admission and cause of death records. We performed Cox Proportional Hazards models to estimate the risk of MCVE among participants with depression compared to those without depression. Fully adjusted models included measures of age, sex, ethnicity, education, income, area-based deprivation, body mass index, alcohol intake, physical activity, smoking, home-ownership, fruit and vegetable consumption, oily fish intake, and family history of stroke, heart disease, hypertension and/or depression.

**Results** We identified a total of 21,842 (7.9%) participants with depression at baseline. During a median of 6.7 years of follow-up, an incident MCVE occurred among 326 participants with depression and 3718 participants without depression. In fully adjusted models, hazard ratios (95% confidence) intervals for MCVE were 1.13 (1.01–1.27) for participants with any indication of depression, 1.14 (1.00–1.31) for participants with self-reported depression, 1.60 (1.18–2.17) for participants with history of a hospital admission with depression, and 1.12 (0.99–1.27) for participants reporting antidepressant use. Similar patterns were observed when stroke and myocardial infarction were used separately as outcomes.

**Conclusion** All measures of depression remained independent risk factors for MCVE after adjustment for a variety of potential confounding factors and effect estimates were similar for all sub-categories of depression. The adjusted hazard ratios should only be interpreted causally if one assumes that the covariates are common sources of depression and MCVE. This assumption remains controversial. Future studies should apply more advanced statistical methods in order to determine the effect of lifestyle factors as potential mediators and explore potential for interactions.