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Prevalence and treatment of depression in a hospital department of internal medicine

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Abstract

Background: Depressive disorders are overrepresented among patients admitted to nonpsychiatric units of general hospitals, but the majority of depressed patients are not identified in this setting. Effective and well-tolerated treatments and reliable diagnostic criteria, together with new assessment tools (self-administered or not), have been developed with encouraging results. Nevertheless, few studies have utilized standardized instruments and extensive clinical interviews by well-trained psychiatrists to assess depression. New research should test these tools in a French-speaking environment.

Methods: The investigation covered 292 patients aged 18–65 who were admitted over a period of 6 months to the internal medicine units of Geneva University Hospitals. Each patient filled in a self-administered questionnaire for depression [Patient Health Questionnaire (PHQ-9)]; 212 patients were also evaluated by a psychiatrist using *DSM-IV* diagnostic assessment and the Hamilton Depression Rating Scale during the first week of their hospital stay; both assessments were single-blinded.

Results: Psychiatric clinical interviews identified a high proportion (26.9%) of depressive disorders (37% among women) for all diagnoses; 11.3% (17.3% among women) of the patients met the *DSM-IV* criteria for major depression. The PHQ-9 identified depressive disorders among 34.9% of patients (42% among women) and identified a major depressive syndrome among 18.4% of patients (29.6% among women). Physicians in the internal medicine unit identified only about half the depressive patients; at the time of psychiatric examination, fewer than one in four patients was receiving antidepressant therapy.

Conclusions: Our findings confirm the results of previous investigations, which showed that the failure to detect and treat depression is a major health problem among patients admitted to nonpsychiatric units of a general hospital.

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1. Introduction

Depression is the main reason for contacting consultation–liaison psychiatric services [1]. Nevertheless, the majority of patients admitted to general hospitals with symptoms of depression receive no specific treatment [2,3]. Physicians in the nonpsychiatric units of university hospitals overlook about half the cases of depression (Table 3); the proportion of missed cases, inappropriate diagnoses and absence of treatment is higher in recent studies [4-6]. When all is said and done, only about one case of depression in four receives appropriate therapy at the general hospital [5]. This is an important issue since patients with medical problems have a high prevalence of affective disorders [7] and a high proportion develop clinically significant depressive disorders during nonpsychiatric hospitalizations [3–8], especially in comparison with the proportion among the general population and among those followed up in primary care [2]. Furthermore, a diagnosis of depression during a nonpsychiatric hospital stay is linked not only to poorer social performance and quality of life [5,9,10] but also to a less favorable clinical outcome for the basic medical

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disorder (whatever the latter's severity) [11,12], to a lengthened hospital stay [13–15] and to increased hospitalization costs [3]. A significant proportion of patients presenting with a major depressive disorder during the earlier part of their stay at a general hospital show persistent and severe depression on discharge and during follow-up over several months [16,17]. Current and effective therapies for depression are well tolerated and are, by and large, compatible with nonpsychiatric treatment. A review of several investigations [18] highlights the need to develop more effective evaluation methods and decision processes [19] for those patients hospitalized with depression in general hospitals [3].

Numerous studies based on the above observations have attempted to develop psychometric instruments for the detection of major depression — and of depressive disorders in general — among these subjects [20]. Results have not been entirely satisfactory: important differences persist according to the type of instrument, the way these instruments are applied and the training level of the evaluators. Standard interviews are reliable and efficient but require considerable time and are not readily accessible to standard practice in a nonpsychiatric environment. Conversely, self-administered questionnaires are easier to handle but tend to result in overdiagnosis for depression when compared with structured interviews and do not discriminate well when it comes to the clinical importance of the disorder [21]. In addition, self-administered questionnaires are responsive to different linguistic or cultural contexts.

Depression diagnosis should be therefore performed by well-trained psychiatrists using standard interviews as well as accomplishing a full clinical examination in order to control two important factors: the level of training and the gathering of all necessary information to achieve a complete diagnosis. In view of the above, the general purpose of the present investigation is to assess the prevalence and severity of depression among French-speaking patients admitted to internal medicine units, with the use of various diagnostic tools, including a full clinical examination by a psychiatrist — in addition to the gamut of *DSM-IV* criteria for mood disorders, the Hamilton Depression Rating Scale (HDRS) and the self-administered French version of Patient Health Questionnaire (PHQ-9) [22,23]. There is extensive prior work in the area of detection of depression of inpatients, but few investigations use diagnoses provided by well-trained psychiatrists as the gold standard. Furthermore, as far as we know, there are no other prevalence studies investigating French-speaking inpatients in Switzerland that are grounded on *DSM-IV* criteria established by well-trained psychiatrists as the gold standard. At the same time, this study is the first test of the French translation of the PHQ-9 [24]. Results about sensitivity and specificity of the French language version of the PHQ-9 compared with the gold standard of the diagnosis from psychiatric interview are reported elsewhere [25].

2. Methods

2.1. General framework and patient selection

The study was undertaken among patients aged 18 to 65 who were admitted to internal medicine units at the University Hospitals of Geneva (Hôpitaux Universitaires de Genève), a large community hospital (with 2200 beds and 47,000 admissions a year and where all medical specialties are available) that is affiliated with the University of Geneva Medical School. The French version was compiled, according to the state of the art, through several steps of translation and blind back-translation by professional translators who were highly familiar with PHQ-9. The protocol for this investigation was approved by the Ethics Committee of the Department of Medicine at the Hôpitaux Universitaires de Genève. The patients gave their informed consent to participation in the investigation and were fluent enough in French to allow for valid assessment. Exclusion criteria were the following: a diagnosis of mental retardation; the presence of a confusional state, of dementia or of any other mental or physical disorder affecting the patient's judgment; or preventing the patient from taking part in assessment. Between November 3, 2003, and March 24, 2004, 1053 consecutive patients were admitted to internal medicine units. Of these 1053 patients, 735 (70%) did not meet the inclusion criteria, mostly because of age (Table 1). Of the remaining 318 eligible patients, 25 could not take part — 24 left during the first 24 h and 1 was not seen within the prescribed time frame. The remaining 292 patients (91.8% of those eligible) were included in the investigation and examined within 1 week of their admission by a professional psychologist who also distributed, supervised and collected the PHQ-9 forms as appropriate.

2.2. Data collection

Admission and PHQ-9 testing were separated by 0 to 4 days (mean=1.05, median=1, S.D. =0.83). Of the

Table 1
Patient selection

	n	%	
Selected	1053	100.00	
Excluded	735		
	600	81.60	Age
	27	3.70	Refusal
	43	5.90	Language problems
	25	3.40	Left on the same day
	24	3.30	Somatic problems
	3	0.40	Dementia
	2	0.30	Mental retardation
	11	1.50	Confusional state and psychiatric emergency
Included	318	100.00	
	25	7.80	Left or died within 24 h
	1	0.04	Not seen within time limits
Tested	292	91.80	PHQ-9 only
	212	72.60	PHQ-9 and psychiatric assessment (*DSM-IV* diagnosis and HDRS)

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