The connection between pain and depression is a significant issue in primary care, and the authors present the evidence for it being a frequent finding and a clinically relevant one. They briefly describe the pathophysiological roots of the common mechanisms for pain and depression, establishing the rationale for the association between both problems. The discussion on the common neuroendocrine pathways and the shared central nervous system pathways is a useful brief review of the subject, suggesting the scope of interventions likely to address both conditions.

The plasticity and remodelling of central neural connections under the influence of chronic, long-term pain and depression, is relevant to the claim of worse outcomes for pain in the presence of depression and for depression in the presence of pain.

The authors are concerned with what they perceive as a lack of recognition of depression in patients presenting with pain. The fact that they state their concern in this direction (‘seeing pain detracts from seeing depression’), rather than ‘seeing depression detracts from seeing pain’) is relevant for our comments below.

It is therefore a useful endeavour to review the availability and reliability of a tool to screen for the combined presence of pain and depression. However, in spite of a comprehensive literature review, the authors could not find such a tool.

This prompted them to propose that the current ‘two-question’ screening for depression be expanded to include a third question: ‘during the last month, have you often been bothered by pain?’ They see such a tool being used in primary care nurse-led patient reviews.

There are some unproven assumptions in this paper, which may undermine the conclusion. Firstly, while the causal direction was ‘pain obscures depression’, the proposed new tool merely adds to the detection of pain in situations when depression is already currently screened for. It does not, therefore, improve the recognition of depression when pain is present. Also, the assumption that depressive mood disorders present with a constellation of symptoms with a pattern that is independent from the existence of pain, is not uniformly accepted.

Moreover, the claim that ‘the origin of pain probably makes little difference to the established association (between pain and depression)’ is not robustly supported by evidence.

The body of the paper is a thorough and useful review of the rationale for the screening of ‘the other condition’ whenever either pain or depression is detected. Although the suggestion that ‘pain-fuelled depression’ will respond to similar treatments as ‘depression-fuelled pain’ is not robustly supported by evidence, this does not detract from the usefulness of keeping the association in the foreground of chronic disease assessments.

If I may, I would suggest that pain screening is amplified to be equally a two-question affair: ‘During the last month, have you often been bothered by pain?’ ‘During the last month, would you say that pain limited your ability to work, rest, or enjoy yourself?’ And the use of such ‘2+2’ screening tool is advisable whenever risk factors for either pain or depression are found, be it chronic illness, history of abuse, past history of recurrent pain, past history of mood disorder, history of addiction / substance misuse, etc.

In conclusion, this paper is a helpful reflection on the significance of the association between pain and depression and the clinical relevance of keeping that association in mind whenever either is found.

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