Letters to the Editor

The State of Care for Persons With a Diagnosis of Depression

An Analysis Based on Routine Data From a German Statutory Health Insurance Carrier

by Dr. PH Jona T. Stahmeyer, M.A. Caroline Märtens, Prof. Dr. rer. pol. Daniela Eidt-Koch, Prof. Dr. med. Kai G. Kahl, PD Dr. rer. pol. Jan Zeidler, and Dr. rer. biol. hum. Sveja Eberhard in issue 26/2022

Inaccuracies

The article is relevant in the healthcare setting but contains some inaccuracies.

- It is not clear when or whether relative frequency/rate refers to diagnostic cases or individuals.
- In the article, the diagnostic category ICD-10 F33.4 ("Recurrent depressive disorder, currently in remission") is included with the other or not further specified depressive disorders and categorized as non-specific. It is, however, a specific diagnostic category that applies to clinically mostly asymptomatic states in the context of depressive disorders. These formally do not require inpatient care but as a rule exclusively outpatient care. The association shown is relevant as the authors of the article categorize 47.2% of all coded diagnoses of depression as non-unspecific. (What's the proportion of cases/individuals with the code ICD-10 F33.4?)
- In the analysis of outpatient medication provision, only the ATC groups of antidepressants, benzodiazepines, and lithium were considered. Regularly, however, psychopharmacotherapy for depressive disorders includes further substances (for example, anxiolytics [ATC N05B] or hypnotics and sedatives [ATC N05C]. This is especially the case for persons with depressive disorders who have other comorbid psychological/mental disorders. To assess the outpatient medication provision adequately, all substances in the ATC group N (nervous system) should have been considered.
- In the summary, the conclusion is drawn that healthcare services for patients with depressive disorders are particularly deficient in diagnosing the disorder and assessing its severity. (The discussion does not include any corresponding interpretation.) The results of the present study do, however, not allow such a conclusion.

DOI: 10.3238/arztebl.m2022.0335

References

1. Stahmeyer JT, Märtens C, Eidt-Koch D, Kahl KG, Zeidler J, Eberhard S: The state of care for persons with a diagnosis of depression—an analysis based on routine data from a German statutory health insurance carrier. Dtsch Arztebl Int 2022; 119: 458–65

Prof. Dr. med. Maximilian Gahr, MA
Klinik für Psychiatrie und Psychotherapie III, Universitätsklinikum Ulm
maximilian.gahr@uni-ulm.de

The Drawbacks of Pharmacotherapy Without Accompanying Psychotherapy

My thanks to Stahmeyer et al. for their analysis of the state of care for persons with depression (1). On the basis of these data, further interesting aspects can be deducted in addition to the conclusions reached by the authors. In the S3 guideline for the treatment of depression, psychotherapy without pharmacotherapy can be considered in moderately severe depressive episodes. It is therefore surprising that 60% were given pharmacotherapy, but only 10% psychotherapy. This clearly marks underprovision of psychotherapy without explaining it in greater detail. Data show that pharmacotherapy without accompanying psychotherapy for recurrent depression has disadvantages/drawbacks for further episodes in the long term (2). As the waiting time for a psychotherapy place is currently about 20 weeks, these numbers are, however, unsurprising (3). Optimal needs based planning is required, as is an upgrade of talking therapy medicine. The fact that most patients are (thankfully) treated by general practitioners is also identifiable as a healthcare deficit. Pharmacotherapy requires fundamental specialist medical knowledge, especially in a scenario of non-response and because of interactions and adverse effects. Finally, let me say, as a geriatric psychiatrist, that on the basis of these data the numbers of older people with depression barely differs from those of younger people. But the healthcare deficit is even more pronounced in older people—patients older than 65 receive substantially less psychotherapy (4). In view of a steadily ageing population, this healthcare bottleneck is going to narrow even more. What would be desirable is to train psychotherapists more intensively in this area, so as to abolish stigmatizing comments such as "older people are less motivated to change" and thus reduce the access threshold for psychotherapy places.

DOI: 10.3238/arztebl.m2022.0336

References

1. Stahmeyer JT, Märtens C, Eidt-Koch D, Kahl KG, Zeidler J, Eberhard S: The state of care for persons with a diagnosis of depression—an analysis based on routine data from a German statutory health insurance carrier. Dtsch Arztebl Int 2022; 119: 458–65.
2. Zhang Z, Zhang L, Zhang G, Jin J, Zheng Z: The effect of CBT and its modifications for relapse prevention in major depressive disorder: a systematic review and meta-analysis. BMC Psychiatry 2018; 23;18: 50.
3. Singer S, Maier L, Paserat A, et al.: Wartezeiten auf einen Psychotherapieplatz vor und nach der Psychotherapiestrukturreform. Psychotherapeut 2022; 67, 176–184.
4. Barmer Arztreport 2022: https://www.bifg.de/publikationen/reporte/arztreport/arztreport-fachaerztliche-inanspruchnahme (last accessed on 10 October 2022).

PD Dr. med. Arnim Quante
Klinik für Psychiatrie, Psychotherapie und Psychosomatik
Friedrich von Bodelschwingh-Klinik, Berlin,
a.quante@fvbk.de

Depression is not Merely a "Mood Disorder"

Stahmeyer et al. gave an instructive overview of the state of care for persons in the diagnostic category" depression" within the German health insurance system. . The authors speculate that guideline based healthcare services, especially pharmacotherapy and psychotherapy, are insufficiently implemented and accessed (1).

One might, however, argue critically that the general belief in the global effectiveness of pharmacological as well as psychological treatment modalities is not well founded. Stefan Weinmann in his critical book "Die Vermessung der Psychiatrie "[Surveying Psychiatric Practice] pointed out the deceptions and self-deceptions of the psychiatric disciplines. Almost every week I receive calls for help from desperate patients, who have been through their fifth or sixth antidepressive medication, have unsuccessfully received two or three psychological treatments, or attempted mindfulness trainings (which—although currently heavily promoted—often are counterintuitive in severely depressed patients [3]). American studies have shown that especially patients with a diagnosis of depression often turn to "complimentary " methods, including different forms of massages. This is easily explained: Depression is not primarily a "mood disorder" with "accompanying somatic symptoms," but—as Thomas Fuchs and others have argued —it is a somatic illness with significant changes of the essential interoceptive processes that regulate our general state of health i.e. our "Gemeingefühl " as former German researchers had named it.

Against this background the findings of controlled studies seem plausible, which have unequivocally shown the antidepressive efficacy of various manual treatments. (2, 3). The proved effectiveness of professional touch in a wide range of indications from neonatology to geriatric and palliative medicine, advocate the establishment of touch medicine as a new and important medical discipline.

DOI: 10.3238/arztebl.m2022.0337

References

1. Stahmeyer JT, Märtens C, Eidt-Koch D, Kahl KG, Zeidler J, Eberhard S: The state of care for persons with a diagnosis of depression—an analysis based on routine data from a German statutory health insurance carrier. Dtsch Arztebl Int 2022; 119: 458–65.
2. Baumgart S, Müller-Oerlinghausen B, Schendera CFG: Wirksamkeit der Massagetherapie bei Depression und Angsterkrankungen sowie bei Depressivität und Angst als Komorbidität—Eine systematische Übersicht kontrollierter Studien. Phys Med Rehab Kuror 2011; 21, 167–182.
3. Müller-Oerlinghausen B, Eggart M, Norholt H, Gerlach M, Kiebgis GM, Arnold MM, Moberg KU: Berührungsmedizin—ein komplementärer therapeutischer Ansatz unter besonderer Berücksichtigung der Depressionsbehandlung. Dtsch Med Wochenschr 2022; 147; e32–e40.
4. Fuchs T: Depression, intercorporeality, and interaffectivity. J Conscious Stud 2013, 20, 219–38.

Prof. Dr. med. Bruno Müller-Oerlinghausen
Medizinische Hochschule Brandenburg Theodor Fontane, Neuruppin
bruno.mueller-oerlinghausen@web.de

Recommendations Seem Arbitrary

The authors deserve thanks for their recent evaluation of routine data on the state of care for people with a diagnosis of depression (1). To summarize, the healthcare situation is described as "overall insufficient," because, for example, "only 10% of patients with severe depression receive services that are subject to an application process in line with the psychotherapy guideline, and only 60% of patients were prescribed antidepressants." Aptly, the methodological limitation is then mentioned that the authors have not found it possible to determine the causes for this on the basis of routine SHI data. In spite of this, in their concluding sentence they recommend that more intensive training needs to be provided in continuing medical education on important aspects such as correct diagnosis, severity estimation, as well as the initiation of guideline-oriented therapy, especially in the primary care sector (1).

This recommendation seems arbitrary on the background of the named methodological limitations, is not consistent with the presented data, and focuses one-sidedly on doctor-related causes, whose proportion in the insufficient state of care remains unclear.

Intervention studies of the outpatient care for people with depression in Germany from recent years have shown that more intensive training and collaboration do not necessarily translate into improved guideline adherence or quality of care (2). Rather (and at least also) the structural causes of the unsatisfactory care situation—namely, too few outpatient and inpatient psychotherapy places—should be researched and tackled (3).

DOI: 10.3238/arztebl.m2022.0338

References

1. Stahmeyer JT, Märtens C, Eidt-Koch D, Kahl KG, Zeidler J, Eberhard S: The state of care for persons with a diagnosis of depression—an analysis based on routine data from a German statutory health insurance carrier. Dtsch Arztebl Int 2022; 119: 458–65.
2. Engels A, König HH, Magaard JL et al.: Depression treatment in Germany—using claims data to compare a collaborative mental health care program to the general practitioner program and usual care in terms of guideline adherence and need-oriented access to psychotherapy. BMC Psychiatry 2020; 20: 591.
3. Hölzel LP, Bjerregaard F, Bleich C, et al.: Coordinated treatment of depression in elderly people in primary care—a cluster-randomized, controlled study (GermanIMPACT). Dtsch Arztebl Int 2018; 115: 741–7.

Prof. Dr. med. Andreas Klement
Dr. med. Christian Petzold
Hausärztliche Gemeinschaftspraxis, Dresden
andreas.klement@medizin.uni-halle.de

In Reply:

We thank the authors of the letters to the editor for their positive feedback, but also for their further comments and constructive criticism to our analysis. The study aimed to provide as broad an overview of the care situation of patients with diagnosed depression (1). We are thankful for the comment that the diagnosis ICD-10 F33.4 is a specific diagnosis and not an unspecific diagnosis in the sense of the formed category. The article focused on severity assessment and classification, which form the basis of an evidence-based therapy, so we knowingly accepted this inaccuracy. Only 11,100 of the altogether 1.28 million diagnoses of depression were based on the ICD-10 code F33.4. No effects on

the results are therefore to be expected. Expanding our considerations of medication provision to include all substance classes for the ATC group "N" did not strike us as expedient in an overview of the state of care. The focus should be on the specific medication classes or drug combinations recommended according to the guideline. When considering specific groups of patients—for example, patients with certain comorbidities—further relevant classes of active substances could obviously be included.

Further, we regard the suggestion to consider specifically individual groups of patients—for example, older patient—or a more in-depth consideration of care—for example, about the analysis of combination treatment of psychotherapy and pharmacotherapy or treating/prescribing groups of doctors—as starting points for further and follow-up analyses.

We consider the conclusions of our article—with the focus that indications exist that patients are not always receiving guideline-conform treatment and that more intensive training needs to be provided in continuing medical education on important aspects such as correct diagnosis, severity estimation, as well as the initiation of guideline-oriented therapy—as confirmed in any case by our analyses and in spite of the limitations of analyzing health insurance data. It is debatable why for so many patients no severity assessment exists, even though this is the basis of guideline conform therapy. The reasons why doctors did not initiate severity assessments could not be determined in our analyses. Unawareness, lack of knowledge of the guideline or a lack of time in everyday clinical practice may be among the reasons. In any case, further training and continuing medical education form the basis and an appropriate means for improving the awareness/knowledge of guideline recommendations regarding diagnosis and therapy. Further obstacles to implementing guideline-conform therapy—whether process related or structural—will however, inevitably be considered. The routine use of simple clinical tools, the implementation of standardized processes via practice software systems, or specific disease management programs can help improve guideline conformity of treatment. The extent to which the development of additional care services contributes to abolishing healthcare deficits and thereby lowering the disease burden is the subject of controversial discussion (2).

DOI: 10.3238/arztebl.m2022.0339

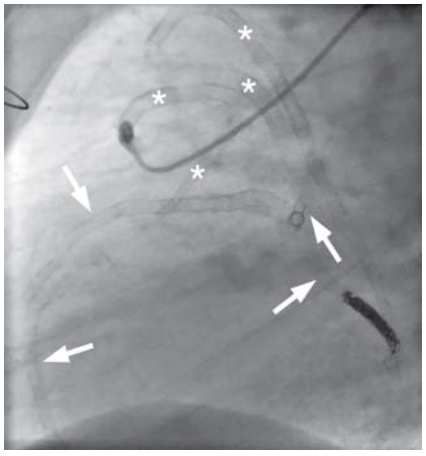
References

1. Stahmeyer JT, Märtens C, Eidt-Koch D, Kahl KG, Zeidler J, Eberhard S: The state of care for persons with a diagnosis of depression—an analysis based on routine data from a German statutory health insurance carrier. Dtsch Arztebl Int 2022; 119: 458–65.
2. Thom J, Bretschneider J, Kraus N, Handerer J, Jacobi F: [Healthcare epidemiology of mental disorders: why is the prevalence not declining despite growing provision of care?]. Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz 2019; 62: 128–39.

On behalf of the authors
Dr. PH Jona T. Stahmeyer
Stabsbereich Versorgungsforschung
AOK – Die Gesundheitskasse für Niedersachsen, Hannover
Jona.Stahmeyer@nds.aok.de

Competing interest statement
The authors of all contributions to the discussion declare that no conflict of interest exists.

CLINICAL SNAPSHOT



Coronary Heart Disease—A Protracted Treatment Course

A 65-year-old male patient that had undergone coronary bypass surgery and multiple coronary interventions presented with typical resting angina without ST elevations on ECG but an elevated troponin T level (142 ng/L). Cardiovascular risk factors included hypertension, hyperlipoproteinemia, former nicotine abuse, and positive family history. The patient, who had an active lifestyle, had no other diseases with the exception of stage IIa PAD. The patient did not have a living will. During cardiac catheterization, we placed two stents in highly stenosed vessels— these were stents number 39 and 40. Over the preceding 14 years, the patient had undergone altogether 29 cardiac catheterizations, with stent placement in the native coronary arteries *(arrows)* as well as the four aortocoronary vein bypasses *(asterisks) (Figure)*. The overall length of the implanted stents was 75.4 cm. This case illustrates that in isolated cases, extensive measures are sometimes required in CHD patients in order to achieve freedom from symptoms. This calls for an approach tailored to the wishes of the patient as well as treatment planning that includes palliative measures/treatment limits in late-stage CHD. No new coronary interventions have been required over the course of the patient's meanwhile 2-year follow-up.

Prof. Dr. med. Marc-Alexander Ohlow, Dr. med. Martin Winterhalter, Medizinische Klinik 1, SRH Wald-Klinikum Gera, marc-alexander.ohlow@srh.de

Conflict of interest statement: The authors state that no conflict of interest exists.

Translated from the orignal German by Christine Rye.

Cite this as: Ohlow MA, Winterhalter M: Coronary heart disease—a protracted treatment course. Dtsch Arztebl Int 2023; 120: 98. DOI: 10.3238/arztebl.m2022.0392