A preliminary study to examine the adequacy of long-term treatment of depression and the extent of recovery in general practice

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SUMMARY

About 1% of patients in general practice take antidepressants for long periods. Many receive repeat prescriptions, without review. It might be assumed that these patients are well and are on adequate maintenance treatment. Our findings refute this assumption; of 78 patients on long-term repeats, only a third were in remission and a fifth had Beck Depression Inventory scores suggesting persisting syndromal major depression. Subtherapeutic dosing of classic tricyclics was the norm rather than the exception. Patients on long term antidepressant treatment need regular review and adequate treatment to ensure remission is maintained.

Keywords: antidepressants; repeat prescribing; Beck Depression Inventory.

Introduction

The optimum outcome in treating depression is to achieve and maintain remission. This can only be guaranteed by using adequate doses of antidepressants.[1] In general practice, many patients receive repeat prescriptions for long-term treatment to avoid unnecessary consultations. Patients on repeat prescriptions should not require changes in treatment in the foreseeable future. In the treatment of depression, this implies that such patients are in full remission; patients who remain symptomatic should have regular reviews to assess the need for treatment changes.

It is not known what proportion of patients receiving repeat prescriptions in general practice have persisting symptoms, nor whether the doses of antidepressants used are sufficient to prevent relapse or recurrence. The aims of this study were to assess symptoms of depression in patients on long-term treatment and to determine the proportion of patients receiving adequate doses of antidepressants.

Method

Standards regarding dosing and the severity of persisting symptoms were agreed by the authors. It was taken as axiomatic that acute-phase and long-term treatment doses should be the same.

Dosing

There is still ambiguity about the optimal doses of tricyclic antidepressants. Some studies demonstrate the efficacy of high doses only, while others suggest that low doses possess some efficacy.[2] Thus, we adopted two standards regarding doses of tricyclic drugs. The first was that doses should be $\geq$125 mg/day (this is the consensus of the Royal College of Psychiatrists[3]). The second was that doses should be $\geq$75 mg/day (this is the smallest dose of a tricyclic that has been shown to be superior to placebo in a controlled trial).[2] Consensus on adequate doses of SSRIs was easily attained. Therapy with fluoxetine and paroxetine would be considered adequate at $\geq$20 mg/day.

Severity of persisting symptoms

For the purpose of this study we decided to take a Beck Depression Inventory (BDI) score of $\leqslant$11 as defining full remission of depression, a score $\geq$24 as equivalent to syndromal major depression, and intermediate scores as subsyndromal illness. The ideal standard would be that all patients on long-term treatment should be in full remission.[4] We set a second, lower standard that no patient on repeat prescriptions should be ill at a syndromal level.

The study site was a training practice of nine partners in a relatively affluent area. All patients who had been on repeat prescriptions of amitriptyline, dothiepin, fluoxetine or paroxetine for longer than six months were identified. Those with a non-mood indication were excluded. Of 193 cases, 100 were randomly selected as subjects. The current dose of the antidepressant was obtained from the computer record. The subjects were mailed a BDI and a short questionnaire to confirm the dose of the drug and its indication. Non-respondents were sent a single reminder.

Results

Seventy-eight questionnaires were returned to be evaluated. There were 24 males (31%) and 54 females (69%). The mean age was 57 years (range 20–91 years). Twenty-one patients were aged over 70 years. Those receiving amitriptyline or dothiepin totalled 55; 23 were receiving paroxetine or fluoxetine.

The distribution of doses is shown in Table 1. Patients on tricyclics were less likely to be receiving adequate doses than those on selective serotonin reuptake inhibitors (SSRIs) (χ^2 = 15.2, P<0.001). The geometric mean dose of the tricyclic drugs was 70 mg (mode 50 mg).

Only 35% of patients had BDI scores of $\leqslant$11. Forty-four per cent had scores >11 and <24 (persisting subsyndromal disorder), and 21% had a BDI score $\geq$24. The mean BDI score was 17.5 in the tricyclic patients and 15.8 in the patients receiving SSRIs (t = 0.67, P = 0.5).

Discussion

The study has limitations, but it paints a pessimistic picture. Only 35% of patients were in full remission and about a fifth were

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Table 1. Distribution of doses and BDI scores.

	Daily dose (mg)			BDI score		
AMI/DOT n=55	≥125 13%	<125, ≥75 43%	<75 44%	≤11 31%	>11, <24 45.5%	≥24 23.5%
PAR/FLU n=23	≥20 100%	<20 0%		≤11 43.5%	>11, <24 39%	≥24 17.5%

AMI=amitriptyline, DOT=dothiepin, PAR=paroxetine, FLU=fluoxetine.

probably ill at the syndromal level. This means patients had either never attained remission or, if they had, had then suffered an undetected relapse.

The failure to meet even the lower standard for tricyclic dosing (≥75 mg) in many patients causes concern. Although a parochial study, this data is similar to Milne's, with tricyclic doses being only 30–40% of the maximums suggested by the British National Formulary.[5] However, attaining or maintaining remission cannot be simply a question of prescribing an adequate dose of antidepressant for a long enough time; patients with depression need regular monitoring to ensure remission is achieved and maintained.

The emphasis at present is on improving the diagnosis of depression in primary care, but this study suggests there is little point in making a diagnosis if we cannot effect a desirable outcome.

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