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NICE guidelines for the management of depression

Are clear for severe depression, but uncertain for mild or moderate depression

Guidelines from the National Institute for Clinical Excellence (NICE) focus on clinical conditions that have a substantial impact on public health and aim to improve standards of care and reduce variations in provision. Depression is a common condition, contributing 12% of the total burden of non-fatal global disease.¹ Variations in its treatment within the NHS are striking and perplexing.^{2,3} We welcome these guidelines and recent advice from the Medicines and Healthcare products Regulatory Agency (MHRA) concerning the prescription of antidepressants.^{4,5}

The methods underpinning the guidelines were rigorous and produced a definitive summary of current evidence. However, the uncertainty of many recommendations is disappointing. The guidelines advocate a stepped care approach, but the weakness of evidence supporting structured interventions for mild to moderate depression limits the value of recommendations referring to initial steps.

The review of the evidence highlights associations between the severity of depression and response to antidepressant medication. Thus NICE is able to provide clear guidance on the treatment of moderate to severe depression—antidepressant medication is recommended and, after careful review, that this should be a selective serotonin reuptake inhibitor (SSRI). New guidance by the Committee on Safety of Medicines and the MHRA about prescribing SSRIs now respects concerns about hitherto unpublished risks of agitation and increased suicidality.⁶

The guidelines endorse the conclusions of the technology appraisal by NICE of electroconvulsive therapy. This should continue to be used, but its use should be restricted to achieving rapid and short term improvement in disabling symptoms in individuals with a severe depressive illness after other treatment options have proved ineffective or when the condition is potentially life threatening.

The guidelines recommend use of cognitive behaviour therapy or interpersonal therapy, which are as effective as antidepressant medications. When cognitive behaviour therapy is combined with medication for severe depression, it is associated with better outcomes than antidepressant medication alone and reduces relapse rates. The guidelines do not recommend the routine use of psychodynamic psychotherapies. Clear support for specific psychotherapeutic interventions is limited to trials on severe to moderate depression, as the association between severity and efficacy found for medication is also present for psychotherapeutic interventions.

Overall the recommendations for routine treatment of severe to moderate depression are clear and unsurprising. What is less clear is the appropriate treatment for mild to moderate depression. The systematic review on which the guidelines are based identifies evidence supporting problem solving therapies and counselling, but evidence on other interventions is weak or absent. This contrast between clear evidence based recommendations for the manage-

ment of severe depression and uncertainty, because of poorer evidence, about the management of mild or moderate depression is the central weakness of the guidelines. Diagnostic categories are based on ICD 10 definitions of mild, moderate, and severe depression. If these are applied strictly the decision to use or not use an antidepressant or pursue psychological therapy will be based on uncertain criteria, such as the number of reported symptoms.⁷ These shortcomings are acknowledged, but the guidelines offer limited advice on how to determine whether or not a particular case may benefit from treatment. The guidelines thus fail to support an important but often uncertain clinical decision.

People with mild to moderate depression or the associated mixed anxiety and depressive disorders constitute most of those whose care might be influenced by these guidelines. The review concluded that firm evidence is lacking that these conditions are responsive to antidepressant medication or specific psychological treatments. These are mostly sub-threshold disorders where identifying the presenting difficulty as a treatable pathology may be inappropriate.⁸ These diagnoses commonly emerge through negotiation between patient and practitioner in pursuit of a construct to legitimise engagement with the healthcare system.⁹ Until research has established who is likely to benefit from active treatment, practitioners will continue to be tempted to respond to requests for help by allowing such negotiations to result in a medical diagnosis. This may satisfy the practitioner's desire to do something and the patient's search for help. What it does not do is reflect the evidence base.

To advance further the management of what is termed mild to moderate depression, we need a better understanding of the interaction that occurs when individuals seek medical help for an emotional problem.¹⁰ Two trends deserve attention. Firstly, changes in social networks leave the vulnerable with limited access to informal emotional support. Secondly, professionals providing support are increasingly obliged to restrict interventions to those with evidence of effectiveness. On the whole these are limited to those evaluated from a medical perspective. As a result distress may be defined as depression by patients as a necessary means to access support and by doctors as a way of legitimising the provision of such support. The idea that societal change influences diagnosis is not new.¹¹ This medicalisation of unhappiness would benefit from sociological as well as clinical research.¹²

Hugh Middleton *senior lecturer*

Division of Psychiatry, University of Nottingham, Nottingham NG3 6AA

Ian Shaw *professor of health policy*

Sally Hull *clinical senior lecturer*

School of Sociology and Social Policy, University of Nottingham, Nottingham NG7 2RD

Gene Feder *professor of primary care research and development*

Barts and the London, Queen Mary's School of Medicine and Dentistry, London E14NS (g.s.feder@qmul.ac.uk)

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Changes in blood supplies, regulations, and transfusion practice

Clinicians need to prepare for shortages now

In the United Kingdom, we have come to take for granted the supply of blood for transfusion. Changes that might reduce the supply of blood are afoot and are going to affect all clinicians who use blood and blood products. We need to act now to decrease our dependence or we will be faced with deciding which patient is going to get the remaining bag of blood in the blood fridge—with all the clinical and ethical problems that will ensue. I outline why blood shortages may occur and describe some simple methods to avoid the use of donor blood.

A second possible case of variant Creutzfeldt-Jakob disease (vCJD) transmitted by transfusion has been reported,¹ leading to further tightening of the exclusion of blood donors who may have had a transfusion since 1980. These restrictions have reduced the number of donors and total number of red cell donations. This comes on top of a general trend of falling numbers of donors.² The Department of Health has recently circulated a plan for the management of shortages in case blood supplies run low.³ Hospitals will need to reduce the stock of blood they hold. The indications for transfusion have been broadly divided into immediately life saving, urgent but can be deferred for day or so, or desirable. Elective operations with >20% chance of requiring blood are the first to be cancelled. Hospitals with good blood conservation measures are likely to weather shortages with less impact on patients. We all need to use blood appropriately and maximise efforts to reduce the use of allogeneic blood if possible to make the smaller amount available accessible to all patients that need transfusion.

The effective use of blood has been the subject of two health circulars in England, and the recommendations in them have been implemented only partly.^{4,5} The appointment of specialist practitioners of transfusion and transfusion nurses has been limited by inadequate funding in trusts, but their numbers are increasing gradually. Reducing the need for donor blood, however, will require the efforts of all clinicians

looking after patients. Some ways of doing this are listed in the box.

The decision to transfuse patients is often based on the level of haemoglobin, the so called haemoglobin trigger. Because anaemia is often multifactorial and the patients response varies, there is still uncertainty as to the right level for individual patients.⁶ Lower Hb trigger levels are increasingly being used. Autologous transfusion techniques have been shown in randomised controlled trials to reduce the need for allogeneic blood.⁷ Future developments include the use of enzymes to change the ABO blood group glycoproteins and platelet substitutes to blood group O, the "universal donor."^{8,9}

One driver to reduce the use of blood has been the price of blood, which has risen in recent years as further attempts have been made by transfusion services to improve the safety of blood. The introduction of universal leucodepletion, polymerase chain reaction testing for hepatitis C virus, human T

Steps that can reduce the need for allogeneic blood

- Review patients in pre-admission clinics before surgery
 - Treat iron deficiency anaemia with oral or intravenous iron
 - Stop antiplatelet and anticoagulants drugs before surgery if feasible
 - Use intraoperative cell salvage
 - Avoid hypothermia during surgery
 - Use postoperative cell salvage (joint surgery)
 - Consider the use of rhEPO in defined clinical settings
 - Use transfusion protocols to aid when transfusions are given (haemoglobin triggers)
- (Adapted from James V. *A national blood conservation strategy for NBTC and NBS: report from the working party on alternatives to transfusion*. London: National Blood Service, 2004.)

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