CORRESPONDENCE

Coordinated Treatment of Depression in Elderly People in Primary Care

A Cluster-Randomized, Controlled Study (GermanIMPACT)

by Dr. phil. Lars P. Hölzel, Dipl.-Psych. Frederike Bjerregaard M.Sc., Dr. phil. Christiane Bleich, Dipl.-Psych., Sigrid Boczor PhD, Prof. Dr. phil. Dr. med. Martin Härter, Dipl.-Psych., Prof. Dr. med. Hans-Helmut König M.Sc., Dr. rer. biol. hum. Thomas Kloppe M.A., Prof. Dr. med. Wilhelm Niebling, Prof. Dr. med. Martin Scherer, Iris Tinsel M.A., and Prof. Dr. med. Michael Hüll

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Multiple Causes Behind Care Deficits

I am grateful to the authors for addressing the existing care deficits when it comes to depression in elderly people. They identified negative attitudes as the reason why psychotherapy is rarely offered to these patients (1).

In addition, a lack of curricula for further training in gerontopsychotherapy and waiting times of several months for psychotherapy significantly reduce treatment success and independence (2). Lack of mobility outside the home is also a problem (3).

Here, the intervention over the phone described in the article offers advantages. The inclusion criteria are tailored to "young elderly" free from any significant physical or mental illness. .

The study did not report how many patients at t0 had a PHQ-D score <5 (= remission), whether patients with dependence on sleeping pills or with moderate cognitive deficits (4), which frequently correlate with depression in elderly people, were excluded, and what type of further treatment is provided to the almost 75% of patient without remission.

It would be advisable to include psychotherapeutic intervention in the stepwise treatment plan for non-responders. In subsequent studies, the intervention should be compared with guideline psychotherapy and the control group should receive non-therapeutic telephone contacts. Despite its limitations, the intervention is important. It emphasizes the key role of the general practitioner in the diagnosis and initiation of treatment and offers low-threshold access to the treatment of depression in elderly patients. Treatment companions as specially trained medical assistants of GP practices could be implemented if this service were included in the EBM.

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Dr. med. Jana Hummel
Praxis für ambulante Geriatrie und Gerontopsychotherapie, Mannheim, Germany
praxis@geriatrie-rheinneckar.de

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In Reply

We would like to thank Dr. Hummel for her valuable comments and are delighted about her positive feedback. Contrary to her view, our understanding is that the intervention does not target younger and healthier patients but patients typically seen in GP practices. Exclusion criteria, such as an upper age limit or physical illnesses, were deliberately omitted (1, 2); likewise, patients with moderate cognitive deficits or prolonged benzodiazepine dependence were not excluded from the study. Thus, almost all patients had comorbidities and 79.8% of patients experienced pain. Patients aged ≥ 75 years (n = 93) accounted for 37.5% of the study population which shows that not only "young elderly" were reached.

Dr. Hummel's question regarding the PHQ scores can be answered as follows: Because of the interval of 3 weeks on average between screening in the GP practice and inclusion in the study, lower PHQ scores at baseline were obtain in some of the subjects. Indeed, 5.6% (14 patients) had a PHQ score <5.

The high percentage of non-remitting patients—both in the control group and the intervention group—demonstrates the chronic nature of depression in the elderly.

Patients of both groups had access to all treatment options available on an outpatient basis; the organizers of the study did not offer any special services.

The option to drop out of the study and start a guideline psychotherapy was only used by 6 of the altogether 248 participants.

We agree that it would be valuable to extend the stepwise treatment program by a further step, e.g. guideline psychotherapy or inpatient care, to be offered to elderly patients with severe or chronic depression. However, this implementation study initially addressed only the low-threshold access to psychiatric care/psychotherapy and confirmed the effectiveness demonstrated in similar studies conducted in other health systems, which is important for the development of corresponding healthcare offerings.

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Dr. phil. Lars P. Hölzel
Klinik für Psychiatrie und Psychotherapie
Universitätsklinikum Freiburg, Medizinische Fakultät,
Albert-Ludwigs-Universität Freiburg
Parkklinik Wiesbaden Schlangenbad, Schlangenbad, Germany
hoelzel@parkklinik-schlangenbad.de

Prof. Dr. phil. Dr. med. Martin Härter
Institut und Poliklinik für Medizinische Psychologie
Universitätsklinikum Hamburg-Eppendorf, Hamburg, Germany

Dr. rer. biol. hum. Thomas Kloppe
Institut und Poliklinik für Allgemeinmedizin
Universitätsklinikum Hamburg-Eppendorf, Hamburg, Germany

Prof. Dr. med. Michael Hüll
Klinik für Alterspsychiatrie- und psychotherapie
Zentrum für Psychiatrie und Psychotherapie, Emmendingen, Germany

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The authors declare that no conflict of interest exists.

CLINICAL SNAPSHOT

Ogilvie Syndrome in Disseminated Tuberculosis

A 25-year-old male student from Indonesia presented with weight loss, deterioration in performance, dyspnea, and vomiting. On the basis of radiographically demonstrable lung infiltrates, abdominal air–fluid levels, CT-morphological signs of small-bowel stenosis, and the demonstration of acid-fast rods (sputum, gastric juice), we diagnosed disseminated tuberculosis (TB) with mechanical ileus. An HIV test was negative. Six weeks of tuberculostatic treatment brought no clinical improvement, and there were increasing massively distended intestinal loops with refractory painful obstipation. Resistance testing was normal, so we suspected a TB immune reconstitution inflammatory syndrome and started prednisolone. This achieved a partial response and the small-bowel stenosis was no longer evident; however, the massively dilated loops of colon remained just as prominent *(Figure)*. We diagnosed infection-associated Ogilvie syndrome, and following failure of neostigmine we used the serotonin (5-HT4) receptor agonist prucalopride, upon which intestinal function completely returned to normal. The term Ogilvie syndrome (acute colonic pseudo-obstruction) is used to describe a massively dilated, atonic large intestine. The cause probably lies in a functional disorder of the autonomic nervous system. If drug treatment fails, endoscopic decompression or (in rare instances) surgical treatment (resection, cecostomy) may be considered.

Dr. med. Marco Krasselt, Sektion Rheumatologie, Klinik und Poliklinik für Gastroenterologie und Rheumatologie, Department für Innere Medizin, Neurologie und Dermatologie, Universitätsklinikum Leipzig

Dr. med. Marc Exner, Klinik für Diagnostische und Interventionelle Radiologie, Department für Diagnostik, Universitätsklinikum Leipzig

Prof. Dr. med. Christoph Lübbert, D.T.M.&H., Interdisziplinäres Zentrum für Infektionsmedizin (ZINF), Fachbereich Infektions- und Tropenmedizin, Klinik und Poliklinik für Gastroenterologie und Rheumatologie, Department für Innere Medizin, Neurologie und Dermatologie, Universitätsklinikum Leipzig, christoph.luebbert@medizin.uni-leipzig.de

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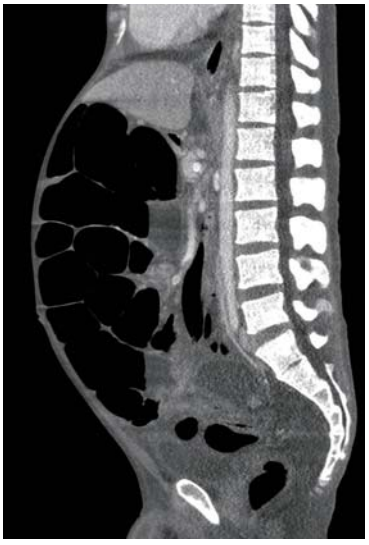

Figure: Sagittal contrast-enhanced computed tomography of the abdomen after 6 weeks of tuberculostatic treatment followed by administration of prednisolone. The scan shows massively distended loops of large bowel (including the rectum) with no demonstrable mechanical cause. The diagnosis was Ogilvie syndrome in disseminated tuberculosis with involvement of the abdomen. The initially described small-bowel stenosis is no longer apparent.