



Dr. Eric Johnson is a family practice doctor in Grand Forks with a special interest in diabetes -- and a special knack for writing. Feel free to ask him questions, which he will answer in this column.

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The link between diabetes and depression

Q. What's the association between diabetes and depression?

Most experts would agree that the rate of depression and related psychiatric illnesses, such as anxiety disorders, are higher in the diabetes population.

In 2005, *Diabetes Care* published a meta-analysis of 42 studies which showed that the rate of depression is *doubled* in the presence of diabetes! Women with diabetes had a particularly high rate in this analysis at 28%. The prevalence of depression did not vary with the type of diabetes.

A Norwegian study also published in *Diabetes Care* in 2005 showed that those with diabetes without complications did not have an increased rate of depression. Even so, most diabetes patients should be assessed for depression periodically, particularly in the face of complications or adherence issues. Both of those are all too common.

The American Diabetes Association Standards of Medical Care advocates periodic screening for depression as part of routine care, rather than waiting for the appearance of the problem to address it. Our experience in diabetes management reveals that many patients referred for adherence issues do indeed have depression, and treatment of depression often improves how well they take care of their diabetes -- in addition to how they manage their lives generally.

Medications for depression for the general population are often appropriate for diabetes patients. Special attention should be paid to possible weight gain, as

this can occasionally be an issue in treatment. SSRI's have a long track record, and are often efficacious. The agents include fluoxetine (Prozac), paroxetine (Paxil), sertraline (Zoloft), Citalopram (Celexa), and Escitalopriam (Lexapro).

A downside to these agents is that they can cause sexual dysfunction, and should be a consideration in men with erectile dysfunction. An alternative can be bupropion (Wellbutrin), a non-SSRI agent which has a low incidence of this side effect. Wellbutrin should not be used in patients with suspected eating disorders -- also more common in people with diabetes-- since use of bupropion can increase the risk of seizure in some people.

A newer novel agent, duloxetine (Cymbalta), in the SNRI family, is interesting in that it is not only indicated for depression, but is also FDA-approved for diabetic neuropathy. This potentially could be very effective for the many patients who are dealing with both of these issues.

Not surprisingly, patients with diabetes and co-morbid depression incur higher health care costs and need more health care resources. Screening people with diabetes for depression is a given. If the person is depressed, start treatment or make a referral to initiate treatment. That's the first step to improve outcomes.

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Make sure you are up to date and following guidelines. The ADA Standards of Care for diabetes are updated each January and can be found at this site:

http://care.diabetesjournals.org/cgi/reprint/30/suppl_1/S4

If you have comments about the column, or questions for Dr. Johnson's future columns, please contact gailhand@qwest.net

Depression and Diabetes-- Dr. Johnson's Column #8, Oct. 5, 2007



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