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Depression and physical comorbidity in primary care

Enric Aragonès[a,*], Josep L. Piñol[b], Antonio Labad[c]

[a]Constantí Primary Care Centre, Catalan Health Institute, Spain
[b]Reus-Altebrat Primary Health Care Service, Catalan Health Institute, Spain
[c]Unit of Psychiatry, Rovira i Virgili University, Reus, Spain

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Abstract

Objective: To analyse how clinical characteristics in depressed patients, as well as the management of their depression, are related to the presence of significant physical comorbidity. **Methods:** This is a two-phase cross-sectional study that took place in 10 primary care centres in Tarragona (Spain). A total of 906 consecutive patients were screened for depression with a self-rating questionnaire and 306 were subject to a structured interview that contained the diagnoses of major depression and dysthymia (*DSM-IV*), and the severity of the physical comorbidity (Duke Severity of Illness Scale: DUSOI). The association of several clinical variables with the presence of physical comorbidity was evaluated. **Results:** The comorbidity was of moderate to extreme severity (DUSOI >50) in 31.7% of cases. The patients with comorbidity visited the physician more often. There were no differences in the consumption of antidepressants, reason for the consultation (psychological/somatic), or the probability of being detected as depressed. Neither were there any differences in the severity or disability between both groups. **Conclusion:** Physical comorbidity is frequent in primary care depressed patients. In general, the characteristics of depression and the handling by the doctor are similar in patients with and without comorbidity.

Keywords: Depressive disorder; Dysthymic disorder; Primary health care; Comorbidity; Chronic disease

Introduction

Depression and physical illness are closely related, particularly in medical settings such as primary care. Depression is particularly prevalent in those patients who suffer from chronic physical diseases. In a previous article, we reported that the prevalence of major depression in primary care patients who suffered from two chronic diseases or more was 23%, while in those who did not suffer from a chronic disease it was 11% [1]. In some cases, depression may be related or caused by specific physiopathological effects (e.g., cerebrovascular diseases) but this association is often mediated by disability, pain, or stress derived from physical disease [2].

It has been clearly shown that physical comorbidity influences the detection, diagnosis, and outcomes of the treatment of depression. The presence of medical comorbidity seems to be a barrier for diagnosing depression [3]. The doctor may think that the patient has a good reason to be depressed because of the presence of physical disease [4] and erroneously believe that it would be neither appropriate nor effective to treat it. During primary care visits, and particularly in patients with comorbidity, numerous demands and complaints compete for the doctor's attention and, since time is limited, the detection of and the therapeutic approach to depression mean that this health problem must be actively prioritized over other problems [5]. In an eminently medical context such as primary care, the priorities and expectations of the patient tend to lean towards physical disease [6] and doctors tend to be more interested in the physical complaints than in the emotional distress.

Even if doctors are sensitive to the detection and handling of depression, they have to cope with the difficulty

* Corresponding author. Centre d'Atenció Primària de Constantí, C/ dels Horts, 6, 43120 Constantí, Tarragona, Spain. Tel.: +34 977 524109; fax: +34 977 521873.
E-mail address: earagones.tarte.ics@gencat.net (E. Aragonès).

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of evaluating the somatic or neurovegetative symptoms of depression (e.g., insomnia, anorexia, fatigue, confusion, etc.) which can overlap the symptoms of physical disease.

The therapeutic approach to depression is also complicated when there is physical comorbidity [7], and the presence of physical disease has been associated with a worse response to treatment [8,9].

The aim of this study was to analyse how sociodemographic and clinical characteristics in depressed patients, as well as the management of their depression, are related to the presence of significant physical comorbidity.

Methods

The study was carried out in 23 medical surgeries at 10 primary care centres in the province of Tarragona (Spain). All consecutive patients between 18 and 70 years old who visited for any health problem were eligible. The criteria for exclusion were language limitations or concurrent disease that prevented participation, or a psychotic disorder. A more detailed description of the study design has been published recently [1].

Study design

Our study was cross-sectional and took place in two phases [10]: the first phase consisted of a screening for depression with a self-rating test, and the second examined a subsample consisting of all the subjects who screened positively (probable cases) plus a random selection of one out of every seven who had negative results (probable noncases).

Measures

First phase (screening)

We used Zung's Self-Rating Depression Scale (SDS) [11]. This test is useful for detecting and measuring the severity of depression. For the screening, the SDS Index used as the cut-off point was ≥55%, which had been previously validated in our environment [12].

Second phase

To establish the diagnoses of depressive disorders, the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) was used [13]. We considered the diagnoses of major depressive disorder and dysthymic disorder. The SCID includes the Global Assessment of Functioning Scale (GAF), which measures the effect of mental illness on the general level of psychological, social, and work activity of the subject (Axis V of the *DSM-IV*). The interview was conducted by two specifically trained doctors in accordance with the method proposed by the authors of the SCID [14].

The severity of the physical comorbidity was measured with the Duke Severity of Illness Checklist (DUSOI) [15]. This checklist was fulfilled by the family physician of each patient aided, if it was needed, by a member of the research team. For each physical diagnosis, a score was assigned that depended on the symptoms, complications, prognosis, and forecast of the response to treatment. An equation, which gives greater weight to the main diagnosis and decreasing values to the others, provides a value of overall severity on a scale of 0–100. This continuous value is grouped in the following categories of severity: absent (0), mild (1–25), middle (26–50), moderate (51–75), and extreme (76–100).

To measure the quality of life related to health, the SF-12 Health Questionnaire was used [16]. This instrument gives two scores: a component of physical health and a component of mental health.

Patients were openly asked about their reasons for visiting and their symptoms, which were classified as somatic or psychological/social (Chapters P and Z of the International Classification of Primary Care, WONCA) [17]. They were also asked about the number of times they had been to the doctor in the preceding 3 months and about the pharmacological treatments currently being taken.

After the visit of each of the patients evaluated in this phase, the doctors filled in a questionnaire in which they were required to state whether they believed a clinically significant depressive disorder was present or not. The doctors were unaware of the result of the screening and the psychiatric interview, and they had to base their judgement on the content of the current consultation, on the patient's clinical history, and on previous knowledge they had of the patient.

Analysis

The patients who had been diagnosed as currently suffering from major depression and/or dysthymia during the psychiatric interview were selected and divided into two groups: those with and without significant physical comorbidity defined by the score on the DUSOI scale. Significant physical comorbidity was considered to be present when the score was >50 (moderate or extreme severity), and it was considered not to be present if the score was ≤50 (middle or mild severity, or absent).

The association of several sociodemographic and clinical variables with the presence of physical comorbidity was analysed in this sample of depressed patients. The analysis used the chi-square test for the categorical variables and the ANOVA test for the continuous variables. The level required for statistical significance was set at $P<.05$.

Results

Of 1050 consecutive patients between 18 and 70 years old, 23 were excluded because of a concurrent disease that prevented participation, 6 because of language limitations,