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Editorial

Editorial: Chronic Diseases Associated with Depression

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Editorial

Depression is a psychological condition that is heterogeneous and frequently associated with other illnesses. These correlations often tend to be bidirectional: people with depression, such as diabetes, cardiovascular disease, cancer, and stroke, have an elevated risk of many chronic conditions. Several signs, including low mood, sleep disorder, loneliness, lack of initiative, and anhedonia, are involved in depression. Few are known, however, whether the pattern of symptoms will vary depending on the physical disease status.

Depression, which affects around 350 million people, is one of the most prevalent psychiatric illnesses worldwide. In 2013, it was the second largest cause of Years Lived with Disabilities (YLDs), impairing 5% to 10% of the global adult population. Changes such as the loss of loved ones, the use of medications, and the occurrence of several diseases may affect the mental health of the elderly during the aging process, increasing their susceptibility to depression.

Depression stems from a dynamic interaction of social, psychological and biological causes, according to the World Health Organisation. Depression in the elderly is correlated with many variables. Depression symptoms can be triggered or worsened by physical symptoms, although the opposite often happens, with depressive symptoms predicting the emergence of health problems. Adverse health risk behaviours and psychobiological changes associated with major depressive disorders (MDD) may raise the risk of chronic diseases, and depressive symptoms contributing to MDD may be precipitated by biological changes and complications associated with chronic medical conditions.

Among people living with HIV, depressive symptoms are prevalent and likely to recur. Our findings endorse the course of the HIV/AIDS Strategy for Ontario to 2026, which addresses HIV-related medical issues (such as depression) and the social drivers of health to improve the general well-being of people living with or at risk of HIV. Our findings highlight the value of providing appropriate mental health services and illustrate the need for long-term support and routine depression management, particularly for high-risk individuals.

PLWHA has found untreated depression, indicating the need to determine access to medical care. To maximize HIV care outcomes, a collaborative approach could be useful. Inflammatory cascade regression analysis and depressive symptoms as independent variables in logistic regressions, the approximate standardized continuous factor scores from each EIP were used to test associations between inflammatory processes and depressive symptoms over time, stratified by HIV serostatus.

Age-adjusted models, black race, higher education, current smoking, obesity, infection with HCV, consumption of alcohol, and cocaine use. To account for multiple contributing observations from each participant, generalized estimating equations (GEE) were used. Compared to having no depressive symptoms per standard-deviation improvement in EIP ratings, the primary interest calculation was the relative likelihood of having clinically significant depressive symptoms. Wald experiments have been used to assess words for the relationship between HIV serostatus and EIPs. Using a standard CES-D threshold of 16 to allow comparison with other literature, we refitted models evaluating the relative odds of having mild depressive symptoms per standard-deviation increase in EIP scores and repeated the study.

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