

Screening for Depression: Proposed Work Plan

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Proposed Work Plan

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1. Purpose and Background

Purpose

Depression is a complex mental illness that is associated with disability and reduced quality of life for the person with the disorder, as well as posing a substantial societal burden. The purpose of this evidence review is to provide the Canadian Task Force on Preventive Health Care (CTFPHC) with the most recent literature to develop evidence-based recommendations. This will allow the CTFPHC to adequately re-evaluate the 2002 Canadian Task Force recommendation on screening for depression,^{1,2} which in turn evaluated the previous Canadian guidelines.³

In addition to the previous Canadian Task Force recommendations, there have been two related sets of recommendations.^{4,5} for screening for depression in adults based on systematic reviews^{4,6} sponsored by the United States Preventive Services Task Force (USPSTF). There are also recent recommendations for adolescents.⁷

The aim of this evidence report is to evaluate the literature on the effectiveness of screening for depression in asymptomatic adults on critical and important outcomes. Depression includes major depressive disorder (MDD) and related disorders (such as dysthymia and subsyndromal depression).

Condition Background

Definition

Depression is classified as ICD-10 Classification of Mental and Behavioural Disorders (ICD-10) (WHO, 1992) as a depressive episode (F32), recurrent depressive episode (F33) or mixed anxiety and depressive disorder (F41.2). Less severe forms of depression include 'sub-threshold depressive symptoms,' which fall below the criteria for major depression and which do not have a coding in ICD-10, and sub-threshold depressive symptoms persisting longer term (dysthymia disorder F34.1). To make a diagnosis of a depression, three key factors must be taken into consideration: severity, duration, and course. Although symptom count using a standardized instrument is important, it is primarily used to assess severity and not for diagnosis alone.

Major depressive disorder (MDD) is the occurrence of one or more major depressive episodes (MDE) and can be classified from mild to severe. An MDE is defined as a period of at least 2 weeks that is characterized either by depressed mood and/or markedly diminished interest or pleasure in all, or almost all, activities in addition to at least four other symptoms.⁸ When considering the less severe forms of depression, dysthymic disorder is characterized by a chronically depressed mood and at least two other depressive symptoms, that occur most of the day, more days than not, for at least two years. DSM-IV includes specifiers that can be used to further describe the characteristics of MDE or dysthymic disorder, such as whether an episode of depression includes psychosis or occurs in the postpartum period. Depression is common in adults and adolescents and is characterized by chronic, recurrent episodes that have significant impact on disability and mortality.

MDD has also been associated with a spectrum of clinical needs ranging from information and support to intensive treatment or hospitalization. The problem of heterogeneity of symptoms has been debated in the literature. Some have attempted to modify the diagnostic criteria so that they align more closely with clinical decisions. Others have posited proposals for guiding management using flexible approaches that can accommodate heterogeneity. Efforts to

redefine the condition have attempted to disentangle clinically relevant depression (i.e., those episodes that require clinical interventions) from episodes that represent responses to stress or loss and that are likely to be self-limited or non-pathological.^{9,10}

Prevalence and burden of disease

Prevalence of depression has been estimated to vary from 5 to 8.2 percent of the Canadian population afflicted annually.^{11,12} Kessler reported estimates of 16.2 percent lifetime prevalence and 6.6 percent annual prevalence of depression in the United States for adults.¹³ These are slightly higher than European prevalence rates of 12.8 percent lifetime and 3.9 percent annual.¹⁴ However, the burden of MDD is amplified by the typically chronic and recurrent nature of this disorder.¹⁵⁻¹⁷ As cognitive problems are a hallmark of MDD, its negative effect is especially destructive in the knowledge-based economy prominent in western societies.¹⁸ Furthermore, MDD in the Canadian population is associated with a wide variety of adverse outcomes such as negative employment transitions,¹⁹ elevated chronic disease incidence,²⁰⁻²³ injury risk,²⁴ diminished participation in preventive health activities,²⁵ and a negative impact on chronic disease risk factors such as obesity^{26,27} and smoking.^{28,29}

European estimates of the prevalence of dysthymic disorder in adults based on DSM-IV criteria, are 4.1 percent lifetime and 1.1 percent annual.¹⁴ Despite increases in provision of treatment for people with depression,³⁰ a reduction in prevalence has not yet been discernable in those countries where before–after comparisons have been feasible.^{31,32} This may be in part because a substantial number of people with depression remain untreated or receive inadequate treatment.³³ Subsyndromal depression, although poorly recognized, is at least as common as MDD and linked to poor quality of life.³⁴

MDD is a leading cause of disability across the world;^{9,35} specifically, depression is the second leading medical cause of long-term disability and the fourth leading cause of global burden of disease, and is predicted to become the second leading cause by 2020. The ongoing transition to a knowledge-based economy is expected to further magnify the impact of MDD on occupational functioning.¹⁸ Depressive disorders negatively affect quality of life (QOL); 63 percent of respondents with MDD had severe impairment in QOL, while 85 percent of those with double depression (MDD and dysthymic disorder) and 56 percent of those with dysthymic disorder had QOL impairment in the severe range.³⁶ The economic burden of depressive disorders is estimated to be \$83.1 billion.

The National Comorbidity Survey Replication study in the United States found that role impairment in people with MDD was lowest in the occupational domain and highest in the social domain.¹³ About 60 percent of respondents with an MDE in the past year reported severe or very severe role impairment. Parental depression has a negative effect on the development of their children and on family dynamics^{37,38} and intergenerational effects may amplify the impact of depression on population health.³⁹

Etiology and natural history

There are several competing theories about the etiology of MDD. These include genetic predisposition, biochemical imbalances, endocrine and neurophysiological dysfunction, psychological, and/or social processes and factors. The evidence is limited for each of these factors, but from a healthcare perspective, the observations that some physical illnesses (e.g., hypothyroidism, Cushing's Syndrome, cardiac disease, diabetes) are frequently associated with depression tends to support the physical or endocrine role in the development of depression.⁴⁰ With the aggressive exploration of brain function with neuroimaging, there is some evidence to suggest that brain structure and function are related to depression.⁴¹ Similarly, psychological

assessment findings provide some evidence for the role of cognitive and emotional processes as a causal factor in depression.⁴²

The risk of depression can commence from ages less than 12 years, in adolescence (12 to 18 years) and into adulthood (greater than 18 years). The Netherlands Mental Health Survey and Incidence Study assessed episode duration in community residents with new-onset episodes. Although 50 percent of people recovered within 3 months, the recovery rate flattened over time, and the authors estimated that approximately 20 percent would have episodes lasting longer than 24 months.⁴³ Some estimates suggest that at least 10 percent of patients have persistent or chronic depression.¹³

Traditionally, depression has been thought of as a time-limited disorder lasting on average four to nine months and that complete recovery is an attainable outcome following treatment. However, it is apparent that incomplete recovery (residual symptoms) and relapse are common. At least 50% of people following their first episode of major depression will go on to have at least one more episode and after the second and third episodes, the risk of further relapse rises to 70% and 90% respectively.⁴⁴

Overall, the recovery from a first episode is highly favourable; the corollary is not true, as those with recurrent episodes sustain long term symptoms and are less likely to achieve remission.

Consequences if left untreated

Depression exerts a negative impact on physical health; it reduces adherence to medical treatment,⁴⁵ reduces participation in preventive activities,⁴⁶ and increases the likelihood of risk factors such as obesity,⁴⁷ smoking,⁴⁸ and sedentary lifestyles.⁴⁹ MDD may be associated with immune dysfunction,⁵⁰⁻⁵³ cardiovascular disease,⁵⁴⁻⁵⁶ endocrine and neurological diseases and a general increase in chronic disease incidence.²⁰ Mortality rates are high: approximately 4 percent of people with a mood disorder die by their own hand and about two thirds of suicides are preceded by depression.

Depression also has a negative impact on occupational functioning. In one study, depressed workers had significantly greater performance deficits than control workers with regard to performing mental interpersonal tasks, time management, output and physical tasks.⁵⁷ When depressed workers were compared to workers with rheumatoid arthritis, the depressed employees were almost five times more likely to become unemployed than those with arthritis.⁵⁸ Depressed employees are also more likely to become unemployed or miss time at work than physically ill employees.⁵⁹

Risk factors

The factors most commonly associated with depression are gender, age, and family history of depression, and chronic physical illness.^{5,6,60,61} The most consistent finding in cross-national studies of risk factors for depression is that women are at higher risk than men.⁶² In Canada women are twice as likely as men to develop depression in their lifetime,⁶³ although these gender differences tend to decrease with age.¹¹ People under 20 years old have the highest rate of depression symptoms and age of onset of the illness is most commonly late adolescence or early adulthood,^{62,63} while the prevalence decreases with age.^{64,65} Family history of depression is frequently cited as a risk factor for depression, and one Canadian study of the cumulative incidence of major depressive episodes (MDE) over 6 years found that family history of MDE was the strongest independent predictor of MDE (HR = 2.01, 95% CI: 1.51, 2.68).⁶⁵ They also found that both female gender or having one or more chronic conditions were strongly associated with MDE (HR = 1.72, 95% CI: 1.36, 2.18 and HR = 1.54, 95% CI: 1.18-2.00 respectively) while age (entered as a continuous variable, per year) was negatively associated with MDE (HR = 0.98, 95% CI: 0.97, 0.99). Finally, they found that income, employment status,

marital status, educational levels, ethnicity and geographic location were not significantly associated with MDE. The two most controversial results in this study relate to income and marital status; prevalence studies regularly cite low income and single marital status (including widowed, separated or divorced) as being strongly associated with depression.^{62,64,66}

One risk factor not considered in many prevalence or incidence studies of depression is aboriginal heritage. According to the Mood Disorders Society of Canada,⁶³ 30.4 percent of Aboriginal Canadians living on reserves have had at least one MDE compared to 10-12 percent of the general population, and 26.1 percent have chronic depression compared to 2.7 percent of the general population.⁶⁷ In addition, off-reserve Aboriginal people are 1.5 times more likely to experience depression than the general population.⁶³

Interventions/treatments of persons diagnosed with MDD, dysthymia or subsyndromal depression

In primary care, the range of interventions offered following diagnosis may extend from close monitoring of mild episodes without immediate treatment (watchful waiting), through guided self-management,⁶⁸ brief psychological or behavioural interventions, pharmacological management, and, if needed, referral to more specialized services or hospital admission.

Patients with positive findings for depression and related disorders will be recommended for treatment which consists primarily of pharmacological interventions [e.g., selective serotonin reuptake inhibitors (SSRIs) non-SSRI's] alone or psychological therapies [cognitive behavioural therapy (CBT), interpersonal therapy (IPT), and other psychotherapies (behaviour therapy, family therapies, short term dynamic psychotherapy)] or other non-pharmacological treatments that may include exercise, light therapy, acupuncture or herbal remedies and supplements (e.g., St. John's Wort, SAME); some non-pharmacological therapies may have not been validated for their efficacy.

Recently, a stepped care approach to treatment has gained prominence. In a stepped care approach, more intensive treatments (e.g., second and third line treatments) are applied to persons who have not, or may not benefit from first-line treatments (which tend to be monotherapy type interventions considered to be simpler in scope), or for those who can be accurately predicted not to benefit from such treatment.⁶⁹ Often low intensity in the first step, these initial interventions may include watchful waiting (no intervention), non-pharmacological treatments (including psychological interventions), or monotherapy drug interventions. The aim in this stepped approach is to reserve high intensity and high resource interventions for those who do not respond to more benign therapies. There is always the risk, however, that the preference for first step approaches may lead to initial inadequate management of those with more severe symptoms or higher needs. This inevitably causes more suffering (endurance of symptoms) and exposure to ineffective treatments. Recently, NICE guidelines from the United Kingdom, where a stepped care approach is advocated, have taken this risk into account by considering the symptom severity at the start.⁶⁰ The overall effectiveness of this approach has yet to be determined.

Phases of treatment of major depressive disorder

Based on the work of Kupfer et al.,⁴⁴ there are three phases of treatment for MDD: acute, continuation, and maintenance. Acute treatment is aimed at the elimination of symptoms of depression and restoration of psychosocial functioning. Continuation is a prolongation of treatment from 4 to 9 months, such that the episode of depression is considered completely resolved. For the continuation phase, the treatment aims to return patients to baseline function and quality of life and to prevent recurrence of symptoms. For the maintenance phase, the

treatment goal is to prevent recurrence of new episodes of MDD. In this context, relapse is understood to occur during the continuation phase, but recurrence during the maintenance phase.

Adverse effects of antidepressants and other treatments

There are a variety of treatments used for treating depression and for the majority of these (e.g., exercise, light therapy, acupuncture) the potential for harms do not differ from a person with other illnesses who are receiving these therapies. As such, we focus on the potential for serious adverse events associated with the use of antidepressants rather than the more frequent but less severe events (i.e., weight gain, sexual dysfunction, dry mouth, etc.).

There is concern about worsening or emergent suicidal ideas and attempts associated with antidepressants that has led to black box warnings in the U.S. and elsewhere. Meta-analyses of RCTs have not demonstrated an increased risk of completed suicide⁷⁰ or increased suicidality with SSRIs and newer antidepressants⁷¹ across all age groups. In age-stratified analyses, there is evidence that younger subjects have an increased risk of suicidality when treated with antidepressants while antidepressants have a protective effect in older subjects.⁷² The U.S. Food and Drug Administration recommends that patients treated with antidepressant medications should be monitored regularly for increases in suicidal thoughts and behaviours.⁷³ Monitoring should include the assessment of emergent agitation, irritability, or changes in behaviour. The risk of suicide attempts appears to be maximal during the first one to two months of treatment.

Serotonin syndrome or neuroleptic malignant syndrome-like events can occur when SSRIs/SNRIs are co-prescribed with MAO inhibitors or other serotonergic agents. SSRIs are associated with risk of upper gastrointestinal tract bleeding, especially when used with non-steroidal anti-inflammatory drugs (NSAIDs)⁷⁴ in the elderly with osteoporosis and fractures.⁷⁵ Hyponatremia and agranulocytosis are also reported in a small number of patients.⁷⁶

Current clinical practice

In Canada, a recently published series of guidelines from the Canadian Society for Mood Disorders (CANMAT) have set forth a stepped approach to the treatment of MDD.⁷⁷⁻⁸¹ There are recommendations for monotherapies (pharmacological, non-pharmacological, psychological, and for alternative treatments) and for augmentation or combination therapies.

2. Previous Review and CTFPHC Recommendations

There have been two sets of recommendations by the CTFPHC that have evaluated the value of screening for depression.^{1,3} The more recent CTFPHC review used evidence from a concurrent review undertaken by the Agency for Healthcare Research and Quality (AHRQ) and sponsored by the USPSTF⁸² and then updated the evidence from 2001 until approximately 2003 (although the dates are not well detailed in the original document).

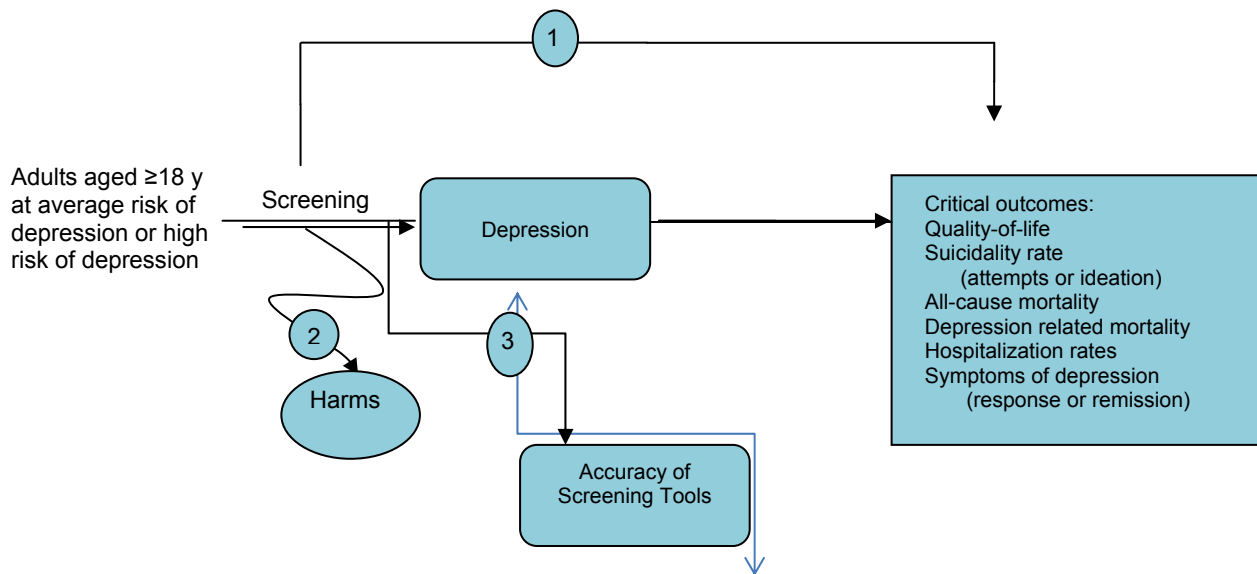
MacMillan et al.(2004) recommended “screening adults in the general population for depression in primary care setting that have integrated programs for feedback to patients and access to case management for mental health care”.¹ This was based on good to fair evidence and was a grade B recommendation. Good evidence was found to suggest that “there is insufficient evidence to recommend for or against screening adults in the general population for depression in primary care settings where effective follow-up and treatment are not available.”¹

In 2009, the USPSTF task force updated their 2002 recommendations, and recommended “screen when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up” and did not recommend screening if these supports were not in place.⁵

3. Analytic framework

The analytic framework (Figure 1) shows the key questions to be addressed in the evidence review.

Figure 1. Analytic framework for screening for depression



4. Key and Contextual Questions

Key questions (KQ):

The CTFPHC have proposed a staged review. In the context of this evidence review, if the review findings indicate that there is insufficient evidence for KQ1 to establish the clinical benefit of screening for depression or that screening for depression causes undue harm (KQ2), then further systematic review for KQ3 is unwarranted.

Stage 1: Evaluating the evidence for benefits or harms of screening for depression

KQ1a. What is the evidence for the benefit of screening for depression in asymptomatic adults 18 years of age or over from the general population not at high risk for depression in (i) primary care or (ii) other outpatient settings to improve critical outcomes?

KQ1b. What is the evidence for the benefit of screening for depression in adults at high risk for depression in (i) primary care, (ii) other outpatient settings, or (iii) specialty clinic setting to improve critical outcomes?

KQ2a. What is the evidence for the harms of screening for depression in asymptomatic adults 18 years of age or over from the general population not at high risk for depression in (i) primary care or (ii) other outpatient settings?

KQ2b. What is the evidence for the harms of screening for depression in adults at high risk for depression in (i) primary care, (ii) other outpatient settings, or (iii) specialty clinics?

Stage 2: Evaluating the evidence for accuracy of tools to detect depression in primary care settings

KQ3a. What are the depression screening tool(s) that are most effective (accurate) in diagnosing or detecting depression in adult patients in primary care settings?

KQ3b. What is the effectiveness of short screening questions tools (ultra short=1-4 items and taking less than 2 minutes to complete; short=5-14 items and 2 to 5 minutes) compared with long screening tools (≥ 15 items and more than 5 minutes) to screen for depression in primary care settings?

Contextual questions:

In unselected and high risk adult populations in primary care, outpatient and specialty clinic settings previously identified.

SCREENING

1. What is the evidence concerning the optimal interval of screening for depression?
2. What is the cost-effectiveness of screening for depression?
3. What are the patient preferences and values regarding screening?
4. What process and outcome performance measures or indicators have been identified in the literature to measure and monitor the impact of screening for depression?

TREATMENT

5. What are patient preferences and values for treatment interventions antidepressants and/or psychotherapy) for depression?

6. What are the benefits and harms associated with the treatment (antidepressants and/or psychotherapy) for depression?

5. Approaches to the Literature search and Review Methods

Stage 1: Evaluating the evidence for benefits or harms of screening for depression

We considered updating the O'Connor et al., (2009) review which served as the evidentiary base for the 2009 USPSTF recommendations for adults.⁵ This review screened the studies included in the review from the evidentiary base for the original USPTSF recommendations based on the Pignone et al., (2002)⁴ systematic review. The O'Connor review used a targeted search approach that included literature from 1998 to early 2009. EMBASE was not searched in this review. Studies that included high risk subjects or were undertaken in non-healthcare settings were excluded. In addition, studies not meeting a threshold of quality and a 6 week follow-up were excluded. The eligibility criteria in this previous review do not capture the literature necessary to address all key questions in Stage 1 of the review process.

Given the research questions of interest to the Canadian Task Force, we propose undertaking a de novo systematic review to address the research questions in Stage 1. We are proposing to search Cochrane Central Register of Controlled Trials and Cochrane Database of Systematic Reviews, MEDLINE®, EMBASE, PsycINFO®, reference lists of eligible studies, and grey literature searches.

Stage 2: Evaluating the evidence for accuracy of tools to detect depression in primary care settings

KQ3a: What are the depression screening tool(s) that is/are most effective (accurate) in adult patients in primary care settings?

The original USPSTF systematic review by Pignone et al. (2002)⁴, evaluated the accuracy of tools used to diagnose/ screen for depression in primary care; in this review 41 studies were identified evaluating 13 different instruments for adults in primary care settings. However, this review only included MEDLINE and Cochrane databases in their search and included studies up to 1999. This review is approximately 10 years out of date.

We are proposing a modified update of this systematic review, whereby we would include EMBASE prior to 1999, but all other databases following this year threshold. Our updated search would include all the databases listed in KQ1-2.

KQ3b: What is the effectiveness of short screening questions tools (2-3 items) compared with long screening tools (>10 items) to screen for depression?

A recent review by Mitchell and Coyne, (2007)⁸³ has potentially addressed this question of the relative value of short screening questions; the literature search ended in 2006 and therefore, is in need of updating. The original review searched MEDLINE®, CINAHL, EMBASE and PsycINFO®. One option to consider is to update this review in the same databases and to search from 2006 forward; however, the review has significant methodological flaws. The working group will have to consider

6. Inclusion/ Exclusion Criteria

Stage 1: Evaluating the evidence for benefits or harms of screening for depression

Population: Asymptomatic adults over the age of 18 years from the general population who are not at high risk for depression, or who are at high risk for depression

Intervention: Screening for depression using screening tools, questionnaires, or instruments. Formal diagnostic testing following a positive screen is not required as most patients do not undergo formal diagnosis following a positive screen.

Comparator: No screening

Outcomes: Quality of life, suicidality rate (attempts or ideation), all-cause mortality, depression-related mortality, hospitalization rates, symptoms or depression (response or remission)

Harms: Psychological stress (labelling, anxiety, stigma), false positives, false negatives, decreased day-to-day functioning, increased symptoms

Setting: Primary care, other outpatient settings (where feedback is provided to the clinician or where feedback is not provided for the question on clinical benefits of screening), specialty clinic setting for high risk patient groups (including adults with chronic illnesses, chronic pain with or without cancer, alcohol and substance abuse disorder, aboriginals, perinatal women; feedback provided to the clinician or program or feedback not provided).

Study design: RCTs, observational studies with a comparator group. Observational studies without a comparison group will be excluded.

Studies considered for the 'Harms of screening'-any quantitative study design

Language: English and French

Stage 2: Evaluating the evidence for short screening questions;

The eligibility criteria for this will be discussed if the review progresses to this stage.

7. Quality and strength of evidence criteria

The retrieved included studies will be reviewed according to the criteria set out in the CTFPHC Procedure Manual.

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Appendix 1: Search strategy

MERSC Depression Screening Detailed Search Strategies

Stage 1: KQ1 and 2

Medline-OVID

December 8 2010

1. depressive disorder/ or depression, postpartum/ or depressive disorder, major/ or dysthymic disorder/ or seasonal affective disorder/
2. Depression/
3. dysthym*.tw.
4. (subclinical adj2 depressi*).tw.
5. (subsyndromal adj2 depressi*).tw.
6. (subthreshold adj2 depressi*).tw.
7. (subdiagnostic adj2 depressi*).tw.
8. (postnatal adj2 depressi*).tw.
9. (postpartum adj2 depression).mp.
10. (perinatal adj2 depressi*).tw.
11. or/1-10
12. mass screening/
13. screen*.mp.
14. case finding.tw.
15. casefinding.tw.
16. or/12-15
17. 11 and 16
18. depressive disorder/ or depression, postpartum/ or depressive disorder, major/ or dysthymic disorder/ or seasonal affective disorder/
19. Depression/
20. dysthym*.tw.
21. (subclinical adj2 depressi*).tw.
22. (subsyndromal adj2 depressi*).tw.
23. (subthreshold adj2 depressi*).tw.
24. (subdiagnostic adj2 depressi*).tw.
25. (postnatal adj2 depressi*).tw.
26. (postpartum adj2 depression).mp.
27. (perinatal adj2 depressi*).tw.
28. or/18-27
29. mass screening/
30. screen*.mp.
31. case finding.tw.
32. casefinding.tw.
33. or/29-32
34. 28 and 33
35. (adverse adj2 (effects or events)).tw.
36. harm*.tw.
37. label*.tw.
38. adverse effects.fs.
39. ((inappropriat* or unnecess* or unneed*) adj3 (treat* or Surg* or therap* or regimen*)).mp.
40. over treatment.mp.
41. overtreatment.mp.
42. or/35-41

43. 34 and 42
44. 17 or 43
45. limit 44 to yr="1994 -Current"

EMBASE-OVID

December 8 2010

1. (depressi* or dysthm* or affective or mood).ti.
2. (subclinical adj2 depressi*).tw.
3. (subsyndromal adj2 depressi*).tw.
4. (subthreshold adj2 depressi*).tw.
5. (subdiagnostic adj2 depressi*).tw.
6. exp depression/
7. (perinatal adj2 depressi*).tw.
8. (postnatal adj2 depressi*).tw.
9. (postpartum adj2 depression).mp.
10. or/1-9
11. mass screening/
12. screen*.mp.
13. case finding.tw.
14. casefinding.tw.
15. or/11-14
16. 10 and 15
17. human/
18. nonhuman/
19. animal/
20. animal experiment/
21. or/18-21
22. 32 not (32 and 28)
34. 27 not 33
35. trial.tw.
36. 34 or 35
37. 16 and 36
38. limit 37 to yr="1994 -Current"
39. limit 38 to (english or french)
40. limit 39 to (editorial or letter or note)
41. 39 not 40
42. (adverse adj2 (effects or events)).tw.
43. harm*.tw.
44. label*.tw.
45. unnecessary.tw.
46. overtreatment.tw.
47. over treatment.tw.
48. harm reduction/
49. or/42-48
50. (depressi* or dysthm* or affective or mood).ti.
51. (subclinical adj2 depressi*).tw.
52. (subsyndromal adj2 depressi*).tw.
53. (subthreshold adj2 depressi*).tw.
54. (subdiagnostic adj2 depressi*).tw.
55. exp depression/
56. (perinatal adj2 depressi*).tw.

57. (postnatal adj2 depressi*).tw.
58. (postpartum adj2 depression).mp.
59. or/50-58
60. mass screening/
61. screen*.mp.
62. case finding.tw.
63. casefinding.tw.
64. or/60-63
65. 59 and 64
66. 49 and 65
67. limit 66 to yr="1994 -Current"
68. limit 67 to (english or french)
69. 68 or 41

PsycINFO-OVID

December 8 2010

1. (depressi* or dysythm* or affective or mood).ti.
2. (subclinical adj2 depressi*).tw.
3. (subsyndromal adj2 depressi*).tw.
4. (subthreshold adj2 depressi*).tw.
5. (subdiagnostic adj2 depressi*).tw.
6. (postnatal adj2 depressi*).tw.
7. (postpartum adj2 depression).mp.
8. (perinatal adj2 depressi*).tw.
9. exp depression/
10. exp major depression/
11. or/1-10
12. mental disorders/
13. depress*.ti,ab.
14. 12 and 13
15. 11 or 14
16. health screening/ or screening/
17. screen*.ti,ab.
18. case finding.ti,ab.
19. casefinding.ti,ab.
20. or/16-19
21. clinical trials/
22. random sampling/
23. ((singl\$ or doubl\$ or trebl\$ or tripl\$) adj25 (blind\$ or mask\$)).ti,ab.
24. placebo\$.ti,ab.
25. random\$.ti,ab.
26. trial.tw.
27. or/21-26
28. (adverse adj2 (effects or events)).tw.
29. harm*.tw.
30. label*.tw.
31. unnecessary.tw.
32. overtreatment.tw.
33. over treatment.tw.
34. ((inappropriat* or unnecess* or unneed*) adj3 (treat* or Surg* or therap* or regimen*)).mp.
35. or/28-34

36. 15 and 20
37. 27 and 36
38. (adverse adj2 (effects or events)).tw.
39. harm*.tw.
40. label*.tw.
41. unnecessary.tw.
42. overtreatment.tw.
43. over treatment.tw.
44. ((inappropriat* or unnecess* or unneed*) adj3 (treat* or Surg* or therap* or regimen*)).mp.
45. psychological stress/
46. or/38-45
47. 36 and 46
48. 37 or 47
49. limit 48 to yr="1994 -Current"
50. limit 49 to (english or french)

EBM Reviews - Cochrane Central Register of Controlled Trials

December 8 2010

1. depressive disorder/ or depression, postpartum/ or depressive disorder, major/ or dysthymic disorder/ or seasonal affective disorder/
2. Depression/
3. dysthym*.tw.
4. (subclinical adj2 depressi*).tw.
5. (subsyndromal adj2 depressi*).tw.
6. (subthreshold adj2 depressi*).tw.
7. (subdiagnostic adj2 depressi*).tw.
8. (postnatal adj2 depressi*).tw.
9. (postpartum adj2 depression).mp.
10. (perinatal adj2 depressi*).tw.
11. or/1-10
12. mass screening/
13. screen*.mp.
14. case finding.tw.
15. casefinding.tw.
16. or/12-15
17. 11 and 16
18. depressive disorder/ or depression, postpartum/ or depressive disorder, major/ or dysthymic disorder/ or seasonal affective disorder/
19. Depression/
20. dysthym*.tw.
21. (subclinical adj2 depressi*).tw.
22. (subsyndromal adj2 depressi*).tw.
23. (subthreshold adj2 depressi*).tw.
24. (subdiagnostic adj2 depressi*).tw.
25. (postnatal adj2 depressi*).tw.
26. (postpartum adj2 depression).mp.
27. (perinatal adj2 depressi*).tw.
28. or/18-27
29. mass screening/
30. screen*.mp.
31. case finding.tw.

32. casefinding.tw.
33. or/29-32
34. 28 and 33
35. (adverse adj2 (effects or events)).tw.
36. harm*.tw.
37. label*.tw.
38. adverse effects.fs.
39. ((inappropriat* or unnecess* or unneed*) adj3 (treat* or Surg* or therap* or regimen*)).mp.
40. over treatment.mp.
41. overtreatment.mp.
42. or/35-41
43. 34 and 42
44. 17 or 43
45. limit 44 to yr="1994 -Current"

Stage 1—Context Questions for Treatment

Medline-OVID (Treatment)

April 6 2011

1. *Depression/dh, de, dt, mo, px, rh, th [Diet Therapy, Drug Effects, Drug Therapy, Mortality, Psychology, Rehabilitation, Therapy]
2. exp *Depressive Disorder/dh, de, dt, mo, px, rh, th
3. or/1-2
4. exp *Antidepressive Agents/
5. exp *Exercise Therapy/
6. exp *Behavior Therapy/
7. or/4-6
8. 3 and 7
9. meta-analysis/
10. exp meta-analysis as topic/
11. (meta analy* or metaanaly* or met analy* or metanaly*).tw.
12. review literature as topic/
13. (collaborative research or collaborative review* or collaborative overview*).tw.
14. (integrative research or integrative review* or intergrative overview*).tw.
15. (quantitative adj3 (research or review* or overview*)).tw.
16. (research integration or research overview*).tw.
17. (systematic* adj3 (review* or overview*)).tw.
18. (methodologic* adj3 (review* or overview*)).tw.
19. exp technology assessment biomedical/
20. (hta or thas or technology assessment*).tw.
21. ((hand adj2 search*) or (manual* adj search*)).tw.
22. ((electronic adj database*) or (bibliographic* adj database*)).tw.
23. ((data adj2 abstract*) or (data adj2 extract*)).tw.
24. (analys* adj3 (pool or pooled or pooling)).tw.
25. mantel haenszel.tw.
26. (cohrane or pubmed or pub med or medline or embase or psycinfo or psyclit or psychinfo or psychlit or cinahl or science citation index).ab.
27. or/9-26
28. 8 and 27
29. limit 28 to yr="2005 -Current"
30. limit 29 to (english or french)

Medline-OVID (Adverse Events Treatment)

March 24 2011

1. depression/
2. exp depressive disorder/
3. or/1-2
4. exp *Antidepressive Agents/ae, ct, po, to [Adverse Effects, Contraindications, Poisoning, Toxicity]
5. exp *Exercise Therapy/ae, ct, po, to
6. exp *Behavior Therapy/ae, ct
7. (adverse or harm?).ti.
8. 5 or 6 or 7
9. 3 and 8
10. 4 or 9
11. meta-analysis/
12. exp meta-analysis as topic/
13. (meta analy* or metaanaly* or met analy* or metanaly*).tw.
14. review literature as topic/
15. (collaborative research or collaborative review* or collaborative overview*).tw.
16. (integrative research or integrative review* or intergrative overview*).tw.
17. (quantitative adj3 (research or review* or overview*)).tw.
18. (research integration or research overview*).tw.
19. (systematic* adj3 (review* or overview*)).tw.
20. (methodologic* adj3 (review* or overview*)).tw.
21. exp technology assessment biomedical/
22. (hta or thas or technology assessment*).tw.
23. ((hand adj2 search*) or (manual* adj search*)).tw.
24. ((electronic adj database*) or (bibliographic* adj database*)).tw.
25. ((data adj2 abstract*) or (data adj2 extract*)).tw.
26. (analys* adj3 (pool or pooled or pooling)).tw.
27. mantel haenszel.tw.
28. (cohrane or pubmed or pub med or medline or embase or psycinfo or psyclit or psychinfo or psyclit or cinahl or science citation index).ab.
29. or/11-28
30. 10 and 29
31. animals/ not (animals/ and humans/)
32. 30 not 31
33. limit 32 to (english or french)
34. limit 33 to yr="2005 -Current"

Medline-OVID (Patient Preferences Treatment)

March 28 2011

1. *"patient acceptance of health care"/ or *patient compliance/ or *patient participation/ or patient satisfaction/ or patient preference/ or *treatment refusal/
2. (women? adj3 (acceptance or preference? or satisfaction or experience?)).tw.
3. (consumer? adj3 (acceptance or preference? or satisfaction or experience?)).tw.
4. (patient? adj3 (acceptance or preference? or satisfaction or experience?)).tw.
5. willingness to pay.tw.
6. ((conjoint or contingent) adj3 (valuation or analysis)).tw.
7. or/1-6
8. *Depression/dh, de, dt, mo, px, rh, th [Diet Therapy, Drug Effects, Drug Therapy, Mortality, Psychology, Rehabilitation, Therapy]

9. exp *Depressive Disorder/dh, de, dt, mo, px, rh, th
10. or/8-9
11. exp *Antidepressive Agents/
12. exp *Exercise Therapy/
13. exp *Behavior Therapy/
14. or/11-13
15. 10 and 14
16. 7 and 15
17. limit 16 to (english or french)
18. limit 17 to yr="2005 -Current"

Stage 2—KQ3a&b

Medline-OVID

March 15 2011

1. Depression/
2. exp Depressive Disorder/
3. 1 or 2
4. exp mass screening/
5. exp "Sensitivity and Specificity"/
6. "reproducibility of results"/
7. 4 or 5 or 6
8. (beck adj2 depression).tw.
9. CES-D.tw.
10. Diagnostic interview schedule.tw.
11. General health questionnaire.tw.
12. (Hamilton adj3 scale).tw.
13. (hopkins adj3 checklist).tw.
14. HSCL.tw.
15. SCL-90.tw.
16. medical outcomes study.tw.
17. MHI-5.tw.
18. mental health inventory.tw.
19. MADRS.tw.
20. Montgomery-Asberg.tw.
21. PRIME-MD.tw.
22. structured clinical interview.tw.
23. SDDS-PC.tw.
24. Symptom Driven Diagnostic System for Primary Care.tw.
25. Zung.tw.
26. or/8-25
27. exp Primary Health Care/
28. general practice/ or family practice/
29. Ambulatory Care/
30. 27 or 28 or 29
31. 26 and 30
32. 3 and 7
33. 31 and 32
34. limit 33 to ed=20010801-20110117
35. depressive disorder/ or depression, postpartum/ or depressive disorder, major/ or dysthymic disorder/ or seasonal affective disorder/

36. Depression/
37. dysthym*.tw.
38. (subclinical adj2 depressi*).tw.
39. (subsyndromal adj2 depressi*).tw.
40. (subthreshold adj2 depressi*).tw.
41. (subdiagnostic adj2 depressi*).tw.
42. (postnatal adj2 depressi*).tw.
43. (postpartum adj2 depression).mp.
44. (perinatal adj2 depressi*).tw.
45. or/35-44
46. mass screening/
47. screen*.mp.
48. case finding.tw.
49. casefinding.tw.
50. detect.tw.
51. diagnos*.tw.
52. recogni?e.tw.
53. or/46-52
54. 45 and 53
55. depressive disorder/di or depression, postpartum/di or depressive disorder, major/di or dysthymic disorder/di or seasonal affective disorder/di
56. Depression/di
57. 55 or 56
58. 54 or 57
59. (short or brief).tw.
60. (3 item or three item or three question 3 question).tw.
61. (1 item or single item or single question or 1 question).tw.
62. (2 item or two item or two question or 2 question).tw.
63. patient health questionnaire.tw.
64. or/59-63
65. 58 and 64
66. limit 65 to yr="1994 -Current"
67. 34 or 66

EMBASE-OVID

March 15, 2011

- 1 (beck adj2 depression).tw.
- 2 CES-D.tw.
- 3 Diagnostic interview schedule.tw.
- 4 General health questionnaire.tw.
- 5 (Hamilton adj3 scale).tw.
- 6 (hopkins adj3 checklist).tw.
- 7 HSCL.tw.
- 8 SCL-90.tw.
- 9 medical outcomes study.tw.
- 10 MHI-5.tw.
- 11 mental health inventory.tw.
- 12 MADRS.tw.
- 13 Montgomery-Asberg.tw.
- 14 PRIME-MD.tw.
- 15 structured clinical interview.tw.

16 SDDS-PC.tw.
17 Symptom Driven Diagnostic System for Primary Care.tw.
18 Zung.tw.
19 or/1-18
20 (depressi* or dysthm* or affective or mood).ti.
21 (subclinical adj2 depressi*).tw.
22 (subsyndromal adj2 depressi*).tw.
23 (subthreshold adj2 depressi*).tw.
24 (subdiagnostic adj2 depressi*).tw.
25 exp depression/
26 (perinatal adj2 depressi*).tw.
27 (postnatal adj2 depressi*).tw.
28 (postpartum adj2 depression).mp.
29 or/20-28
30 mass screening/
31 exp primary health care/
32 general practice/
33 exp ambulatory care/
34 31 or 32 or 33
35 mass screening/
36 screen*.mp.
37 case finding.tw.
38 casefinding.tw.
39 "sensitivity and specificity"/
40 reproducibility/
41 or/35-40
42 19 and 34
43 29 and 41
44 42 and 43
45 limit 44 to (english or french)
46 mass screening/
47 screen*.mp.
48 case finding.tw.
49 casefinding.tw.
50 detect.tw.
51 diagnos*.tw.
52 recogni?e.tw.
53 or/46-52
54 (short or brief).tw.
55 (3 item or three item or three question 3 question).tw.
56 (1 item or single item or single question or 1 question).tw.
57 (2 item or two item or two question or 2 question).tw.
58 patient health questionnaire.tw.
59 or/54-58
60 (depressi* or dysthm* or affective or mood).ti.
61 (subclinical adj2 depressi*).tw.
62 (subsyndromal adj2 depressi*).tw.
63 (subthreshold adj2 depressi*).tw.
64 (subdiagnostic adj2 depressi*).tw.
65 exp depression/
66 (perinatal adj2 depressi*).tw.

- 67 (postnatal adj2 depressi*).tw.
- 68 (postpartum adj2 depression).mp.
- 69 or/60-68
- 70 exp depression/di
- 71 53 and 69
- 72 70 or 71
- 73 59 and 72
- 74 limit 73 to em=200615-201102
- 75 limit 74 to (english or french)
- 76 limit 45 to em=200125-201102
- 77 75 or 76

PsycINFO-OVID

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- 1. (beck adj2 depression).tw.
- 2. CES-D.tw.
- 3. Diagnostic interview schedule.tw.
- 4. General health questionnaire.tw.
- 5. (Hamilton adj3 scale).tw.
- 6. (hopkins adj3 checklist).tw.
- 7. HSCL.tw.
- 8. SCL-90.tw.
- 9. medical outcomes study.tw.
- 10. MHI-5.tw.
- 11. mental health inventory.tw.
- 12. MADRS.tw.
- 13. Montgomery-Asberg.tw.
- 14. PRIME-MD.tw.
- 15. structured clinical interview.tw.
- 16. SDDS-PC.tw.
- 17. Symptom Driven Diagnostic System for Primary Care.tw.
- 18. Zung.tw.
- 19. or/1-18
- 20. (depressi* or dysythm* or affective or mood).ti.
- 21. (subclinical adj2 depressi*).tw.
- 22. (subsyndromal adj2 depressi*).tw.
- 23. (subthreshold adj2 depressi*).tw.
- 24. (subdiagnostic adj2 depressi*).tw.
- 25. (postnatal adj2 depressi*).tw.
- 26. (postpartum adj2 depression).mp.
- 27. (perinatal adj2 depressi*).tw.
- 28. exp depression/
- 29. exp major depression/
- 30. or/20-29
- 31. mental disorders/
- 32. depress*.ti,ab.
- 33. 31 and 32
- 34. 30 or 33
- 35. health screening/ or screening/
- 36. screen*.ti,ab.
- 37. casefinding.tw.

38. case finding.tw.
39. test reliability/ or "error of measurement"/ or interrater reliability/ or test standardization/
40. psychometrics/
41. exp statistical analysis/
42. or/35-41
43. primary mental health prevention/
44. primary health care/
45. outpatient treatment/
46. general practitioners/ or family medicine/ or family physicians/
47. or/43-46
48. 42 and 47
49. 19 and 34
50. 48 and 49
51. limit 50 to (english or french)
52. (short or brief).tw.
53. (3 item or three item or three question 3 question).tw.
54. (1 item or single item or single question or 1 question).tw.
55. (2 item or two item or two question or 2 question).tw.
56. patient health questionnaire.tw.
57. or/52-56
58. (depressi* or dysythm* or affective or mood).ti.
59. (subclinical adj2 depressi*).tw.
60. (subsyndromal adj2 depressi*).tw.
61. (subthreshold adj2 depressi*).tw.
62. (subdiagnostic adj2 depressi*).tw.
63. (postnatal adj2 depressi*).tw.
64. (postpartum adj2 depression).mp.
65. (perinatal adj2 depressi*).tw.
66. exp depression/
67. exp major depression/
68. or/58-67
69. mental disorders/
70. depress*.ti,ab.
71. 69 and 70
72. 68 or 71
73. health screening/ or screening/
74. screen*.ti,ab.
75. case finding.ti,ab.
76. casefinding.ti,ab.
77. detect.tw.
78. diagnos*.tw.
79. recogni?e.tw.
80. or/73-79
81. 57 and 72 and 80
82. limit 81 to yr="1994 -Current"
83. limit 82 to (english or french)
84. limit 51 to yr="2001 -Current"
85. 83 or 84

1 (beck adj2 depression).tw.
2 CES-D.tw.
3 Diagnostic interview schedule.tw.
4 General health questionnaire.tw.
5 (Hamilton adj3 scale).tw.
6 (hopkins adj3 checklist).tw.
7 HSCL.tw.
8 SCL-90.tw.
9 medical outcomes study.tw.
10 MHI-5.tw.
11 mental health inventory.tw.
12 MADRS.tw.
13 Montgomery-Asberg.tw.
14 PRIME-MD.tw.
15 structured clinical interview.tw.
16 SDDS-PC.tw.
17 Symptom Driven Diagnostic System for Primary Care.tw.
18 Zung.tw.
19 or/1-18
20 (depressi* or dysthm* or affective or mood).ti.
21 (subclinical adj2 depressi*).tw.
22 (subsyndromal adj2 depressi*).tw.
23 (subthreshold adj2 depressi*).tw.
24 (subdiagnostic adj2 depressi*).tw.
25 [exp depression/]
26 (perinatal adj2 depressi*).tw.
27 (postnatal adj2 depressi*).tw.
28 (postpartum adj2 depression).mp.
29 or/20-28
30 [mass screening/]
31 [exp primary health care/
32 [general practice/]
33 [exp ambulatory care/]
34 31 or 32 or 33
35 [mass screening/]
36 screen*.mp.
37 case finding.tw.
38 casefinding.tw.
39 ["sensitivity and specificity"/]
40 [reproducibility/]
41 or/35-40
42 19 and 34
43 29 and 41
44 42 and 43
45 limit 44 to (english or french)
46 [mass screening/]
47 screen*.mp.
48 case finding.tw.
49 casefinding.tw.
50 detect.tw.
51 diagnos*.tw.

52 recogni?e.tw.
 53 or/46-52
 54 (short or brief).tw.
 55 (3 item or three item or three question 3 question).tw.
 56 (1 item or single item or single question or 1 question).tw.
 57 (2 item or two item or two question or 2 question).tw.
 58 patient health questionnaire.tw.
 59 or/54-58
 60 (depressi* or dysthm* or affective or mood).ti.
 61 (subclinical adj2 depressi*).tw.
 62 (subsyndromal adj2 depressi*).tw.
 63 (subthreshold adj2 depressi*).tw.
 64 (subdiagnostic adj2 depressi*).tw.
 65 [exp depression/]
 66 (perinatal adj2 depressi*).tw.
 67 (postnatal adj2 depressi*).tw.
 68 (postpartum adj2 depression).mp.
 69 or/60-68
 70 [exp depression/di]
 71 53 and 69
 72 70 or 71
 73 59 and 72
 74 limit 73 to em=200615-201102
 75 limit 74 to (english or french)
 76 limit 45 to em=200125-201102
 77 75 or 76
 78 44 or 73
 79 limit 78 to (english or french)
 80 79 not 77
 81 19 and 29 and 41
 82 limit 81 to last 10 years

EBM Reviews - Cochrane Central Register of Controlled Trials <4th Quarter 2010>
 March 15, 2011

1 (beck adj2 depression).tw.
 2 CES-D.tw.
 3 Diagnostic interview schedule.tw.
 4 General health questionnaire.tw.
 5 (Hamilton adj3 scale).tw.
 6 (hopkins adj3 checklist).tw.
 7 HSCL.tw.
 8 SCL-90.tw.
 9 medical outcomes study.tw.
 10 MHI-5.tw.
 11 mental health inventory.tw.
 12 MADRS.tw.
 13 Montgomery-Asberg.tw.
 14 PRIME-MD.tw.
 15 structured clinical interview.tw.
 16 SDDS-PC.tw.
 17 Symptom Driven Diagnostic System for Primary Care.tw.

18 Zung.tw.
19 or/1-18
20 (depressi* or dysythm* or affective or mood).ti.
21 (subclinical adj2 depressi*).tw.
22 (subsyndromal adj2 depressi*).tw.
23 (subthreshold adj2 depressi*).tw.
24 (subdiagnostic adj2 depressi*).tw.
25 (postnatal adj2 depressi*).tw.
26 (postpartum adj2 depression).mp.
27 (perinatal adj2 depressi*).tw.
28 exp depression/
29 exp major depression/
30 or/20-29
31 mental disorders/
32 depress*.ti,ab.
33 31 and 32
34 30 or 33
35 health screening/ or screening/
36 screen*.ti,ab.
37 casefinding.tw.
38 case finding.tw.
39 test reliability/ or "error of measurement"/ or interrater reliability/ or test standardization/
40 psychometrics/
41 exp statistical analysis/
42 or/35-41
43 19 and 34
44 42 and 43
45 depressive disorder/ or depression, postpartum/ or depressive disorder, major/ or
dysthymic disorder/ or seasonal affective disorder/
46 Depression/
47 dysthym*.tw.
48 (subclinical adj2 depressi*).tw.
49 (subsyndromal adj2 depressi*).tw.
50 (subthreshold adj2 depressi*).tw.
51 (subdiagnostic adj2 depressi*).tw.
52 (postnatal adj2 depressi*).tw.
53 (postpartum adj2 depression).mp.
54 (perinatal adj2 depressi*).tw.
55 or/45-54
56 mass screening/
57 screen*.mp.
58 case finding.tw.
59 casefinding.tw.
60 detect.tw.
61 diagnos*.tw.
62 recogni?e.tw.
63 or/56-62
64 55 and 63
65 depressive disorder/di or depression, postpartum/di or depressive disorder, major/di or
dysthymic disorder/di or seasonal affective disorder/di
66 Depression/di

67 65 or 66
68 64 or 67
69 (short or brief).tw.
70 (3 item or three item or three question 3 question).tw.
71 (1 item or single item or single question or 1 question).tw.
72 (2 item or two item or two question or 2 question).tw.
73 patient health questionnaire.tw.
74 or/69-73
75 68 and 74
76 limit 75 to yr="2006 -Current"
77 limit 44 to yr="2001 -Current"
78 76 or 77

Stage 2: KQ3

Database: Ovid MEDLINE(R) <1948 to January Week 2 2011>
Search Strategy:

-
- 1 Depression/ (57031)
 - 2 exp Depressive Disorder/ (66143)
 - 3 1 or 2 (120513)
 - 4 exp mass screening/ (82691)
 - 5 exp "Sensitivity and Specificity"/ (317838)
 - 6 "reproducibility of results"/ (203530)
 - 7 4 or 5 or 6 (519980)
 - 8 (beck adj2 depression).tw. (5080)
 - 9 CES-D.tw. (1580)
 - 10 Diagnostic interview schedule.tw. (1136)
 - 11 General health questionnaire.tw. (2537)
 - 12 (Hamilton adj3 scale).tw. (5448)
 - 13 (hopkins adj3 checklist).tw. (434)
 - 14 HSCL.tw. (207)
 - 15 SCL-90.tw. (1483)
 - 16 medical outcomes study.tw. (2241)
 - 17 MHI-5.tw. (54)
 - 18 mental health inventory.tw. (138)
 - 19 MADRS.tw. (903)
 - 20 Montgomery-Asberg.tw. (1053)
 - 21 PRIME-MD.tw. (207)
 - 22 structured clinical interview.tw. (2650)
 - 23 SDDS-PC.tw. (6)
 - 24 Symptom Driven Diagnostic System for Primary Care.tw. (9)
 - 25 Zung.tw. (941)
 - 26 or/8-25 (22854)
 - 27 exp Primary Health Care/ (61085)
 - 28 general practice/ or family practice/ (56709)
 - 29 Ambulatory Care/ (31457)
 - 30 27 or 28 or 29 (141921)
 - 31 26 and 30 (1605)
 - 32 3 and 7 (6838)
 - 33 31 and 32 (166)
 - 34 limit 33 to ed=20010801-20110117 (108)
 - 35 depressive disorder/ or depression, postpartum/ or depressive disorder, major/ or dysthymic disorder/ or seasonal affective disorder/ (66143)
 - 36 Depression/ (57031)
 - 37 dysthym*.tw. (2146)
 - 38 (subclinical adj2 depressi*).tw. (134)
 - 39 (subsyndromal adj2 depressi*).tw. (171)
 - 40 (subthreshold adj2 depressi*).tw. (179)
 - 41 (subdiagnostic adj2 depressi*).tw. (4)
 - 42 (postnatal adj2 depressi*).tw. (1124)
 - 43 (postpartum adj2 depression).mp. (2658)
 - 44 (perinatal adj2 depressi*).tw. (170)
 - 45 or/35-44 (121356)

46 mass screening/ (67950)
47 screen*.mp. (365689)
48 case finding.tw. (2492)
49 casefinding.tw. (69)
50 detect.tw. (168728)
51 diagnos*.tw. (1253332)
52 recogni?e.tw. (56752)
53 or/46-52 (1721790)
54 45 and 53 (25339)
55 depressive disorder/di or depression, postpartum/di or depressive disorder, major/di or
dysthymic disorder/di or seasonal affective disorder/di (23155)
56 Depression/di (10709)
57 55 or 56 (32924)
58 54 or 57 (45663)
59 (short or brief).tw. (454580)
60 (3 item or three item or three question 3 question).tw. (330)
61 (1 item or single item or single question or 1 question).tw. (1440)
62 (2 item or two item or two question or 2 question).tw. (295)
63 patient health questionnaire.tw. (485)
64 or/59-63 (456563)
65 58 and 64 (3515)
66 limit 65 to ed=20060601-20110118 (1472)
67 limit 66 to (english or french) (1400)
68 34 or 67 (1488)