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Re-thinking the article by Thombs and colleagues

We take issue with all four key reasons given by Thombs and colleagues¹ to advise against routine screening for depression.

First, *unacceptably high false-positive rates can result*. To support this point, Thombs and colleagues offered one reference that claimed there are 50% false-positive rates, whereas systematic reviews reveal the existence of quality tools with greater than 80% sensitivity and greater than 80% specificity where the false-positive rates are in a very acceptable 10%–20% range.²

Second, *screening absorbs valuable resources better spent elsewhere*. This opinion is already undermined because numerous clinics use screening procedures where patients respond via touch-screen computers or kiosks. System set-up cost is modest but long-term use is cheap.

Third, *there is no evidence that screening benefits patients*. Carlson and colleagues³ conducted a randomized controlled trial in which screened patients had better emotional outcomes than non-screened patients. Interestingly, one of the authors advising against screening in the *CMAJ* article¹ also attempted to negate the positive outcomes of the Carlson and colleagues³ study in a letter to the editor.⁴ Furthermore, Thombs and colleagues consider only improved patient outcomes as a justification for screening, and they ignore the social justice of equal access to care and that routine screening allows for databased resource allocation.

Fourth, *treatment for depression is not very effective*. The authors cite only evidence that selective serotonin reuptake inhibitors are of limited use, but

they ignore the impressive literature on the effects of psychological therapies on depression.⁵ Also detrimental to the stance of the authors are two systematic reviews revealing that psychological treatment is most effective for high levels of depression, and that psychological treatment for depression and anxiety in patients with cancer was three times as effective when patients had first been screened for actual existence of depression and anxiety.⁶

Last, why focus only on screening for depression when there other treatable types of distress, like anxiety or symptom burden, that affect patients' quality of life?

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References

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The authors respond

Linden and Vodermaier¹ claim that the rate of false-positives with screening for depression is “very acceptable.” Whether a false-positive rate is acceptable depends on the prevalence of disease in the population being screened. Given the prevalence of depression in a typical primary care setting and that about half of patients with depression

are typically identified without screening,² most individuals who screen positive in primary care will not have depression (Figure 1). This is hardly acceptable when one considers the potential harms to patients with false-positive screens and resultant costs to society.^{2,3} The cost of screening includes assessments, consultations, treatment and follow-up services and is much greater than the cost of administering a questionnaire.^{4,5} Linden and Vodermaier cite a single randomized controlled trial (RCT) in patients with cancer,⁶ which did not improve depression scores at follow-up, to support routine screening of depression in primary care. That trial was described as a screening trial, but it did not use depression or distress screening scores to determine which patients would be offered a psychosocial evaluation. Rather, patients received a consultation if they requested one, regardless of their questionnaire results. Referrals for supportive services were potentially recommended to patients following consultation based on many different factors, including, but not limited to, symptoms of depression or anxiety, distress, pain, fatigue, drug or alcohol use, as well as concerns about transportation, parking, and groceries.

Linden and Vodermaier suggest that screening could provide the “social justice of equal access to care.” Access to care would achieve social justice if the benefits of that care outweighed its harms, but this has not been shown for screening for depression. Linden and Vodermaier appear to agree that treatment for depression is most effective when patients have more severe symptoms of depression. Yet most patients who screen positive, but are not otherwise recognized as having depression, will have relatively low depression severity² (as described in our article).²

No RCT results have shown that patients who are screened for depression have better depression outcomes than patients who are not screened for depression, and there have been many