Depression

Introduction

Depression:
- is strongly and consistently associated with a poor quality of life
- causes more reduction in role and social functioning than would be due to the physical illness alone
- reduces physical functioning
- is often associated with symptoms that are difficult to control
- has a major impact on the patient’s family.

Treatment of depression can significantly improve quality of life and is as effective in palliative care as in other situations.

Assessment

All patients should be assessed for depression.

Physical symptoms commonly associated with depression can be caused by physical illness or treatments so may be less helpful in establishing a diagnosis. These can include:
- weight/appetite change
- insomnia
- loss of energy
- fatigue
- psychomotor slowing
- loss of libido.

Depressive symptoms in palliative care patients include:
- greater severity of dysphoric mood
- excessive feelings of guilt, worthlessness, hopelessness
- social withdrawal and loss of pleasure in daily activities
- a wish for earlier death (or suicidal ideation)
- a positive response to the question: “Do you feel depressed?”

Risk factors for depression in palliative care can include:
- personal or family history of depression.
- concurrent life stresses
- multiple losses
• unfulfilled life aspirations
• absence of social support
• history of substance misuse/dependence
• oropharyngeal, pancreatic, breast and lung cancers (more common).

Additional barriers to diagnosis exist and include:
• patient/family feeling that a “fighting spirit” is needed to maximise active treatment/support from health professionals
• difficulty deciding whether depression is a primary problem or reflects suboptimal symptom control
• concerns about polypharmacy and drug interactions
• other physical/psychological conditions mimicking depression:
  - exclude hypoactive delirium
  - exclude hypothyroidism
  - screen for dementia
  - review medication (\textsuperscript{1} haloperidol can cause motor retardation)
• complex care packages; many staff involved and lack of continuity.

Assessment tools

A number of assessment tools are available. In primary care, the PHQ-9 can be used as a screening tool. The brief Edinburgh Depression Scale is suited to palliative care patients. The Hospital Anxiety and Depression questionnaire is widely available but focuses on physical symptoms so may be less helpful in this context.

Management

General
• In mild depression, psychological support can be as effective as medication.
• Adequate pain control may significantly improve depressive symptoms.
• Spiritual distress may be a component of depression, or distinct from it.
• Consider supportive psychotherapy or cognitive behavioural therapy.
• Patients with severe depression and/or suicidal ideation are uncommon but should be referred to psychological medicine/psychiatry for assessment.

Medication
• There is no evidence of superior efficacy for a particular antidepressant agent.

\textsuperscript{1} Indicates this medicine is associated with QT prolongation
• A current or previously effective antidepressant should be used unless contra-indicated.
• Consider side effects and any co-morbid illnesses.
• Check for drug interactions.
• Potential therapeutic benefit of side effects may inform medication choice.

Selective serotonin reuptake inhibitors (SSRIs)

SSRIs are better tolerated and are safer in overdose than other classes of antidepressant and so are often considered first line. Notes about specific SSRIs are given below.

• Sertraline: This may be a useful SSRI if there has been a recent cardiac event.
• Citalopram/escitalopram: Tablet and oral suspension available. It is useful for agitated depression/anxiety and relatively safe if the patient is at risk of seizures. There is a risk of QT prolongation and drug interactions. Review concurrent medications, refer to British National Formulary (BNF).
• Fluoxetine: It is long acting and offers low risk of withdrawal effects. It has many drug interactions so it may not be suitable in palliative care patients.

Side effects include:

• nausea, vomiting, anorexia, dyspepsia, diarrhoea
• risk of gastrointestinal (GI) bleeding - avoid or use with caution if history of GI bleeding, patient over 80 years or taking non-steroidal anti-inflammatory drugs (NSAIDs)/aspirin
• insomnia, sweating, impaired sexual function
• vivid dreams, agitation, hyponatraemia
• risk of serotonin syndrome in combination with other serotonergic medicines, for example tricyclics and some opioids.

Mirtazapine

• Tablet and oro-dispersible tablet.
• Appetite stimulant and sedative, particularly at lower doses.
• Well tolerated in the elderly and patients with heart failure.

Tricyclic antidepressants (under specialist advice)

• Amitriptyline: also treats nerve pain.

Side effects include:

• dry mouth, hypotension and confusion limit dose
• avoid if cardiac disease or risk of seizures
• sedative/anxiolytic action may be helpful.
Practice point

- Antidepressants should be withdrawn gradually wherever possible.

Resources

- International Association for Hospice and Palliative Care. 2013. The IAHPC Manual of Palliative Care:  

- NHS Scotland Palliative Care Guidelines. Delirium Guideline.  

References


International Association for Hospice and Palliative Care. 2008. The IAHPC Manual of Palliative Care


