Enhanced depression care improved arthritis pain and function in older patients

Lin EH, Katon W, Von Korff M, et al. **Effect of improving depression care on pain and functional outcomes among older adults with arthritis: a randomized controlled trial.** JAMA. 2003;290:2428-34.

QUESTION

In older patients with depression and arthritis, does enhanced depression care improve arthritis-related pain and function?

DESIGN

Randomized {allocation concealed*}†, unblinded,* controlled trial with 12 month follow-up (preplanned subgroup analysis of Improving Mood-Promoting Access to Collaborative Treatment [IMPACT] trial).

SETTING

18 primary care clinics at 8 health care organizations in 5 U.S. states.

PATIENTS

1001 patients ≥ 60 years of age (mean age 72 y, 68% women) who had major depression or dysthymia, had been diagnosed with or treated for arthritis in the previous 3 years, and planned to use a participating clinic as the main source of general medical services in the upcoming year. Exclusion criteria were history of bipolar disorder or psychosis, ongoing treatment by a psychiatrist, current alcohol use problems, severe cognitive impairment, or acute risk for suicide. 964 patients (96%) were included in the analysis (850 patients [85%] completed 12-month follow-up; missing data were imputed).

INTERVENTION

495 patients were allocated to depression care management by a nurse or psychologist who met weekly with a supervising psychiatrist and expert primary care physician. The depression care manager provided education and helped patients to identify treatment preferences (antidepressants and/or a 6- to 8-session psychotherapy program). In-person or telephone follow-up occurred every 2 weeks during acute-phase treatment, with monthly follow-up thereafter. 506 patients were allocated to usual care (antidepressants and referral to specialty mental health services).

MAIN OUTCOME MEASURES

Outcomes included arthritis pain intensity, arthritis-related interference with daily activities, pain interference with work or other daily activities, and depression (20-item severity scale adapted from the Hopkins Symptom Checklist).

MAIN RESULTS

Analysis was by intention to treat. At 12 months, patients in the intervention group had lower pain intensity and less interference with daily activities because of arthritis or pain impairment than did patients in the usual-care group (Table). Intervention-group patients were more likely to have a 50% reduction in Hopkins Symptom Checklist scores than usual-care group patients (41% vs 18%, odds ratio 3.28, 95% CI 2.4 to 4.5).

CONCLUSION

In primary care patients with depression and arthritis, enhanced collaborative depression care reduced arthritis pain intensity and interference with daily activities (because of arthritis or pain) more than usual depression care.

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*See Glossary.

†Information provided by author.

Enhanced collaborative depression care vs usual care for patients with depression and arthritis at 12 months‡

Outcomes	Mean scores		Mean between-group difference (95% CI)
	Enhanced care	Usual care	
Pain intensity§	5.62	6.15	–0.53 (–0.92 to –0.14)
Arthritis interference with daily activities§	4.40	4.99	–0.59 (–1.00 to –0.19)
Pain interference with daily activities‖	2.92	3.17	–0.26 (–0.41 to –0.10)

‡Adjusted for recruitment method and study site.
§Scale of 0 to 10, 0 = none.
‖Scale of 0 to 5, 0 = none.

COMMENTARY

The high prevalence of rheumatic disorders in the elderly poses major medical management issues. Joint replacement is often impracticable, and antirheumatic drugs are notorious for their high incidence of adverse effects, especially in this age group. Other forms of management need serious consideration. The study by Lin and colleagues rightly draws attention to the importance of treating coexisting depression, which is common and often unrecognized in older persons.

A recent qualitative review of suicide (1) indicates that the role of severe depression may be underappreciated in rheumatology, particularly in women with rheumatoid arthritis. The carefully designed and analyzed trial by Lin and colleagues showed that joint symptoms and functional capacity, as well as depression, improved more in patients receiving a structured antidepressive treatment regimen than in similar patients given routine care. More patients in the intensively treated group (66%) received antidepressive drugs than in the usual-care group (52%).

The measures of improvement in joint problems were entirely subjective, and the study was unblinded. The study report did not describe objective joint findings or changes in concomitant antirheumatic drug treatment. Thus, the benefits of antidepressive treatment for joint complaints may simply reflect the altered perception of joint discomfort by depressed patients. Furthermore, it is not easy to distinguish among the benefits conferred by antidepressive drugs, psychotherapy, and the benign influence of concerned carers, especially in an unblinded study. One would not wish to expose older patients to the potential problems of psychotropic drugs if human sympathy and support would suffice. Indeed, adequate social support might prove equally beneficial and more cost-effective than formal antidepressive treatment, however expertly delivered.

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Reference

1. **Timonen M, Viilo K, Hakko H, et al.** Suicides in persons suffering from rheumatoid arthritis. Rheumatology (Oxford). 2003;42:287-91.