Why treat depression differently from other medical problems?

Pierre Blier, MD, PhD

Department of Psychiatry, University of Florida, Gainesville, Fla.

Several studies have clearly shown that depression carries one of the largest global burdens of all medical problems. Precise details are provided in Dr. Kennedy's introduction to the articles in this special issue.[1] The World Health Organization estimates that depression will, unfortunately, become the number-one illness in terms of global burden by the year 2010.[2] Although we hope this gloomy statistic will not be reached, there are many factors that act in favour of achieving this outcome. First, there remains an obvious negative perception in our society about major depression; perhaps because of this, it is estimated that more than half the individuals meeting the criteria for major depression never consult any health care practitioner.[3,4] The individuals who do present with major depression are often not diagnosed, do not receive an antidepressant or, if they do, the dose is frequently suboptimal.[5,6] Finally, in the best-case scenario (i.e., a depressed patient receives an adequate dose of an antidepressant drug for a sufficient time), only 30%–50% of patients experience a complete remission. In this issue, Dr. Tranter and colleagues[7] emphasize the deleterious effects of settling for a response rather than a thorough remission.

Another significant problem is the insufficient duration of treatment after the remitted state has been achieved. Since major depression is associated with a significant mortality rate, if one considers only the prevalence of suicides associated with this disorder, this represents a poor performance by the medical community. How can we blame individuals with major depression for not consulting us when we have consistently displayed such a poor track record in treating the disorder over the years?

To reverse such negative trends, several changes will have to be implemented in the management of major depression. A very important one, as highlighted in the series of articles of this issue, is for health care practitioners to aim for remission rather than response. Another is to do away with the practice of prescribing an antidepressant at a minimal effective dose and waiting for weeks, if not months, before assessing the treatment response. The rationale often put forth for this course of action is that there is no urgency in getting a rapid onset of action because patients have already been ill for months or years. The reality is that by the time patients consult for their depression, they are often in a crisis situation. Consequently, there is a pressing need for relief. This should call for frequent visits to manage possible side effects, optimize the treatment regimen and maintain compliance. Ideally, utilizing a user-friendly standardized rating scale would help to monitor a patient's status effectively. The 7-item Hamilton scale proposed by Dr. McIntyre and colleagues appears to be a rapid and sensitive tool to achieve this.[8]

Given the low remission rate achieved with single antidepressant drugs, a significant proportion of patients may end up on 2 or more antidepressant drugs, a potentiating agent, or all of the above. In severe cases of depression, why not start with 2 agents that will

Correspondence to: Dr. Pierre Blier, Department of Psychiatry, University of Florida, PO Box 100256, Gainesville FL 32610–0256; fax 352 392-2579; blier@psych.med.ufl.edu

Medical subject headings: antidepressive agents; depressive disorder; drug combinations; psychiatric status rating scales; recurrence; remission induction; treatment outcome.

J Psychiatry Neurosci 2002;27(4):231-2.

© 2002 Canadian Medical Association

initially improve comfort (i.e., choose antidepressant drugs with side effects that counteract each other) and potentially obtain a more rapid onset of action or a higher remission rate in the standard minimal time of 6–8 weeks? There are numerous examples where such an approach has been successful in other fields of medicine. Indeed, for severe infections when the pathogen is not known, 2 antibiotics are used initially. It is standard practice to use a β_2-adrenergic agonist and a corticosteroid to treat asthma. As well, in cases of malignant hypertension, more than one agent may be used simultaneously.

The main concern with respect to this approach to treat depression has been prescribing a second drug that may not be necessary. Why not approach the problem from a different perspective: obtain a remission in a severe depression with 2 agents, chosen on the basis of their complementary mechanisms of action and their potential to maximize patient comfort, and then worry about possibly discontinuing one drug when the patient is in full remission? There is evidence, for example, with asthma, that when children are kept asymptomatic, the long-term prognosis is improved (unpublished data). In this series, Kennedy[1] alludes to similar data with respect to achieving remission early in the treatment of major depression and long-term prognosis. A study is being conducted at the University of Florida to examine such a strategy (i.e., prescribing 2 versus 1 antidepressant from the beginning of treatment to assess onset of action and efficacy, and when remission is achieved in patients taking 2 drugs, discontinuing 1 of them).

Major depression is a grave illness; it should be treated in a more aggressive fashion, following the same principles used in other fields of medicine. Indeed, who among us can claim that depression has not taken away one of our acquaintances, friends or family members because of suicide? I cannot.

Competing interests: Dr. Blier has received consultant's fees from Organon, Eli Lilly, Asahi Pharmaceuticals, Merck, Forest Laboratories, Janssen and Bristol-Myers Squibb; has received speaker's fees from Organon, Eli Lilly, Pfizer, Forest Pharmaceuticals, Janssen and GlaxoSmithKline; has received grant funding from Organon, Eli Lilly and Merck; and has been a contract employee of Forest Laboratories, Janssen and Steel Beach Productions.

References

1. Kennedy S. Full remission: a return to normal functioning. *J Psychiatry Neurosci* 2002;27(4):233-4.
2. Murray CJ, Lopez AD. Regional patterns of disability-free life expectancy and disability-adjusted life expectancy: global Burden of Disease Study. *Lancet* 1997;349:1347-52.
3. Lepine JP, Gastpar M, Mendlewicz J, Tylee A. Depression in the community: the first pan-European study DEPRES (Depression Research in European Society). *Int Clin Psychopharmacol* 1997;12:19-29.
4. Davidson JR, Meltzer-Brody SE. The under-recognition and undertreatment of depression: what is the breadth and depth of the problem? *J Clin Psychiatry* 1999;60(Suppl 7):4-9.
5. Tylee A, Gastpar M, Lepine JP, Mendlewicz J. DEPRES II (Depression in the European Society II): a patient survey of the symptoms, disability and current management of depression in the community. DEPRES Steering Committee. *Int Clin Psychopharmacol* 1999;14:139-51.
6. Tylee A, Gastpar M, Lepine JP, Mendlewicz J. Identification of depressed patient types in the community and their treatment needs: findings from the DEPRES II (Depression in the European Society II): survey. DEPRES Steering Committee. *Int Clin Psychopharmacol* 1999;14:153-65.
7. Tranter R, O'Donovan C, Chandarana P, Kennedy S. Prevalence and outcome of partial remission in depression. *J Psychiatry Neurosci* 2002;27(4):241-7.
8. McIntryre R, Kennedy S, Bagby M, Bakish D. Assessing full remission. *J Psychiatry Neurosci* 2002;27(4):235-9.

NEUROSCIENTISTS

Neuropsychiatry Research Unit
Department of Psychiatry
University of Saskatchewan

Two assistant professor positions (permanent) in the areas of neuroanatomy, molecular genetics, molecular neuropsychopharmacology, and biological psychiatry are available. The successful candidate(s) should possess a PhD or MD with at least 3 years of research experience. The university is committed to employment equity. All qualified candidates are encouraged to apply; however, Canadians and permanent residents will be given priority. The salary and benefits will be commensurate with qualifications. Some start-up funds will be provided. The positions are open until filled.

Applicants should submit a CV, three references and a statement of current research intereests, to:

Dr. Xin-Min Li, Director
Neuropsychiatric Research Unit
Department of Psychiatry
University of Saskatchewan
Saskatoon, SK S7N 5E4 Canada
Fax 306 966-8830
Email xin-min.li@usask.ca

POSTDOCTORAL FELLOW AND GRADUATE STUDENT POSITIONS ARE ALSO AVAILABLE.

JPN-12