International Journal of Healthcare Sciences ISSN 2348-5728 (Online)
Vol. 5, Issue 2, pp: (147-152), Month: October 2017 - March 2018, Available at: www.researchpublish.com

Early Detection of Depression by Family Doctors in Primary Care

[1]Saad Abdullah M Alshahrani, [2]Ismail Mohammed Dhafer Alshahrani

[1,2]Aseer Central Hospital

Abstract: **The main objective of this review was to discuss the roles of family physicians in early diagnosis of depression, we intended also to review the most common causes of depression which receive treatment in primary care. A search was conducted of MEDLINE, EMBASE, and Cochrane Central for English-language published d studies up to, September, 2017. Search strategy were concerned with those articles discussing the diagnosis of depression by family physicians in primary care setting. The recognition, as well as treatment of depression, is a challenging for family physicians in primary care where there are many patients with numerous discussions and a multitude of causes for distress. An analysis difficulty could be seen in the distinction of a depression with dominating somatic symptoms from stress and anxiety, somatoform problems, as well as clinical conditions. When somatic symptoms, specifically unpleasant physical problems, go along with the currently disabling psychological as well as behavioral signs and symptoms of depression, the program of the illness might be more serious. As the very first point of contact for patients, the family doctor is in a special position to detect as well as handle significant anxiety. An additional essential facet of assessing a person with major depression is performing a self-destruction threat analysis, which is defined in our following post in this three-part collection.**

Keywords: **Depression, dominating somatic symptoms, self-destruction.**

1. INTRODUCTION

Depressive and anxiety disorders are the most common mental illness in the population, epression is twice as usual in females as in men [1]. The risk of a major anxiety enhances 1.5 to 3.0 times if the health problem is present in a first-degree family member as compared to no such ailment in a first-degree loved one [2,3]. Both disorders are typically co morbid as well as develop a common factor for assessment in family medicine [4]. Depression prevails in primary care, yet its medical diagnosis as well as reliable treatment is questionable as a result of variations in scientific technique, lack of proof on the" finest" treatments and accessibility to them, and also because of its complex nature and also disputed definition [5].

Nevertheless, recognition of depression conditions is poor, with less than a third of medically substantial cases obtaining determined [6]. Diagnosis of specific psychiatric conditions would certainly be difficult in the health care because of high price of co-morbidity among different problems. It has emerged that a proportion of patients in the health care do not fit right into specific psychiatric disorders, mostly conceptualized making use of patients seen in the tertiary or second care. Lots of people with depressive symptoms likewise have various other physical or psychological conditions. This psychiatric as well as physical co-morbidity would certainly have effects for the category, therapy as well as outcome of the depressive illness [7]. Underdiagnosis and subsequent sub-optimal management lead to persisting signs, excess health solution usage and also loss of working capability [8].

Under recognition of depression in primary care is a crucial public health trouble that has high social costs connected to impairment, morbidity, mortality, and also extreme healthcare application [9,10]. During the past decade, published findings of studies concerning the acknowledgment of anxiety in medical care setups identified numerous possibly crucial impacts: medical professional characteristics, such as gender, years of technique, training background, and also setup;

patient characteristics and also symptom presentation; and health care system variables, such as wage or capitation repayment [11,12].

The main objective of this review was to discuss the roles of family physicians in early diagnosis of depression, we intended also to review the most common causes of depression which receive treatment in primary care.

2. METHODOLOGY

A search was conducted of MEDLINE, EMBASE, and Cochrane Central for English-language published d studies up to, September, 2017. Search strategy were concerned with those articles discussing the diagnosis of depression by family physicians in primary care setting, and following MeSH terms were used through the mentioned databases; "DEPRESSION, PRIMARY CARE, FAMILY PHYSCIANS, DIAGNOSIS, SCREENING, DETECTION". References from included articles were screened for more relevant studies.

3. DISCUSSION

Risk factors and Etiology of depression:

Anxiety is believed to result from disturbance of the typical mind neurochemistry. Work in this location has actually caused the advancement of new medicines to treat depression. These medicines show up to influence a variety of central monoamine natural chemicals. Central norepinephrine neural paths are likely involved in activities of alertness, inspiration and general levels of energy [13,14].

Any person with a previous depressive episode is at threat of additional episodes, as the natural course of major depression entails constant relapses [15]. There is a bidirectional relationship in between major anxiety as well as chronic condition. The SMHS showed that practically half of the persons with significant depression had at least one chronic physical condition [16]. People with chronic physical conditions are understood to be at better threat of major clinical depression [17,18]. The prevalence of significant clinical depression is greater in persons with chronic medical conditions such as heart diabetic issues, illness and stroke mellitus; coexisting significant anxiety is associated with poorer diagnosis and also a boosted price of problems that are related to these problems [19,20] A considerable organization was found between significant anxiety as well as a variety of diabetic complications. Those who were dispirited were additionally more probable to die after a cardiovascular disease compared to non-depressed patients [21].

Apart from the normal symptoms of significant depression such as sleeping disorders as well as low energy level, patients typically present to primary care doctors with somatic signs and symptoms [22]. Physical signs and symptoms associated with major anxiety consist of backaches, nonspecific bone and joint grievances, having several (3 or even more) somatic grievances, as well as having vague problems [23] Patients may experience wearing away memory. A review has shown that major depression is connected with interest shortage as well as bad cognitive functioning, particularly when the patient is really depressed [23]. The senior, in particular, are much less most likely to report reduced state of mind, rather providing with physical problems and also damage in cognitive ability [24].

Clinicians ought to also pay attention to life event stressors, as these are associated with the onset of major depression, especially face to faces with a hereditary proneness [25,26]. Such stressors consist of recent loss or bereavement, psychological or physical abuse, occurrences including embarrassment, and difficult relationships [26]. Given that major clinical depression commonly exists together with other psychiatric conditions (e.g. anxiety disorders, drug abuse as well as somatoform conditions), patients that offer with these diagnoses need to be screened for significant depression, and the other way around [27].

- **Depression Screening in family practice, and somatic symptoms of depression:**

Major clinical depression is a chronic health problem of significant morbidity, with high prices of regression and reappearance; nevertheless, several patients suffering from significant depression do not seek aid early [15,16]. This could be as a result of numerous factors: absence of understanding right into their medical problem; the stigma related to the label of mental disease; as well as financial aspects [28]. The SMHS discovered that the mean time between the onset of ailment and help-seeking was five years [16]. Hence, viewing screening as the very first step, followed by diagnosis, early treatment and follow-up, was revealed to result in much better results [29,30].

There are numerous great suggestions that support testing for major clinical depression. The clinical practice standards on major depression released by the Ministry of Health, Singapore, in 2012 suggest screening for significant clinical depression in risky individuals where the benefits outweigh the threats [31]. The United States Preventive Services Task Force suggests testing for major clinical depression in the basic adult populace and having sufficient systems in place to make certain correct diagnosis, treatment and follow-up [31]. While the Canadian Task Force on Preventive Healthcare does not advise routine screening of adults in health care, it supports watchfulness for major clinical depression in patients with risk factors as well as signs and symptoms of sleeping disorders, reduced state of mind, anhedonia and also suicidal ideas [32]. The 2016 upgraded guidelines from the National Institute for Health and Care Excellence, United Kingdom, suggest that clinicians screen for significant depression in persons that have chronic clinical conditions with damaged function, as well as individuals with a past history of significant anxiety, by asking if low mood, pessimism as well as anhedonia are additionally existing [33].

In a professional research, Hamilton reported that somatic symptoms prevailed in a great majority of depressed patients [34]. Somatic symptoms, particularly somatic stress and anxiety and also exhaustion, were documented in up to 80% of a sample of 260 women and also 239 guys dealing with major anxiety. These somatic signs and symptoms very frequently had an underlying psychopathological appropriate hypochondriasis, both in ladies and males. This study confirmed earlier studies showing that depressive disorders with mainly somatic discussion were most likely to be the most typical form of anxiety, both in inpatient as well as outpatient care [35,36]. Hagnell and Rorsman stressed the Indicative value of somatic symptoms in depressed medical care patients regarding their danger of suicide [37].

For the terrific bulk of clinically depressed patients looking for specialist assistance in the main healthcare system, family doctors and also internists are the crucial user interface for diagnosis and treatment of clinical depression [38]. Primary-care patients with clinical depression really frequently existing with somatic grievances. This appears to be more the policy compared to the exception worldwide [39]. Two of the three most typical signs reported throughout a present depressive episode were somatic (no energy/restless: 73%, damaged sleep/decreased sleep: 63%) as shown by the European Study Society study (DEPRES II) [40]. In another primary care research study, got to a comparable searching for of patients presenting their depressive or anxiousness disorders exclusively with somatic signs and symptoms in a frustrating majority (73%). The recognized somatic symptoms were the main factor for the first visit to the primary care medical professional [41]. In an US research study in 573 patients with the medical diagnosis of significant depression, 2 thirds (69%) experienced basic pains as well as discomforts, hinting at a close relationship between discomfort symptoms and also clinical depression [42].

The Geriatric Depression Scale (GDS) [43] is a 30-item depression set of questions especially made for usage in older adults. The GDS examines the cognitive as well as affective facets of significant clinical depression, yet intentionally omits evaluation for somatic symptoms. The rationale is that such an evaluation could be non-discriminatory in the elderly as a result of the physiological results of age as well as existence of chronic medical conditions. A score ≥ 11 on the GDS has a 84% level of sensitivity and 95% specificity for significant clinical depression in elderly patients. The questionnaire is easy to use, as the things require a yes-no feedback. The sheer number of products could be cumbersome in the busy outpatient setting. Shorter variations of the GDS, including 15-item, ten-item, four-item and also one-item versions, have actually been discovered to be valuable in determining depressive signs and symptoms in elderly outpatients [44].

- **Criteria and differentials for major depression:**

The primary care practitioner need to recognize with the standards for the diagnosis of major depression, while bearing in mind problems that can exist together or resemble with major clinical depression. A vital very first step to management is making an accurate diagnosis [45]. A meta-analysis has shown that, while primary care doctors are able to rule out significant clinical depression face to faces that are not depressed, incorrect positives are common in persons who are identified as depressed [45]. There is additionally hesitation to tag patients as depressed although they fulfil the diagnostic requirements. Underdiagnosing major clinical depression brings about delay or non-treatment, while over diagnosing it brings about antidepressant overuse, unacceptable references to psychiatric solutions and also missing natural conditions that are mistaken as significant anxiety [46,47].

The DSM-5 supplies a collection of standards that must be met in order to diagnose significant clinical depression (**Table 1**) [48]. The patient is said to have major clinical depression if reduced mood or anhedonia (specified as loss of passion or enjoyment) exists virtually on a daily basis for 2 or even more weeks, along with various other signs. Nevertheless, it is

necessary to keep in mind that the DSM-5, like any other diagnostic tool, acts as a standard and must not replace clinical reasoning [48].

Table 1:

A. Two to four of the following symptoms have been present during the same two-week period:
1. Dysphoria – Depressed mood most of the day, nearly every day 2. Anhedonia – Markedly diminished interest or pleasure most of the day, nearly every day 3. Significant appetite or weight change 4. Insomnia or hypersomnia nearly every day 5. Psychomotor agitation or retardation (observable by others) 6. Anergia – Fatigue nearly every day 7. Thoughts of worthlessness or inappropriate guilt nearly every day 8. Impaired concentration or memory nearly every day 9. Recurrent thoughts of death or suicide, or suicide attempt
B. At least one of the symptoms includes dysphoria or anhedonia
C. The symptoms cause clinically significant distress of psychosocial impairment
D. The symptoms are not due to the physiologic effects of a substance, medication, or general medical condition
E. Persistent depressive disorder (dysthymia) and cyclothymic disorder are not present
F. The mood disturbance does not occur exclusively during a psychotic disorder

4. CONCLUSION

The recognition, as well as treatment of depression, is a challenging for family physicians in primary care where there are many patients with numerous discussions and a multitude of causes for distress. An analysis difficulty could be seen in the distinction of a depression with dominating somatic symptoms from stress and anxiety, somatoform problems, as well as clinical conditions. When somatic symptoms, specifically unpleasant physical problems, go along with the currently disabling psychological as well as behavioral signs and symptoms of depression, the program of the illness might be more serious. As the very first point of contact for patients, the family doctor is in a special position to detect as well as handle significant anxiety. An additional essential facet of assessing a person with major depression is performing a self-destruction threat analysis, which is defined in our following post in this three-part collection.

REFERENCES

[1] Murphy JM, Laird NM, Monson RR, Sobel AM, Leighton AH. A 40-year perspective on the prevalence of depression: the Stirling County Study. Arch Gen Psychiatry 2000;57:209-15.

[2] Bland RC. Epidemiology of affective disorders: a review. Can J Psychiatry 1997;42(4):367-77.

[3] Sadovnick AD, Remick RA, Lam RW, Zis AP, Yee IM, Huggins NJ, et al. Mood Disorder Service Genetic Database: morbidity risks for mood disorders in 3,942 first-degree relatives of 671 index cases with single depression, recurrent depression, bipolar I, or bipolar II. Am JMed Genet 1994;54:132-40.

[4] McManus P, Mant A, Mitchell P, Britt H, Dudley J: Use of antidepressants by general practitioners and psychiatrists in Australia. Aust N Z J Psychiatry. 2003, 37 (2): 184-189.

[5] Dowrick CJ. Beyond depression: a new approach to understanding and management. Oxford: Oxford Medical Publications, Oxford University Press, 2004.

[6] Patel V, Weiss HA, Chowdhary N, Naik S, Pednekar S, Chatterjee S, et al. Effectiveness of an intervention led by lay health counsellors for depressive and anxiety disorders in primary care in Goa, India (MANAS): a cluster randomised controlled trial. Lancet. 2010;376:2086–95.

[7] Lloyd K. The epidemiology of neuroses: Neurotic disorders in primary care. Curr Opin Psychiatry. 1993;6:179–83.

[8] Patel V, Pereira J, Coutinho L, Fernandes R, Fernandes J, Mann A. Poverty, psychological disorder and disability in primary care attenders in Goa, India. Br J Psychiatry. 1998;171:533–6.

[9] Perez-Stable E, Miranda J, Munoz R, Ying Y. Depression in medical outpatients: underrecognition and misdiagnosis. Arch Intern Med. 1990;150:1083–1088.

[10] Satcher D. Mental health: a report of the Surgeon General (Executive Summary). Public Health Rep.2000;115:89–101

[11] Simon G, VonKorff M, Piccinelli M, Fullerton C, Ormel J. An international study of the relation between somatic symptoms and depression. N Engl J Med. 1999;341:1329–1335.

[12] Wells K, Hays R, Burnam A, Rogers W, Greenfield S, Ware J Jr. Detection of depressive disorders for patients receiving prepaid and fee-for-service care: results from the medical outcome study. JAMA.1989;262:3298–3302.

[13] Stahl SM. *Essential psychopharmacology of depression and bipolar disorder*. New York: Cambridge University Press; 2000. p. 20-63.

[14] Remick RA. Diagnosis and management of depression in primary care: a clinical update and review. *CMAJ: Canadian Medical Association Journal*. 2002;167(11):1253-1260.

[15] Burcusa SL, Iacono WG. Risk for recurrence in depression. Clin Psychol Rev. 2007;27:959–85.

[16] Chong SA, Abdin E, Vaingankar JA, et al. A population-based survey of mental disorders in Singapore. Ann Acad Med Singapore. 2012;41:49–66.

[17] Moussavi S, Chatterji S, Verdes E, et al. Depression, chronic diseases, and decrements in health: results from the World Health Surveys. Lancet. 2007;370:851–8.

[18] Katon W, Ciechanowski P. Impact of major depression on chronic medical illness. J Psychosom Res. 2002;53:859–63.

[19] Hare DL, Toukhsati SR, Johansson P, Jaarsma T. Depression and cardiovascular disease: a clinical review. Eur Heart J. 2014;35:1365–72.

[20] Simon GE. Treating depression in patients with chronic disease: recognition and treatment are crucial; depression worsens the course of a chronic illness. West J Med. 2001;175:292–3.

[21] Lin EH, Rutter CM, Katon W, et al. Depression and advanced complications of diabetes: a prospective cohort study. Diabetes Care. 2010;33:264–9.

[22] Kapfhammer HP. Somatic symptoms in depression. Dialogues Clin Neurosci. 2006;8:227–39.

[23] Gerber PD, Barrett JE, Barrett JA, et al. The relationship of presenting physical complaints to depressive symptoms in primary care patients. J Gen Intern Med. 1992;7:170–3.

[24] Fiske A, Wetherell JL, Gatz M. Depression in older adults. Annu Rev Clin Psychol. 2009;5:363–89.

[25] Kendler KS, Thornton LM, Gardner CO. Genetic risk, number of previous depressive episodes, and stressful life events in predicting onset of major depression. Am J Psychiatry. 2001;158:582–6.

[26] Tennant C. Life events, stress and depression: a review of recent findings. Aust N Z J Psychiatry. 2002;36:173–82.

[27] Hirschfeld RM. The comorbidity of major depression and anxiety disorders: recognition and management in primary care. Prim Care Companion J Clin Psychiatry. 2001;3:244–54.

[28] Kessler RC, Berglund PA, Bruce ML, et al. The prevalence and correlates of untreated serious mental illness. Health Serv Res. 2001;36(6 Pt 1):987–1007.

[29] 7. Halfin A. Depression: the benefits of early and appropriate treatment. Am J Manag Care. 2007;13(4 Suppl):S92–7.

[30] 8. Kupfer DJ, Frank E, Perel JM. The advantage of early treatment intervention in recurrent depression. Arch Gen Psychiatry. 1989;46:771–5.

[31] Siu AL. US Preventive Services Task Force (USPSTF), et al. Screening for depression in adults: US Preventive Services Task Force recommendation statement. JAMA. 2016;315:380–7.

[32] Joffres M, Jaramillo A, et al. Canadian Task Force on Preventive Health Care. Recommendations on screening for depression in adults. CMAJ. 2013;185:775–82.

[33] National Institute for Health and Care Excellence. Surveillance review of CG90: Depression in adults: management and treatment. Available at: https://www.nice.org.uk/guidance/cg90/documents/cg90-depression-in-adults-update-surveillance-review-decision2 .

[34] Hamilton M. Frequency of symptoms in melancholia (depressive illness). *Br J Psychiatry.*1989;154:201–206.

[35] Akiskal HS. Diagnosis and classification of affective disorders: new insights from clinical and laboratory approaches. *Psychiatr Dev.* 1983;2:123–160.

[36] Jones D., Hall SB. Significance of somatic complaints in depression in patients suffering from psychotic depression. *Acta Psychotherapeutica.* 1963;11:193–199.

[37] Hagnell O., Rorsman B. Suicide and endogenous depression with somatic symptoms in the lundby study. *Neuropsychobiology.* 1978; 4:180–187.

[38] Paykel ES., Brugha T., Fryers T. Size and burden of depressive disorders in Europe. *Eur Neuropsy chopharmacol.* 2005; 15:411–423.

[39] Kroenke K. The interface between physical and psychological symptoms. *Prim Care Companion J Clin Psychiatry.* 2003;5:11–18.

[40] Tylee A., Gastpar M., Lepïne JP., et al. DEPRES II (Depression research in European society II): a patient survey of the symptoms, disability, and current management of depression in the community. DEPRES Steering Commitee. *Int Clin Psychopharmacol.* 1999;14:139–151.

[41] Kirmayer LJ., Robbïns JM., Dworkïng M., et al. Somatisation and the recognition of depression and anxiety in primary care. *Am J Psychiatry.* 1993;150:734–741.

[42] Bair MJ., Robinson RL., Katon W., et al. Depression and pain comorbidity: a literature review. *Arch Intern Med.* 2003;163:2433–2445.

[43] Yesavage JA, Brink TL, Rose TL, et al. Development and validation of a geriatric depression screening scale: a preliminary report. J Psychiatr Res. 1982-1983;17:37–49.

[44] D'Ath P, Katona P, Mullan E, Evans S, Katona C. Screening, detection and management of depression in elderly primary care attenders. I: The acceptability and performance of the 15 item Geriatric Depression Scale (GDS15) and the development of short versions. Fam Pract. 1994;11:260–6.

[45] Mitchell AJ, Vaze A, Rao S. Clinical diagnosis of depression in primary care: a meta-analysis. Lancet. 2009;374:609–19.

[46] Boland RJ, Diaz S, Lamdan RM, Ramchandani D, McCartney JR. Overdiagnosis of depression in the general hospital. Gen Hosp Psychiatry. 1996;18:28–35.

[47] Berardi D, Menchetti M, Cevenini N, et al. Increased recognition of depression in primary care. Comparison between primary-care physician and ICD-10 diagnosis of depression. Psychother Psychosom. 2005;74:225–30.

[48] American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington, DC: American Psychiatric Association; 2013.