

## Short Report

# Identifying depression in patients following admission for acute coronary syndrome

Prasuna Reddy,<sup>1</sup> James A. Dunbar,<sup>1</sup> Edward Janus,<sup>1,2</sup> Alan Wolff,<sup>1,3</sup>  
Stephen Bunker,<sup>1</sup> Mark Morgan<sup>1,4</sup> and Adrienne O'Neil<sup>1</sup>

<sup>1</sup>University Department of Rural Health, Flinders University and Deakin University, Warrnambool, <sup>2</sup>Western Hospital, Department of Medicine, University of Melbourne, Melbourne, <sup>3</sup>Wimmera Health Care Group, Horsham, Victoria, and <sup>4</sup>Hawkins Medical Clinic, Mount Gambier, South Australia, Australia

Cardiovascular disease and its relationship with depression is supported by considerable evidence.<sup>1,2</sup> The presence of anxiety symptoms, either with or without depression, is common. A recent study of patients with coronary heart disease found 50% exhibited symptoms of depression, 70% symptoms of anxiety and 48% symptoms of stress.<sup>3</sup> Untreated depression also results in a poorer prognosis for patients with cardiovascular problems.<sup>4</sup> Despite the evidence connecting depression with chronic disease, there is poor recognition and undertreatment of depression in both primary care and hospital medical practice.

The purpose of our study was to trial four screening questions to identify depression and anxiety in patients admitted for acute coronary syndrome (ACS) in two rural hospitals in Victoria and South Australia. Participants included 21 women and 32 men who were interviewed at two time periods: within two weeks of discharge from hospital (Time 1), and eight weeks after the initial interview (Time 2). Participants were between 40 and 71 years of age at the time of the first interview. The screening questions assess primary symptoms of depression (dysphoria and anhedonia)<sup>5</sup> and anxiety (tension and fearfulness).

The results show overall, within two weeks of discharge from hospital (Time 1), in response to the screening questions: 25% ( $n = 13/53$ ) reported both depression and anxiety, 21% ( $n = 11/53$ ) reported depression but no anxiety, and 11% ( $n = 6/53$ ) reported anxiety but no depression. Only two of these patients were receiving treatment for depression.

At two months post discharge, of the 24 patients reporting depression symptoms at Time 1, nine had improved showing neither depression nor anxiety, four showed depression only, four showed anxiety only, and the remaining seven patients showed both depression and anxiety. Two patients who showed neither depression nor anxiety at Time 1 reported depression at Time 2. None of the patients reporting depression or anxiety was receiving treatment.

Only 13 patients who had been admitted for ACS had attended cardiac rehabilitation programs; four of these patients reported depression or anxiety at two weeks post discharge. All but five of the 53 patients interviewed said they had seen their GP at least once since leaving hospital. None had been screened for depression on GP visits.

Our results show that 55% of patients who report depression within two weeks of admission to hospital for treatment of ACS improve over the next two months. However, for 45% of patients, symptoms of depression persist at two months post discharge, and 9% of those who do not show depression at admission do report depression about 10–12 weeks post discharge. It might not be worthwhile to screen for depression while a patient is in hospital, but it is useful to do an assessment at two months post discharge. At this time, patients have less regular contact with specialist health professionals in hospitals. As uptake of cardiac rehabilitation programs is generally low in rural areas, partly because of distance, the other main resource for patients needing help is primary care. This is especially true for patients living in rural areas, where they are treated only by their GP. Depression is often missed in primary care settings because of the overlap of somatic symptoms such as changes in sleeping and eating patterns, lethargy and fatigue. Patients are also reluctant to report depression because of the stigma attached to mental health problems.

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**Correspondence:** Prasuna Reddy, University Department of Rural Health, Flinders University and Deakin University, Warrnambool, Victoria, 3280, Australia. Email: p.reddy@unimelb.edu.au

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Using screening questions that assess the cognitive and emotional symptoms of depression will enable general practitioners and other health professionals to quickly identify patients at risk. The identification and management of depression in chronic disease needs to be routinely undertaken when reviewing these patients.

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