

EDITOR'S NOTE

This column reflects our commitment to provide you, the primary care physician, with information that will prove helpful in making informed decisions about the care of your patients who suffer from psychiatric disorders. We will highlight abstracts of high interest to you from our sister publication, *The Journal of Clinical Psychiatry*, and summarize pertinent articles from the general scientific literature. We hope that this section is clinically relevant to your practice and that it will encourage you to expand your horizons.

A Double-Blind Randomized Pilot Study Comparing Quetiapine and Divalproex for Adolescent Mania

DelBello MP, Kowatch RA, Adler CM, et al.

J Am Acad Child Adolesc Psychiatry 2006;45:305–313

Objective: To determine the efficacy of quetiapine compared with divalproex for the treatment of adolescent mania.

Method: In a double-blind study beginning July 2002 and lasting through January 2004, 50 adolescents (aged 12–18 years) diagnosed with bipolar I disorder, manic or mixed episode, were randomly assigned to receive quetiapine (400–600 mg/day) or divalproex (serum level 80–120 µg/mL) for 28 days. Change in Young Mania Rating Scale (YMRS) score across the study period was the primary measure of efficacy.

Results: Across the 28 days of the study, no statistically significant group difference in YMRS scores between the quetiapine cohort and the divalproex cohort were revealed by repeated measures analysis of variance using the last-observation-carried-forward data ($p = .3$). When both the last-observation-carried-forward ($p = .01$) and observed data ($p = .03$) were subjected to mixed regression analyses (comparison of slopes), YMRS scores improved more quickly in the quetiapine than in the divalproex group. The quetiapine group showed rates of response and remission significantly greater than the divalproex group ($p < .03$). Rates of adverse events were not significantly different between the groups.

Conclusions: Quetiapine appears to be at least as effective as divalproex in the treatment of acute manic symptoms secondary to bipolar disorder in adolescents. In addition, it is possible that treatment with quetiapine reduces manic symptoms more rapidly compared with divalproex. Placebo-controlled studies are necessary to confirm these results, but it appears that monotherapy with quetiapine may be useful for the treatment of bipolar adolescents with manic or mixed episodes.

Methylphenidate-Enhanced Antidepressant Response to Citalopram in the Elderly: A Double-Blind, Placebo-Controlled Pilot Trial

Lavretsky H, Park S, Siddarth P, et al.

Am J Geriatr Psychiatry 2006;14:181–185

Objective: To assess whether methylphenidate might accelerate and enhance antidepressant response to citalopram in elderly depressed patients.

Method: Sixteen outpatients with major depression were treated for 10-weeks in this double-blind trial. Response was defined as a score of less than 10 on the 24-item Hamilton Rating Scale for Depression.

Results: Five patients receiving citalopram and methylphenidate exhibited an accelerated response by week 3, while no patients receiving citalopram and placebo did. The improvement in depressive symptoms shown by patients receiving citalopram and methylphenidate was significant compared with that shown by patients receiving citalopram and placebo.

Conclusion: Combination treatment with citalopram and methylphenidate seems to be an effective approach to accelerating and enhancing antidepressant response in elderly depressed patients who are limited in their treatment choices by issues of tolerability and safety.

The Association Between Moderate Alcohol Use and Illness Severity in Bipolar Disorder: A Preliminary Report

Goldstein BI, Velyvis VP, Parikh SV

J Clin Psychiatry 2006;67:102–106

Objective: To examine the association of alcohol consumption with symptoms, illness course, and health care utilization among nonalcoholic patients with bipolar disorder.

Method: Subjects were 148 patients with bipolar I or II disorder enrolled in a longitudinal study of cognitive-behavioral therapy versus psychoeducation. Subjects were 18 to 60 years old, in full or partial remission, and non-heavy

drinkers with no history of substance use disorders. At least 4 weeks of consistent naturalistic treatment with mood stabilizer was required for enrollment. Measures included the Structured Clinical Interview for DSM-IV, the Hamilton Rating Scale for Depression, the Clinician-Administered Rating Scale for Mania, and the Khavari Alcohol Test. Data were gathered from July 2002 to December 2004.

Results: Mean weekly alcoholic beverage consumption was minimal among both men (3.8 standard drinks, SD = 8.9) and women (1.2 standard drinks, SD = 1.9). Nonetheless, total alcohol consumption among men was associated with lifetime manic episodes ($F = 10.2$, $df = 1$, $p = .003$) and emergency department visits ($F = 4.3$, $df = 1$, $p = .046$). Spirits consumption among men was strongly associated with lifetime manic episodes ($F = 81.8$, $df = 1$, $p < .001$) and emergency department visits ($F = 14.0$, $df = 1$, $p < .001$). Among women, the frequency of alcohol consumption was associated with lifetime episodes of depression ($F = 15.5$, $df = 1$, $p < .001$) and hypomania ($F = 4.8$, $df = 1$, $p < .03$). Wine consumption among women was associated with lifetime hypomanic episodes ($F = 13.6$, $df = 1$, $p < .001$) and current manic symptoms ($F = 4.0$, $df = 1$, $p < .05$).

Conclusion: Despite low volumes of consumption, alcohol was associated with measures of illness severity in bipolar disorder among both men and women. The adverse effects of alcohol on bipolar disorder may occur over a range of consumption, rather than being confined to heavy drinkers.

Maintenance Treatment of Major Depression in Old Age

Reynolds CF 3rd, Dew MA, Pollock BG, et al.
N Engl J Med 2006;354:1130–1138

Background: Elderly patients with major depression, including those having a first episode, are a population at high risk for recurring depression, disability, and death.

Method: The efficacy of maintenance therapy with paroxetine and monthly sessions of interpersonal psychotherapy in patients aged 70 years or older who had depression (55 percent of whom were experiencing a first episode) was assessed in a 2-by-2, randomized, double-blind, placebo-controlled trial. One hundred sixteen patients with a response to treatment with paroxetine and psychotherapy were randomly assigned to 1 of 4 maintenance-treatment protocols (either paroxetine or placebo combined with either monthly psychotherapy or clinical-management sessions) for 2 years or until major depression recurred. Clinical-management sessions were supervised by the same nurses, social workers, and psychologists who conducted psychotherapy and consisted of conversations about symptoms.

Results: In 35% of the patients administered paroxetine and psychotherapy, 37% of those administered paroxetine and clinical-management sessions, 68% of those administered placebo and psychotherapy, and 58% of those administered placebo and clinical-management sessions, major depression recurred within 2 years ($p = .02$). The relative risk of recurrence among those administered placebo was 2.4 times (95% CI = 1.4 to 4.2) that among those administered paroxetine after the effect of psychotherapy had been adjusted for. The number of patients needed to be treated with paroxetine to prevent 1 recurrence was 4 (95% CI = 2.3 to 10.9). The benefit derived from paroxetine was greater in patients with fewer and less severe coexisting medical conditions (e.g., hypertension or cardiac disease) ($p = .03$ for the interaction between treatment with paroxetine and baseline severity of medical illness).

Conclusions: Two years of maintenance therapy with paroxetine reduced the likelihood of recurrent depression in patients 70 years of age or older with major depression who had a response to initial treatment with paroxetine and psychotherapy. Maintenance psychotherapy administered monthly failed to prevent recurrent depression. (ClinicalTrials.gov number NCT00178100)

A Flexible Item to Screen for Depression in Inner-City Minorities During Palliative Care Symptom Assessment

Francoeur RB

Am J Geriatr Psychiatry 2006;14:228–236

Objective: The validity of a single item to screen depression is controversial. It is possible that the “yes/no” forced-response option encourages bias in inner-city minority populations, especially in the elderly and men, groups that view depression as stigmatizing or that regard the healthcare system with suspicion. It is possible, on the other hand, that an open-choice format with a category for ambivalent and missing responses, administered during the legitimate context of assessing physical symptoms, might be found acceptable.

Method: In this retrospective study, data from 146 black and Latino inner-city patients were analyzed; these men were receiving palliative care for a variety of physical ailments. The most recent comprehensive patient assessment conducted by a black female nurse and a bilingual Latina social worker, provide the basis for bivariate analyses and ordinal regressions.

Results: Pain and symptom attitudes, which are more “hopeful” in older men with unknown depression status than in younger and older women with unknown depression status or no depression, are predicted by the depression item (no, unknown, yes).

Conclusions: Because older men in the unknown category for depression evince more “hopeful” pain and symptom attitudes, it is possible that depression, apathy, and resignation in older minority men will be hidden from clinicians without the option of the open-choice depression item.

New Possibilities of Treatment for Panic Attacks in Elderly Patients: Escitalopram Versus Citalopram

Rampello L, Alvano A, Raffaele R, et al.

J Clin Psychopharmacol 2006;26:67–70

Objective: To compare the efficacy and safety of citalopram and its S-enantiomer escitalopram at half the dosage in elderly patients with panic attacks.

Method: Forty patients with DSM-IV panic attacks were enrolled in this open, community-based study and assigned to 8 weeks of treatment with escitalopram ($N = 20$) or citalopram ($N = 20$). Weekly rate of panic attacks served as the primary outcome measure, and the Hamilton Rating Scales for Anxiety (HAM-A) and Depression (HAM-D) and the Cooper Disability Scale (CDS) were the secondary outcome measures. Between-group differences were evaluated with repeated-measures analysis of variance.

Results: A similar decrease in the weekly rate of panic attacks according to HAM-A, HAM-D, and CDS scores was seen in both groups after 8 weeks. However, a significant change from baseline was evident after only 2 weeks in the escitalopram group ($p < .001$) but not until after 4 weeks in the citalopram group ($p < .01$).

Conclusions: Because of its efficacy and safety, and for the advantages of a reduced total dose and a more rapid onset of action compared with citalopram, escitalopram could be considered among first-line treatments in elderly patients with panic attacks. These results await confirmation in further studies.

Psychosocial and Vascular Risk Factors for Depression in the Elderly

Holley C, Murrell SA, Mast BT

Am J Geriatr Psychiatry 2006;14:84–90

Objective: To assess 2 competing hypotheses addressing the relationship between vascular and psychosocial risk factors for late-life depression. According to the stress-vulnerability hypothesis, the depressogenic effect of psychosocial risk is stronger when cardiovascular risk factors (CVRFs) occur. According to the other hypothesis, the depressogenic effects of psychosocial risk factors and vascular risk factors have no combined effect and separately are risk factors for depression.

Method: New episodes of significant depressive symptoms (CES-D score > 16) in 1474 community-dwelling elders with low levels of depression at baseline (CES-D score < 8) were predicted in a longitudinal (baseline and 6- and 12-month follow-up) study.

Results: Stress at wave 2 and CVRFs at baseline interacted significantly. Specifically, stress predicted wave 2 depression more strongly in participants with ≥ 2 CVRFs. In depression not preceded by a stressful life event, there was no evidence that CVRFs played a larger role than in depression that was preceded by a stressful life event.

Conclusions: Stress had more of a depressogenic effect when significant vascular risk (as defined by CVRFs) was present. Vascular risk may increase vulnerability to depression by worsening the effect of stress on depression. One explanation for this finding is that vascular disease may disrupt mood regulation circuits in the brain and lower its ability to respond to stressful events.

Cerebrovascular Risk Factors, Executive Dysfunction, and Depression in Older Primary Care Patients

Sanders ML, Lyness JM, Eberly S, et al.

Am J Geriatr Psychiatry 2006;14:145–152

Objective: It is possible that “executive” cognitive functions are of specific clinical importance in geriatric depression and reflect underlying cerebrovascular disease. This study assessed the associations of particular aspects of executive function with cerebrovascular risk factors, depression, and overall functional status.

Method: On the basis of patient interviews and medical chart review, study measures were completed on 448 primary care patients aged ≥ 65 years or older. The presence of stipulated independent associations was identified by multiple regression techniques.

Results: Cerebrovascular risk factors were associated with major depression and with some cognitive measures, but only limited associations with depression and with the most specific measures of executive function were found and were not independent of overall medical burden. Measures of initiation-perseveration and mental set shifting were associated with overall functional disability; no association was found between these cognitive measures and depression diagnosis or depressive symptoms when also covarying medical burden or excluding patients with dementia.

Conclusions: The potential functional significance of these components of cognition should be recognized by clinicians. Longitudinal risk factor studies and complementary techniques like neuroimaging may help identify pathogenetically distinct subcomponents of later-life depression that might respond in a preferential way to particular therapies.

Opportunities for Cost-Effective Prevention of Late-Life Depression: An Epidemiological Approach

Smit F, Ederveen A, Cuijpers P, et al.

Arch Gen Psychiatry 2006;63:290–296

Background: The prevalence of clinically relevant late-life depression is 16% and is associated with substantial societal costs through its disease burden and unfavorable prognosis. Prevention of depression is an inviting, if not essential, way to produce health gains and decrease future costs. This study sought to identify high-risk groups for depression prevention with the goal of generating maximum health gains with the lowest cost.

Method: This 3-year population-based cohort study set in the general population in the Netherlands included 2200 community residents, aged 55 to 85 years. Of these, 1925 were not depressed at baseline. The Center for Epidemiological Studies Depression Scale was used to measure the onset of clinically relevant depression. The researchers calculated indices of potential health gain and the effort (costs) necessary to bring about those health gains for each of the risk factors (and their combinations).

Results: One in every 5 cases of clinically relevant late-life depression is a new case. As a result, depression prevention must play a primary role in decreasing the number of new cases. Directing prevention efforts toward elderly people who have depressive symptoms, experience functional impairment, and have a small social network, in particular women, as well as people who have limited educations or who have chronic diseases, is the best way to accomplish this goal.

Conclusions: Targeting selected high-risk groups for prevention efforts may help decrease the incidence of depression and is probably more cost-effective than alternative approaches. In addition, this study indicates that we possess the methodology to conduct ante hoc cost-benefit analysis in preventive psychiatry. This ability helps set a rational research and development agenda in advance of evaluating the cost-effectiveness of interventions in time-consuming and costly trials.