

Practice Guidelines

Depression After ACS Events: AAFP Releases Updated Guidelines

Key Points for Practice

- Patients are at high risk of depression after acute coronary syndrome events and should be routinely screened for depression.
- Standard depression treatment with antidepressant medications and/or cognitive behavior therapy is effective after acute coronary syndrome events, with the combination of both having the strongest evidence of benefit.
- Women have higher rates of depression after acute coronary syndrome events than men.

From the AAFP Editors

More than 25 million U.S. adults have heart disease, with more than 1 million adults hospitalized with acute coronary syndrome (ACS) events each year. After ACS events, patients are at increased risk of mental health disorders, including major depressive disorder, which affects one in five ACS survivors.

The American Academy of Family Physicians (AAFP) has released a guideline focusing on depression in adults within three months of an ACS event (unstable angina or myocardial infarction). The guideline is based on a systematic review of randomized controlled trials and observational studies and covers screening and treatment. It updates a 2009 guideline on depression after myocardial infarction.

Recommendations

Physicians should screen patients who have had a recent ACS event for depression using a standardized screening tool (weak recommendation,

low-quality evidence). Further evaluation should be performed to confirm the diagnosis of depression (good practice point).

The AAFP recommends depression screening in the general adult population and has found adequate evidence that use of depression screening tools in patients with recent ACS events is comparable with that in the general population. Depression after ACS events can be accurately diagnosed using screening instruments such as the Beck Depression Inventory II, Geriatric Depression Scale, Hospital and Anxiety Depression Scale, and Patient Health Questionnaire. The Beck Depression Inventory II has the most data supporting its use following ACS events, but use is limited by the five to 10 minutes required to complete. Any of these tools can be implemented in the outpatient setting, and it is reasonable to base the choice of screening test on availability, physician comfort, and ease of use. Because of the low positive predictive value of these tests, further screening is recommended in those who screen positive on initial evaluation.

Physicians should prescribe antidepressant medications, preferably selective serotonin reuptake inhibitors or serotonin-norepinephrine reuptake inhibitors, and/or cognitive behavior therapy when depression is diagnosed after an ACS event (strong recommendation, moderate-quality evidence).

Moderate-quality evidence shows that treatment can improve depression symptoms after ACS events. A combination of medication and cognitive behavior therapy is supported by the strongest evidence; however, the choice of treatment should be based on patient preference, access to services, and clinical judgment.

See related guideline at <https://www.aafp.org/afp/2019/0615/od2.html>.

This series is coordinated by Sumi Sexton, MD, Editor-in-Chief.

A collection of Practice Guidelines published in *AFP* is available at <https://www.aafp.org/afp/practguide>.

CME This clinical content conforms to AAFP criteria for continuing medical education (CME). See CME Quiz on page 735.

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Although there are limited comparative effectiveness data for antidepressant medications to treat depression after ACS events, selective serotonin reuptake inhibitors are recommended over tricyclic antidepressants based on high-quality evidence from the review for the 2009 AAFP guideline. None of the randomized controlled trials reviewed demonstrated that antidepressants have an effect on cardiovascular mortality or overall mortality, but observational studies have suggested that antidepressants may impact both of these outcomes.

Implementation in Practice

Barriers to screening for depression include physician discomfort with the topic or treatment ability; lack of time, reimbursement, or institutional support; limited access to behavioral health services, especially in rural areas; patients not wanting to burden their families with a depression diagnosis; and spiritual or cultural stigmas.

Decisions regarding the choice of screening tool, the timing of screening during a visit, and the team member who will perform the screening depend on the clinic's preference and workflow. Appointing a champion, at the practice or organizational level, can help make the implementation of a new screening protocol more efficient and successful. A lack of access to behavioral health services and other social determinants of health can be addressed by maintaining a directory of patient resources, working with case managers employed by insurance companies who can assist patients, and considering telemedicine options.

There are disparities between men and women in depression diagnosis, presentation, treatment, and outcomes, mostly because of differences in pathophysiology and mechanisms of heart disease. However, some disparities are related to differences in the counseling and treatment men and women receive. For example, women are 12% less likely than men to be referred to cardiac

rehabilitation, despite having lower quality of life and higher rates of depression than men after ACS events. Minorities are also less likely to be referred to cardiac rehabilitation, and sex/gender, race, and cultural differences can affect response to treatment. Shared decision-making in treatment decisions is essential. Involving family members and considering the patient's culture and beliefs may also be helpful for some patients.

Editor's Note: Although *AFP* has previously summarized AAFP guidelines in the Practice Guidelines department, this is the first time the full guideline is simultaneously being published online (<https://www.aafp.org/afp/2019/0615/od2.html>). Readers are encouraged to view the entire guideline and read more about AAFP's guideline development process in the *AFP* Community Blog (<http://afpjournal.blogspot.com/>). This guideline updates the 2009 AAFP guideline on screening and treatment of depression after myocardial infarction. Although the recommendations for regular screening and treatment are unchanged, the quality of evidence has improved in the past decade. Evidence supports the use of depression screening tools and treatment with medication and/or cognitive behavior therapy to improve depressive symptoms, which might influence cardiovascular mortality. The guideline highlights the importance of screening and treating women and minorities who typically receive less care after ACS events.—Sumi Sexton, MD, Editor-in-Chief, and Michael Arnold, MD, Medical Editing Fellow

Guideline source: American Academy of Family Physicians

Evidence rating system used? Yes

Systematic literature search described? Yes

Guideline developed by participants without relevant financial ties to industry? Yes

Recommendations based on patient-oriented outcomes? Yes

Published source: <https://www.aafp.org/afp/2019/0615/od2.html>

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