



Letter to the editor

Depressive symptoms and health care within 30 days after discharge from a cardiac hospital unit



We read with great interest the article by Jakob Hornung and colleagues in *The General Hospital Psychiatry* investigating the association between depressive symptoms in coronary heart disease (CHD) patients and in- and outpatient health care utilization during the 30 days following treatment in a cardiac hospital unit [1].

The current study focused on the health care utilization within 30 days of discharge from a cardiac-related hospitalization. Although association between depressive symptoms and re-hospitalization was not established, significant association was found between depressive symptoms at baseline and outpatient hospital and physician visits. We would like to discuss several aspects of the study that could have influenced these findings.

Firstly, in the exclusion criteria the authors have not talked about the presence of any co-morbid psychiatric illness, substance use disorder, past or family history of psychiatric illness in the participants. These factors could have significantly affected the depressive symptomatology as well as the future healthcare utilization within the mentioned cohort [2].

Secondly in Figure 1, in two instances it is shown about the exclusion of patients due to absence of CHD. This is not very clear as the main purpose of chart review was to exclude patients without CHD. However, despite the initial chart review, nine participants did not have CHD and they were excluded only after initial consent.

Thirdly, the kind of care provided by professionals of various specialties and sub-specialties on out-patient visits could have varied among various participants. Further, the number of follow ups required for a patient visiting a psychotherapist would depend on the type of therapy as well as the number of sessions of the therapy. In contrast, a person might need fewer visits to the radiologists for investigation. Hence, the number of follow ups could vary as per the indication, treatment and quality of care. This could have a bearing on the further number of outpatient visits and on the significance of association.

Fourth, it also becomes important to consider many other variables which have not been addressed in the study but could have had a bearing on the somatic and depressive symptoms and the ensuing health care visits such as personality traits, coping skills, quality of life, awareness about one's illness, life events, and adjustment issues [3–6].

Lastly, the authors state that the prevalence of depressive symptoms in the given population was 38.8%. However, it has not been mentioned whether those participants with depressive symptoms were further referred to a psychiatrist or clinical psychologist for a structured assessment. Also, whether and what kind of mental healthcare to these participants was given has not been mentioned, which could have a potential bearing on the long-term psychological morbidity. Further, the role of integrated multidisciplinary services to patients such as those in the study also needs to be emphasized to lower the overall long-term burden of care.

Disclosure statement

The authors declare no conflict of interest.

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