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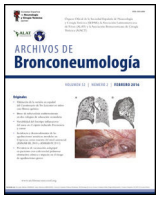

Editorial

COPD is more than just lung function: Let's not forget depression☆

EPOC más allá de la función pulmonar: no se olviden de la depresión

In a personalized medicine setting, a multidisciplinary approach to patients becomes increasingly necessary. This may be of particular importance in highly prevalent chronic diseases such as chronic obstructive pulmonary disease (COPD).[1] COPD, like other chronic respiratory diseases, is frequently associated with comorbidities, such as depression, that worsen patients' quality of life, interfere with their perception of other symptoms, and aggravate their prognosis.[2–6]

Depression is more common in COPD patients than in the general population, although its prevalence varies significantly depending on various factors, such as the population under study or the methods and tools used for its diagnosis.[2,3] Approximately 25% of patients with COPD are estimated to have mild or subclinical forms of depression that often remain undetected by health professionals, and as such, remain untreated.[7]

Several risk factors for developing depression have been identified in COPD patients, including more severe dyspnea, active smoking, presence of other comorbidities, low educational level, low socioeconomic status, and, in general, a poorer quality of life.[8] The pathophysiological mechanisms underlying the association between COPD and depression have not been clearly established, although there appears to be a 2-way relationship between these entities that share common characteristics: anhedonia, apathy, lack of motivation, reduced physical activity, social isolation, and a feeling of loss of control over one's life.[9] COPD patients suffer from fatigue, anorexia, respiratory distress, weight loss, decreased physical activity, and muscle weakness, conditions that facilitate the appearance of depressive symptoms that are aggravated when patients lack social and emotional support.[7,10] Depression, in turn, worsens functional capacity and predicts limitations in basic activities of daily living, while the dependence it creates aggravates depressive symptoms.[11,12] Other contributing factors may include changes in sleep and eating patterns, or reduced physical activity, leading to weakness, loss of energy, and deterioration of neurophysiological systems.[13]

The high prevalence and potential negative impact of depression on COPD mean that depressive symptoms must be investigated in these patients. Various methods are available for these purposes, including a series of scales that have been validated to evaluate depression in COPD, and that allow detection of both patients with established depression and those at risk of depression.[2,9,14] These include the Patient Health Questionnaire (PHQ-9), the Hospital Anxiety and Depression Scale (HAD), the Zung and Conde Self-rating Depression Scale (SDS), or the Center for Epidemiological Studies Depression Scale (CES-D). They consist of a variable number of items that evaluate mood, activities performed, and certain cognitive and emotional aspects in the days prior to the interview, and are easily self-administered.

To improve treatment outcomes, intervention should be early and multidisciplinary. According to some authors, antidepressant drugs appear to be less effective in people with COPD, possibly because of their persistent chronic respiratory symptoms.[14] However, pharmacological treatment could be useful in many patients, so not only should it not be excluded, it should be offered as part of the therapeutic strategy. Offering advice on healthy living habits, including proper diet and exercise and methods for controlling dyspnea, and providing emotional and psychological support improves treatment compliance and encourages patients to stop smoking, a habit that is related to COPD progression and the severity of depressive symptoms.[1,15] Interventions based on patient cooperation, such as respiratory rehabilitation, improve dyspnea, increase tolerance to exertion, decrease anxiety, improve depression, promote health, and reduce the frequency of emergency visits and the number of hospitalizations.[1]

It is therefore up to us to make an effort to offer an individualized, patient-centered clinical approach to COPD that also explores the psychological aspects that may interfere with or affect the course and prognosis of their disease.

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