CENTRALIZED, STEPPED, PATIENT PREFERENCE-BASED TREATMENT FOR PATIENTS WITH POST-ACUTE CORONARY SYNDROME DEPRESSION: CODIACS VANGUARD RANDOMIZED CONTROL TRIAL

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Background: Controversy remains about whether depression can be successfully managed after acute coronary syndrome (ACS) and the costs and benefits of doing so. Our objective was to determine the effects of providing centralized, patient preference-based, stepped depression care post-ACS on depressive symptoms and health care costs.

Methods: We performed a multicenter randomized controlled trial with 150 patients with elevated depressive symptoms (Beck Depression Inventory score >10) 2 to 6 months after an ACS who were recruited and randomized from 7 private and academic ambulatory centers across the United States between March 18, 2010 and January 9, 2012. Masked research staff assessed outcomes. The intervention was six months of centralized depression care (patient preference for problem-solving treatment, pharmacotherapy, both, or neither), stepped every 6 to 8 weeks, given by telephone or the internet (n=73) (active treatment group) compared with locally administered, physician-guided depression care (usual care group) (n=77). The main outcome measures were change in depressive symptoms during 6 months and total health care costs.

Results: Depressive symptoms decreased significantly more (t = −3.5; P=.01) in the active treatment group (change, −10.1; 95% confidence interval (CI), −12.0 to −8.1) than in the usual care group (change, −6.6; 95% CI, −8.5 to −4.8). Although cost was higher ($1110) for active treatment than usual care ($414; adjusted difference, +$687; 95% CI, $466 to $909; P<.001), after including all health care costs (ambulatory care, hospitalizations, and cardiac procedures), the difference was no longer significant (adjusted difference, −$325; 95% CI, −$2639 to +$1989; P=.78).

Conclusions: For patients with post-ACS depression, active treatment produced substantial reduction in depression. The depressive symptom effect size of 0.59 was approximately double that reported in meta-analyses of other depression treatment trials. This kind of depression care is feasible, effective, and cost neutral and should be tested in a large phase 3 pragmatic trial.