Depression and screening cardiovascular events
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To the Editor: —Peripheral arterial disease (PAD) remains an under-treated disease1, and information about risk factors and prognosis is poorly disseminated in the population2. Nevertheless, PAD and coronary artery disease (CAD) patients share the same risk factors, and risks of future cardiovascular events in PAD patients are comparable with those in CAD patients3. Depression may adversely impact prognosis in CAD patients4, but little is known about depression and prognosis in PAD. Therefore, we read with great interest the work of Cherr and colleagues5 on the relation between psychological factors and cardiovascular events in PAD. Their study generated interesting findings, but there are also a number of issues we would like to address here.

First, the screening method the authors used probably led to an overestimation of depression rates. The General Health Questionnaire is not a depression scale, but rather was developed to assess non-specific psychological distress in community samples6, and a higher cut-off score (≥8) has been recommended to screen for depressive symptoms in patients with chronic somatic disease7.

Second, 80% of depressed patients received antidepressant therapy. Analyses were not adjusted for type of antidepressant, while studies warn against the use tricyclic antidepressants in cardiovascular populations because they are associated with an increased risk of myocardial infarction8,9. Therefore, we cannot rule out the influence of antidepressant use on adverse outcomes in depressed patients.

Finally, in the adjusted analyses, only a rough parameter of disease severity was included (indication for intervention). Table 2 shows us that the group that underwent revascularization was very heterogeneous in terms of disease severity; indication for intervention ranged from claudication to critical leg ischemia and gangrene or tissue loss. It would have been more appropriate to include the lowest ankle-brachial index in the adjusted analyses due to its strong prognostic value for leg ischemia and gangrene or tissue loss. It would have been more appropriate to include the lowest ankle-brachial index in the adjusted analyses due to its strong prognostic value for leg ischemia and gangrene or tissue loss. It would have been more appropriate to include the lowest ankle-brachial index in the adjusted analyses due to its strong prognostic value for leg ischemia and gangrene or tissue loss.

REFERENCES