TREATING LOW PERCEIVED SOCIAL SUPPORT AND DEPRESSION AFTER MYOCARDIAL INFARCTION DOES NOT INCREASE EVENT-FREE SURVIVAL


Does treating depression and low perceived social support (LPSS) with cognitive behaviour therapy and, where indicated, a selective serotonin reuptake inhibitor (SSRI) within 28 days of myocardial infarction (MI) reduce risk of subsequent MI and death?

METHODS

Design: Randomised controlled trial.

Allocation: Concealed.

Blinding: Open for clinicians and patients; outcome assessors and data analysts blinded.

Follow up period: 29 months (mean).

Setting: 73 hospitals associated with 8 clinical centres in the USA; recruitment October 1996 to October 1999; study completed April 2001.

Patients: 2481 people (1084 female, 1397 male) with MI in the previous 28 days, diagnosed with major or minor depression or dysthymia (ENRICHD modified DSM-IV criteria: symptoms present >14 days or >7 days provided at least 1 prior episode of major depression) or LPSS (ENRICHD Social Support Instrument (ESSI)), or both. Exclusions: MI following a coronary intervention; receiving psychotherapy for depression; major comorbidity; participation in another research protocol. Ongoing treatment with antidepressants was a criterion for exclusion before April 1998 but was altered at that time to allow inclusion of people on antidepressants for >14 days whose depression had not improved.

Intervention: The treatment group received CBT for depression. For participants with LPSS, CBT was supplemented with techniques adapted from social learning theory and other psychotherapeutic support trials. Group sessions were initiated after at least 3 individual sessions. Treatment group participants who, after 5 weeks, showed a poor response (reduction of ≤50% in Beck Depression Inventory (BDI) scores; Hamilton Rating Scale for Depression scores >24) were considered for pharmacotherapy. Participants were initiated on sertraline (50 mg/d to 200 mg/d) and if necessary changed to another SSRI or nortriptyline. Behavioural intervention continued for ≤6 months, group therapy for an additional 12 weeks, and pharmacotherapy for 12 months. The control group received usual care.

Outcomes: Non-fatal recurrent MI and all-cause death. Change in BDI and ESSI scores at 6 months were secondary outcomes.

Patient follow up: 93%.

MAIN RESULTS

At 29 months, there was no significant difference between the treatment and usual care groups for the primary outcome (recurrent MI or death: 24%; hazard ratio 1.01; 95% CI 0.86 to 1.18). At 6 months, (see table) the treatment intervention improved psychological outcomes compared with usual care (p<0.001). These differences were not maintained at 30 months for BDI or at 42 months for ESSI scores.

CONCLUSION

Although the intervention may improve depression and LPSS after MI in the short term, it does not decrease the risk of recurrent MI and death.

Table Mean BDI and ESSI scores at baseline and 6 months

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<thead>
<tr>
<th></th>
<th>Mean BDI score</th>
<th>Mean ESSI score</th>
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<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>6 months</td>
</tr>
<tr>
<td>Treatment</td>
<td>15.7</td>
<td>8.2</td>
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<tr>
<td>Usual care</td>
<td>15.7</td>
<td>11.0</td>
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Treating low perceived social support and depression after myocardial infarction does not increase event-free survival

Evid Based Mental Health 2004 7: 22
doi: 10.1136/ebmh.7.1.22

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