Should the mind be a matter? The impact of depression and anxiety on cardiac surgery outcomes

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We read with great interest the article by Dr Kustrzycki et al. [1] about depression and anxiety symptoms 8 years following coronary surgery. This paper discusses an important part of a larger clinical problem: the interaction between psychological or psychiatric disorders and the results of cardiac surgery. This major issue is rarely taken into consideration by cardiac surgeons in their presurgical evaluation.

When we wrote our paper cited in this article, depression and anxiety had only recently been identified as important risk factors for ischaemic heart disease, and were, for the first time, considered as similar in importance to smoking, hypercholesterolemia and arterial hypertension [2]. Furthermore, studies have confirmed that symptoms of depression and anxiety are associated with worse outcomes after coronary surgery. Behavioural factors, in particular hostility and anger, have also been shown to be important independent predictors of adverse outcome after myocardial infarction and myocardial revascularization. All these points emphasize the need for cooperation among surgeons, cardiologists and psychiatrists in the careful preoperative evaluation of these symptoms. This will allow identification of these high-risk patients who may benefit from psychological support tailored to their specific needs with the aim being an improvement of long-term psychiatric and cardiac prognosis.

However, a simple question still remains unsolved: does the effective treatment of these psychiatric symptoms and pathologies really improve the results of coronary surgery or not? The paper by Dr Kustrzycki in our opinion does not provide any response. It is obvious that coronary surgery itself, even a complete success from a cardiac point of view, will not reduce depressive symptoms. Depression is a separate disease that needs specific treatment and psychiatric follow-up. Coronary surgery is certainly not designed to treat depression, but each patient recognized as depressive by a psychiatrist must have the benefit of a specific treatment and careful specialized follow-up. The fact that during the 8 years of follow-up not one patient was treated by a psychiatrist but 22% took psychiatric drugs prescribed by a general practitioner creates a major bias in this study. The differentiation of presurgical anxiety that is considered as normal and anxiety as a real psychiatric pathology is also important.

Finally, the most important message for cardiac surgeons is that the interactions between the mind and the heart are probably more complex than we recognize, and a psychiatric disorder such as depression can clearly be detrimental to the results of cardiac surgery. Close collaboration between cardiologists, surgeons and psychiatrists is mandatory before and after cardiac surgery in order to optimize as much as possible the treatment of these difficult patients.

REFERENCES
