## Dr. Roubille, *et al* reply

*To the Editor:*

We thank Castañeda, *et al*[1] for their comments on our article[2]. 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 recommendations[3]. Given that patients with RA have increased risk of cardiovascular (CV) morbidity and mortality[4], 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 risk[6]. 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 vaccinations[7], 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. Hudson[8] for their comments on our article[2]. 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 available[19]. In the past, Canadian guidelines had endorsed a similar recommendation[20], although more current analysis did not find sufficient evidence to recommend for or against routine screening in at-risk populations[21].

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 bias[22].

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### REFERENCES

1. Castañeda S, Loza E, Daudén E, Carmona L. Consensus statement on the management of comorbidity in patients with rheumatoid arthritis and psoriasis. J Rheumatol 2016;43:990-1.
2. Roubille C, Richer V, Starnino T, McCourt C, McFarlane A, Fleming P, et al. Evidence-based recommendations for the management of comorbidities in rheumatoid arthritis, psoriasis, and psoriatic arthritis: expert opinion of the Canadian Dermatology-Rheumatology Comorbidity Initiative. J Rheumatol 2015;42:1767-80.
3. Loza E, Lajas C, Andreu JL, Balsa A, González-Álvaro I, Illera O, et al. Consensus statement on a framework for the management of comorbidity and extra-articular manifestations in rheumatoid arthritis. Rheumatol Int 2015;35:445-58.
4. McFarlane A, Roubille C, Richer V, Starnino T, McCourt C, Fleming P, et al. Cardiovascular outcomes in patients with rheumatoid arthritis, psoriasis and psoriatic arthritis: a systematic review and meta-analyses. Ann Rheum Dis 2014;73:324-5.
5. Castañeda S, Martín-Martínez MA, González-Juanatey C, Llorca J, García-Yébenes MJ, Pérez-Vicente S, et al; CARMA Project Collaborative Group. Cardiovascular morbidity and associated risk factors in Spanish patients with chronic inflammatory rheumatic

diseases attending rheumatology clinics: Baseline data of the CARMA Project. Semin Arthritis Rheum 2015;44:618-26.
6. Roubille C, Richer V, Starnino T, McCourt C, McFarlane A, Fleming P, et al. The effects of tumour necrosis factor inhibitors, methotrexate, non-steroidal anti-inflammatory drugs and corticosteroids on cardiovascular events in rheumatoid arthritis, psoriasis and psoriatic arthritis: a systematic review and meta-analysis. Ann Rheum Dis 2015;74:480-9.
7. Morel J, Czitrom SG, Mallick A, Sellam J, Sibilia J. Vaccinations in adults with chronic inflammatory joint disease: Immunization schedule and recommendations for patients taking synthetic or biological disease-modifying antirheumatic drugs. Joint Bone Spine 2015 Oct 6 (E-pub ahead of print).
8. Thombs BD, Hudson M. No evidence for depression screening in rheumatoid arthritis, psoriasis, or psoriatic arthritis. J Rheumatol 2016;43:992.
9. Melikoglu MA, Melikoglu M. The relationship between disease activity and depression in patients with Behcet disease and rheumatoid arthritis. Rheumatol Int 2010;30:941-6.
10. Ang DC, Choi H, Kroenke K, Wolfe F. Comorbid depression is an independent risk factor for mortality in patients with rheumatoid arthritis. J Rheumatol 2005;32:1013-9.
11. Papp K, Poulin Y, Vieira A, Shelton J, Poulin-Costello M. Disease characteristics in patients with and without psoriatic arthritis treated with etanercept. J Eur Acad Dermatol Venereol 2014;28:581-9.
12. Akay A, Pekcanlar A, Bozdag KE, Altintas L, Karaman A. Assessment of depression in subjects with psoriasis vulgaris and lichen planus. J Eur Acad Dermatol Venereol 2002;16:347-52.
13. Ak M, Haciomeroglu B, Turan Y, Lapsekili N, Doruk A, Bozkurt A, et al. Temperament and character properties of male psoriasis patients. J Health Psychol 2012;17:774-81.
14. Schneider G, Hockmann J, Ständer S, Luger TA, Heuft G. Psychological factors in prurigo nodularis in comparison with psoriasis vulgaris: results of a case-control study. Br J Dermatol 2006;154:61-6.
15. Murphy H, Dickens C, Creed F, Bernstein R. Depression, illness perception and coping in rheumatoid arthritis. J Psychosom Res 1999;46:155-64.
16. Hider SL, Tanveer W, Brownfield A, Mattey DL, Packham JC. Depression in RA patients treated with anti-TNF is common and under-recognized in the rheumatology clinic. Rheumatology 2009;48:1152-4.
17. Nas K, Sarac AJ, Gur A, Cevik R, Altay Z, Erdal A, et al. Psychological status is associated with health related quality of life in patients with rheumatoid arthritis. J Back Musculoskelet Rehabil 2011;24:95-100.
18. Dowlatshahi EA, Wakkee M, Arends LR, Nijsten T. The prevalence and odds of depressive symptoms and clinical depression in psoriasis patients: a systematic review and meta-analysis. J Invest Dermatol 2014;134:1542–51.
19. U.S. Preventative Services Task Force. Final recommendation statement: depression in adults: screening December 2009. [Internet. Accessed February 1, 2016.] Available from: www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening
20. MacMillan HL, Patterson CJ, Wathen CN, Feightner JW, Bessette P, Elford RW, et al; Canadian Task Force on Preventive Health Care. Screening for depression in primary care: recommendation statement from the Canadian Task Force on Preventive Health Care. CMAJ 2005;172:33-5.
21. Keshavarz H, Fitzpatrick-Lewis D, Streiner DL, Maureen R, Ali U, Shannon HS, et al. Screening for depression: a systematic review and meta-analysis. CMAJ Open 2013;1:E159-67.
22. Hernán MA, Hernández-Díaz S, Robins JM. Randomized trials analyzed as observational studies. Ann Intern Med 2013;159:560-2.

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