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Research report

ICD-10 or DSM-IV? Anhedonia, fatigue and depressed mood as screening symptoms for diagnosing a current depressive episode in physically ill patients in general hospital

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ABSTRACT

Objective: To explore the usefulness of "anhedonia", "fatigue" and "depressed mood" as screening symptoms for predicting a depressive episode in physically ill patients.
Method: 290 patients filled in a modified version of the Patient Questionnaire and were subsequently assessed by psychiatrists with the Composite International Diagnostic Interview (CIDI; ICD-10 version).
Results: 63 patients suffered from a current depressive episode according to the CIDI. If at least two of the three symptoms were used for screening positively (ICD-10 algorithm), the sensitivity was 93.2% and the specificity 72.7%, while the simpler algorithm of DSM-IV – requiring depressed mood or anhedonia to be present – yielded a slightly higher sensitivity (95.2%) and a slightly lower specificity (66.5%). One in five patients with a depressive episode did not report "depressed mood".
Limitation: It remains unclear how relevant the three core symptoms of depression are for the diagnosis of an ICD-10 depression in people who are not physically ill.
Conclusion: The fact that both diagnostic algorithms yielded comparable results suggests that the more parsimonious DSM-IV algorithm is preferable and "fatigue" could be left out as a screening symptom. Since "depressed mood" was absent in a substantial proportion of patients, special attention has to be paid to "anhedonia". Medical students and non-psychiatric clinicians should be especially trained to ask for anhedonia, so that cases of depression will not be overlooked.
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1. Introduction

Depression is a major public mental health problem and one of the leading causes of disease burden and disability (Prince et al., 2007; Günther et al., 2007). A large segment of this burden is due to physically ill patients who suffer from comorbid depression (Spitzer et al, 1994; Sharma et al., 2002; Rentsch et al., 2007; Roca et al., 2009), with an up to five times higher prevalence rate than that found in the general population (Jacobi et al., 2004; Kessler et al., 2005; Ohayon, 2007). Such comorbid depression in physically ill patients contributes to severe disability (Scott et al., 2009), increased healthcare utilisation (Koopmans and Lamers, 2006), prolonged hospital stay (Hosaka et al., 1999), increased risk for substance use disorders (De Graaf et al., 2003) and negatively affects patients' ability to cooperate in the treatment of their physical disorder (Katon et al., 2008) and to manage their activities of daily living (Lyness et al., 1993).

However, depression is often not recognised in non-psychiatric clinical settings (Wancata et al., 2000; Balestrieri et al., 2002; Qin et al., 2008). Reasons for this failure include, in addition to the time pressure in clinical settings, the fear of stigma (Railton et al.,

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2000), and, probably the most important reason, the lack of adequate training of non-psychiatric doctors to recognise psychiatric disorders (Hodges et al., 2001). As one solution for the latter problem screening procedures have been proposed, and recently the trend towards very short screening procedures has become prominent (Whooley et al., 1997; Williams et al., 1999; Arroll et al., 2003; Kroenke et al., 2003; Löwe et al., 2005). Several studies on short screening procedures target the diagnosis of depression according to DSM-III-R or DSM-IV using two screening symptoms, "depressed mood" and "little interest or pleasure" (Whooley et al., 1997; Arroll et al., 2003; Kroenke et al., 2003; Löwe et al., 2005). These symptoms represent core symptoms of depression according to current diagnostic algorithms. According to DSM-IV (American Psychiatric Association, 1994) one of two core symptoms "depressed mood" or "loss of interest or pleasure" and according to ICD-10 (World Health Organization, 1992) two of three core symptoms "depressed mood", "loss of interest or pleasure" and "decreased energy or increased fatiguability" have to be present during a period of at least two weeks to diagnose a depressive episode. However, studies addressing the diagnosis of depression according to ICD-10, the official system for the diagnosis of disorders in clinical practice, are still lacking.

One aspect specific to the screening for depression in physically ill patients, is the fact that the diagnosis of both an ICD-10 and a DSM-IV depressive episode is possible also in the *absence of depressed mood*, if one or two other symptoms are present — "loss of interest or pleasure" in DSM-IV, and "loss of interest or pleasure" combined with "decreased energy or increased fatiguability" in ICD-10. Already, prior to the era of operational diagnostic criteria, attention had been drawn both by European and American psychiatrists to the notion of "depression without depression" (Kielholz, 1974; Klein, 1974). However, non-psychiatric clinicians may be more familiar with the overtly expressed symptom of depressed mood and may miss other hints for a possible comorbid depressive episode.

The purpose of the present study is twofold: first, to explore whether the well proven two question screening procedure (DSM-IV algorithm) would apply also for an ICD-10 diagnosis of a current depressive episode and whether the inclusion of the third core symptom of depression "decreased energy or increased fatiguability" (ICD-10 algorithm) can make a difference; secondly, to analyse the situation of the *absence* of "depressed mood" in the *presence* of "loss of interest or pleasure" alone (DSM-IV) or combined with "decreased energy or increased fatiguability" (ICD-10) in an attempt to answer the question of how many cases of depression are missed if depressed mood is required for screening positively for depression.

2. Method

2.1. Recruitment and participants

The study population consisted of patients of non-psychiatric departments of the Vienna General Hospital, the largest general hospital in the city of Vienna, with more than 2000 beds and numerous large out-patient departments. In- and outpatients aged 18 and older were included. Exclusion criteria were major cognitive impairment (expression of less than 13 names of animals in one minute on the Verbal Fluency Examination; Monsch et al., 1992), psychosis, problems with the German language, and severe physical illness or intensive care conditions.

Patients were recruited consecutively by physicians of non-psychiatric departments. A widespread effort to include all departments was attempted. After detailed explanation of the study, patients were asked to give informed consent for their participation and filled in a self-rated screening questionnaire. Within one week patients were interviewed face to face by experienced study psychiatrists (IS, PB, MF, AT, MK) using the ICD-10 version of the CIDI (Composite International Diagnostic Interview) (Wittchen and Pfister, 1997). Study psychiatrists had no information about the results of the screening.

The ethics committee of the Medical University of Vienna had granted permission to carry out the study.

2.2. Assessment instruments

2.2.1. PQm (Patient Questionnaire modified)

The PQ (Patient Questionnaire) was developed by Spitzer and colleagues (Spitzer et al., 1994) as the self-rated screening part of the PRIME-MD, a short interview for general practitioners for the identification of the most common DSM-IV mental disorders in primary care. Katschnig & Gföllner have produced a shortened and ICD-10 compatible version of the PRIME-MD (called TRIPS — Training for Interactive Psychiatric Screening for five depressive, five anxiety and two alcohol disorders) and have also adapted the PQ for this purpose (Katschnig and Gföllner, 1999; Spiegel et al. 2007). This adapted version of the PQ, the PQm (Patient Questionnaire modified) was used in the present study. It consists of 30 yes/no items on physical and psychological complaints and symptoms present during the previous month. Among the five items covering depression, complaints relating to the three ICD-10 "core symptoms" of depression are included in the present analysis ("feeling down, depressed or hopeless", "little interest or pleasure doing things", "feeling tired or having low energy").

2.2.2. CIDI (Composite International Diagnostic Interview)

The CIDI is a standardised interview for the assessment and diagnosis of psychiatric syndromes and disorders of patients in in- and outpatient care. We used the German ICD-10 version of the CIDI, the M-CIDI (Wittchen and Pfister, 1997). Each diagnostic section of the CIDI constitutes a separate entity, which can be used on its own to diagnose such diverse conditions such as depressive disorders, anxiety disorders, alcohol disorders et al. In the present analysis data collected with the section for mood disorders has been included.

2.3. Statistical analyses

SPSS version 15.0 was used for statistical analyses. Descriptive analyses were conducted and sensitivities, specificities, positive predictive values, negative predictive values, Area under Receiver Operating Characteristics Curves (AUCs; quantitative method for combining sensitivity and specificity into a single metric) and overall misclassification rates were calculated between the core symptoms of depression as elicited by the PQm and an ICD-10 "Current depressive episode" as identified by the CIDI. An ICD-10 current depressive episode includes "depressive episode (F32; i.e. a first depressive episode)", "recurrent depressive disorder (F33)" and "bipolar

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