Author's response to reviews

Title: Screening of Depression In Primary Care Setting - Prevalence and Instrument

Authors:

Waleed Al Qadhi (dwags@hotmail.com)
Saeed Ur Rahman (rahmans@ngha.med.sa)
Mazen Saleh Ferwana (ferwanam@ngha.med.sa)
Abdulmajeed Imad Addin (abdulmajeedim@ngha.med.sa)

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Author's response to reviews: see over
Dear Editorial Board,

Please find below point by point responses to reviewers’ concerns. Majority (over 90%) of the concerns have been addressed, and corrections made. Some additional calculations have been made. Most of the concerns were related to use of references, English language and justification of use of PHQ9 cut off level for point prevalence estimates and cost-analysis. Hopefully almost all have been addressed. Some reviewer suggestions were not feasible with our current resources as most of the day to day work is done manually in our primary care clinics. We hope that these responses would suffice. Kindly let us know if further corrections need to be made. Thanking you with best regards.

Drs. Waleed Qazi, Saeed ur Rahman, Mazen Ferwana and Abdul Majeed Imad Yaseen

**Responses & corrections:**

**Reviewer: Anna Sasdelli**

1. Objectives have been split into primary and secondary, in abstract and end of introduction
2. Substance abuse is rarely enquired about in primary care settings, and yields unreliable information upon screening or surveys, therefore was not included in the questionnaire.
3. Cronbach’s alpha has been calculated and added to the results. PHQ2 and PHQ9 Arabic versions have however already been validated in medical literature.
4. Please see in methodology and results that PHQ9 depression screening tool score 1-4, ‘minimal’ depression was not included in the point prevalence estimates.
5. Methodology and Table 4 results have been revised, and discussion as well.
6. Corrections made in introduction
7. Corrections made in abstract.
8. Replacement of all citation brackets made from ( ) to [ ]
9. Edited and revised.
10. Percentages moved to results from methodology regarding cost-analysis
11. Age adjusted analysis for association with depression scores was not found to be significant and had fewer unreliable number of patients, at the extremes of age.
12. Bibliography reviewed and corrected
13. Abbreviations corrected
14. Missing spaces corrected
15. Edited text for periods
16. Edited text for brackets.
1. This study is about screening for depression in primary care settings in Saudi Arabia, not in general population. Screening visitors for depression has pragmatic applicability in day to day care rather than conducting population-based periodic surveys or surveillance for depression. Selection bias is expected as prevalence of depression in primary health care, sick-visitors would come out higher than general population. Limitations have already been given in the discussion, and expanded. Exclusion of those with pre-existing diagnosed depression would only make the point prevalence estimates conservative.

2. (a) Cost-analysis estimates are usually based on assumptions along with data. If the assumptions are logical, these estimates have utility. (b) It is not feasible to revisit the sampled visitors in our study for some cost-survey as the patients screened for the study, visited the clinics based on medical needs, and were not invited for the purpose of the survey. (c) The cost-estimation is conservative by non-inclusion of psychotherapy costs, which are sporadic and have high variability in practice in the region. In addition, no life-time cost of depression was included, however this favors the premise of the study that despite the fact that not all cost elements could be included, the economic burden of depression is high and needs to be addressed.

3. Missing information has been added to the results, regarding number of questionnaires distributed, those excluded from study, those who declined to participate and the incomplete survey forms rejected.

4. It can be argued that using the PHQ9 cutoff of ≥ 10 score for classifying those with ‘depression’ in the study instead of a gold standard such as DSM IV classification for MDD, would overestimate point-prevalence of depression and costs, but we have used in our analysis, 45% of the 20% ‘depressed’, as receiving treatment which in literature is rated as depression being under diagnosed and undertreated. In addition, this percentage of 9% primary care patients is quite close to MDD point-prevalence based on DSM IV diagnostic criteria, in general population. Using this percentage is conservative and reasonable, knowing that a lot of depression is missed. In addition, diagnostic validity of PHQ9 with clinical judgment based on DSM IV criteria, was beyond the scope of this study, since it is about usefulness of screening instrument (which is more sensitive) in primary care settings, and not diagnostic confirmation by psychiatrists (which is more specific).

5. Changes made throughout the paper
6. Added to methodology before cost-estimate
7. Revised all text
8. Added to methodology
9. Corrections made in Table 3
10. Added to Table 4.
11. Added to introduction.
Reviewer: Mark Haddad

1. Introductory paragraph modified and cited prevalence rates 45-95% with overall 69% prevalence of somatic symptoms added from Simon et al. study.

2. The point prevalence of depression in primary care settings is expected to be higher than the general population as visitors are more likely to be female and sick. In addition, since we used sensitive screening tools and kept the cutoff at a lower threshold for capturing depression, we expected to overestimate point prevalence whereas ‘gold standard’ DSM IV clinical judgment based criteria for diagnosing depression by a psychiatrist is more likely to be specific and maybe overly conservative, and has lesser practical value in gulf-peninsula primary care setting.

3. Whooley reference regarding lack of benefit of screening, is debatable.

4. USPSTF recommendation that screening is not beneficial in the absence of follow-up services, is the main idea behind carrying out this study, to highlight the burden of disease, value of screening, and cost-benefit of providing treatment facilities locally


6. Please see # 4 in Klaas Huijberghts for explanation on using screening instrument cut-off instead of a diagnostic ‘gold standard’

7. Please see # 1 in Klaas Huijberghts for explanation on exclusion criteria and limitations

8. Corrections made in the methodology regarding the number of patients surveyed each day and Please see # 3 in Klaas Huijberghts