Sir,

It has long been known that chronic pain and psychiatric illness are intertwined between one another. The most recent global burden of diseases study indicated low back pain (LBP) and depression comprise the top two leading causes of disability worldwide, where disability is assessed by years lived with disability.[1,2] Pinheiro et al. in their follow-up study, “Symptoms of Depression and Risk of LBP: A Prospective Co-Twin Study,”[3] attempted to investigate whether symptoms of depression increase the risk of chronic LBP with the use of a prospective study design, but with the important adjustment for important confounders including genetic factors, thus the utilization and inclusion of twins.

Although their results did not suggest a possible causal link between depression and LBP (given that no association was found, when genetic and early environmental factors are controlled for), their study did in fact find a significant association between trait depression and future care seeking and activity-limiting LBP.[3] Now, for providers in training and those already practicing, this is an important point to take notice of.

For those who are in the early stages of training, it is imperative that a provider develops good skills and habits earlier rather than later, which will ultimately provide them with the tools to become a better overall clinician. This study focuses on the important finding that patients with depression are more likely to have activity-limiting LBP, whom will have an increased likelihood of seeking care. There are a few points providers must be acutely aware of to be better prepared to address moving forward with their patients.

First, patients who are depressed are more likely to present for specific treatment of their activity-limiting LBP.[3] As a provider, it is imperative to utilize their time in training to garner the skillset to be able to establish a rapport with my new patient, gather a detailed history, and then perform a thorough physical examination that includes a detailed neurological assessment. From this point, the provider must be able to formulate a patient-specific, tailored care plan that may include radiographic imaging, medication management, and of course, potential interventional diagnostic and therapeutic procedures, with the end goal of reduction or potential elimination of their chronic LBP.

The second thing to be aware of is their concurrent depression. This, in fact, could be the more significant point that chronic pain providers may unfortunately not fully address or allocate their patients’ visit time too. Although they may already have been diagnosed with depression, have established care with a psychiatrist or primary care physician who is prescribing them appropriate medications, and concurrently, having frequent therapy appointments with a counselor or therapist, the reality is majority of these patients will not be presenting to you for

If Depression may be Associated with Future Care Seeking of Activity-limiting Low Back Pain, We Must Properly Address the Depression as Well

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the treatment of their LBP with an already in-place, thorough care plan of their depression. Many, in fact, may be presenting to their pain physician without even knowing they are in fact depressed, have not brought this up in conversation with their primary care physician, or may not even have a primary provider to begin with.

The take-home point therefore must be, although it may not be within our expertise to accurately diagnose or treat depression in our patients, simply documenting their potential depression or taking note that they are taking prescribed antidepressant medications is not enough. A portion of our visit time needs to be allocated to addressing their depression. Given that they are now in front of us, providers need to take advantage of this to address their concurrent depression because they may not do so on their own or may not have the means to find another provider to help them with this. Whether this includes a referral to a psychologist, pain psychologist, psychiatrist, or primary care provider to establish care with or a counselor or therapist for monthly or weekly sessions, or even a personal call to their established psychiatry care providing provider to effectively close the loop or foster interdisciplinary care, some further propagation of their depression care needs to be initiated and put in place at this visit.

If their depression is not addressed and only their LBP is, we as providers may unfortunately be finding that our treatments and care plans may not be as efficacious and are only serving as a Band-Aid or cover for their concurrent depression, which may have been a proponent in their care seeking for their activity-limiting LBP to begin with.

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There are no conflicts of interest.

Successful Use of Risperidone, Trihexyphenidyl, and Paroxetine in Pregnancy

Sir,

Use of psychotropic drugs in pregnancy is a matter of concern. The choice of antipsychotic treatment during pregnancy remains subject to controversy, mainly due to a lack of exposure and outcome data that would allow for a meaningful risk estimate.

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