Correction

In the article "'Caseness' for Depression and Anxiety in a Depressed Outpatient Population: Symptomatic Outcome as a Function of Baseline Diagnostic Categories," by Koen Demyttenaere, MD, PhD, and colleagues, published in issue 6 of 2009 (*Prim Care Companion J Clin Psychiatry* 2009;11[6]:307–315), text beginning in the fifth paragraph of the Discussion was accidentally omitted at the time of publication. The added text begins with ". . . and anxiety is similar" in the first sentence and ends at the paragraph beginning: "Second, baseline somatic symptom severity was . . .":

An interesting finding is that the nonpainful somatic symptoms (as assessed with the SSI) show a similar pattern, suggesting that their relationship to depression and anxiety is similar to that for the painful physical symptoms. This finding corroborates recently published results that the scores on the painful SSI items (eg, headaches, pains in lower back, soreness in muscles, neck pain, and pain in joints), as well as the scores on the nonpainful SSI items (eg, feeling fatigued, not feeling to be in good physical health, not feeling well, feeling weak, heavy feelings in arms and legs, hands and feet not warm enough) are all significantly increased in patients with major depression.[30]

HRQoL scores varied substantially across diagnostic categories at baseline. The 1 exception to this observation was that the mean physical aspect of HRQoL (SF-36 PCS) was never more than 1 SD below population norms. However, the emotional component (SF-36 MCS) was far below population norms in all diagnostic categories. It is remarkable that, even in the noncaseness patients, this score was 1.5 SDs below population norms, which suggests that these help-seeking patients do present with substantial impairment of their emotional HRQoL despite not fulfilling screening criteria for anxiety or depression.

The comorbid for anxiety-depression category had significant impairment of SF-36 MCS (more than 2 SDs below population norms), confirming previously published results of significant levels of functional impairment in this subgroup.[31,32] The present analysis also confirms that patients with caseness for comorbid anxiety-depression have the poorest emotional HRQoL, as their MCS was more than 3 SDs below population norms (and more than 20% lower than caseness for depression or caseness for anxiety subjects). A recent Australian study using the SF-12[23] also showed that comorbid major depression and generalized anxiety disorder had a 20% lower mental health score than pure generalized anxiety disorder or pure major depression.

The follow-up data on symptomatic outcome (remission/still caseness) for the 3 diagnostic categories (caseness for depression, caseness for anxiety, and caseness for comorbid anxiety-depression) provide some interesting findings. The study illustrates that a longer duration of treatment (6 months vs 3 months) results in a better symptomatic outcome (about 15% higher remission rates). This finding is consistent with the results of a previous study that found remission rates after 6 months of treatment to be 28.6% higher than after 2 months of treatment.[33]

There is ongoing debate about whether outcomes among patients with depression and substantial anxiety symptoms are poorer than those among patients with depression without anxiety symptoms.[34] Part of the debate is probably due to the fact that different definitions of *anxious depression* were used in the articles. The Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study was designed to be relevant to clinicians by including patients more typical of outpatient practice and found that, when looking at outcomes in nonanxious and anxious depression, remission rates were 33.4% and 22.2%, respectively; remission rates in patients without or with comorbid generalized anxiety disorder were 29.5% and 21.2%, respectively.[35,36] These differences are well in line with the 10% difference in remission rates between caseness for depression subjects and caseness for comorbid anxiety-depression subjects in our sample.

It is also noteworthy that the SF-36 mental health score also dramatically improved after 6 months of treatment (about 30%) in noncaseness for depression or noncaseness for anxiety subjects at baseline.

The regression models assessing which baseline characteristics are associated with 6-month outcomes also show some clinically relevant findings, mostly in line with the findings of STAR*D.[36] First, baseline depression severity as measured by the HADS-D was not significantly associated with remission at 6 months, although other more indirect measures of depression severity (like number of previous episodes or duration of current episode) were. Baseline anxiety severity as measured with the HADS-A was significantly associated with remission at 6 months but only for the caseness for comorbid anxiety-depression subjects.

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The article at PRIMARYCARECOMPANION.COM has been corrected. The staff regret the error.

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