

## **Acute coronary syndromes and depression**

Despite tremendous improvements in the care of patients admitted for acute coronary syndromes (ACS), morbidity and mortality remains high (risk of death >10% in the first year in real-world registries in Europe). In days or weeks after the index event, mood disorders (so-called depressive symptoms) may develop in one third of patients. This occurrence has recently emerged as an important prognostic factor (1). The impact of depressive symptoms – even subclinical (2) - is of the same magnitude as other widely used factors to stratify risk in post-ACS patients such as the absence of myocardial reperfusion, left ventricular dysfunction or non use of beta-blockers or renin-angiotensin system inhibitors. Apart from behavioural consequences, there are clues to suggest that occurrence of depression may amplify perturbation of homeostatic systems such as chronic inflammation and dysimmunity, vago-sympathetic imbalance, coagulation-fibrinolytic abnormalities, and other disturbances associated with a poorer prognosis after an ACS. Despite these strong evidences, and although it affects quality of life and quality of care, depression is seldom considered by health care providers, not only because the symptoms in cardiac patients are often hidden behind somatic complaints or other social impairments, but also because many physicians may feel uncomfortable in the field of psychosocial stress evaluation and care and reluctant to tackle patient feelings and intimate emotional states. This common attitude is likely to contribute to patient sub-optimal management, favouring non compliance to treatments and lifestyle changes, failure of cardiac rehabilitation, delay in returning to work and to social activities (3).

There is no health without mental and emotional health. In post-ACS management, the aim is now to address patient care in a more global perspective, as soon as the patient enters the intensive care unit. In many patients, medical coaching and education about cardiac disease and risk factors management may help depressive symptoms to spontaneously fade away (or even prevent depression to occur). In more prolonged or intense depressions, cardiac rehabilitation together with psychotherapies will help improve the quality of life, depressive symptoms resolution and relapse prevention, and, hopefully, cardiac prognosis (4). In major depressive forms, however, serotonin-reuptake inhibitors have shown to be effective and safe (5). Despite lacking definitive evidence that such a global therapeutic approach truly

impacts cardiac outcome, cardiologists should be aware of this reality and be trained to offer holistic care to their post-ACS patients.

François Ledru, MD

Nicolas Danchin, MD, FESC  
Hôpital Européen Georges Pompidou, Paris, France

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