

DEPRESSION IN PALLIATIVE CARE

Patients with life limiting illness face many psychological challenges: grief about current or anticipated losses, fear and uncertainty about the future, regrets from their past, existential or spiritual issues and concerns about loved ones. Each person brings with them a unique burden of social and psychological vulnerabilities, balanced by their individual coping resources (1). Yet despite this many patients are able to achieve a sense of peace, equanimity and hope (1). Depression and other psychiatric disorders have a significant impact on the ability of patients to negotiate these challenges and are associated significant suffering for patients and families (2). Depression is the most commonly recognised psychiatric disorder in patients with advanced cancer (3). Depression leads to reduced quality of life (4), prolonged hospitalisation and causes significant distress for patients, caregivers and families (5).

Estimates of prevalence of depression in palliative care patients vary from 3.7 – 58% (6) but it has been reported that up to one quarter of hospitalised terminally ill patients have a treatable depressive illness (7). Depression is common in terminal care however in clinical practice it frequently goes undiagnosed or is under treated (2). This results from a number of factors; difficulty in diagnosing depression in patients with advanced illness (2), reluctance of clinicians and patients to discuss emotional issues and the belief that depression is an inevitable consequence of terminal illness (8).

The diagnosis of depression in the context of advanced disease is challenging. Many of the somatic symptoms included in the diagnostic criteria for major depression (e.g. sleep and appetite disturbance) are known symptoms of advanced illness. Diagnosis must therefore focus on psychological symptoms such as hopelessness, worthlessness or inappropriate guilt (9). Endicott proposed that somatic symptoms be substituted for psychological symptoms in patients with cancer, for example: poor appetite/weight change with fearfulness or depressed appearance and insomnia/hypersomnia with social withdrawal (10). Asking patients directly about their mood has been shown to be both sensitive and specific for depression (11) although some patients, are unable to acknowledge or identify their own depression or may express it in another way e.g. “nervousness” (1).

Depression causes significant distress for terminally ill patients and their families and may exacerbate other symptoms such as pain and fatigue (2). Therefore it is important that depression is treated actively as part of a holistic approach to care. The empathy and support of family/friends and the clinical team is as important as the pharmacological management of depression (6). Approach to treatment should include good symptom management (pain, nausea etc.), fostering of social connections and social relationships, pastoral and spiritual care (12). The treatment of depression should not be restricted to psychotropic medications (6). A Cochrane review demonstrated the effectiveness of psychotherapy in patients with incurable cancer (13). Psychotherapeutic interventions however require patients to be able to engage in the treatment process and they will still take time to produce therapeutic outcomes (6).

Pharmacotherapy is an important treatment for major depression in palliative care (6). However, studies show that rates of prescription are low, with only 10% of hospice patients receiving antidepressants and a large proportion of these being prescribed in the last 2 weeks of a patient’s life leaving insufficient time to reach clinical efficacy (9).

Choice of pharmacotherapy must take into account patient factors such as prognosis, renal function, previous antidepressant history and co morbidities (6). The literature recommends the use of selective serotonin reuptake inhibitors (SSRIs) or the newer agent mirtazapine as first line pharmacotherapy for depression in palliative care patients (14) (6). Other agents, such as venlafaxine, also have evidence of antidepressant effect and may be an appropriate choice for certain patients (14).

Conventional antidepressant medications have a delay of clinical effect up to 6 weeks (14). Patients with a prognosis less than 3 months may therefore not live long enough to benefit from treatment. In this patient population psychostimulants offer a more rapid treatment option (15). A rapid response may also be required for patients with significant psychomotor retardation in the setting of depression, where delay to clinical efficacy is associated with unacceptable suffering. In this setting, psychostimulants are indicated for symptom relief whilst other treatments take effect (16). A review of the literature on the use of palliative use of psychostimulants in advanced cancer showed a response rate for depression of over 80% within 2 days of initiating treatment (17). Psychostimulants should only be prescribed by experienced specialist practitioners.

CONCLUSION

Depression impacts on almost every aspect of care; symptom management, negotiating spiritual and existential issues, and treatment decisions. The incidence is frequently underestimated in patients with advanced disease, therefore health professionals must have a high index of suspicion when caring for this patient population. Active treatment of depression is an important part of palliative care.

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