



Risk factors for depression in the elderly inflammatory bowel disease population ☆,☆☆,★,★★,☆☆☆



Millie D. Long^{a,b,*}, Michael D. Kappelman^{b,c}, Christopher F. Martin^{a,b}, Wenli Chen^b, Kristen Anton^{b,d}, Robert S. Sandler^{a,b}

^a University of North Carolina at Chapel Hill, Department of Medicine, Division of Gastroenterology and Hepatology, USA

^b Center for Gastrointestinal Biology and Disease, Chapel Hill, NC, USA

^c University of North Carolina at Chapel Hill, Department of Pediatrics, Division of Gastroenterology and Hepatology, USA

^d Geisel School of Medicine at Dartmouth, USA

Received 14 February 2013; received in revised form 1 July 2013; accepted 2 July 2013

KEYWORDS

Inflammatory bowel disease;
Crohn's disease;
Ulcerative colitis;
Depression;
Adherence

Abstract

Background and aims: Little is known about depression in elderly individuals with inflammatory bowel diseases (IBD). We assessed the point prevalence of depression and determined associations with disease activity, quality of life, and medication adherence in elderly patients with IBD. **Methods:** We identified elderly (≥ 65 years) individuals within Crohn's and Colitis Foundation of America Partners, an online IBD cohort. Individuals completed the short geriatric depression scale (GDS). We used bivariate statistics to determine whether demographic or disease-related factors, disease activity, quality of life or medication adherence was associated with depression. We used logistic regression to estimate independent effects of depression on medication adherence.

☆ Conference presentation: This work was presented as a poster at the American College of Gastroenterology meeting, October 2012.

☆☆ Grant support: This work was supported by a Career Development Award from the Crohn's and Colitis Foundation of America (M.D.L.), NIH P30 DK34987 (R.S.S.), and NIH 1K08DK088957-01 (M.D.K.).

★ Author contribution: All authors have made substantial contributions to this work. M.D.L. participated in all of the following: (1) the conception and design of the study, acquisition of data, analysis and interpretation of data, (2) drafting the article or revising it critically for important intellectual content, and (3) final approval of the version to be submitted. M.D.K. participated in 1) the conception and design of the study and (2) final approval of the version to be submitted. C.F.M. participated in 1) the conception and design of the study, acquisition of data, analysis and 2) final approval of the version to be submitted. W.C. participated in 1) acquisition of data and 2) final approval of the version to be submitted. K.S. participated in 1) acquisition of data and 2) final approval of the version to be submitted. R.S.S. participated in 1) the conception and design of the study and (2) final approval of the version to be submitted.

★★ We certify that this article, including related data, figures and tables has not been previously published and the article is not under consideration elsewhere.

☆☆☆ The authors have no financial disclosures relevant to this work. Dr. Long has previously served as consultant to UCB, Inc.

* Corresponding author at: Campus Box 7080, University of North Carolina at Chapel Hill, Chapel Hill, NC 27599-7080, USA. Tel.: +1 919 843 5795; fax: +1 919 966 6842.

E-mail address: millie_long@med.unc.edu (M.D. Long).

Results: A total of 359 elderly individuals with IBD completed the GDS. The mean age was 70.2 years (SD 4.7); mean disease duration was 25.6 years (SD 17.6), and 62.6% had Crohn's disease (CD). The point prevalence of depression was 22.6%. Lower education levels ($p = 0.001$), higher corticosteroid use (<0.01) and lower exercise levels (<0.001) were associated with depression. For both CD and ulcerative colitis (UC), those with depression had increased disease activity (short Crohn's disease activity index 52.5 versus 29, $p = 0.005$, and simple clinical colitis activity index 5 versus 2, $p = 0.003$). Depressed patients had lower quality of life (short IBD questionnaire 4.6 versus 5.7, $p < 0.001$). Depressed individuals had reduced medication adherence (adjusted OR 2.18; 95% CI 1.04–4.57).

Conclusions: Depression is common in this geriatric IBD cohort. Depression is independently associated with reduced medication adherence. Recognition and treatment of depression in elderly patients with IBD could improve outcomes.

© 2013 European Crohn's and Colitis Organisation. Published by Elsevier B.V. All rights reserved.

1. Introduction

Developed countries, such as the United States, with low birth rates and low mortality have contributed to an overall aging of the population.¹ This aging population has a significant impact on costs of health care delivery.² It is therefore important to understand and optimize health care delivery to the elderly, particularly among those with chronic diseases. Depression is highly prevalent among individuals with chronic diseases. Importantly, depression can adversely affect the course and outcome of common chronic conditions. Therefore, improved recognition and treatment of depression in the elderly chronic disease population could improve outcomes.

Depression is a major health problem in the United States (US), with 1 in 10 adults meeting criteria for current depression.³ Risk factors for depression in chronic disease populations have included measures of poor health, female gender, lack of social support and levels of physical activity.⁴ An estimated 8.3% of diabetics, for example, meet criteria for major depression.⁵ Unfortunately, among diabetics, a significant proportion of individuals with depression are undiagnosed (as many as 45% of diabetics with depression remain undiagnosed).⁴ Depression can be both costly and debilitating.

Individuals with inflammatory bowel diseases (IBD) are one chronic disease population at increased risk for depression. Among IBD patients in Canada, the period prevalence of depression has been estimated to be triple that of the general population (16.3% versus 5.6%).⁶ Risk factors for depression in the IBD population include female gender, lack of a partner, younger age, increased pain, and functional limitations.⁶ Fewer data are available about depression specifically in the elderly IBD population. There are well-described differences in depression rates and characteristics amongst the elderly general population. Risk factors for incident depression in the elderly general population include older age, personal history of depression, death of a spouse, health related factors and comorbid anxiety.⁷ In fact, in older age groups, psychoeducational and psychological interventions designed to increase protective factors have been shown to reduce incident depression by 20–25% over 1–2 years in the general population.⁸ Such interventions could be implemented in an IBD population if depression were found to be prevalent.

We chose to focus on the elderly within this study due to the following factors: high rates of depression found in this segment of the general population without data in IBD, differing risk factors for depression in the elderly general population, and the potential for under-recognition and under-treatment of this problem in the IBD community. As depression in the elderly can be both preventable and treatable, with significant benefits on quality of life, we aimed to 1) assess the point prevalence of depression in an elderly cohort of patients with IBD using a readily available screening tool, 2) assess factors associated with depression in the elderly IBD population and 3) determine whether depression is associated with disease activity, quality of life, or medication adherence in this age group.

2. Materials and methods

We identified elderly patients with IBD (≥ 65 years old) who were enrolled in Crohn's and Colitis Foundation of America (CCFA) Partners, an internet-based cohort of individuals living with IBD. The cohort construction and characteristics have been described elsewhere.⁹ In brief, using multiple means of recruitment, over 12,000 individuals with self-reported IBD have enrolled in this online cohort registry since initiation. Cohort members are followed up every 6 months. Follow up includes a core survey with information on disease phenotype, disease activity, medications, and various patient reported outcomes (PROs). When possible, validated instruments for self report are used: the short Crohn's disease activity index (sCDAI),¹⁰ the simple clinical colitis activity index (SCCAI),¹¹ the Manitoba IBD index (MIBDI),¹² the short IBD questionnaire (SIBDQ),¹³ Morisky Medication Adherence Scale (MMAS)¹⁴ and Godin Leisure time index.¹⁵ There is also the opportunity for optional "modules" at 6 month intervals to assess specific components of living with IBD, such as depression.

In this study, we invited elderly individuals ≥ 65 years of age enrolled in CCFA Partners cohort to complete the short form of the geriatric depression scale (GDS)¹⁶ at the time of their planned 6 month-follow up interval (6 months after initial entry into the cohort). This module includes 15 yes/no questions and takes less than 10 minutes to complete (Fig. 1). A score of ≥ 5 on this scale suggests depression (specifically depressive risk warranting further evaluation). Scores up to 8 are considered consistent with mild depression; scores of 9–11

Download English Version:

<https://daneshyari.com/en/article/6099344>

Download Persian Version:

<https://daneshyari.com/article/6099344>

[Daneshyari.com](https://daneshyari.com)