

Table. Subgroup of Patients With Mild Iron-Deficiency Anemia<sup>a</sup>

	Ferrous Sulfate Group		Iron Polysaccharide Complex Group	
	No. of Patients	Median (IQR)	No. of Patients	Median (IQR)
<b>Hemoglobin Concentration, g/dL</b>				
Week 0	14	9.3 (9.1-9.6)	7	9.6 (9.2-9.9)
Week 4	12	11.5 (10.7-11.8)	7	10.4 (9.1-11.4)
Week 8	10	12.4 (11.9-12.6)	6	10.9 (10.1-11.3)
Week 12	9	12.3 (11.9-13.3)	6	11.2 (10.0-11.3)
<b>Serum Ferritin, ng/mL</b>				
Week 0	14	4.6 (1.8-6.0)	7	2.9 (1.4-6.0)
Week 4	12	15.1 (12.9-28.0)	7	3.5 (2.6-13.8)
Week 8	10	16.3 (12.2-19.7)	6	8.6 (3.2-17.9)
Week 12	9	11.7 (6.8-30.2)	6	5.9 (4.6-15.1)
<b>Total Iron-Binding Capacity, mg/dL</b>				
Week 0	14	472 (434-541)	7	512 (467-566)
Week 4	12	400 (376-487)	7	500 (382-543)
Week 8	10	412 (331-441)	6	447 (385-516)
Week 12	9	356 (320-450)	6	438 (384-498)

Abbreviation: IQR, interquartile range.

SI conversion factors: To convert ferritin to pmol/L, multiply by 2.247; hemoglobin to g/L, multiply by 10.0; total iron-binding capacity to μmol/L, multiply by 0.179.

<sup>a</sup> Defined as a hemoglobin concentration of 9 g/dL or greater at baseline.

on both hematologic and nonhematologic outcomes, particularly in infants and children with IDA, are needed.

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## Nonpharmacologic Treatments for Depression in Older Adults

**To the Editor** In their review article,<sup>1</sup> Drs Kok and Reynolds discussed the clinical challenge of treating late-life depression. They provided an exhaustive analysis of pharmacological treatments, including dosing, intensity, harmful effects, target populations, and clinical significance and

offered useful clinical information and directions for future research. However, their analysis of other treatments lacked depth and they missed an important opportunity to provide readers an understanding of the full range of proven approaches for addressing late-life depression.

As the authors suggested, pharmacological treatments for depression have risks, may not be preferred by older adults themselves, and result in only about one-third entering remission. Thus, more careful attention must be given to nonpharmacological interventions tested in clinical trials and shown to be efficacious with no adverse events or concerns for polypharmacy.

The authors noted that factors associated with late-life depression may be intrinsic (personality traits, functional impairment), extrinsic (social isolation, stressful life events), or both. Nonpharmacological approaches are multicomponent and address modifiable intrinsic or extrinsic factors affecting mood. For example, Get Busy, Get Better: Helping Older Adults Beat the Blues,<sup>2</sup> a nonpharmacological intervention based on the premise that modifiable social and environmental factors contribute to mood disturbances, involves care management, referral, depression education, stress reduction, and behavioral activation. Statistically and clinically significant reductions in depressive symptoms, anxiety, and functional disability were found, as well as improvements in depression knowledge and behavioral activation levels, favoring treatment in comparison with a waitlist control group. Also, 44% in the immediate treatment group were in remission by 4 months compared with 27% in the waitlist control group, with the latter group benefiting similarly upon treatment receipt.

Such approaches point to the importance of understanding and addressing the social and environmental context of older adults experiencing late-life depression.<sup>3-5</sup> Additionally, these approaches can be delivered by a wide range of health and human service professionals trained in the intervention and delivered in various health care contexts, including through aging services.<sup>2,4,5</sup>

We agree with the authors that treating late-life depression in frail older persons is a challenge, but nonpharmacological efficacious approaches exist and should be considered.

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1. Kok RM, Reynolds CF III. Management of depression in older adults: a review. *JAMA*. 2017;317(20):2114-2122.

2. Gitlin LN, Harris LF, McCoy MC, et al. A home-based intervention to reduce depressive symptoms and improve quality of life in older African Americans: a randomized trial. *Ann Intern Med*. 2013;159(4):243-252.

3. Kiosses DN, Ravdin LD, Gross JJ, Raue P, Kotbi N, Alexopoulos GS. Problem adaptation therapy for older adults with major depression and cognitive impairment: a randomized clinical trial. *JAMA Psychiatry*. 2015;72(1):22-30.
4. Avari JN, Alexopoulos GS. Models of care for late-life depression of the medically ill: examples from chronic obstructive pulmonary disease and stroke. *Am J Geriatr Psychiatry*. 2015;23(5):477-487.
5. Bartels SJ, Pratt SI, Mueser KT, et al. Long-term outcomes of a randomized trial of integrated skills training and preventive healthcare for older adults with serious mental illness. *Am J Geriatr Psychiatry*. 2014;22(11):1251-1261.

**In Reply** We agree with Dr Gitlin and Mr Aravena concerning the importance of placing late-life depression within a psychosocial context. We mentioned in our review that “recent life events, coping with functional impairment, or having a lack of social contacts are examples of psychosocial factors that are frequent contributors to depression among older adults and should be addressed as part of treatment planning.”

Treating depression in older adults with antidepressants should be combined with addressing these contributors, as, for example, with the Get Busy, Get Better intervention. Combining antidepressants with psychotherapy may be more effective than either treatment alone and patients find combined treatment more acceptable. We agree that behavioral and psychotherapeutic approaches have a strong evidence base to support their efficacy and utility; unfortunately, the evidence base for combining psychotherapy and pharmacotherapy is not as strong. A recent meta-analysis found only 4 studies in which the combination of psychotherapy and pharmacotherapy was compared with pharmacotherapy alone.<sup>1</sup> The difference was not significant ( $g = 0.41$ ; 95% CI,  $-0.05$  to  $0.88$ ) but may be the result of the small number of studies. Only 1 study was found in which combined treatment was compared with psychotherapy only, with combined treatment resulting in greater improvement, although differences were small.<sup>2</sup> Even if no obvious psychosocial factors can be found that contribute to depression, antidepressants should be combined with psychoeducation and brief psychosocial interventions.

We recommended in our review that psychotherapy should be an initial treatment choice for patients with mild to moderate depression. We wish that psychotherapy was more widely available. The wide availability of antidepressants and the challenge to find a psychotherapist with experience with older adults are not acceptable reasons for using psychotherapy less often than antidepressants. With increasing integration of and improving reimbursement for behavioral health care in primary care medicine, we hope to see greater use of behavioral and psychotherapeutic approaches.

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1. Cuijpers P, Karyotaki E, Pot AM, Park M, Reynolds CF III. Managing depression in older age: psychological interventions. *Maturitas*. 2014;79(2):160-169.
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## CORRECTION

**Incorrect Data in the Statistical Methods Section:** In the Rational Clinical Examination article entitled “Does This Child Have Pneumonia? The Rational Clinical Examination Systematic Review”<sup>1</sup> published in the August 1, 2017, issue of *JAMA*, incorrect data were reported in the Statistical Methods section. In the first paragraph of the section, the sentence should have read “From a pragmatic standpoint, at a pretest probability of 20%, the presence of a finding with an LR equal to 2 would increase the probability to 33%, and the absence of a finding with an LR equal to 0.5 would decrease the probability to 11%.” Additionally, the first sentence of the Findings section in Key Points should have read “In this systematic review and meta-analysis, the presence of hypoxia and increased work of breathing (grunting, nasal flaring, and retractions) were associated with the diagnosis of pneumonia.” This article was corrected online.

1. Shah SN, Bachur RG, Simel DL, Neuman MI. Does this child have pneumonia? the Rational Clinical Examination systematic review. *JAMA*. 2017;318(5):462-471.

## Guidelines for Letters

Letters discussing a recent *JAMA* article should be submitted within 4 weeks of the article's publication in print. Letters received after 4 weeks will rarely be considered. Letters should not exceed 400 words of text and 5 references and may have no more than 3 authors. Letters reporting original research should not exceed 600 words of text and 6 references and may have no more than 7 authors. They may include up to 2 tables or figures but online supplementary material is not allowed. All letters should include a word count. Letters must not duplicate other material published or submitted for publication. Letters not meeting these specifications are generally not considered. Letters being considered for publication ordinarily will be sent to the authors of the *JAMA* article, who will be given the opportunity to reply. Letters will be published at the discretion of the editors and are subject to abridgement and editing. Further instructions can be found at <http://jamanetwork.com/journals/jama/pages/instructions-for-authors>. A signed statement for authorship criteria and responsibility, financial disclosure, copyright transfer, and acknowledgment and the ICMJE Form for Disclosure of Potential Conflicts of Interest are required before publication. Letters should be submitted via the *JAMA* online submission and review system at <https://manuscripts.jama.com>. For technical assistance, please contact [jama-letters@jamanetwork.org](mailto:jama-letters@jamanetwork.org).

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