Capsule Commentary on Gallo et al., Multimorbidity, Depression, and Mortality in Primary Care: Randomized Clinical Trial of an Evidence-Based Depression Care Management Program on Mortality Risk

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One problem in translational research is that it usually isolates studies to a narrow class of patients and a single disease. However, as Gallo correctly points out, older adult patients usually present with multiple comorbid diseases, each with their own management algorithm.¹ Such algorithms sometimes suggest strategies for the index disease that might complicate or be contraindicated in patients with comorbid conditions. Primary care physicians are used to dealing with and balancing multiple competing needs of their older patients. Depression commonly complicates disease and numerous observational studies have shown that when present, comorbid depression increases mortality. Unfortunately, subsequent randomized trials of depression management have failed to show a survival benefit. For example, regarding cardiovascular disease, observational studies have found that patients with depression have increased mortality,² but randomized controlled trials (RCTs) on managing depression in patients with heart failure or post myocardial infarction have failed to demonstrate a mortality benefit.³

Gallo et al. provide yet more observational data that improved depression care may save lives. They randomized depressed patients to usual care or more intensive management, and found that depressed participants randomized to usual care with high levels of medical comorbidity were three times more likely to die than those with depression and minimal medical comorbidity. Patients receiving more intensive depression managed with high disease burden experienced a nonsignificant mortality rate that was 1.75 times greater than that among those with depression and low levels of medical

comorbidity. The authors conclude that, “depression management mitigated the combined effect of multimorbidity and depression on mortality” and “should be integral to optimal patient care, not a secondary focus.”¹

That depression management should be integral to optimal patient care is not an argument that needs buttressing. Depression has a profound impact on the lives of the individual, their family and the workplace. Depression is most commonly managed in primary care and every provider has experienced the remarkable improvement in the quality of their patient’s life with appropriate depression management. This endless, and thus far fruitless, search for an additional mortality reason to justify making depression management an integral skill for primary care physicians seems unnecessary and misguided.

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Compliance with Ethical Standards:

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