

Letters Correspondance

Another approach to managing depression

We read the CME article “An approach to managing depression”¹ with great interest. Both in Canada and in the Netherlands, patients suffering from depression are most commonly treated by their family physicians.^{2,3} We agree with the authors that validated rating scales are very useful for assessing the severity of depression, monitoring response to therapy, and determining remission of depressive symptoms. Family physicians, GP psychotherapists, and psychiatrists should probably use these scales more often.

We were disappointed that the article’s main thrust seemed to be encouraging use of the HAM-D7 scale; in fact, in addition to a full-page reproduction of this scale, the HAM-D7 was mentioned 14 times. We have attempted to use this scale in our family practices and have found it to be quite time-consuming. It does not fit well into the flow of the normal 15-minute (or less) office visit. Although the criterion standard for diagnosis of depression in clinical practice remains a focused in-depth interview by an experienced clinician, for busy family physicians, the ideal test is brief, accurate, easily completed by patients, and reliable for screening, diagnosis, and outcome assessment.

An excellent example of such a validated scale is the nine-item Patient Health Questionnaire (PHQ-9).⁴⁻⁸ Although copyrighted, the PHQ-9 is available as a free download and can be copied for use by clinicians. The PHQ-9 has been validated for screening, diagnosis, evaluation of severity, monitoring response to therapy, and determining remission. Adult patients with grade 4 English literacy skills can complete the form in less than 3 minutes. Clinicians can score it quickly and easily and can then use the answers to direct the course of the consultation. The sensitivity and specificity of the PHQ-9 compare favourably with a structured psychiatric interview. Compared with the HAM-D7, the PHQ-9 is much faster and easier for physicians

to administer and is, therefore, more likely to be adopted in busy family practices.

Preliminary research on use of the PHQ-9 in a British Columbia family practice collaborative has confirmed excellent uptake by family physicians, with 70% of more than 2000 patients with depression completing at least one PHQ-9 in the first year of analysis (work in progress). The Guideline and Protocols Advisory Committee, jointly sponsored by the Ministry of Health Services and the BC Medical Association, has adopted the PHQ-9 as the preferred scale for following depression (see www.healthservices.gov.bc.ca/msp/protoguides/gps/depression.pdf). It is also in increasingly wide use in the United States. The PHQ-9 can be downloaded and copied free from <http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/questionnaire/>.

Finally, one of the authors of the CME article is the originator of the HAM-D7 scale,⁹ and is the principal investigator of an industry-funded validation study of the HAM-D7 in primary care. We think this should have been mentioned in the “Competing interests” section.

—Michelle Greiver, MD, CCFP
North York, Ont

—Ellen Anderson, MD, MHSC
Sooke, BC

—Evelyn van Weel-Baumgarten, MD, PHD
Nijmegen, The Netherlands
by e-mail

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Response

We thank Drs Greiver, Anderson, and van Weel-Baumgarten for their interest and comments regarding the HAM-D7 scale.

The issue that they raise, as we understand it, is that the time required to administer the HAM-D7 is not compatible with the “normal 15-minute (or less) office visit.” They state that a diagnostic scale or symptom measurement tool that could be administered in “less than 3 minutes” would be better accepted in busy family practices.

The experiences of Drs Greiver, Anderson, and van Weel-Baumgarten appear to diverge from those of many of their colleagues in primary and tertiary care settings across Canada.

The first author of the original HAM-D7 validation (R.S.M.) has personally observed (at Mainpro-C, provincial, and national primary care meetings) more than 500 primary care physicians from across Canada administer the HAM-D7. The time to administer the HAM-D7 has been approximately 2 to 5 minutes. Our group has recently validated the HAM-D7 in 47 primary care centres across Canada. The primary care physicians in this initiative reported that the brevity of the scale was a great asset when compared with other scales.

We do not know why Dr Greiver and her colleagues find the scale “quite time-consuming.” The seven items contained in the HAM-D7 are the most frequently endorsed symptoms of depression, including depressed mood, anxiety, and suicidal ideation. These depressive symptoms have high face validity and should be evaluated systematically in any depressed patient. The HAM-D7 is simply a mechanism for quantifying and objectifying the evaluation.

The authors mention and endorse use of the nine-item Patient Health Question (PHQ-9). The PHQ-9 is a self-administered scale, derived from a longer psychiatric diagnostic screening tool, the Primary Care Evaluation of Mental Disorders (PRIME-MD).

The PRIME-MD screens for five of the most common groups of psychiatric disorders in primary care: depression, anxiety, alcohol abuse, somatoform disorders, and eating disorders.

Pfizer Inc holds the copyright to the PHQ-9. Pfizer is the manufacturer of sertraline (Zoloft). In Canada and the United States, sertraline is indicated for depression and several anxiety disorders. Pfizer sales and marketing departments heavily promoted the PRIME-MD across Canada to assist family physicians in diagnosing psychiatric disorders, notably depression and anxiety.

Nevertheless, we believe that the PHQ-9 is a well validated and very useful diagnostic and evaluation tool.¹ To our knowledge, however, the PHQ-9 has not been validated in both primary and tertiary care settings, with a remission cutoff score that correlates with the HAM-D17 score of 7 or less. The HAM-D17 score of 7 or less, albeit imperfect, is the most cited definition of remission in depression.²

The original HAM-D7 validation (the scale reported in the *Canadian Family Physician* article³) was not supported by any pharmaceutical company. The HAM-D7 is the property of academia and is available free of charge to practitioners. Subsequent validation of the HAM-D7 in primary care was supported by Wyeth, the manufacturer of venlafaxine (Effexor). That disclosure will appear on all communications regarding this national primary care validation study, the results of which are yet to be reported.

We do agree with Dr Greiver and her colleagues that scales should be employed more frequently in clinical practice. The HAM-D7 is not a diagnostic scale. It is a symptom-measurement tool that can be

administered quickly, is comprehensive, has high face validity, and helps determine the effectiveness of antidepressant medication and whether remission has occurred. The HAM-D7 is currently the only brief depression scale with remission cutoff scores defined for primary and specialty health care settings that correlate with the most cited definition of remission in depression research.

We hope the HAM-D7 will help sharpen the focus in the therapeutic environment and improve patient outcomes. We also hope that further research will continue to refine critical end points in depression and how best to measure them.

—Roger S. McIntyre, MD, FRCPC
Head, Mood Disorders

Psychopharmacology Unit
University Health Network

—Jakub Z. Konarski, MSC
Toronto, Ont
by email

Competing Interests

Dr R.S. McIntyre is a consultant and speaker for Pfizer, Wyeth, Organon, GlaxoSmithKline, Janssen-Ortho, Eli Lilly, AstraZeneca, Biovail, Oryx, Lundbeck, and Bristol-Myers Squibb. He has received research funding from Janssen-Ortho, Eli Lilly, AstraZeneca, Wyeth, Servier, Novartis, and Organon.

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New family practice residency program

We thought your readers involved in teaching family practice residents might be interested in learning of a new program we have instituted.

St Paul's Hospital is a tertiary care teaching hospital with family practice as a full-admitting service. We have designated beds where patients are admitted from emergency and managed by their family physicians and first-year family practice residents. We believe that, in tertiary care teaching hospitals, this is unique to the Ottawa program and our program.

The challenges of maintaining a family doctor presence in a tertiary care hospital are well known. In many tertiary care facilities many barriers exist for family physicians, not the least of which is the "culture." A relative shortage of general internal medicine services in our facility has resulted in an opportunity to highlight the profile and value of family medicine.

As of October, we have started a new family practice consultation service for inpatient psychiatry. Approximately 100 patients pass through the psychiatry inpatient beds each month. These patients often have medical problems that need addressing, and many do not have family physicians. Until now, the psychiatrists have consulted specialists for these problems. There were concerns, however, with timely access, follow up, and the need for many specialty consultations for one patient. We were asked to provide a regular consultation service to the inpatients. This consists of daily visits by a second-year family practice resident and a family physician to patients with problems. Problems range from liver disease, cellulitis and other dermatologic conditions, minor fractures, and infections, to arthritic conditions, diabetes, and gynecological problems. The program has so far met with great enthusiasm from the psychiatry department and the residents involved.

We intend to submit a program description with our evaluation data. In the meantime, if any other residency program wishes for additional information, they can contact us directly.

—Dara Behroozi, MB BS, CCFP

—Garey Mazowita, MD, CCFP, FCFP

Vancouver, BC

by e-mail

Family practice websites

The recent article by Dr Michelle Greiver, "Practice Tips: Website for your family practice"¹ provided an excellent overview of the topic.