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SUPPLEMENT

The scope of the problem: Physical symptoms of depression

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The association between physical illness and depression is well recognized. In one large cohort study of patients who visited a family physician complaining of a physical symptom, major depression was observed in 11% and minor depression or dysthymia in an additional 12%.[1] Other estimates suggest that 15% of adult medical inpatients and 4.8% to 8.6% of primary care outpatients meet *International Classification of Diseases, Ninth Revision* criteria for major depressive disorder.[2] This means that roughly 1 in every 7 patients who visit a family physician's office probably has some form of depression or significant depressive symptoms. Patients with depression seek help from their family physicians for several reasons:

A patient with 3 or more unrelated medical concerns should be screened for depression

- Patients with chronic illnesses are at twice the risk of depression as those who are not chronically ill.[3]
- Somatic complaints accompanying depression may be the cause for seeking care.
- Many physical conditions are exacerbated by the coexistence of a depressive disorder.
- Depression is associated with a decline in compliance with treatment recommendations, and consequently may contribute to new or uncontrolled medical illness.

ISSUES AFFECTING DIAGNOSIS AND TREATMENT OF DEPRESSION

Family physicians are challenged to successfully address patient needs during brief office visits. Depressive symptoms may be overlooked in the treatment of comorbid medical conditions, as observed in a prospective study that reported a 67% rate of diagnostic accuracy for depression when patients presented with only depression-related complaints, vs only a 29% accuracy in depressed patients with comorbid conditions.[4]

The associations between depression and comorbid medical conditions are complex and incompletely understood. However, the healthcare provider should be aware of the intimate association between depression and comorbid medical illness. Particularly when encountering a patient with 3 or more unrelated medical concerns, it is prudent to at least consider the diagnosis of a depressive illness. Once the possibility of depression is brought to the fore, the diagnosis can then be either ruled out or properly addressed.

CHRONIC MEDICAL DISEASES AND THE RISK FOR DEPRESSION

Patients with comorbid medical illness are at the greatest risk of depressive symptoms.[1] Some of the major types of medical illnesses known to be associated with, or influenced by, comorbid depression are:

Coronary artery disease. The current National Institute of Mental Health (NIMH) publications report that approximately 1 in 5 cardiac patients experiences major depression, either at the time of diagnostic cardiac catheterization or following myocardial infarction (MI).[5] Also, according to NIMH documents, an additional 1 in 5 cardiac patients suffers from minor depression either post-MI or at the time of catheterization.[5] Depression in patients with coronary artery disease has been identified as a risk factor for subsequent ischemic events and mortality, even after controlling for other risk factors.[6,7]

Diabetes. According to the NIMH, depression occurs more frequently in patients with diabetes than in healthy controls, is associated with an 8-times-greater depression relapse rate, and carries an increased risk of medical complications.[5]

Chronic obstructive pulmonary disease (COPD) and asthma. Among patients presenting for emergency room care with an exacerbation of asthma or COPD, Dahlen and Janson found the prevalence of depression to be 12%.[8] More subtle signs of depressive illness were evaluated in a prospective study of 230 patients with moderate asthma; nearly 50% had a positive screen for depressive symptoms based upon the Geriatric Depression Scale (GDS).[9]

Parkinson's disease. In an extensive European review of depression in Parkinson's disease, Burn estimated the prevalence of depression to be as high as 70%.[10] More conservative NIMH data show a 15% to 20% prevalence of major depression among patients with Parkinson's disease, and a 25% prevalence of minor depression.[5]

Migraine headaches. In a review of 13 studies (6 clinical, 7 community-based), Merikangas and Stevens reported a positive association between migraine and depression in 12 of 13 studies.[11]

Rheumatoid arthritis. In a review of pain management in rheumatic disease, Huyser and Parker cited evidence that over 50% of patients with rheumatoid arthritis experienced depressive symptoms.[12]

One in 5 cardiac patients experiences major depression, either at the time of cardiac catheterization or following myocardial infarction

HIV/AIDS. According to current NIMH statistics, lifetime rates of depression among persons living with HIV infection range from 22% to 45%.[5] Depressive symptoms have been associated with HIV disease progression in several studies.[13,14]

Cancer. According to NIMH data, depression occurs in as many as 50% of all cancer patients.[5] Furthermore, according to NIMH findings, the diagnosis of depression in cancer patients is often hindered by physicians' tendency to mistakenly attribute depressive symptoms (ie, weight loss, sleep disturbance, poor appetite) to the effects of cancer or cancer therapy.[5]

Patient features and history

Independent of the presence of comorbid medical conditions, certain patient features or history may alert the family physician to a heightened risk for depressive illnesses. One major risk factor is female gender. Depression is 2 to 3 times more likely to strike in women than men.[15,16] Other relevant factors include evidence of:

- A previous episode of depression[17]
- Depression among first-degree relatives
- Previous suicide attempts

- Postpartum stress
- Poor social support
- Negative life events (eg, death, disability, or divorce)
- Alcohol or substance abuse[18]
- Involvement in domestic violence[19,20]
- Risk-taking behaviors in adolescents.[21,22]

Family physicians equipped to recognize the importance of assessing depression can better identify patients at greatest risk for serious morbidity and mortality.

PEARL Some patients try to present their best face—to avoid addressing issues—when visiting their doctor

Throughout the diagnostic process, it is helpful to maintain a high index of suspicion and consider mood as another vital sign—as crucial to monitor as blood pressure or temperature. Some patients try to present their best "face"—to avoid addressing issues—when visiting a doctor. Family physicians may need to delve more deeply, to break through the most superficial layer of doctor-patient interaction, and question a patient's mood at face value. By assessing mood regularly and accurately, family physicians can afford their patients the most compassionate, comprehensive, and effective strategy for the management of both the depression and the physical medical problem.

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