Resources is a boring strapline for what is designed to be a useful new section of the *BJGP*.

Theophrastus will be here, of course, encouraging readers to look at the journals, and from next month we'll accelerate the deadlines so that the previous month, not decade, is reviewed.

Nick Summerton, in this issue, melds critical reading and evidence-based medicine into day-to-day general practice — **Evidence in Practice**. Teams from Newcastle, the Netherlands and Australia will do likewise in subsequent issues.

In **Vignette**, Leone Ridsdale reflects on long experience as a GP, supplying anecdote, or narrative depending on one's attachment to fashion. Her tales are for registrars and their trainers, to discuss.

A review of (systematic) reviews, or **Cochrane Squared**, will follow when we identify a willing volunteer. Cubed?

Alec Logan

Evidence in practice — number 1. Depression

Clinical question — Is there an accurate question to use for depression screening in primary care?

The evidence. Screening for depression in primary care with two verbally asked questions: cross-sectional study. *BMJ* 2003; **327:** 1144-1146.[1]

Background. Undiagnosed depression can lead to long-term disability and yet it is often under-recognised in general practice. It has been estimated that up to half of patients with treatable depression in primary care remain undetected.[2]

To date, two approaches have been advocated to seek to improve the recognition of depression in primary care: the use of depression screening questionnaires or the detailed evaluation of patients at increased risk of depression (for example, those with chronic medical illnesses, chronic pain syndromes, recent life changes/stresses, fair/poor self-rated health or unexplained physical symptoms).[3]

Unfortunately, the various screening questionnaires available are often not easily accommodated during the course of a busy GP surgery. There is a need for a simple, but accurate, question to be identified that could be applied quickly and easily in the context of a routine consultation.

Study design. A consecutive series of 670 patients not already taking psychotropic drugs were invited to become involved in a cross-sectional validation study. These patients were spread among 15 general practices in New Zealand.[1] The 476 patients who agreed to participate were asked two questions by their GP:

- During the past month have you often been bothered by feeling down, depressed or hopeless?
- During the past month have you often been bothered by little interest or pleasure in doing things?

Subsequently, the patient completed the mood module of the computer assisted composite international diagnostic interview. Complete information was available for 421 patients out of the original 670.

Outcome measure. By comparing the two question responses (individually and combined) against the computer assisted interview — the 'gold standard' — sensitivities, specificities and positive predictive values were calculated.

Results. See Table 1.

Commentary. In assessing the accuracy of any screening question for depression it is important to appreciate that unlike, for example, cancer detection there is no ideal gold standard. It is therefore reassuring that the authors were able to cite other evidence to support their contention that the computer assisted interview was a reasonable approximation to the 'truth' (in terms of validity and reliability).

In terms of the population studied it is likely that there was some selection operating between those that participated and those that did not. The patients were stated to have been consecutively recruited from 15 practices. However, complete information was only available on 63% of the 670 invited and this amounts to an average of 28 patients per practice. It would be interesting to know whether the patients evaluated in this study were skewed more towards 'high-risk patients' as happens in many cross-sectional diagnostic studies of this type.

A further development of this study would be to assess the reliability (reproducibility) of the two questions for particular patient groupings. As GPs we are well aware that we adjust our psychological questioning according to, for example, age, sex, social class and ethnic origin in order to enhance response reliability. The median age in the current study was 46 years and one-third were men.

The bottom line: Two brief verbal questions for screening for depression had reasonable sensitivity and specificity in a younger primary care population.

Nick Summerton

Table 1. Discriminant characteristics of questions.

	Sensitivity[a] (%)	Specificity[b] (%)	Positive predictive value[c] (%)
Question 1	86	72	18
Question 2	83	79	22
Both questions	97	67	18

[a]Sensitivity: the probability of a positive result if the disease is present. [b]Specificity: the probability of a negative result if the disease is absent. [c]Positive predictive value: the probability that the disease (depression) is present if the question is positive.

Table 1 is amended from Tables 1 and 2 from Arroll B, Khin N, Kerse N. Screening for depression in primary care with two verbally asked questions: cross sectional study. *BMJ* 2003; **327:** 1144-

References
1. Arroll B, Khin N, Kerse N. Screening for depression in primary care with two verbally asked questions: cross sectional study. *BMJ* 2003; **327:** 1144-1146.
2. Kessler D, Bennewith O, Lewis G, Sharp D. Detection of depression and anxiety in primary care: follow-up study. *BMJ* 2002; **325:** 1016-1017.
3. Williams JW, Noel PH, Cordes JA, Ramirez G, Pignone M. Is this patient clinically depressed? *JAMA* 2002; **287:** 1160-1170.

Vignette 1

I was coming to the end of surgery one evening when our receptionist buzzed through. An elderly lady had phoned to say her husband had fallen and was stuck on the bathroom floor. I was near to finishing and I asked my receptionist to find out if it was urgent, or if it could wait. My receptionist got back to say it could wait.

It was probably about 20 minutes or half an hour before I left. I knew the couple slightly as they were my father's friends. The man lay wedged across the doorway between the bathroom and the corridor. He was clearly very ill. Examining him, I found he was deeply unconscious, sweating, and his blood pressure was low. He had no femoral pulsations, and I realised this was a ruptured aortic aneurysm. I called the ambulance and fretted until it arrived.

He was operated on at the district hospital the same night, but he did not recover consciousness. I visited him in intensive care. He was covered with monitors, and I felt gloomy about whether he would survive. He died, and my parents went to his funeral.

I regretted not leaving the surgery earlier. Thirty minutes less of shock and cerebral anoxia might have helped.

How was I to choose between leaving the worried well, who had booked an appointment, and going out to an emergency? I have visited many 'emergencies', which were not, but how do you tell? What makes people sitting in the waiting room with an appointment so important? These things seemed easier to decide on in a hospital, than as the sole doctor working in a practice surgery one night.

Leone Ridsdale

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From the journals, July 2004

***New Eng J Med* Vol 351**
33 Why does blood pressure go up in some people? Despite a century of research, we're still left using terms like 'essential', 'idiopathic' and 'primary' to hide our ignorance. The level of aldosterone is probably part of the story: people in the highest quartile were the most likely to become hypertensive in this study from Framingham.
125 Yet another conundrum to do with prostate specific antigen (PSA): if it increases by more than 2 ng/ml per year, your patient may well have micro-metastases, and will probably not be cured by radical local treatment.
241 Pregnancy increases the demand for thyroxine almost immediately, so that women on replacement treatment need a dose increase of 30% right away.
354 'Don't worry, it's just a virus: take these tablets for a few days to get you over the worst.' The management of labyrinthitis, as performed with dizzying skill by most of us: but which tablets should we really be using? Probably oral corticosteroids, according to this study, which also used valaciclovir in two of its arms: the antiviral made no difference, but methylprednisolone hastened recovery.
427 As a screening tool for women at high risk of breast cancer, magnetic resonance imaging (MRI) proved better than mammography in this Dutch study.

***Lancet* Vol 364**
249 Was all that endless cervical screening over the last three decades worthwhile? Probably, at £36k per life saved, according to this modelling exercise.
263 Challenge your local rheumatologists to provide a rapid access service, using this paper (the TICORA study) to show that it can be done without extra cost, but with considerable patient benefit.
365 A study that confirms the high level of protection against meningococcal serogroup C disease achieved by the current conjugate vaccine.
423 At a time when the new contract is making us do some serious homework on chronic disease management, here's a Nottingham study showing just how bad we are at looking after our diet-controlled diabetics.
428 Ever tried to develop a clinical guideline with a local specialist? Here's an interesting large study of how the process actually takes place, using a variety of models.

***JAMA* Vol 292**
65 As we flounder about trying to help women who have had to give up hormone replacement therapy, there's a strong temptation to recommend products containing soy isoflavones. But they do nothing for bone density, cognitive function or lipid profile in women over 60 years old. It's soy depressing.
338 Many readers less Luddite than Theophrastus will have taken part in the UK GP Research Database project in the 1990s: here it is trawled for information about the risk of suicide following prescription of dosulepin, amitriptyline, fluoxetine and paroxetine. The study finds little difference.
351 Can MMR vaccine cause febrile convulsions, especially in high risk children? Yes, but very rarely.
366 A useful summary of the evidence on which treatments best prevent exacerbations in adult asthma. Low-dose inhaled steroids still top the bill.
442 Calculating risk in women with a family history of breast cancer is something a computer does quite well: but patients still prefer to see a genetic counsellor to talk things over.

Other Journals
In all grades of heart failure, β-adrenergic blockers have been shown to improve survival, at least as much as ACE inhibitors, but we are all scared of using them. *Arch Intern Med* (**164:** 1389) looks at the adverse effects described in the randomised trials for heart failure and finds that more patients were actually withdrawn from placebo than from β-blockers. On page 1395 there is a meta-analysis which shows that drugs can help weight loss in type 2 diabetes, but their effect on long-term outcomes is unknown. *Ann Intern Med* (**141:** 16) tackles the tricky subject of how much true cross-reactivity there is between penicillins and cephalosporins in allergic patients: about 10%, if there has been a true reaction and a positive skin test.
Pediatrics (**114:** e96) is a Canadian study comparing azithromycin with erythromycin for the treatment of whooping cough. It works as well and is better tolerated. On page 217 is a discussion of bariatric surgery for severely overweight adolescents: a worrying prospect. Imagine Charles Dickens' outbursts, had he thought his Fat Boy might end up in the hands of Yankee surgeons.

Plant of the Month: *Kirengeshoma palmata*
Pale yellow shuttlecock shaped flowers in a shady spot: one of the loveliest late perennials.