Depression in the Rheumatology Clinic: How Common is It and What Can You Do About It?

A Scleroderma Patient-Centered Network (SPIN) Presentation

Dr Brett Thombs, PhD

Jewish General Hospital

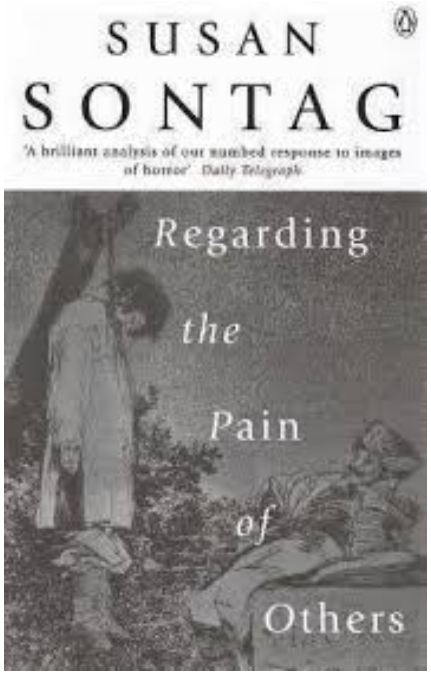
McGill University

Disclosures

- I am Chair of the Canadian Task Force on Preventive Health Care which develops guidelines to support prevention activities in Canadian primary health care.
- I am the Director of the Scleroderma Patient-centered Intervention Network (SPIN), which has received funding from the Canadian Institutes of Health Research for mental health programs in scleroderma.
- I have received funding from the Canadian Institutes of Health Research for evidence reviews related to depression screening.
- I have no relevant financial relationships with any for-profit entity that could be considered a conflict of interest.

"Compassion is an unstable emotion. It needs to be translated into action, or it withers."

- Susan Sontag, Regarding the Pain of Others



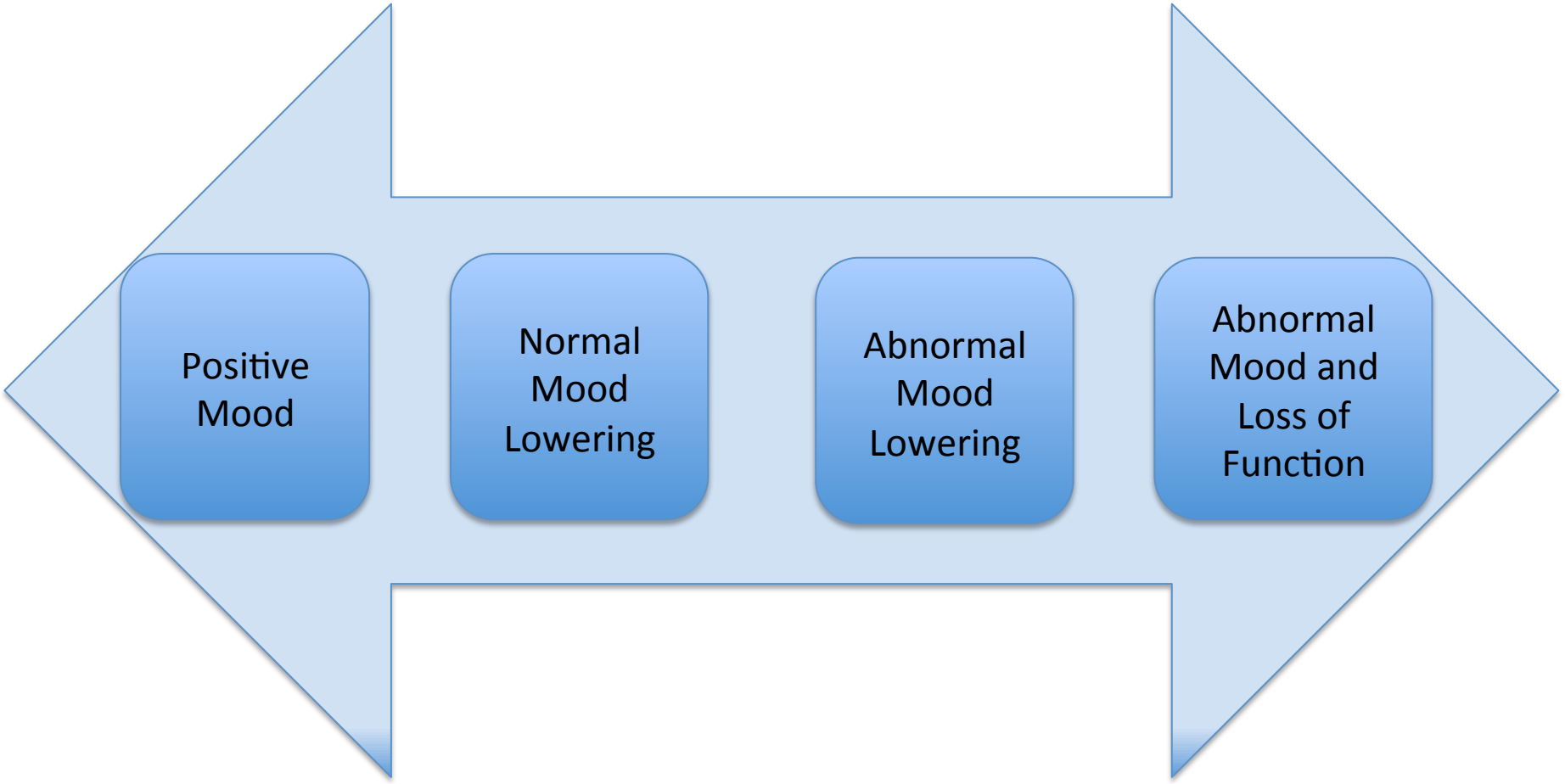
“Facts are stubborn things; and whatever may be our wishes, our inclinations, or the dictates of our passions, they cannot alter the state of facts and evidence.”

John Adams

Overview

- How common is depression in rheumatology clinics and why do published prevalence estimates vary so much?
- Should I screen patients for depression in my rheumatology clinic?
- How effective are depression treatments for rheumatology patients and what are possible harms?

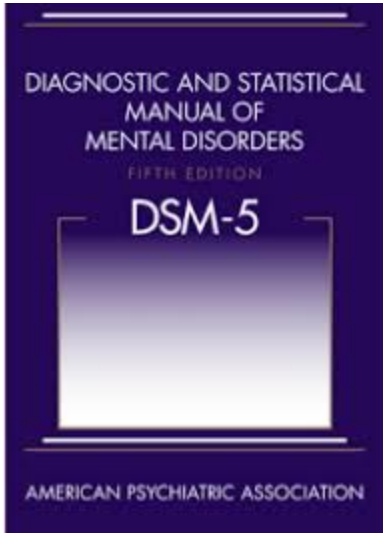
What is Depression?



What is Depression?

- Major depressive disorder
  - Pervasive
  - Persistent
  - Wide range of symptoms

What is Depression? Diagnostic Criteria



- Duration of <u>at least 2 weeks</u>

- Total of at least 5 symptoms, including depressed mood or loss of interest:
  - **Depressed mood**
  - **Loss of interest or pleasure**
  - Significant weight loss or gain
  - Significant change in sleep patterns
  - Agitation or retardation
  - Fatigue or loss of energy
  - Guilt or worthlessness
  - Inability to concentrate
  - Thoughts of death or suicide

- Clinically significant impairment in social, occupational or other areas of function

- Symptoms not attributable to medical condition

What is Depression? Vulnerabilities

- Losses
- Stressful life events
- Poor social support
- Familial factors
- Genetic factors
- Physical illness

How Common is Major Depression in Rheumatology Patients and Why do Published Prevalence Estimates Vary so Much?

How Common is Depression in Rheumatology Clinics?

RHEUMATOLOGY

Rheumatology 2013;52:2136–2148
doi:10.1093/rheumatology/ket169
Advance Access publication 3 September 2013

Meta-analysis

The prevalence of depression in rheumatoid arthritis: a systematic review and meta-analysis

Faith Matcham[1], Lauren Rayner[1], Sophia Steer[2] and Matthew Hotopf[1]

Abstract

Objective. There is substantial uncertainty regarding the prevalence of depression in RA. We conducted a systematic review aiming to describe the prevalence of depression in RA.

Methods. Web of Science, PsycINFO, CINAHL, Embase, Medline and PubMed were searched for cross-sectional studies reporting a prevalence estimate for depression in adult RA patients. Studies were reviewed in accordance with the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) guidelines and a meta-analysis was performed.

Results. A total of 72 studies, including 13 189 patients, were eligible for inclusion in the review. Forty-three methods of defining depression were reported. Meta-analyses revealed the prevalence of major depressive disorder to be 16.8% (95% CI 10%, 24%). According to the PHQ-9, the prevalence of depression was 38.8% (95% CI 34%, 43%), and prevalence levels according to the HADS with thresholds of 8 and 11 were 34.2% (95% CI 25%, 44%) and 14.8% (95% CI 12%, 18%), respectively. The main influence on depression prevalence was the mean age of the sample.

Conclusion. Depression is highly prevalent in RA and associated with poorer RA outcomes. This suggests that optimal care of RA patients may include the detection and management of depression.

Key words: depression, rheumatoid arthritis, prevalence, meta-analysis, systematic review.

How Common is Depression in Rheumatology Clinics?

Tool	Definition/threshold	No. of studies	No. of participants	Prevalence, % (95% CI)
Diagnostic criteria				
DSM	Major depression	4	480	16.8 (10, 24)
	Dysthymic disorder	3	420	18.7 (−2, 39)
	Unspecified depression	2	280	6.4 (−4, 17)
	Depressive disorder	1	200	1.5
	Adjustment disorder and depression	1	200	0.5
ICD-10	Unspecified depression	1	80	66.3
Screening questionnaires				
Beck Depression Inventory (BDI)	10	2	129	34.9 (27, 43)
	15	1	50	46.0
	16	1	60	63.3
	19	1	52	23.0
	30	1	52	2.0
BDI-SF[a]	8	1	75	22.0
BDI-pc[b]	4	1	228	7.0
Centre for Epidemiological Studies Depression Scale (CESD)	9	1	77	31.2
	10	1	426	29.8
	12	1	141	13.0
	15	2	301	36.2 (31, 42)
	16	14	3333	36.0 (32, 40)
	17	1	725	20.3
	19	2	142	37.9 (30, 46)
	23	1	125	16.0
	27	1	148	7.4
CESD-13[c]	9	1	92	26.6
	13	1	92	8.1
Geriatric Depression Scale (GDS)	5	1	461	2.0
	10	1	461	11.0
S-GDS[d]	7	1	726	14.0
GDS-5[e]	2	1	98	24.5
Hospital Anxiety and Depression Scale (HADS)	7	3	536	48.0 (9, 87)
	8	7	1193	34.2 (25, 44)
	9	3	583	32.1 (14, 50)
	10	4	344	14.9 (4, 26)
	11	12	2398	14.8 (12, 18)
	15	1	509	4.5
Inventory to Diagnose Depression (IDD)	DSM-III	1	74	27.0
	DSM-III-R	1	74	16.2
	DSM-IV	1	58	14.0
Patient Health Questionnaire (PHQ-9)	10	2	659	38.8 (34, 43)
Self-Rating Scale (SRS)	40	2	726	52.6 (52, 60)
	48	2	98	35.3 (31, 40)

- 40 Methods
- Prevalence from 0.5% to 63.3%

Addressing overestimation of the prevalence of depression based on self-report screening questionnaires

Brett D. Thombs PhD, Linda Kwakkenbos PhD, Alexander W. Levis BSc, Andrea Benedetti PhD

Cite as: *CMAJ* 2018 January 15;190:E44-9. doi: 10.1503/cmaj.170691

KEY POINTS

- The common practice of reporting the percentage of patients with scores above cut-off thresholds in screening questionnaires for depression as disorder prevalence substantially overestimates prevalence and misinforms users of epidemiological evidence.
- Exaggeration of the prevalence of depression is disproportionately high in low-prevalence populations and blurs distinctions between high- and low-prevalence populations.
- Researchers should use diagnostic interview methods that have been validated for estimating prevalence.

Addressing overestimation of the prevalence of depression based on self-report screening questionnaires

Brett D. Thombs PhD, Linda Kwakkenbos PhD, Alexander W. Levis BSc, Andrea Benedetti PhD

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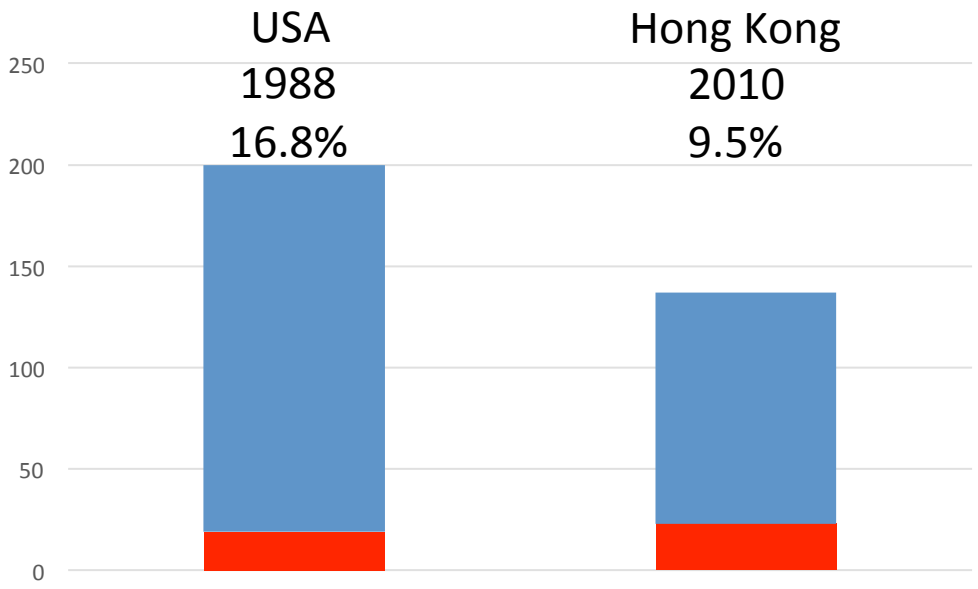
Table 1: Comparison of true prevalence and percentage of patients above a cut-off threshold for screening tests

True prevalence, %	Sensitivity	Specificity	Percentage of patients above cut-off	Percentage of patients with false-positive screens among those above cut-off	Percentage of patients with false-negative screens among those below cut-off	Percentage of patients above cut-off – true prevalence	Percentage of patients above cut-off/true prevalence
Basic scenario:* sensitivity and specificity were constant across levels of true prevalence							
0.0	78.0	87.0	13.0	100.0	0.0	13.0	–
5.0	78.0	87.0	16.3	76.0	1.3	11.3	3.3
10.0	78.0	87.0	19.5	60.0	2.7	9.5	2.0
15.0	78.0	87.0	22.8	48.6	4.3	7.8	1.5
20.0	78.0	87.0	26.0	40.0	5.9	6.0	1.3
25.0	78.0	87.0	29.3	33.3	7.8	4.3	1.2
30.0	78.0	87.0	32.5	28.0	9.8	2.5	1.1

How Common is Depression in Rheumatology Clinics?

Major Depression in Rheumatoid Arthritis
Matcham et al. (2013)



Random-effects Meta-Analysis
12.8% (N = 337)

How Common is Depression in Rheumatology Clinics?

Journal of Affective Disorders 131 (2011) 172–178

Contents lists available at ScienceDirect

Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Research report

Chronic conditions and major depression in community-dwelling older adults

Kirsten M. Fiest [a], Shawn R. Currie [b], Jeanne V.A. Williams [c], JianLi Wang [d,*]

[a] Department of Psychiatry, University of Calgary, Canada
[b] Departments of Psychiatry and Psychology, University of Calgary, Canada
[c] Department of Community Health Sciences, University of Calgary, Canada
[d] Departments of Psychiatry and Community Health Sciences, University of Calgary, Canada

Canadian Community Health Survey-Mental Health and Wellbeing (CCHS-1.2; 2002)

Prevalence of major depression (MD) overall and in older adults and seniors with self-reported long-term medical conditions (95% CI).

Chronic Medical Condition	Annual MD Prevalence (18+)	Annual MD Prevalence (50+)	Annual MD Prevalence (50–64)	Annual MD Prevalence (65+)
CFS	26.1 (19.8–32.4)	18.3 (11.1–25.4)	17.7 (9.6–25.8)	19.4 (6.8–32.0)
Fibromyalgia	17.4 (12.7–22.0)	14.4 (9.2–19.6)	16.0 (9.3–22.6)	10.2 (3.6–16.8)
Migraine	11.0 (9.6–12.5)	8.8 (6.7–11.0)	9.2 (6.7–11.6)	7.8 (3.7–11.9)
Bowel Disorders	10.1 (7.7–12.4)	7.1 (4.7–9.4)	8.8 (5.5–12.1)	5.0 (1.4–8.7)
Asthma	8.5 (7.1–9.8)	6.9 (4.9–8.9)	10.3 (7.2––13.4)	2.6 (0.7–4.6)
Emphysema/ COPD	9.0 (6.0–12.0)	6.7 (3.9–9.5)	9.3 (4.1–14.5)	4.9 (1.7–8.2)
Effects of Stroke	8.3 (4.7–12.0)	6.6 (2.7–10.6)	8.0 (1.5–14.5)	6.0 (1.3–10.8)
Back Problems	7.9 (7.1–8.7)	5.4 (4.4–6.4)	6.8 (5.3–8.2)	3.3 (2.2–4.4)
Heart Disease	5.5 (4.2–6.9)	4.9 (3.4–6.5)	7.6 (4.4–10.8)	3.5 (2.1–5.0)
Arthritis/ Rheumatism	6.3 (5.5–7.1)	4.5 (3.7–5.2)	6.9 (5.6–8.3)	2.4 (1.7–3.1)
High Blood Pressure	4.7 (3.9–5.4)	3.8 (3.0–4.6)	5.7 (4.2–7.1)	2.1 (1.4–2.8)

CFS = chronic fatigue syndrome; COPD = chronic obstructive pulmonary disease.

How Common is Depression in Rheumatology Clinics?

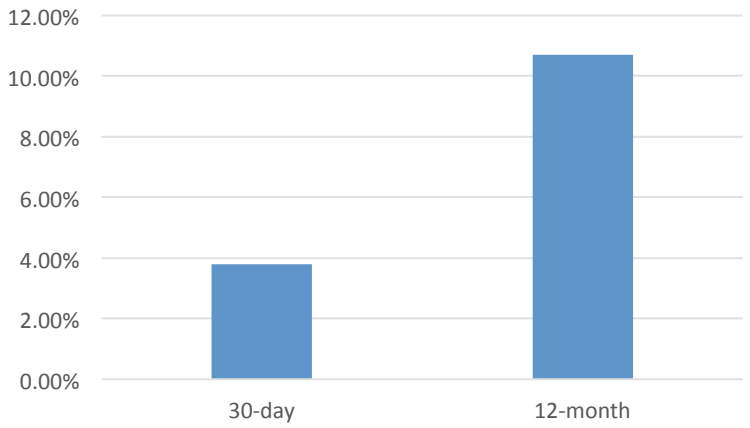
RHEUMATOLOGY

Rheumatology 2013;52:669–675
doi:10.1093/rheumatology/kes347
Advance Access publication 18 December 2012

Original article

Prevalence of current, 12-month and lifetime major depressive disorder among patients with systemic sclerosis

Lisa R. Jewett[1,2], Ilya Razykov[2,3], Marie Hudson[2,4], Murray Baron[2,4] and Brett D. Thombs[1,2,3,4,5,6] on behalf of the Canadian Scleroderma Research Group*



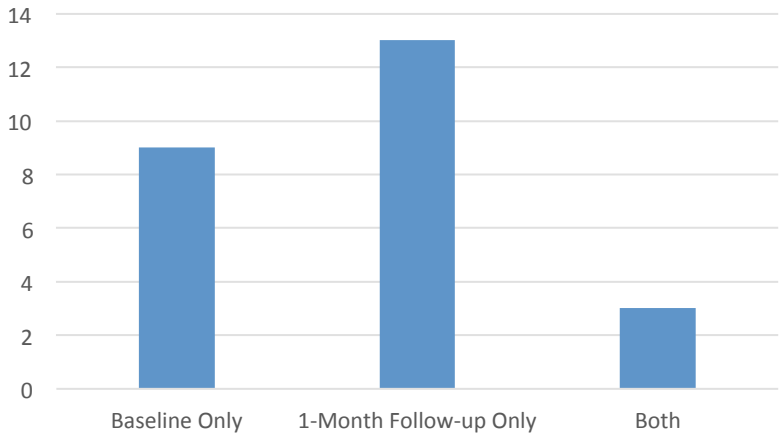
How Common is Depression in Rheumatology Clinics?

Arthritis Care & Research
Vol. 67, No. 3, March 2015, pp 411–416
DOI 10.1002/acr.22447

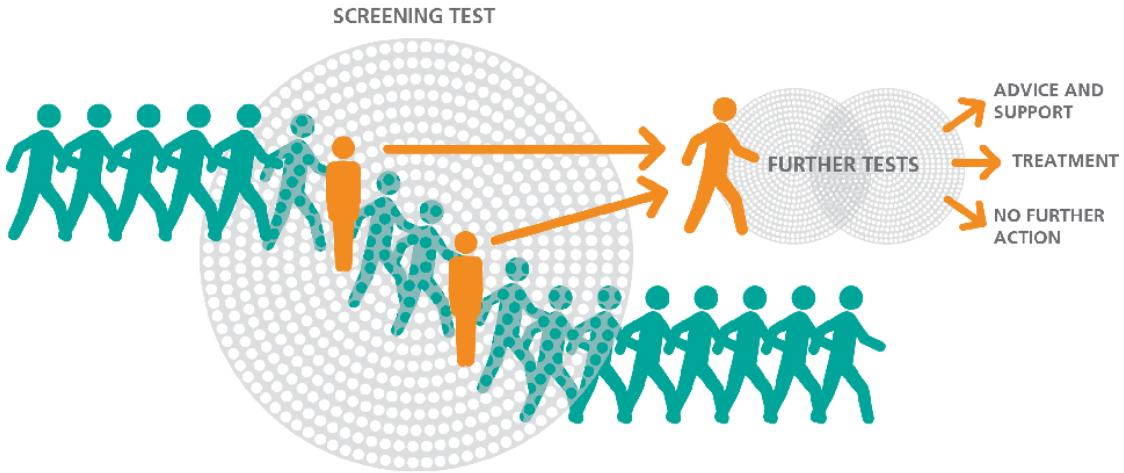
ORIGINAL ARTICLE

Major Depression Diagnoses Among Patients With Systemic Sclerosis: Baseline and One-Month Followup

BRETT D. THOMBS, LISA R. JEWETT, LINDA KWAKKENBOS, MARIE HUDSON, MURRAY BARON, AND THE CANADIAN SCLERODERMA RESEARCH GROUP



Should I screen patients for depression in my rheumatology clinic?



Should I Screen my Patients for Depression?

The Journal of Rheumatology **Volume 42, no. 10**

Evidence-based Recommendations for the Management of Comorbidities in Rheumatoid Arthritis, Psoriasis, and Psoriatic Arthritis: Expert Opinion of the Canadian Dermatology-Rheumatology Comorbidity Initiative

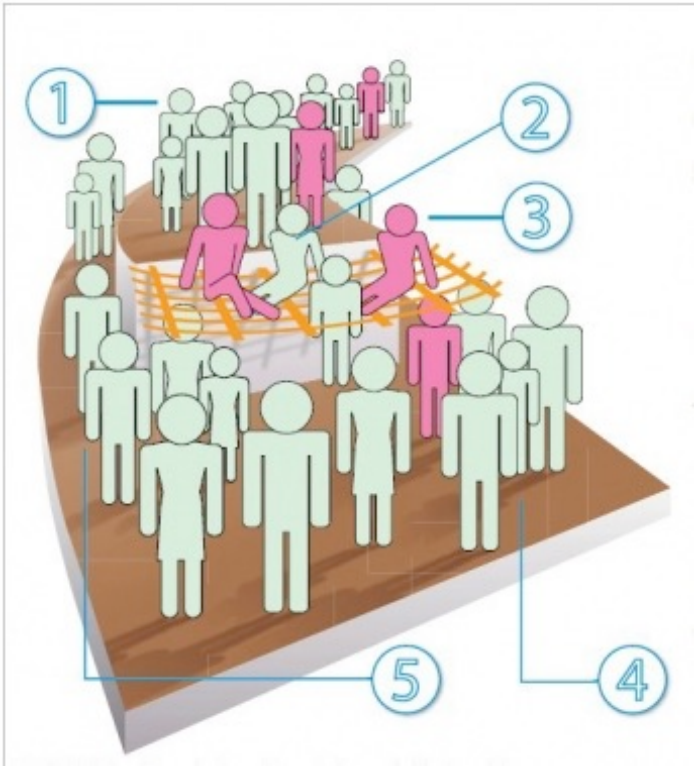
Camille Roubille, Vincent Richer, Tara Starnino, Collette McCourt, Alexandra McFarlane, Patrick Fleming, Stephanie Siu, John Kraft, Charles Lynde, Janet Pope, Wayne Gulliver, Stephanie Keeling, Jan Dutz, Louis Bessette, Robert Bissonnette and Boulos Haraoui

Healthcare providers should be aware of increased symptoms of depression in patients with RA, PsA, or PsO. Patients should be screened for these symptoms and managed appropriately.

Should I Screen my Patients for Depression?

- 2013 Guideline
- Lack of evidence:
  - No RCTs have shown benefit from depression screening
  - Concern about high rate of false positive screens and potential harm to patients without evidence of benefit
- Recommended that clinicians be alert for depression, but do not screen

What is Screening?



- Purpose to identify otherwise unrecognisable disease
- By sorting out apparently well persons who probably have a condition from those who probably do not
- Not diagnostic
- Positive tests require referral for diagnosis and, as appropriate, treatment
- A program – of which a test is one component

Illustration: This information was originally developed by the UK National Screening Committee/NHS Screening Programmes (www.screening.nhs.uk) and is used under the Open Government Licence v1.0

What is Depression Screening?

- Systematically testing all patients in a given group
- To identify previously unidentified, untreated depressed patients without obvious signs
- Using screening score to determine who is assessed
- Potentially beneficial
- Will definitely consume resources
- May harm some patients

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*

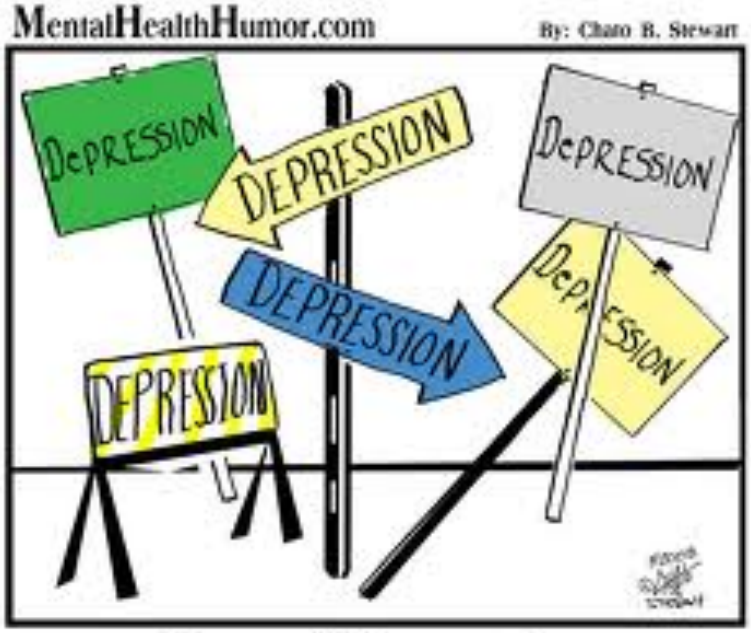
	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
add columns:		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) TOTAL:				

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

What Depression Screening Is Not

- A good routine clinical interview, querying for functional or health problems, and probing for depression, perhaps with a screening tool, when signs are present
- The use of depression questionnaires to inform mental health consultations, monitor treatment, or detect relapse
- The only way in which we can attend to or pay attention to depression or the only way in which patients can get treatment for depression



Signs of Depression

Should I Screen my Patients for Depression?

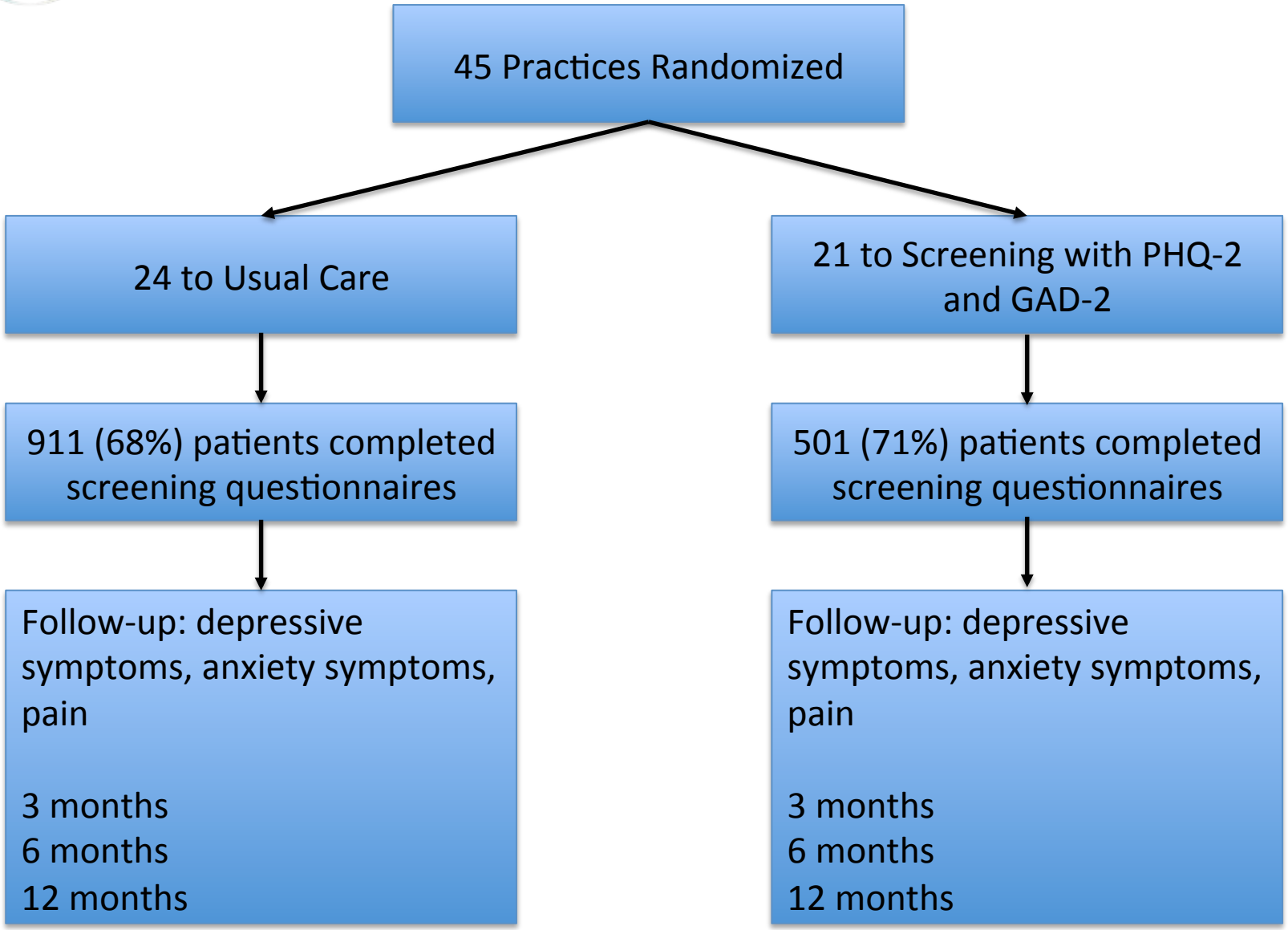
PLOS | MEDICINE

RESEARCH ARTICLE

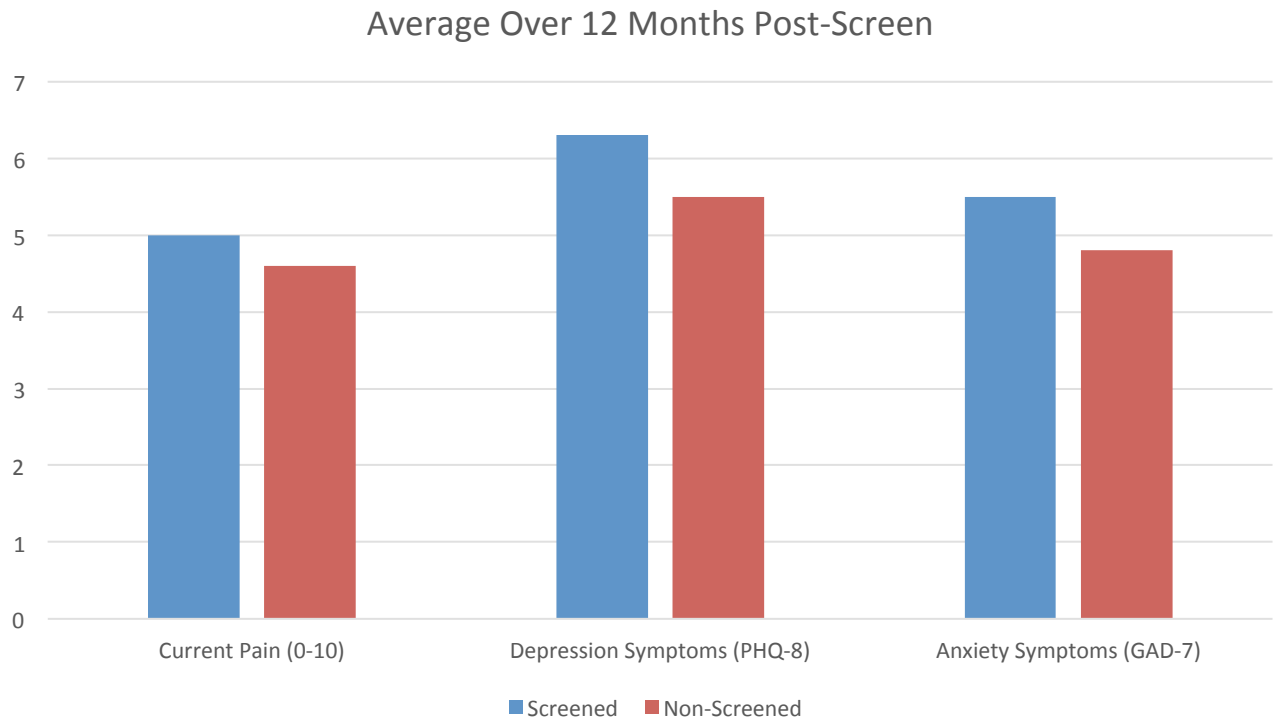
The effects of implementing a point-of-care electronic template to prompt routine anxiety and depression screening in patients consulting for osteoarthritis (the Primary Care Osteoarthritis Trial): A cluster randomised trial in primary care

Christian D. Mallen[1,2]*, Barbara I. Nicholl[3], Martyn Lewis[1], Bernadette Bartlam[1], Daniel Green[1], Sue Jowett[1], Jesse Kigozi[1], John Belcher[1], Kris Clarkson[1], Zoe Lingard[1], Christopher Pope[1], Carolyn A. Chew-Graham[1,2], Peter Croft[1], Elaine M. Hay[1,2], George Peat[1]

Should I Screen my Patients for Depression?



Should I Screen my Patients for Depression?



Should I Screen my Patients for Depression? USPSTF, UK NSC, CTFPHC Questionnaire-based Guidelines

Topic	Trial	N	Primary Health Outcomes	Secondary Health Outcomes
Adult Depression	Williams	969	1 Negative	----------
Adult Depression	Leung	462	1 Negative 1-2 Positive	13 Negative
Developmental and Language Delays	Guevara	2103	----------	----------
Developmental and Language Delays	de Koning / Van Agt	10355	7 Negative	2 Negative
Intimate Partner Violence	MacMillan	6743	6 Negative	15 Negative
Suicide Risk	Crawford	443	1 Negative	2 Negative

How effective are depression treatments for rheumatology patients and what are possible harms?

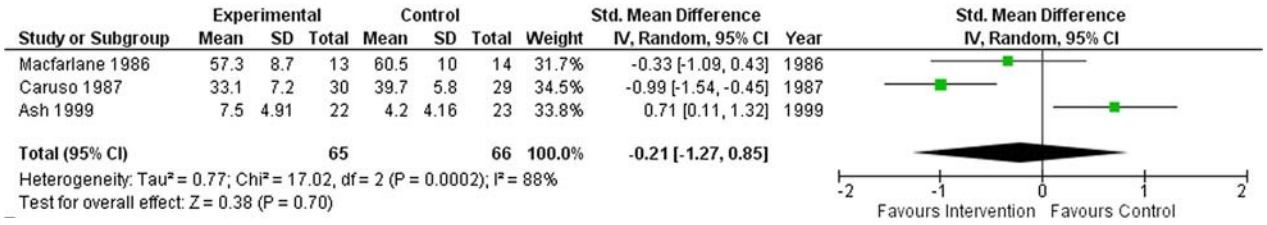
How Effective are Depression Treatments in Rheumatology?

OPEN

Systematic Review and Meta-analysis of Interventions for Depression and Anxiety in Persons With Rheumatoid Arthritis

Kirsten M. Fiest, PhD, Carol A. Hitchon, MD, MSc,* Charles N. Bernstein, MD,*
Christine A. Peschken, MD, MSc,* John R. Walker, PhD,† Lesley A. Graff, PhD,†
Ryan Zarychanski, MD, MSc,†‡ Ahmed Abou-Setta, MD, PhD,‡ Scott B. Patten, MD, PhD,§
Jitender Sareen, MD,|| James Bolton, MD,||
Ruth Ann Marrie, MD, PhD,*¶
and for the CIHR Team "Defining the Burden and Managing the Effects of Psychiatric Comorbidity in Chronic Immunoinflammatory Disease"*

JCR: Journal of Clinical Rheumatology • Volume 23, Number 8, December 2017



Study or Subgroup	Experimental Mean	SD	Total	Control Mean	SD	Total	Weight	Std. Mean Difference IV, Random, 95% CI	Year
Macfarlane 1986	57.3	8.7	13	60.5	10	14	31.7%	-0.33 [-1.09, 0.43]	1986
Caruso 1987	33.1	7.2	30	39.7	5.8	29	34.5%	-0.99 [-1.54, -0.45]	1987
Ash 1999	7.5	4.91	22	4.2	4.16	23	33.8%	0.71 [0.11, 1.32]	1999
Total (95% CI)			65			66	100.0%	**-0.21 [-1.27, 0.85]**	

Heterogeneity: Tau² = 0.77; Chi² = 17.02, df = 2 (P = 0.0002); I² = 88%
Test for overall effect: Z = 0.38 (P = 0.70)

How Effective are Depression Treatments in Rheumatology?

CLINICAL REVIEW

CLINICIAN'S CORNER

Treatment of Fibromyalgia Syndrome With Antidepressants

A Meta-analysis

Winfried Häuser, MD
Kathrin Bernardy, PhD
Nurcan Üçeyler, MD
Claudia Sommer, MD

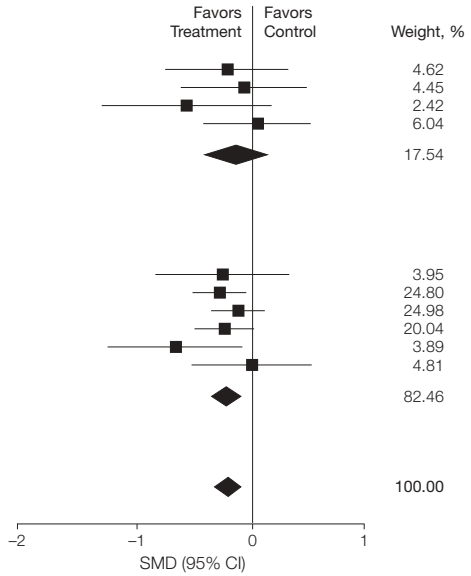
Context Fibromyalgia syndrome (FMS) is a chronic pain disorder associated with multiple debilitating symptoms and high disease-related costs. Effective treatment options are needed.

Objectives To determine the efficacy of antidepressants in the treatment of FMS by performing a meta-analysis of randomized controlled clinical trials.

How Effective are Depression Treatments in Rheumatology?

Figure 5. Effectiveness of Antidepressants in Fibromyalgia for the Outcome Depressed Mood

Study	Treatment: Individuals, No.	Treatment: Effect Size, Mean (SD)	Control: Individuals, No.	Control: Effect Size, Mean (SD)	SMD (95% CI)	Weight, %
Mean						
Goldenberg et al,[55] 1996	22	7.80 (4.70)	19	9.30 (6.50)	–0.26 (–0.88 to 0.35)	4.62
Goldenberg et al,[55] 1996	20	8.70 (6.00)	19	9.30 (6.50)	–0.09 (–0.72 to 0.53)	4.45
Wolfe et al,[61] 1994	15	8.30 (5.86)	9	13.90 (10.82)	–0.67 (–1.53 to 0.18)	2.42
Yavuzer et al,[62] 1998	28	5.54 (5.56)	25	5.36 (2.68)	0.04 (–0.50 to 0.58)	6.04
Subtotal	85		72		–0.17 (–0.49 to 0.14)	17.54
Test for heterogeneity: $\chi^2_3 = 2.07$; $P = .56$; $I^2 = 0\%$						
Test for overall effect: $z = 1.07$; $P = .29$						
Mean change						
Anderberg et al,[47] 2000	17	–1.13 (2.87)	18	–0.33 (2.14)	–0.31 (–0.98 to 0.36)	3.95
Arnold et al,[50] 2005	111	–3.79 (4.34)	109	–2.24 (4.70)	–0.34 (–0.61 to –0.08)	24.80
Arnold et al,[50] 2005	110	–2.97 (4.72)	109	–2.24 (4.70)	–0.15 (–0.42 to 0.11)	24.98
Arnold et al,[49] 2004	88	–3.32 (7.97)	89	–1.02 (7.83)	–0.29 (–0.59 to 0.01)	20.04
Arnold et al,[48] 2002	19	–1.50 (2.80)	18	0.50 (2.10)	–0.79 (–1.46 to –0.12)	3.89
Norregaard et al,[58] 1995	21	–1.00 (6.10)	21	–0.90 (7.90)	–0.01 (–0.62 to 0.59)	4.81
Subtotal	366		364		–0.27 (–0.42 to –0.13)	82.46
Test for heterogeneity: $\chi^2_5 = 4.00$; $P = .55$; $I^2 = 0\%$						
Test for overall effect: $z = 3.66$; $P < .001$						
Overall	451		436		**–0.26 (–0.39 to –0.12)**	100.00
Test for heterogeneity: $\chi^2_9 = 6.39$; $P = .70$; $I^2 = 0\%$						
Test for overall effect: $z = 3.77$; $P < .001$						



CI indicates confidence interval; SMD, standardized mean difference.

How Effective are Depression Treatments in Rheumatology?

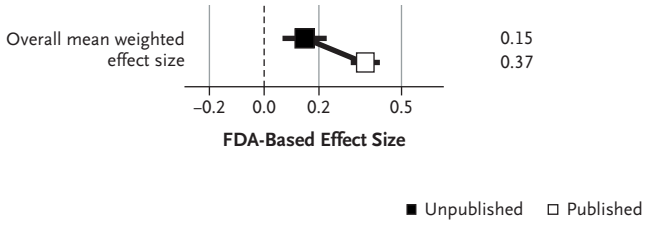
The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

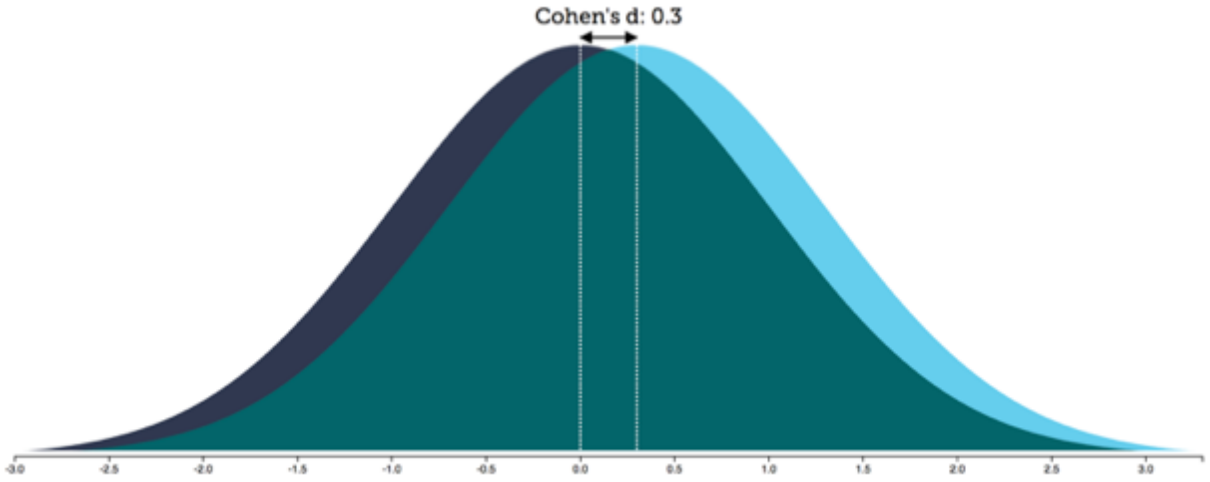
Selective Publication of Antidepressant Trials and Its Influence on Apparent Efficacy

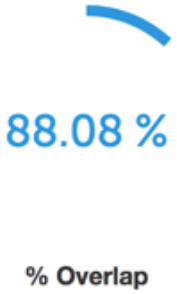
Erick H. Turner, M.D., Annette M. Matthews, M.D., Eftihia Linardatos, B.S., Robert A. Tell, L.C.S.W., and Robert Rosenthal, Ph.D.

ABSTRACT



How Effective are Depression Treatments in Rheumatology?





NNT = 8 to 10

How Effective are Depression Treatments in Rheumatology?

CLINICAL GUIDELINES | Annals of Internal Medicine

Comparative Benefits and Harms of Second-Generation Antidepressants: Background Paper for the American College of Physicians

Gerald Gartlehner, MD, MPH; Bradley N. Gaynes, MD, MPH; Richard A. Hansen, PhD, RPh; Patricia Thieda, MA; Angela DeVeaugh-Geiss, MS; Erin E. Krebs, MD, MPH; Charity G. Moore, PhD, MSPH; Laura Morgan, MA; and Kathleen N. Lohr, PhD

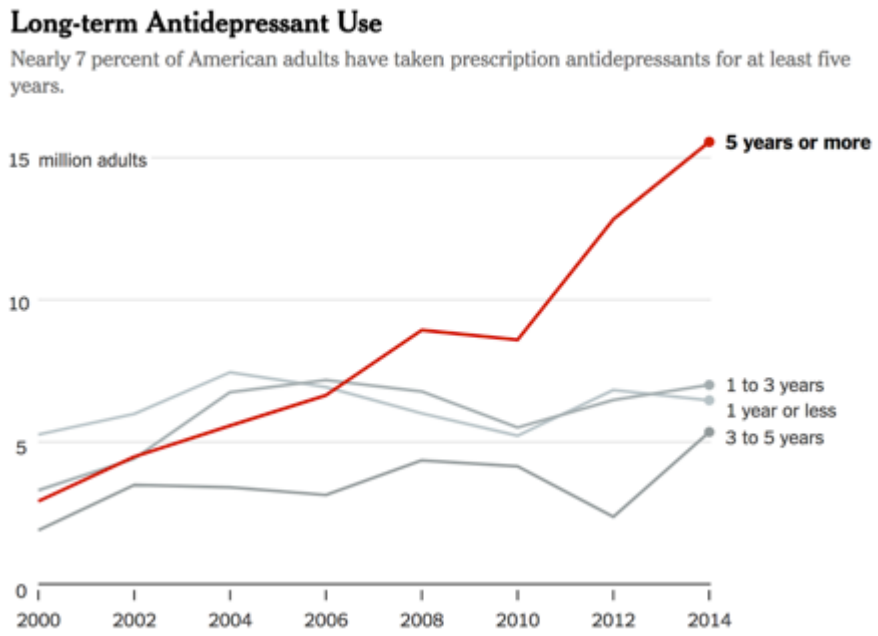
Table 3. **Summary of Findings on Adverse Events: Comparative Risk for Harms**

Outcome of Interest and Disorder	Strength of Evidence*	Findings
General tolerability		
Adverse events profiles	High	Adverse events profiles are similar among second-generation antidepressants. Incidence rates of specific adverse events differ.
Nausea and vomiting	High	Meta-analysis of 15 fair-quality studies indicates that venlafaxine has a higher rate of nausea and vomiting than selective serotonin reuptake inhibitors as a class (33% vs. 22%).
Diarrhea	Moderate	Evidence from 15 fair-quality studies indicates that sertraline has a higher incidence of diarrhea than bupropion, citalopram, fluoxetine, fluvoxamine, mirtazapine, nefazodone, paroxetine, or venlafaxine (11% vs. 8%).
Weight change	Moderate	Seven fair-quality trials indicate that mirtazapine leads to higher weight gain than citalopram, fluoxetine, paroxetine, or sertraline (0.8 to 3.0 kg after 6 to 8 weeks).
Somnolence	Moderate	Six fair-quality studies provide evidence that trazodone has a higher rate of somnolence than bupropion, fluoxetine, mirtazapine, paroxetine, and venlafaxine (42% vs. 25%).
Discontinuation syndrome	Moderate	A good-quality systematic review provides evidence that paroxetine and venlafaxine have the highest rates of the discontinuation syndrome; fluoxetine has the lowest (data not reported).
Discontinuation rates	High	Meta-analyses of efficacy trials indicate that mean overall discontinuation rates are similar (23%). Venlafaxine has a higher rate of discontinuations from adverse events and a lower rate of discontinuations from lack of efficacy than selective serotonin reuptake inhibitors as a class.
Severe adverse events		
Sexual dysfunction	Moderate	Evidence from 5 fair-quality trials provide evidence that bupropion causes significantly less sexual dysfunction than fluoxetine, paroxetine, or sertraline. Among selective serotonin reuptake inhibitors, paroxetine has the highest rates of sexual dysfunction. Overall, more than 50% report sexual dysfunction.
Suicidality	Low	Evidence from existing studies is insufficient to draw conclusions about the comparative risk for suicidality.
Seizures	Low	Evidence from existing studies is insufficient to draw conclusions about the comparative risk for seizures. Weak evidence indicates that bupropion may increase risk for seizures.
Cardiovascular events	Low	Evidence from existing studies is insufficient to draw conclusions about the comparative risk for cardiovascular adverse events. Weak evidence indicates that venlafaxine might increase risk for cardiovascular adverse events.
Hyponatremia	Low	Evidence is insufficient to draw conclusions about the comparative risk for hyponatremia.
Hepatotoxicity	Low	Evidence from existing studies is insufficient to draw conclusions about the comparative risk for hepatotoxicity. Weak evidence indicates that nefazodone might increase risk for hepatotoxicity.
Serotonin syndrome	Low	Evidence from existing studies is insufficient to draw conclusions about the comparative risk for the serotonin syndrome. Observational studies indicate no differences in risk among second-generation antidepressants.

How Effective are Depression Treatments in Rheumatology?

The New York Times

Many People Taking Antidepressants Discover They Cannot Quit



How Effective are Depression Treatments in Rheumatology?

Special Article

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Withdrawal Symptoms after Selective Serotonin Reuptake Inhibitor Discontinuation: A Systematic Review

Giovanni A. Fava[a, b] Alessia Gatti[a] Carlotta Belaise[a] Jenny Guidi[a]
Emanuela Offidani[c]

Table 1. Signs and symptoms of withdrawal from SSRI

System involved	Symptoms
General	Flu-like symptoms, fatigue, weakness, tiredness, headache, tachycardia, dyspnea
Balance	Gait instability, ataxia, dizziness, light-headedness, vertigo
Sensory	Paresthesias, electric-shock sensations, myalgias, neuralgias, tinnitus, altered taste, pruritus
Visual	Visual changes, blurred vision
Neuromotor	Tremor, myoclonus, ataxia, muscle rigidity, jerkiness, muscle aches, facial numbness
Vasomotor	Sweating, flushing, chills
Sleep	Insomnia, vivid dreams, nightmares, hypersomnia, lethargy
Gastrointestinal	Nausea, vomiting, diarrhea, anorexia, abdominal pain
Affective	Anxiety, agitation, tension, panic, depression, intensification of suicidal ideation, irritability, impulsiveness, aggression, anger, bouts of crying, mood swings, derealization and depersonalization
Psychotic	Visual and auditory hallucinations
Cognitive	Confusion, decreased concentration, amnesia
Sexual	Genital hypersensitivity, premature ejaculation

How Effective are Depression Treatments in Rheumatology?

Optimized Antidepressant Therapy and Pain Self-management in Primary Care Patients With Depression and Musculoskeletal Pain

A Randomized Controlled Trial

Kurt Kroenke, MD
Matthew J. Bair, MD, MS
Teresa M. Damush, PhD
Jingwei Wu, MS
Shawn Hoke, BA
Jason Sutherland, PhD
Wanzhu Tu, PhD

Context Pain and depression are the most common physical and psychological symptoms in primary care, respectively. Moreover, they co-occur 30% to 50% of the time and have adverse effects on quality of life, disability, and health care costs.

Objective To determine if a combined pharmacological and behavioral intervention improves both depression and pain in primary care patients with musculoskeletal pain and comorbid depression.

Results At 12 months, 46 of the 123 intervention patients (37.4%) had a 50% or greater reduction in depression severity from baseline compared with 21 of 127 usual care patients (16.5%) (relative risk [RR], 2.3; 95% confidence interval [CI], 1.5-3.2), corresponding to a much lower number of patients with major depression (50 [40.7%] vs 87 [68.5%], respectively; RR, 0.6 [95% CI, 0.4-0.8]). Also, a clinically significant (≥30%) reduction in pain was much more likely in intervention patients (51 intervention patients [41.5%] vs 22 usual care patients [17.3%]; RR, 2.4 [95% CI, 1.6-3.2]), as was global improvement in pain (58 [47.2%] vs 16 [12.6%], respectively; RR, 3.7 [95% CI, 2.3-6.1]). More intervention patients also experienced benefits in terms of the primary outcome, which was a combined improvement in both depression and pain (32 intervention patients [26.0%] vs 10 usual care patients [7.9%]; RR, 3.3 [95% CI, 1.8-5.4]).

Conclusion Optimized antidepressant therapy followed by a pain self-management program resulted in substantial improvement in depression as well as moderate reductions in pain severity and disability.

Trial Registration clinicaltrials.gov Identifier: NCT00118430

JAMA. 2009;301(20):2099-2110 www.jama.com

How Effective are Depression Treatments in Rheumatology?

Effect of Improving Depression Care on Pain and Functional Outcomes Among Older Adults With Arthritis

A Randomized Controlled Trial

Elizabeth H. B. Lin, MD, MPH
Wayne Katon, MD
Michael Von Korff, ScD
Lingqi Tang, PhD
John W. Williams, Jr, MD, MHSc
Kurt Kroenke, MD
Enid Hunkeler, MA
Linda Harpole, MD
Mark Hegel, PhD
Patricia Arean, PhD
Marc Hoffing, MD
Richard Della Penna, MD
Chris Langston, PhD
Jürgen Unützer, MD, MPH
for the IMPACT Investigators

Context Depression and arthritis are disabling and common health problems in late life. Depression is also a risk factor for poor health outcomes among arthritis patients.

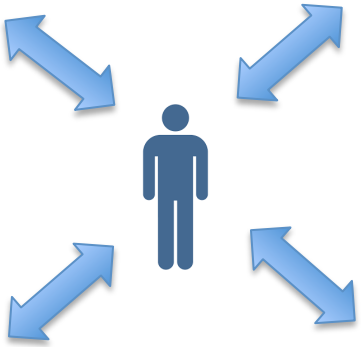
Objective To determine whether enhancing care for depression improves pain and functional outcomes in older adults with depression and arthritis.

Results In addition to reduction in depressive symptoms, the intervention group compared with the usual care group at 12 months had lower mean (SE) scores for pain intensity (5.62 [0.16] vs 6.15 [0.16]; between-group difference, –0.53; 95% confidence interval [CI], –0.92 to –0.14; $P=.009$), interference with daily activities due to arthritis (4.40 [0.18] vs 4.99 [0.17]; between-group difference, –0.59; 95% CI, –1.00 to –0.19; $P=.004$), and interference with daily activities due to pain (2.92 [0.07] vs 3.17 [0.07]; between-group difference, –0.26; 95% CI, –0.41 to –0.10; $P=.002$). Overall health and quality of life were also enhanced among intervention patients relative to control patients at 12 months.

Conclusions In a large and diverse population of older adults with arthritis (mostly osteoarthritis) and comorbid depression, benefits of improved depression care extended beyond reduced depressive symptoms and included decreased pain as well as improved functional status and quality of life.

JAMA. 2003;290:2428-2434 www.jama.com

Disease Management and Support



Summary

- Depression is a substantial added burden for many rheumatology patients.
- Depression based on valid diagnoses may be present in up to 10% of patients in rheumatology clinics, but likely higher in fibromyalgia (15-20%).
- Screening would not benefit patients but would use resources and harm some patients. Be aware and discuss when indicated.

Summary

- Treatment is most effective when done in context of collaborative care.
- Partnering with family doctors and a cautious approach to treatment are approaches most consistent with evidence.
- Many patients with low mood and other symptoms would benefit from approaches that include support in disease management and social support.

Thank You!