To the Editor:

We thank Castañeda, *et al*¹ for their comments on our article². We do support comorbidity management in rheumatoid arthritis (RA), psoriatic arthritis (PsA), and psoriasis (PsO) in daily practice to ensure optimal care and outcomes, and completely agree with the recently published Spanish recommendations³. Given that patients with RA have increased risk of cardiovascular (CV) morbidity and mortality⁴, CV monitoring appears critical. In the CARMA (CARdiovascular in rheuMATology) study, Castañeda, *et al*⁵ reported that patients with RA, PsA, and PsO had higher prevalence of CV events while receiving biological therapy despite being in low disease activity for almost half of the patients. Notably, almost half of the patients also received nonsteroidal antiinflammatory drugs and/or glucocorticoids (patients with RA), which may have increased CV risk⁶. Regardless of the other confounding factors, these data reinforce the importance of CV monitoring and appropriate management in these populations. Moreover, in agreement with Castañeda, *et al*, we also support depression screening and management, as well as vaccinations⁷, given the increased risk of infection associated with the use of biologic agents. Although of great importance, oral health and sexual disorders have not been selected by the Delphi voting process and were not addressed in our review because of the decision to limit our review to 8 questions/situations. We agree that they are important issues and deserve special attention and specific evidence-based recommendations. Finally, we strongly recommend a multidisciplinary and integrated approach to improve RA/PsA/PsO comorbidity management.

As to the issue of depression, we thank Mr. Thombs and Dr. Hudson⁸ for their comments on our article². We agree that, unfortunately, research on depression screening and management is lacking. Our article was a comprehensive literature review identifying multiple studies that demonstrated that the prevalence of depression in patients with psoriatic disease and RA was higher compared with control groups^{9,10,11,12,13,14,15,16,17}. A published metaanalysis that helped corroborate our finding reported an overall depression prevalence of 28% in PsO and that patients with PsO were more likely to have depression than those without PsO (OR 1.57, 95% CI 1.40–1.76)¹⁸. There appears to be robust data to support the higher risk of depression among our patients with chronic inflammatory disorders.

We do agree that screening for depression in the general population can be quite controversial and recognize that several conflicting sets of guidelines have been published. For example, the US Preventative Services Task Force recommends routine screening of all adults by their primary care provider when appropriate supports are available¹⁹. In the past, Canadian guidelines had endorsed a similar recommendation²⁰, although more current analysis did not find sufficient evidence to recommend for or against routine screening in at-risk populations²¹.

Screening can take many forms such as compressive self-administered questionnaires. However, screening need not be arduous or time-consuming. An alternative screening method can include simple tools such as the “2-question” approach endorsed by the US Preventative Services Task Force: “Over the past 2 weeks, have you felt down, depressed, or hopeless?” and “Over the past 2 weeks, have you felt little interest or pleasure in doing things?”¹⁹, which can be quite sensitive in detecting depression.

Positive screens do not necessarily require high consumption of our limited healthcare resources. We envision close collaboration with family physicians and nurse practitioners to ensure that patients at risk of depression have their healthcare needs met. Thombs and Hudson report being concerned that a positive screen test may result in the potentially unnecessary use of antidepressants. However, with such rapid screening questions, we do not expect that antidepressants would be considered until after a clinical assessment of our patients. We also encourage a broad definition of depression management that does not focus solely on the use of antidepressants, but would include supportive counseling, social networks, and peer-support groups.

We hope that future studies will provide a thorough analysis of the harms and benefits of depression screening in patients with PsO, PsA, and RA, and

we are actively exploring such research. We also caution about the overvaluation of the randomized controlled trial (RCT) in the assessment of the quality of evidence and invite alternative study designs such as prospective cohorts using methods such as propensity scores and instrumental variables. These may better account for confounding than in the so-called “pragmatic RCT,” which is at risk of postrandomization confounding and selection bias²².

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