Depression screening for patients with acne in the United States compared to other skin diseases, 2005 to 2016

To the Editor: We read with interest the research letter by Taylor and Barbieri.[1] In the letter, the authors analyzed the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey data sets from 2005 to 2016 to identify patterns in depression screening at visits for acne. They found that dermatologists screen patients with acne for depression less frequently than primary care providers (PCPs); they suggested that dermatologists lack knowledge of appropriate referrals and treatments for mental health and that dermatologists should increase the screening of patients with acne for depression. Although we commend Taylor and Barbieri for raising awareness of mental health in dermatology patients, we hesitate to agree with their conclusions.

In their letter, Taylor and Barbieri[1] report depression rates of 2.2% by PCPs and 0.6% by dermatologists at acne visits, which was significantly lower by multivariate logistic regression adjusting for age, sex, and region. However, the authors also report depression screening rates by PCPs and dermatologists to be 2.8% and 0.0% for all other visits, respectively, which was also statistically significant. Therefore, it is difficult to determine if depression screening rates are low for acne visits or if they are low for any dermatology visit overall. Additionally, race/ethnicity and health status are independent predictors of depression screening,[2] but they were not included in the regression models, potentially biasing results.

To address these concerns and further investigate depression screening rates among dermatologists, we analyzed a similar patient subpopulation in the 2005 to 2016 National Ambulatory Medical Care Survey (aged 10 through 40 years with a visit to a dermatologist). We were able to replicate the authors' results of a 0.6% screening rate for acne visits and 0.0% for nonacne visits. A multivariate logistic regression model examining all visits to dermatologists was constructed to determine whether acne was associated with lower rates of depression screening. In our model, depression screening was the dependent (outcome) variable, and primary diagnosis of acne was the independent (predictor) variable. Covariates included age, sex, region, race/ethnicity, and total number of chronic illnesses as a proxy for health status. We found that acne was actually associated with a higher rate of depression screening by dermatologists (adjusted odds ratio, 2.08; 95% confidence interval, 1.27-3.41; $P = .004$) compared to other skin diseases.

Given the high prevalence of comorbid depression and suicidality in skin diseases,[3,4] we applaud Taylor and Barbieri[1] for advocating for closer attention to patients' mental health. However, we believe their results and our analysis preclude any disease-specific recommendations for depression screening. Depression is nonspecific to acne, so any practice-changing guidelines must consider the array of other chronic skin conditions also associated with mental illness. Furthermore, screening guidelines for patients with acne are especially important, given that a large portion of the patient population consists of adolescents, and depression screening in adolescents is controversial.[5] Regardless of screening recommendations, however, dermatologists must be diligent in identifying and facilitating the care for comorbid psychiatric illness in all patients with chronic skin diseases.

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Funding sources: None.

Disclosure: Dr. Kwatra is an advisory board member for Pfizer, Regeneron Pharmaceuticals, and Menlo Therapeutics. Authors Sutaria and Pollock have no conflicts of interest to declare.

IRB approval status: Not applicable.

Reprints not available from the authors.

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https://doi.org/10.1016/j.jaad.2020.09.082