

# Letters

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## Depression and musculoskeletal problems

A recent study by Mallen *et al*,<sup>1</sup> published in the October issue of the *BJGP*, concluded that older patients consulting their GP due to musculoskeletal pain have frequently comorbid depressive symptoms, and that brief depression screening during the consultation can miss a large number of persons with depressive symptoms. The authors found that a total of 51.4% of the study participants had depressive symptoms, according to a screening instrument self-administered at home (Hospital Anxiety and Depression Scale, HADS), versus only 20.8% on GP-administered screening (involving two questions) during the consultation.

Recently, we performed a study, in a general practice in Estonia, as part of the PREDICT (Prediction of Future Episodes of Depression in Primary Medical Care: Evaluation of Risk Factor Profile) study. The study group was formed of consecutive patients ( $n = 1094$ ), aged 18–75 years, who sought consultation from their family doctor.<sup>2</sup> Occurrence of depression was assessed by using the Composite International Diagnostic Interview (CIDI) (version 2.1),<sup>3</sup> which provides a 6-month depression diagnosis, according to the International Classification of Diseases (ICD-10). We also analysed the medical records of all patients with respect to their comorbidity. A total of 202 participants aged  $\geq 50$  years had presented with musculoskeletal pain. Of them 48 (23.8%) were depressed and 154 (76.2%) were non-depressed. Briefly, most older

persons with musculoskeletal pain in our study were non-depressed.

The difference in the prevalence of depressive symptoms in older people with musculoskeletal pain can be related to the study instrument: Mallen *et al*<sup>1</sup> used screening instruments while we employed the diagnostic instrument CIDI. There are a number of different instruments for screening depression but most of them lead to a high number of false-positive results, which can be misleading. Therefore, for a more precise evaluation of concomitant depression, diagnostic instruments should be used after screening.

In conclusion, we agree that persons with musculoskeletal pain may represent a group at high risk of depression requiring attention from their GP. However, most older persons with musculoskeletal pain in primary care do not have the diagnosis of depression.

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## REFERENCES

1. Mallen CD, Peat G. Screening older people with musculoskeletal pain for depressive symptoms in primary care. *Br J Gen Pract* 2008; **58**(555): 688–693.
2. King M, Nazareth I, Levy G, *et al*. Prevalence of common mental disorders in general practice attendees across Europe. *Br J Psychiatry* 2008; **192**(5): 362–367.
3. World Health Organization. *Composite International Diagnostic Interview (CIDI) Version 2.1*. Geneva: WHO, 1997.

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## Authors' response

Comorbid depression in older people is an important clinical topic that, to date, has failed to receive the attention it deserves. We welcome the findings reported by Suija *et al*, which provide further evidence that depressive comorbidity is common in older people with musculoskeletal pain.

It is perhaps not surprising that different results were found between the two studies. Our study<sup>1</sup> found that just over a third of older primary care consultants with musculoskeletal pain had depressive symptoms measured using the Hospital Anxiety and Depression Scale<sup>2</sup> whereas Suija *et al* used the Composite International Diagnostic Interview, finding that 23.8% of participants had a depression diagnosis.

Suija *et al* comment that the majority of older people with musculoskeletal pain are non-depressed. While this is true for both studies, the high level of either depressive symptoms or diagnoses remains clinically important. A prevalence of comorbid depression of around 25% is consistent with those reported for other conditions, such as diabetes and coronary heart disease. The importance of detecting and adequately treating depression for these conditions is well documented. Since comorbid depression is consistently associated with a poor prognosis for musculoskeletal pain<sup>3</sup> we strongly feel that a holistic approach, which includes an assessment of depressive symptoms and severity, should be taken to ensure high-quality patient care and improved patient outcomes.

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### REFERENCES

1. Mallen CD, Peat G. Screening older people with musculoskeletal pain for depressive symptoms in primary care. *Br J Gen Pract* 2008; **58**(555): 688–693.
2. Zigmond AS, Snaith RP. The hospital anxiety and depression scale. *Acta Psychiatr Scand* 1983; **67**(6): 361–370.
3. Mallen CD, Peat G, Thomas E, *et al.* A systematic review of prognostic factors for joint pain in primary care: a systematic review. *Br J Gen Pract* 2007; **57**(541): 655–661.

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## The end of practice-based research?

Recently, McWhinney<sup>1</sup> has stated that there is little being published in the journals of family medicine and general practice concerning clinical insight and discovery. In particular, he has deplored the lack of clinical research carried out by single practitioners working with their own patients. As one who first joined the Royal College of General Practitioners in 1968, I was interested to discover whether this criticism applied to the *BJGP* and whether the approach to the publication of research had changed over 40 years. I therefore surveyed the journal over 6-months from January to June 2008 and compared the research content with that published in the same months of 1968. I was careful to exclude reviews and lectures (Table 1).

It would appear that the combination of working GP and researcher has become extinct. Even if this is not the case, it is fairly obvious that the locus of research has shifted fundamentally from the individual practitioner to the large research team and from the particulars of individual practice to the generalities of large populations. Doubtless this approach has led to the acceptance of

**Table 1. A comparison of research studies published in 6-month periods in 1968 and 2008.**

Year	Studies	Authors (n/study)	Practice-based (%) <sup>a</sup>	GP author (%) <sup>b</sup>
1968	31	36 (1.2)	26 (84)	28 (78)
2008	35	208 (5.1)	0 (0)	0 (0)

<sup>a</sup>Research studies carried out in the author's practice. <sup>b</sup>First author was a working GP.

the discipline of general practice in the wider academic and research community, but the role of the GP seems to have changed from being the investigator to the investigated, and from being the initiator of questions, to being a source of access to the questions of academics from our own and other disciplines.

McWhinney's view is that clinical discovery is essential and 'can be done only by clinicians working with their patients,' so by definition this finding does not augur well for the future of our discipline. He believes that there must be a place for clinicians' observations, hunches, and insights in family medicine and general practice journals. Manifestly, there is no place for this within the current journal and we need such a place — an appropriate mid-point between what is now regarded as a rigorous research paper and the pseudo-intellectual chatterings that occupy the 'Back Pages.'

There is little doubt in my mind that, if Dr William Pickles of Aysgarth<sup>2</sup> were to submit a manuscript entitled 'An outbreak of catarrhal jaundice' to any modern journal, it would be rejected. How would they confirm as evidence-based, the statement 'S. P., page 32, who began with jaundice on August 24th, and who sold sweets in the village shop?' In his world, the world of real general practice, the input of the patient was critical because their meanings could be helpful. As he wrote elsewhere,<sup>3</sup> 'Country beliefs may be helpful, and should not be cursorily ignored. Classically the world gained much when Edward Jenner listened to one of these, and solved the riddle of the milkmaid's flawless cheek.'

McWhinney writes, 'If information is gained only from questionnaires, and the investigator has no contact with the

patient, he has to interpret the words himself without gathering the patient's meaning in the course of a dialogue. This is not a rigorous procedure.' The disappearance of the personal researcher does it improve our discipline? As Marinker<sup>4</sup> succinctly put it, 'At the centre of general practice is the encounter between the doctor and the patient. If we fail to value the uniqueness of the doctor and the patient, the role of feelings and situations in the interpretation of symptoms and findings, we are condemned to be second rate players in a second hand game.'

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### REFERENCES

1. McWhinney IR. Assessing clinical discoveries. *Ann Fam Med* 2008; **6**(1): 3–5.
2. Pickles WN. Epidemic catarrhal jaundice. An outbreak in Yorkshire. *BMJ* 1930; **1**: 944–946.
3. Pickles WN. Epidemiology in country practice. *Proc R Soc Med* 1935; **28**(10): 1337–1342.
4. Marinker M. Journey to the interior: the search for academic general practice. *J R Coll Gen Pract* 1987; **37**(302): 385–388.

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