Treatment of major depressive disorder in primary care in Rome, Italy

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Summary. - This study describes the treatments that 253 patients affected by major depressive disorder, according to DSM-III-R criteria, received by their general practitioners prior to their referral to the outpatients clinic of the Department of Psychiatry of the University of Rome "La Sapienza". Out of 253 study subjects only 97 had received prescriptions of antidepressant drugs. In about 50% of these cases (corresponding to 27.4% of the study population) prescribed dosages were inadequate. In 34.7% of subjects who sought medical help antidepressants were not prescribed and other psychotropic drugs (mostly benzodiazepines) or sedatives were used. In 6% of cases no treatment was prescribed. Over one third of the outpatients had been ill for over one year prior to their referral to a psychiatrist. Remedial actions are considered.

Key words: pharmacoepidemiology, antidepressive drugs.

Riassunto (Trattamento del disturbo depressivo maggiore nella medicina di base nell'area di Roma). - Questo lavoro descrive il trattamento che 253 pazienti affetti da disturbo depressivo maggiore (criteri DSM-III-R) hanno ricevuto da parte dei medici di base prima del contatto con una struttura specialistica universitaria. Dei 253 soggetti inclusi nello studio, solo 97 hanno ricevuto un trattamento con farmaci antidepressivi. Nel 50% di questi casi (corrispondenti al 27.4% del campione) il dosaggio somministrato è risultato inadeguato. Nei restanti casi che si sono rivolti al medico di base o ad altra struttura sanitaria, il 34.7% (n = 57) è stato trattato con psicofarmaci ma non con antidepressivi. In questi casi oltre alla prescrizione di benzodiazepine, non infrequentemente è risultato l'impiego di psicofarmaci per la terapia della depressione. Poi di un terzo del campione, infine, è risultato affetto da sintomi depressivi per più di un anno prima di chiedere aiuto ad uno specialista.

Parole chiave: farmacoepidemiologia, farmaci antidepressivi.

Introduction

A recent study [1] on a random sample of 8743 residents of Rome (Italy) described prescribing patterns of antidepressant drugs in general practice. Forty-four percent of treatments evaluated (no. = 472) had a shorter duration than expected on the basis of current knowledge of clinical pharmacology. Side effects and complications in general seemed insufficient explanations for this phenomenon. Possible unnecessary short courses of treatment of patients who should not have been treated at all and inappropriately short courses of treatment of patients who really needed treatment, were regarded as more likely (and more disturbing) explanations.

In our previous study, we used data from the regional outpatient drug monitoring system, in order to look at prescriptions of antidepressant drugs in a random sample of a population, over a study period of 30 months: the phenomenon under study was the prescriptions of antidepressants but neither diagnosis, nor information on prescribed dosages were available at individual level. To obtain data on case management of depression in primary care, we conducted the present study, where the matter of interest is represented by patients with confirmed diagnosis of major depressive disorder.

Information on prescribed treatment, including dosage, is available.

The present article describes the treatments that 253 patients, affected by major depressive disorder according to DSM-III-R criteria, received from their general practitioners prior to their referral to the outpatient clinic of the Department of Psychiatry of the University of Rome "La Sapienza" (Italy).

Materials and methods

The Department of Psychiatry of the University of Rome "La Sapienza", located in the centre of Rome, is a major institution for the treatment of mental disorders.
In the outpatient clinic of such Department over 2500 patients affected by a wide range of mental disorders are seen per year. They are from the area of Rome, but also from other Italian regions, mostly southern ones. We have examined systematically every single medical record of outpatients seen in the outpatient clinic between June 1991 and April 1995, and among them we identified those who were diagnosed as affected by major depressive disorder, according to DSM-III-R criteria. The outpatient clinic procedures were the following: all psychiatrists in outpatient clinic duty strictly followed DSM-III-R criteria and procedures in making diagnoses; then every single clinical record was reviewed, and every case discussed with a panel of two senior psychiatrists (the same two over the entire study periods, one of them being the chairman of the Department), who checked for adherence to the DSM-III-R criteria. Only cases confirmed by such panel entered our study. From the above clinical records we have abstracted data relevant to our investigation and post it in a standardized precoded questionnaire. Only psychiatrists familiar with the outpatient clinic procedures and records abstracted the data in a systematic and standardized fashion. Data handling, including check for completeness and internal consistency and double data input, was made at the Laboratorio di Epidemiologia e Biostatistica of the Istituto Superiore di Sanità, where computer editing was also done. Standard software packages, such as BMDP (biomedical data package), were used for data exploration, tabulations and analysis.

Results

Of all patients (no. = 253) diagnosed as major depressive disorder, 233 (91%) were resident in the area of Rome. Their age-sex distribution is given in Table 1. The age distributions of the 144 females and the 105 males were similar. Sixty-eight percent (no. = 172) of outpatients were referred to the clinic by their general practitioners or other physicians, 20.6% (no. = 52) were self-referred and 11.4% (no. = 29) were referred by medical institutions. Out of the 253 study subjects 160 (63%) were classified as “single episode” and 93 (37%) as “recurrent” (according to DSM-III-R criteria). Twenty-two were in “partial” or “complete remission” and 14 had “psychotic manifestations”.

Distribution of time intervals between onset of illness and referral to the clinic is given in Fig. 1. Thirty-five percent of the outpatients had been ill for over one year prior to their referral to our clinic.

Out of the 253 study subjects, information about time and type of contact with primary care physician or other medical institutions was unavailable for 10 patients who were therefore excluded from further data analysis. Of the 243 remaining subjects for which complete information was available, 79 had never sought medical help for depression (52 were self-referred and 27 were referred by medical institutions for medical-legal reasons such as invalidity, psychometric testing or psychiatric evaluation for driving or gun-licence) (Fig. 2).

Of the remaining 164 patients, who in fact sought medical help for depression, 57 (34.7%) were treated with psychoactive drugs but not antidepressants. Among them, 46 (80.7%) received benzodiazepines (35 alone and 11 in association), 15 (26.3%) received antipsychotic drugs (6 alone and 9 in association).

Of the remaining 107 patients, 97 (corresponding to 59.1% of subjects who sought medical help) were treated with antidepressants, 63 of them received tricyclic antidepressants (50 alone and 13 in association), 28 were prescribed selective serotonin re-uptake inhibitors (22 alone and 6 in association), 3 were treated with monoamineoxidase inhibitors (2 alone and 1 in association) and 17 with other antidepressant drugs (10 alone and 7 in association).

<table>
<thead>
<tr>
<th>Age</th>
<th>Males %</th>
<th>Females %</th>
<th>Total %</th>
</tr>
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<tbody>
<tr>
<td>0-19</td>
<td>1</td>
<td>4</td>
<td>5</td>
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<tr>
<td>20-29</td>
<td>22</td>
<td>17</td>
<td>39</td>
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<td>30-39</td>
<td>15</td>
<td>30</td>
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<tr>
<td>40-49</td>
<td>13</td>
<td>29</td>
<td>42</td>
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<tr>
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<td>28</td>
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<td>64</td>
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<td>19</td>
<td>18.1</td>
<td>37</td>
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<tr>
<td>70-79</td>
<td>7</td>
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<td>9</td>
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<tr>
<td>80+</td>
<td>-</td>
<td>0.7</td>
<td>1</td>
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</tbody>
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Total 105 100 144 100 249 100

Fig. 1. - Distribution of time intervals between estimated onset of illness and referral to the Department of Psychiatry of the University of Rome "La Sapienza" years 1991-1995.
The 10 remaining patients (6.0% of those who sought medical help), contacted a physician during the course of their illness but, notwithstanding, never assumed any therapy.

Prescribed dosages of antidepressants were inadequate in about 50% of cases. Actually, only 45 patients out of 97 treated with antidepressants received proper antidepressant dose corresponding, in example, to a daily dose of 75 mg of tricyclic antidepressants. As a matter of fact, of the 63 patients treated with tricyclic antidepressants, only 11 subjects were treated properly (75 mg/die of tricyclcs) while 52 subjects, corresponding to 82% of those treated with tricyclics, received underdosed treatment (Fig. 3).

The percentage of inadequate treatment of depression in our sample must include depressed patients to whom psychoactive drugs, but not antidepressants, were prescribed (no. = 57) and depressed patients treated with inadequate doses of antidepressants (no. = 52). The cumulative percentage of inadequate treatment of depression in primary care is therefore corresponding to 70.7% (109 out of 154) of subjects who sought medical help and actually received a psychoactive drug prescription. This percentage does not take in account 10 subjects who sought medical help, contacted a physician during the course of their illness but, notwithstanding, never assumed any therapy. In this case we may assume that the primary care physician referred the patient to the outpatient psychiatric service before prescribing a specific treatment.

**Discussion**

To date the Epidemiologic catchment area study [2] is the largest population study of mental illness based on a screening of a population sample of about 20,000. Prevalence of affective disorders in lifetime is estimated around 8%. Major depressive disorder at any point in time is a relatively common condition affecting about 3% of the general population (2% of men and 4% of women) [3]. The magnitude of the problem, the functional disability and suffering associated with it, the risk of suicide, the high health services utilization, the direct and indirect cost involved, all underscore the public health relevance of the problem of major depressive disorder and the need to offer adequate medical care to all who might benefit from it [4]. Clinicians can easily adopt a proper treatment behaviour, based on sound scientific evidence, by following the recent American Psychiatric Association Practice guidelines for major disorder in adults [5]. A similar document, produced as a result of a consensus conference held recently in Florence [6], is available to Italian clinicians.

The reality, however, at least in our study, is that out of the 243 study subjects diagnosed as suffering from major depressive disorder, according to DSM-III-R and evaluated as needing antidepressant medication, only 97 (corresponding to 39.9% of the sample) were in fact treated. Moreover, among those treated, only 46% (45 out of 97) received adequate antidepressants dosages [5, 6]. About one third of patients not treated with antidepressants, received other psychoactive drugs, mostly benzodiazepines, but also "pseudo drugs", which lack any sound evidence of efficacy: such as phosphatildilserine, brain phosphatides, phosphocreatine, ademetionine, or belladonna + ergotamine + phenobarbitol. This picture reflects a medical care failure. Other studies of antidepressant treatment in primary care show a similar picture [7-11].

Several reasons might explain this phenomenon, including the fact that our sample is obviously not a random sample of depressed patients in the population. Selection bias may in fact have played an important role in determining the denominator of our sample population. It is likely that, as well as it happens for many university departments, more severe cases,
resistant to treatment, with longer illness duration or inadequately treated by general practitioners may have more easily referred to our University Department of Psychiatry. Therefore we cannot rule out the possibility that, among the outpatients seen, cases inadequately treated by their general practitioners constitutes a high percentage. In fact, we do not assume that 70.7% is an unbiased estimate of the patients affected by major depressive disorder in the general population, who did not receive adequate treatment. Nevertheless, there is little doubt that general practitioners in too many instances, omitted the needed prescriptions of antidepressants. Even if antidepressant were prescribed, dosages were inadequate for too many patients. What is also certain is that over one third (57/164) of patients treated with drugs, were not given needed antidepressant drug but other psychoactive drugs or rather “pseudo drugs” which one could, at best, regard as very expensive placebos. But placebos are not justified if an effective treatment is available.

Depression per se, with the associated helplessness, may prevent patients from seeking care. It is nevertheless remarkable that one third of all patients affected by major depressive disorder had been ill for over one year, prior to their referral to a psychiatrist, and, in particular, as many as 42 patients had been ill for over two years, before receiving psychiatric care. A more spread awareness and understanding of depression, not only among the medical profession, but in the community at large, might help in the earlier recognition and treatment of cases. Specific strategies aiming at reducing the gap between our knowledge of the diagnosis and treatment of depression and actual treatment received, are suggested by the recent National Depressive and Manic-Depressive Association Consensus statement on the undertreatment of depression [13].

Conclusions

We have found that in our study population the proportion of patients affected by major depressive disorder receiving adequate treatment is unsatisfactory. Among possible remedial actions, the following should be attempted: a) medical schools in their basic courses of psychiatry, offered to the medical students, should give higher priority and more emphasis to the need of being aware of depression, and should provide not only the basic tools for recognizing and diagnosing depression but also the guidelines for its proper management; b) continuing medical education programs should include affective disorders; c) health education campaigns having as targets both the population at large and health professionals should be implemented [13].

Acknowledgements

We thank Simone Boll for revision of the manuscript.
The study has been entirely supported by a grant from the "Progetto Nazionale Salute Mentale", Istituto Superiore di Sanità, Rome.

Received on 3 November 1997.
Accepted on 10 February 1998.

REFERENCES


