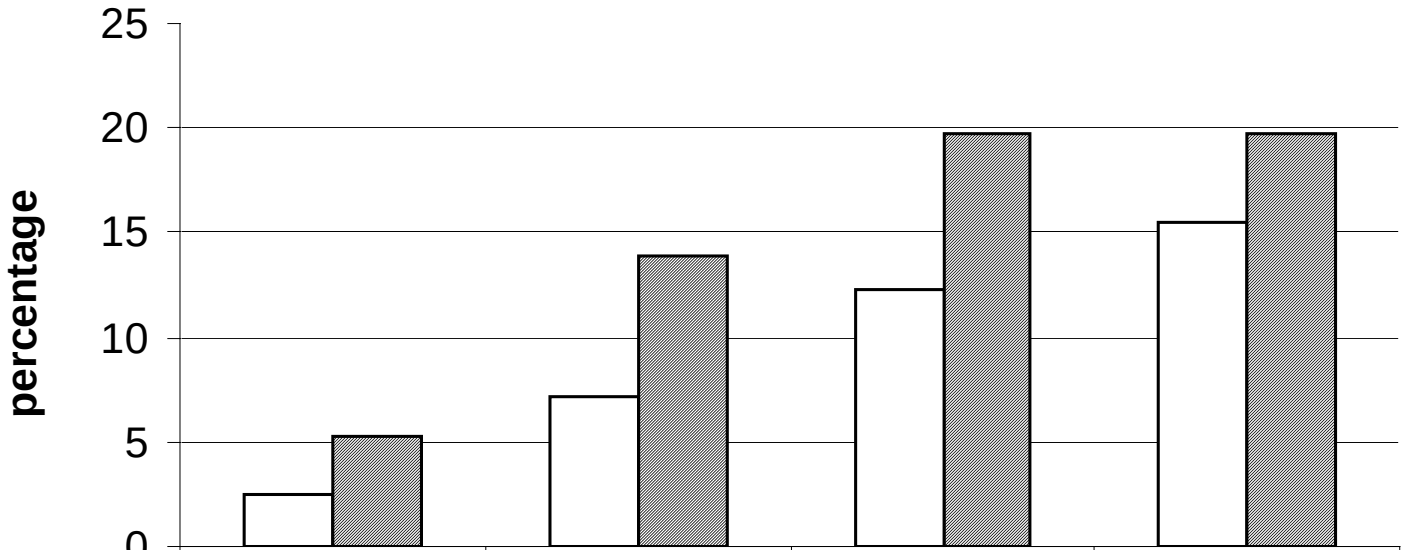


Prevalenza dei disturbi dell'umore osservata per età e sesso. Dati tratti dallo studio *Epidemiological Catchment Area* (Weissman et al., 1991).

Depression prevalence in hospitalized patients (ACE MU)



Rates of antidepressant's prescriptions according to gender and age strata in elderly patients living at home



	<65	65-74	74-84	>84
□ males	2,5	7,2	12,3	15,5
▨ females	5,2	13,9	19,7	19,8

ASL, Brescia

Depression in men

While both men and women can develop the standard symptoms of depression, they often experience depression differently and may have different ways of coping. Men may be more willing to report fatigue, irritability, loss of interest in work or hobbies, and sleep disturbances rather than feelings of sadness, worthlessness, and excessive guilt. Some researchers question whether the standard definition of depression and the diagnostic tests based on it adequately capture the condition as it occurs in men.

Men are more likely than women to report alcohol and drug abuse or dependence in their lifetime; however, there is debate among researchers as to whether substance use is a "symptom" of underlying depression in men, or a co-occurring condition that more commonly develops in men.

Nevertheless, substance abuse can mask depression, making it harder to recognize depression as a separate illness that needs treatment.

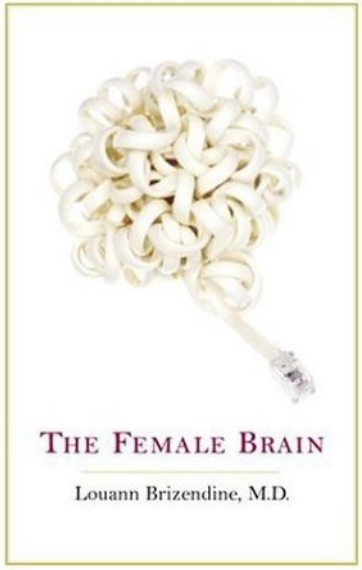
Depression in men

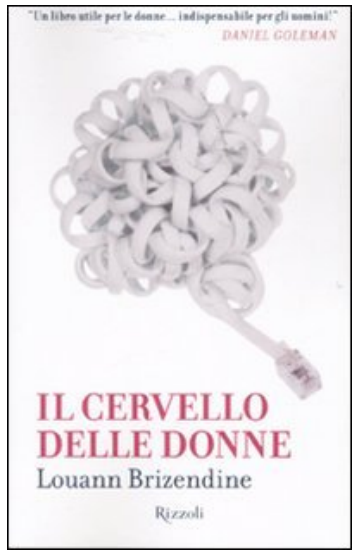
Instead of acknowledging their feelings, asking for help, or seeking appropriate treatment, men may turn to alcohol or street drugs when they are depressed, or become frustrated, discouraged, angry, irritable and, sometimes, violently abusive. Some men may deal with depression by throwing themselves compulsively into their work, attempting to hide their depression from themselves, family, and friends; other men may respond to depression by engaging in reckless behavior, taking risks, and putting themselves in harm's way.
Four times as many men as women die by suicide in the United States, even though women make more suicide attempts during their lives. The alarming suicide rate among men may reflect the fact that men are less likely to seek treatment for depression. Many men with depression do not obtain adequate diagnosis and treatment, which may be life saving.

Depression in women

La depressione femminile …. più frequente di quella maschile, più legata alle défaillances e ai naufragi delle relazioni interpersonali: più radicata nelle metamorfosi dell'intersoggettività come struttura portante della condizione umana.

E. Borgna, Come in uno specchio oscuramente, Feltrinelli, 2007





Gli uomini vengono da Marte e le donne da Venere? La "materia grigia" di uomini e donne è diversa fin dal momento della nascita e la peculiarità biologica delle donne - il ciclo mestruale, la gravidanza, il parto, l'allattamento, la cura dei figli - influisce sullo sviluppo cognitivo, sociale e comportamentale del cervello. Le prime differenze cerebrali si manifestano già dall'ottava settimana di sviluppo fetale - in particolar modo a causa dell'avvio di quella attività ormonale che condizionerà per il resto della vita i sistemi neurali di maschi e femmine. Le donne tenderanno a sviluppare doti uniche una maggiore agilità verbale, la capacità di stabilire profondi legami di amicizia, la facoltà quasi medianica di decifrare emozioni e stati d'animo dalle espressioni facciali e dal tono della voce, e la maestria nel placare i conflitti.

Abbiamo scoperto che gli ormoni condizionano a tal punto il cervello femminile da spingerlo a percepire in maniera diversa la realtà e la vita stessa della donna, dando forma a i suoi valori e ai suoi desideri, e determinando le sue priorità. La loro azione si fa sentire in ogni fase della vita, fin dalla nascita. Ogni stato ormonale –infanzia, adolescenza, giovinezza, maternità e menopausa – agisce da stimolante per differenti connessioni neurologiche, responsabili di nuovi pensieri, emozioni e interessi. A causa di queste fluttuazioni attive dai tre mesi di vita fino a ben oltre la menopausa, lo stato neurologico di una donna non è mai costante. Mentre quello di un uomo è equiparabile a una montagna, che viene erosa impercettibilmente nel corso dei millenni da ghiacciai, intemperie e movimenti tellurici profondi, lo stato neurologico femminile può essere invece paragonato al tempo atmosferico, in perpetuo cambiamento e difficile da prevedere.

Louann Brizendine, 2006

Depressive Symptoms After Acute Myocardial Infarction

Evidence for Highest Rates in Younger Women

Susmita Mallik, MD, MPH, MS; John A. Spertus, MD, MPH; Kimberly J. Reid, MS; Harlan M. Krumholz, MD, SM; John S. Rumsfeld, MD, PhD; William S. Weintraub, MD; Purva Agarwal, MD; Mugdha Santra, MD; Savita Bidyasar, MD; Judith H. Lichtman, PhD; Nanette K. Wenger, MD; Viola Vaccarino, MD, PhD; for the PREMIER Registry Investigators

Background: Depression is common in patients hospitalized with acute myocardial infarction (AMI). In the community, younger women are uniquely prone to depression. Whether younger women are also more likely to have depression during hospitalization with AMI is unknown.

Methods: A total of 2498 AMI patients (1284 patients ≤60 years; 814 women and 1684 men) were enrolled from 19 US centers in the Prospective Registry Evaluating Outcomes After Myocardial Infarction: Events and Recovery (PREMIER) study between January 2003 and June 2004. Depression was assessed at the time of hospitalization and was defined as a Primary Care Evaluation of Mental Disorders Brief Patient Health Questionnaire (PHQ) score of 10 or higher.

Results: Younger (≤60 years) patients had higher mean PHQ scores than older patients (6.4 vs 5.0; $P<.001$) and women had higher mean PHQ scores than men (6.8 vs 5.2; $P<.001$). When stratified by both age and sex, younger women had the highest PHQ scores (8.2; $P<.001$ for the sex-age interaction). The prevalence of depression was 40% in women 60 years or younger, 21% in women older than 60, 22% in men 60 or younger, and 15% in men older than 60. In a logistic model adjusted for study center, race, medical history, and coronary heart disease risk factors, the odds of depression for women 60 years or younger were significantly higher than for the other sex-age groups and were 3.1 times higher than the reference group of men older than 60 years.

Conclusions: The prevalence of depression is high in younger women with AMI. Because depression after AMI has been associated with adverse outcomes, younger women, a high-risk group compared with men, may particularly benefit from aggressive screening and treatment of post-AMI depression.

Arch Intern Med. 2006;166:876-883

Excess mortality or institutionalization after hip fracture: men are at greater risk than women.

Fransen M, Woodward M, Norton R, Robinson E, Butler M, Campbell AJ
J Am Geriatr Soc. 2002; 50:685-90

Mortality During the 2 Years or Institutionalization/Mortality Status at 2 Years for Hip Fracture Cases Versus Controls, Stratified by Gender

	Mortality		Institutionalization/Mortality	
	Women	Men	Women	Men
Adjustment	odds ratio (95% confidence interval)			
Age, marital status, cohabitation	2.21 (1.53–3.18)	7.31 (3.77–14.20)	2.64 (1.96–3.55)	8.68 (4.78–15.74)
Age, physical function	1.71 (1.16–2.52)	6.96 (3.40–14.25)	2.04 (1.48–2.82)	7.92 (4.15–15.11)
Age, medical history	1.43 (0.91–2.26)	5.03 (1.93–13.07)	1.66 (1.15–2.38)	5.57 (2.43–12.77)
All (variables in Tables 1–3)	1.34 (0.83–2.16)	7.18 (2.04–21.99)	1.48 (1.02–2.19)	6.89 (2.75–17.27)

(Fransen M. et al, JAGS 50:685-690, 2002)

Journal of Gerontology: MEDICAL SCIENCES
2006, Vol. 61A, No. 5, 495–499

Gender Differences in Functioning After Hip Fracture

William G. Hawkes, Lois Wehren, Denise Orwig, J. Richard Hebel, and Jay Magaziner

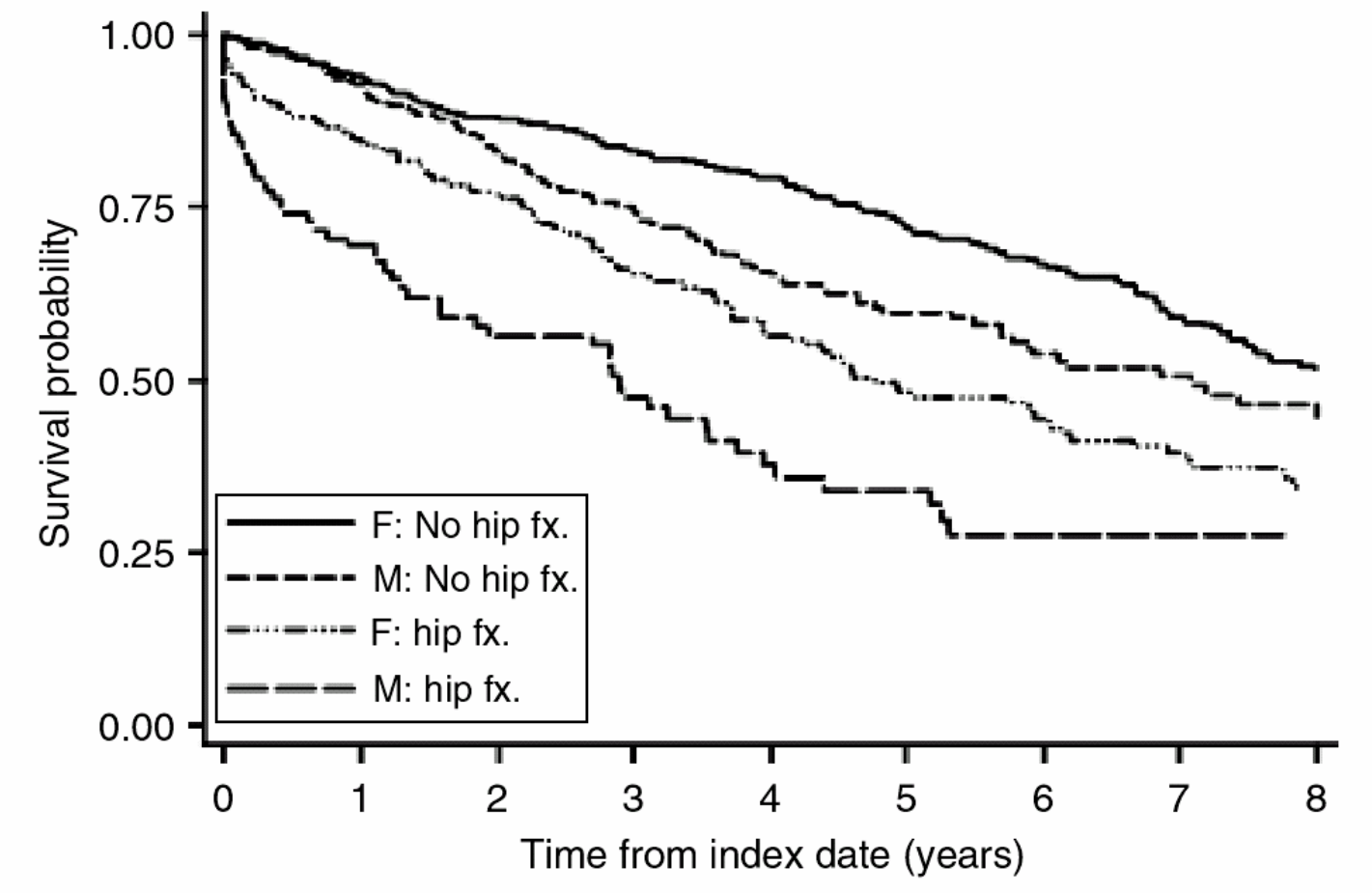
Results. Men in the study were generally younger and suffered greater comorbidity at time of fracture. Men further suffered higher mortality in the year following fracture. Among survivors, little difference between men and women was seen in patterns of recovery of function following fracture.

Conclusions. Hip fracture is not a problem affecting just women. Recovery following fracture for men is probably no better than that for women, even after mortality differentially eliminates the frailest male participants. However, psychosocial factors, greater comorbidity, and higher rates of certain complications among men may require adjustments to interventions designed to restore function. Further research into the consequences of hip fracture for men and women is needed.

Adjusted mortality after hip fracture: From the cardiovascular health study.

Robbins, J. A., Biggs, M. L., and Cauley, J.

J Am Geriatr Soc. 2006, 54:1885-1891.



Kaplan-Meier survival curves for Cardiovascular Health Study participants with hip fracture and age- and race-matched comparison participants without hip fracture, by sex. M = male; F = female.

Twelve month mortality in 621 elderly patients admitted to a GERU according to COPD, depression, and gender.

	Total N=621 N (%) events/total	females N=433 N (%) events/total	males N=188 N (%) events/total
a) No COPD, No Depr	28/249 (11.2)	16/170 (9.4)	12/79 (15.2)
b) No COPD, Yes Depr	44/268 (16.4)	34/212 (16.0)	10/56 (17.9)
c) Yes COPD, No Depr	13/58 (22.4)	5/24 (20.8)	8/34 (23.5)
d) Yes COPD, Yes Depr	20/46 (43.4)	8/27 (29.6)	12/19 (63.2)

L’uomo con COPD (rispetto alla donna) muore di più.
A quali fattori biologici e clinici deve essere attribuita la mortalità più elevata?

Relationship of Depression to Death in Patients With Cardiac Diseases in Elderly Persons According to Gender

Five years mortality in 538 elderly males and females living at home according to heart diseases and depression.

	Total N=538	Males N=176	Females N=362
	N (%)	N (%)	N (%)
No HD & No Depre	50/270 (18.5)	24/91 (26.4)	26/179 (14.5)
Yes HD & No Depre	32/126 (25.4)	14/42 (33.3)	18/84 (21.4)
No HD & Yes Depre	33/88 (37.5)	14/27 (51.9)	19/61 (31.4)
Yes HD & Yes Depre	26/54 (48.1)	9/16 (56.3)	17/38 (44.7)

In elderly subjects depression is an important risk factor of mortality; in our study it is higher than chronic cardiac diseases.

Its effect on mortality may be due to a biological effect on heart function or to changes in health behaviours, such as nonadherence to prescribed treatment plans.

Our data are in favour of the latter, since depression exerts almost the same effect in subjects affected by heart diseases as in non affected ones.

Association between hip fracture and depression in 766 elderly patients admitted to a Geriatric Rehabilitation Unit.

	total N=766	females N=565	males N=201
	N (%)	N (%)	N (%)
Not fractured	286/623 (45.9)	219/439 (49.9)	67/184 (36.4)
Fractured	68/143 (47.5)	57/126 (45.2)	11/17 (64.7)

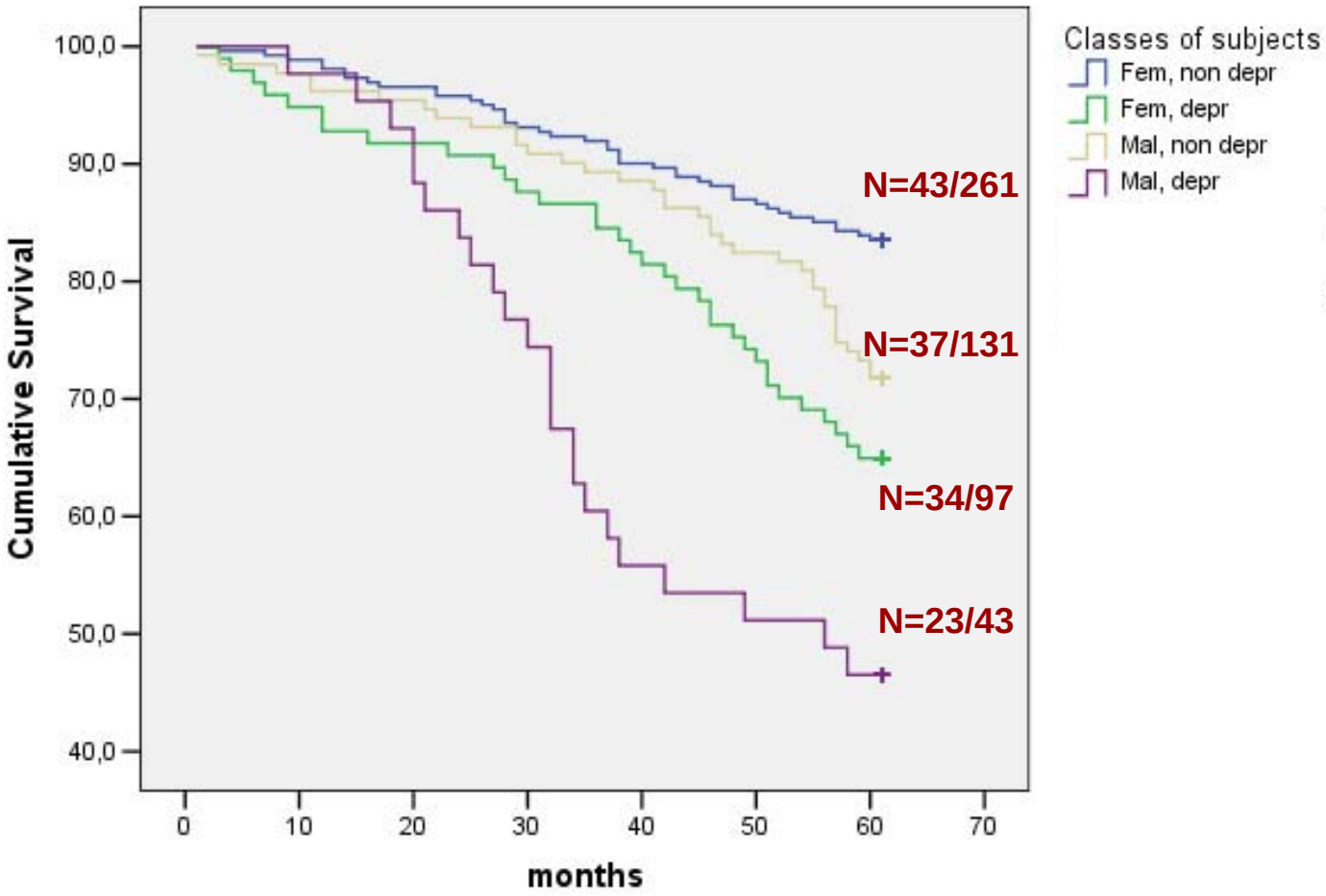
Data are expressed as number of depressed patients over the total number of subjects for each specific group.

Rozzini et al. JAGS (in press)

Dopo frattura di femore l'uomo (rispetto alla donna) diviene più depresso, muore di più e richiede maggiori attenzioni per la ripresa della funzione.
Perché? A quali fattori biologici e clinici deve essere attribuita la maggior comparsa di depressione, la quale a sua volta indurrebbe la mortalità più elevata, con un effetto che si riflette sulla funzione?

È la mancata plasticità dell'organismo maschile (la sua rigidità) che rende ragione della più elevata mortalità?

Mortality rates in elderly persons living at home according to depressive symptoms



Depression

What Every Woman Should Know

DEPARTMENT OF HEALTH AND HUMAN SERVICES • PUBLIC HEALTH SERVICE • NATIONAL INSTITUTES OF HEALTH

NIMH National Institute of Mental Health

Findings that examine the possible culprits of depression in females

-Genetic Factors: Based on data that major depression clusters in families, having a first-degree relative with depression (parent, sibling) is a risk factor for depression. Although results from family or twin studies have not been definitive in showing the exact contribution of genetics to depression. Evidence is accumulating that there is a genetic risk that may be different for women and men. For women, it will be particularly instructive to understand the interaction of genetic, hormonal and experiential factors in their heightened risk for depression.

-Sex Hormones: The link between increased rates of depression and puberty, mood and the menstrual cycle as well as mood and pregnancy suggests a role of gonadal hormones in depression. Specifically, changes in gonadal hormones, disturbances in the hypothalamic-pituitary-gonadal (HPG) axis and attendant effects on neuromodulators (e.g. serotonin) may all be key mechanisms in the initiation of depression. For example, pregnancy and delivery produce dramatic changes in estrogen and progesterone levels, as well as changes in the HPG axis, that may underlie postpartum depression.

Findings that examine the possible culprits of depression in females

-Life Stress and Trauma: Case-control and community-based studies have shown that more than 80 percent of major depression cases were preceded by a serious adverse life event. Traumatic events, such as childhood sexual abuse, adult sexual assault, male partner violence and physical illness also can lead to depression. Initial research has suggested that early trauma has a greater impact on risk for depression than later occurring trauma. Research has also indicated that women may be more likely than men to experience depression in response to a stressful event.

-Interpersonal Relationships and Cognitive Styles: One cognitive style more common in women than men that increases the risk for depression is ruminative thinking - repetitively and passively focusing on symptoms of distress and their possible causes and consequences. Ruminative thinking is also associated with longer and more severe episodes of depression. Current research has demonstrated that relationships are more paramount to women's self-concept than men and that women are more likely to experience stress in response to adverse events occurring in the lives of others and place their needs secondary to those of others. These interpersonal orientations illustrate major psychological differences between men and women that may help account for differences in vulnerability to depression.

Sex differences in antidepressant response in recent antidepressant clinical trials.

Khan A, Brodhead AE, Schwartz KA, Kolts RL, Brown WA.
J Clin Psychopharmacol. 2005; 25:318-24.

Some previous reports suggest that women respond differently than men to antidepressant treatment. Much of this literature compares men and women's response to tricyclics to that of newer antidepressants (SSRIs, SNRI), or only examines one particular antidepressant. This study compares men and women's responses to 6 newer antidepressants. A total of 15 randomized, placebo-controlled trials that included 323 depressed patients were examined for sex differences in antidepressant treatment response. Women had a significantly greater response than men to SSRI antidepressants. A similar trend was seen for those assigned to an SNRI antidepressant, although not to the same extent as with SSRI antidepressants. Although these gender differences in treatment response are not large enough to suggest that gender should guide the clinical use of SSRI and SNRI antidepressants, the results do have implications for the design and interpretation of antidepressant clinical trials. These findings also raise the possibility that antidepressants may work somewhat differently in men and women.

Gender differences in treatment response to sertraline versus imipramine in chronic depression.

Kornstein SG. et al.

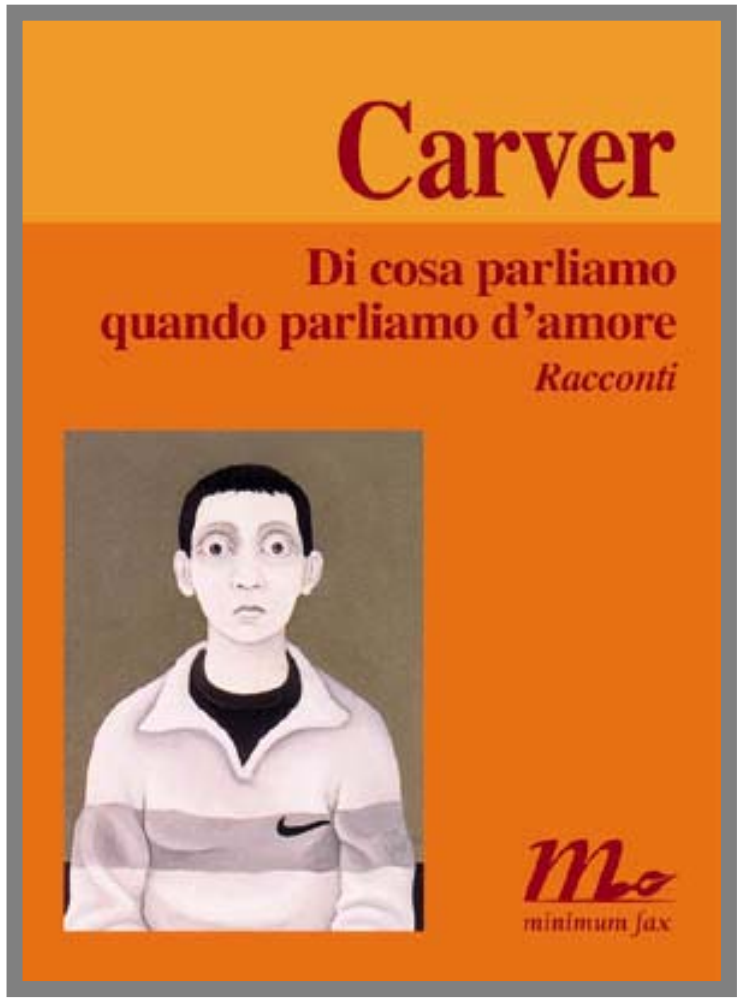
Am J Psychiatry. 2000; 157:1445-52.

OBJECTIVE: The authors examined gender differences in treatment response to sertraline, a selective serotonin reuptake inhibitor (SSRI), and to imipramine, a tricyclic antidepressant, in chronic depression.

METHOD: A total of 235 male and 400 female outpatients with DSM-III-R chronic major depression or double depression (i.e., major depression superimposed on dysthymia) were randomly assigned to 12 weeks of double-blind treatment with sertraline or with imipramine after placebo washout.

RESULTS: Women were significantly more likely to show a favorable response to sertraline than to imipramine, and men were significantly more likely to show a favorable response to imipramine than to sertraline. Gender and type of medication were also significantly related to dropout rates; women who were taking imipramine and men who were taking sertraline were more likely to withdraw from the study. Gender differences in time to response were seen with imipramine, with women responding significantly more slowly than men. Comparison of treatment response rates by menopausal status showed that premenopausal women responded significantly better to sertraline than to imipramine and that postmenopausal women had similar rates of response to the two medications.

CONCLUSIONS: Men and women with chronic depression show differential responsivity to and tolerability of SSRIs and tricyclic antidepressants. The differing response rates between the drug classes in women was observed primarily in premenopausal women. Thus, female sex hormones may enhance response to SSRIs or inhibit response to tricyclics. Both gender and menopausal status should be considered when choosing an appropriate antidepressant for a depressed patient.



What We Talk About When We Talk About Love **(Raymond Carver)**

"Ad un cuore spezzato
nessun cuore si volga
se non quello che ha l'arduo
privilegio
d'aver altrettanto sofferto".

Emily Dickinson (1830-1886)