

Mortality of Subjects with Mood Disorders in the Lundby Community Cohort: A Follow-Up over 50 Years

Mattisson Cecilia*, Bogren M, Bradvik L and Horstmann V

Department of Psychiatry, Institute of Clinical Sciences Lund, Lund, Sweden

*Corresponding author: Mattisson Cecilia, MD, Associate Professor, Department of Psychiatry, Institute of Clinical Sciences Lund, Lund, Sweden, Tel: +46730887791; E-mail: Cecilia.Mattisson@skane.se

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Commentary

The aim of the study was to compare causes of death and mortality among subjects with and without mood disorder in the Lundby Cohort and to analyse additional mental disorders as risk factors for mortality in subjects with mood disorder. This study was carried out in the framework of the Lundby Study, which is an epidemiological study that started in 1947 with further follow-ups in 1957, 1972 and 1997. The original population consisted of 2550 in 1947 and in 1957, 1013 subjects were added to the study, who had been born or moved into the area. This makes two overlapping cohorts including 3563 subjects.

Experienced psychiatrists performed semi-structured diagnostic interviews that basically had been the same during the follow-up period. The diagnostic interview had been developed and used in the Lundby Study. The interview was updated in 1997, although it kept its basic form. One part of the semi-structured interview was structured so as to generate factual information and a part was free. The interview contained about 150 items, including questions about somatic and mental health as well as cross-sectional questions and an assessment of personal traits. Substance abuse and dependence including alcohol was also asked for and sociodemographical variables were registered. The Lundby Study had also access to other sources of information: key-informants, out-patient care registers and in-patient care registers. These sources were used to supplement interview data in order to detect as many episodes of mental disorders as possible. After gathering all information a best estimate consensus diagnosis were assessed at each field investigation. DSM-IV diagnoses and ICD-10 diagnoses were used in the last field investigation. Subjects with mood disorder (n=508, 195 males, 313 females) were identified until 1997. Causes and dates of death between 1947 and 2011 were obtained from the Swedish cause of death register and were compared between subjects diagnosed with mood disorder and other participants. Mortality was compared between those with mood disorders and the remaining cohort with Cox regression analyses.

Subjects with and without mood disorder had similar causes of death. The mortality was increased for subjects with mood disorder

(Hazard Ratio 1.18). However, the mortality was increased only for males (Hazard Ratio 1.5). In the total cohort 68 subjects committed suicide during follow-up. Thirty-six participants (1.2 %, 26 males, 10 females) in the sample without a mood disorder committed suicide, whereas 32 (6.3%, 25 males, 7 females) among those diagnosed with a mood disorder committed suicide.

Alcohol use disorders (34.5 %, 68 males, 5.4%, 17 females) and anxiety disorders (12.8%, 25 males, 19.2%, 60 females) were found to be the most frequent comorbidities among participants with mood disorders. Cox regression models were applied in order to analyze other mental disorders as risk factors for mortality. Comorbid anxiety disorders, organic disorders, dementia and psychotic disorders were risk factors for death.

Summary

Only males with mood disorders had elevated mortality. This is in line with findings from the Stirling County Study indicating that mortality was significantly increased among depressed males which were not matched among depressed females (Murphy, 2010). As expected the suicide rate was higher among participants with mood disorders. Alcohol use disorder is a common comorbidity with mood disorders but did not turn out as a risk factor for mortality in this study. Anxiety disorder did though turn out as a risk factor for mortality.

The clinical implications could be a heightened awareness of depressive symptoms among males seeking care in general practice settings. Males should also be more encouraged to seek help and care in order to treat mood disorder and in particular depressive disorder among them. Also the suicide risk should be assessed meticulously. Comorbid mental disorders such as anxiety disorders should also be considered and treated in order to decrease the mortality. These preventive strategies recommended are time-consuming but nevertheless very important.