Care Management for Poststroke Depression

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See related article, pages 998–1003.

Depression is a common consequence of stroke, occurring in one third of people at some point after stroke.¹ It is important that depression is viewed as more than an understandable consequence of a sudden-onset major life event, because depression after stroke is associated with poorer rehabilitation outcome,²,³ lower quality of life,⁴ and suicide.⁵ Yet few people receive effective management for depression after stroke.¹

Cochrane reviews have reported that there is not sufficient evidence for the benefit of pharmacological or psychologic treatments to prevent⁶ or treat⁷ depression after stroke. Few adequately powered randomized, controlled trials of interventions for poststroke depression have been conducted. Therefore, the study by Williams et al⁸ in the current issue of Stroke is a welcome addition to the literature on this important topic.

Williams et al report the findings of a well-designed randomized, controlled trial evaluating a care management program for poststroke depression in 188 people with major or minor depression between 1 and 2 months after ischemic stroke. Depression response and remission were significantly more likely at the 12-week assessment point in those participants who were randomized to receive the Activate–Initiate–Monitor (AIM) program than those who received usual care.

A description of the AIM intervention can be found in the article by Williams et al. An important feature of the intervention is that it is an active approach to managing depression. The participants received education to make them aware of the symptoms and treatment of their depression. Also, the choice of antidepressant was based on an algorithm that allowed for previous experience with antidepressants and potential contraindications to inform treatment recommendations. The third component was the monitoring of therapy to check progress, adherence, and adverse effects, allowing for a change in medication if required. This concords with the recommendation that treatment should be changed if there is no response by 6 weeks.⁹

The authors should be commended for adopting a treatment approach that goes beyond prescribing medication. The contribution of the overall package of care to treat depression is supported by the finding that the intervention group had favorable outcomes in terms of response and remission to depression, although 56% of the control group also took antidepressant medication at some point during the study.

Limitations to the study are acknowledged by the authors, namely that the 12-week end point is relatively short. This is relevant given the recommendation that antidepressants should be continued for at least 4 months after initial recovery or improvement.⁹ In the study by Williams et al, there was remission of depression in 39% of the intervention group compared with 23% in the control group. A longer duration of treatment and follow up would be informative to ascertain whether there was remission in depression in those patients who had remained depressed at 12 weeks. Because those with less severe depression at recruitment had lower depression scores at 12 weeks, a longer treatment period may be required for those with more severe depression.

Those with severe language impairment or severe cognitive impairment were not eligible for the study. These are common exclusion criteria across studies reporting the frequency¹ and treatment⁷ of poststroke depression. In the present study, objective criteria for these exclusions were given in the form of assessment cutoff points. Presumably, these exclusions are usually used as a result of mood assessment and treatment potentially being more complicated in the presence of language and/or cognitive impairment, particularly using traditional mood measures. However, there is a growing body of evidence to suggest the presence and severity of language impairment can be an important risk factor for poststroke depression.¹⁰,¹¹ Therefore, methods to assess and treat poststroke depression in those with severe language impairment is an area requiring significant attention by clinicians and researchers.

The study by Williams et al makes a valuable contribution to an important topic in stroke rehabilitation, highlighting the benefits of an active management approach for treating depression early after stroke. There remains a need for further research to address the longer-term management of poststroke depression, including approaches appropriate for those with aphasia.

Disclosures

None.

References


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