CG8P-0338

Wellbeing of patients prescribed long-term SSRIs by general practitioners in the UK

Wade AG, Crawford GM, Bezlyak V
Patients Direct, Glasgow, United Kingdom

BACKGROUND

Depression is now recognized as a chronic illness. Guidelines recommend relatively long-term treatment even after an acute episode (1). If patients are to have a good quality of life with the maximum possibility of remaining free from subsequent episodes of depression, it is important that treatment results in patients who are in remission with a minimal number of residual symptoms (2). It is recognized that sleep is both an important and a frequent residual symptom (3). We conducted a survey to determine the status and wellbeing of patients receiving long-term treatment with SSRIs in the UK.

METHODS

Patients receiving long-term antidepressant treatment were identified from prescribing records of GP practices in the West of Scotland. The patients were invited to complete a questionnaire either at the surgery or later at home, returning it in the reply-paid envelope provided. From 893 questionnaires distributed, 316 were completed and returned (35%). Only data from the 256 patients registered to receive an SSRI are reported here. Demographics and previous medication history were collected. Each patient completed a Hospital Anxiety and Depression Scale (HADS) (Box 1). The response to individual questions was also analysed. Simple Laekert questionnaires enquired about specific sleep symptoms to attempt to assess residual symptomatology and whether or not attempts had been made to treat them. Chi-squared testing assessed associations between categorical variables. For continuous variables, comparisons were made using ANOVA or a 2-sample t-test.

HADS Score	Symptom Severity
0 – 7	Normal
0 – 8	Mild
11 – 14	Moderate
15 – 21	Severe

Box 1 Classification of symptoms by HADS

RESULTS

Age and sex of the study population are presented in Table 1. Almost half (48.10%) of the patients surveyed were aged between 35-55 years. The majority of patients (>70%) in all age groups were female. SSRI usage is summarised in Box 2. Depression accounted for the majority of original symptoms cited by the patient as the reason for the initial SSRI prescription (Figure 1).

Variables		Age range			Total
		18–35	36–55	56–70	
Sex	Total	39	114	84	237
	Female	34(87.18%)	92(80.7%)	61(72.62%)	187(78.9%)
	Male	5(12.82%)	22(19.3%)	23(27.38%)	50(21.1%)
Duration of treatment (months)	Total	35	110	80	225
	<1	1(2.86%)	1(0.91%)	1(1.25%)	3(1.33%)
	1–3	7(20%)	13(11.82%)	8(10%)	28(12.44%)
	4–6	10(28.57%)	18(16.36%)	12(15%)	40(17.78%)
	7–12	5(14.29%)	14(12.73%)	10(12.5%)	29(12.89%)
	>12	12(34.29%)	64(58.18%)	49(61.25%)	125(55.56%)

Table 1 - Demography

SSRI History
125 patients (56%) had taken an SSRI for more than 12 months
192 patients (89.72%) claimed to take an SSRI regularly every day
19 patients (8.8%) had stopped taking an SSRI despite still being registered to receive prescriptions
8% patients received additional medication at the time of original prescription of SSRI.

Box 2 – SSRI History

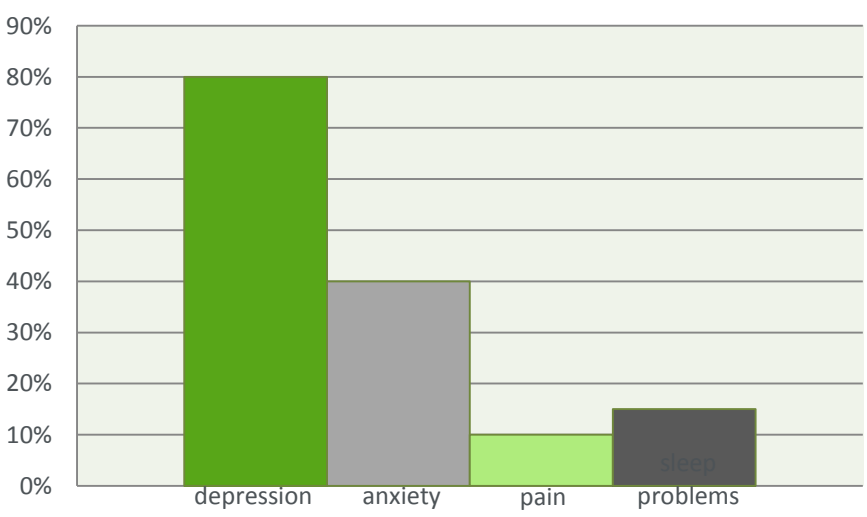

Figure 1 – Symptoms SSRI initially prescribed for

The HADS results presented in Figure 2 show that, despite long-term treatment, these patients are not in remission. Less than half of patients fell into the 'normal' category for depression and only approximately a quarter of patients fell into the 'normal' category for anxiety. When analysed by age, older participants had lower anxiety scores compared with the younger age groups (p=0.017). There was no statistically significant association between duration of SSRI treatment and mean anxiety and depression scores.

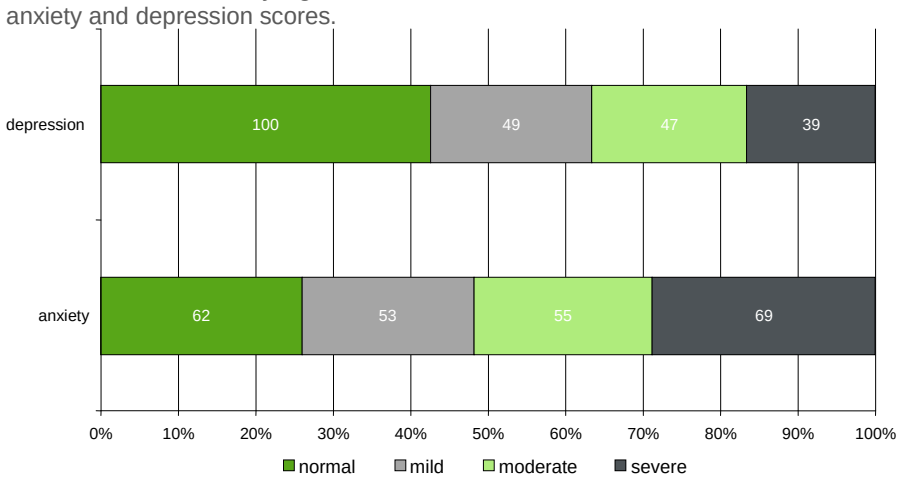

Figure 2 – HADS results

Patients' satisfaction with sleep during SSRI treatment is summarised in Figure 3. Only a minority of patients were satisfied with their current sleep. Almost one third of patients (32%) believed that their sleep problem was noticeable to others and 29% described it as causing significant distress. A statistically significant association between sleep quality before treatment and current sleep satisfaction was noted, with those who had a good or very good sleep quality before treatment being more likely to be satisfied after treatment (p=0.0034). There was no evidence of an association between sex and age with current sleep satisfaction. There was a strong relationship between dissatisfaction with sleep and interference with next day life (p<0.0001). Significant interference with next day life was strongly associated with high scores for HADS-A and HADS-D (both p<0.0001). The majority of patients (61.19%) had not reported the sleep problems to the GP. Of those that had, 50.59% received a prescription. The majority of people prescribed medication (76.74%) for the sleep problems found it helpful but more than half (51.16%) were still taking it. There was no association between additional medication and HADS scores.

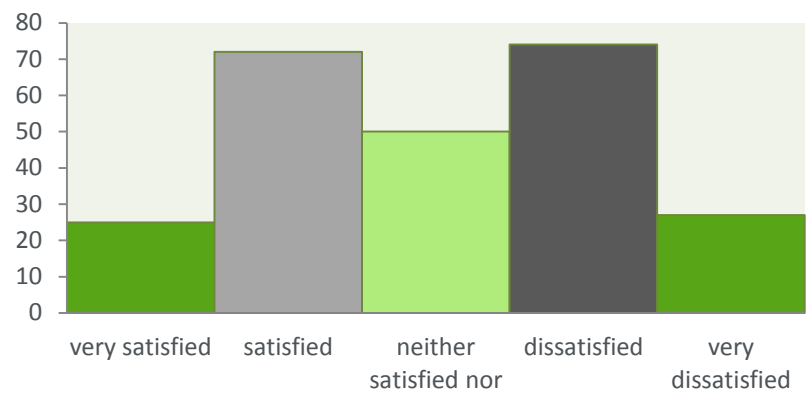

Figure 3a - How satistfied are you with how you sleep just now?

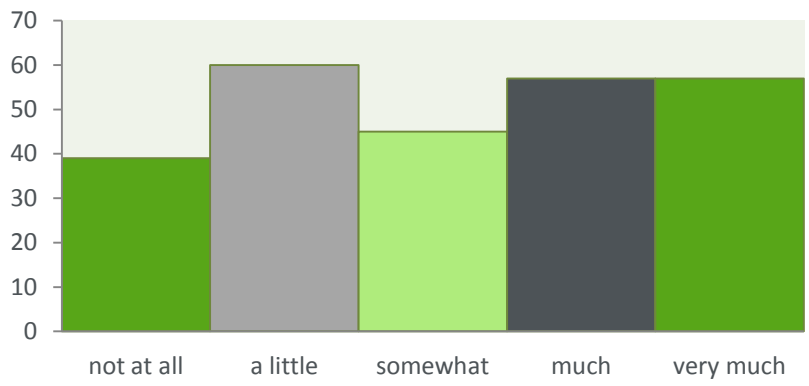

Figure 3b - How does your sleeping interfere with your life the following day?

DISCUSSION

The aim of long-term treatment of depression is to produce a patient who is practically symptom free(4) and fully functioning in society. Most patients in this survey still had significant residual depressive symptoms. This correlates with the findings of a recent review (5) which also found that residual symptoms upon remission have a strong prognostic value. In our study, anxiety and sleep symptoms were prominent in over half the population and the patients reported interference with their daily lives. This is a group of patients in primary care who are on long-term and stable treatment with SSRIs. There appears little evidence of active management of residual depressive or anxiety symptoms to achieve true remission. By contrast, while the majority of patients did not report existing sleep problems, those that did and received medication reported benefit. Long term use of hypnotics presents its own problems but there is some evidence that addressing sleep as a symptom of depression, even longer term can provide benefit(6).

CONCLUSION

Despite long-term SSRI treatment, few patients were in true symptomatic remission. Anxiety and sleep problems were prominent. Residual sleep problems were identified as causing significant distress and impaired function. When reported to the GP, treatment of insomnia was often helpful but led to long-term use in over half the patients.

REFERENCES

1 Goldberg D. The "NICE Guideline" on the treatment of depression. Epidemiol Psichiatr Soc. 2006 Jan-Mar;15(1):11-5.

2 Kennedy N, Foy K. The impact of residual symptoms on outcome of major depression. Curr Psychiatry Rep. 2005 Dec;7(6):441-6.

3 Lam RW. Sleep disturbances and depression: a challenge for antidepressants. Int Clin Psychopharmacol. 2006 Feb;21 Suppl 1:S25-9.

4 Paykel ES, Ramana R, Cooper Z, Hayhurst H, Kerr J, Barocka A. Residual symptoms after partial remission: an important outcome in depression. Psychol Med. 1995 Nov;25(6):1171-80.

5 Fava GA, Ruini C, Belaise C. The concept of recovery in major depression. Psychol Med. 2007 Mar;37(3):307-17.

6 Fava M, McCall WV, Krystal A, Wessel T, Rubens R, Caron J, et al. Eszopiclone co-administered with fluoxetine in patients with insomnia coexisting with major depressive disorder. Biol Psychiatry. 2006 Jun 1;59(11):1052-60.

Acknowledgements
The Wellbeing Study was conducted thanks to an unrestricted grant provided by Servier (UK) Ltd
The authors are grateful to Susan Downie for her help in preparing this poster

Presented at the 21st ECNP Congress, 30 August – 3 September 2008, Barcelona, Spain