Depression

KEY POINTS

- The prevalence of depression in palliative care may be as high as 38% in patients with advanced illness
- Depression leads to greater physical, social, and existential distress, and reduced quality of life in palliative care patients
- Depression can be more difficult to diagnose given the changes of the disease process, which may mimic signs and symptoms of depression (loss of appetite, energy, etc.) and common emotional responses to advanced illness
  - Depression screening tools exist, but they are not specific to the palliative care population
- A combination of non-pharmacological and pharmacological approaches can be used, based on the individual, the severity of symptoms, and their response to treatment
  - Choosing an approach may vary depending on the time and resources available, the patient's prognosis, and the patient's desire for support

ASSESSMENT

- Interdisciplinary assessment is helpful to identify the range of physical, psychological, social, spiritual, and existential factors

Common Features:

- Excessive feelings of worthlessness, guilt, shame, hopelessness, helplessness
- Recurrent thoughts of death and suicide
- Loss of interest/pleasure in almost all activities
- Physiological symptoms such as fatigue, anorexia, or insomnia are not as reliable because these are common in advanced illness

RISK FACTORS FOR DEPRESSION

- Uncontrolled pain or other symptoms
- Unrelieved emotional and spiritual distress
- Overwhelming financial or family distress
- Isolation and abandonment from family, community, and spiritual connections
- Pre-existing mental health issues in patient and/or family caregivers

MANAGEMENT

Non-Pharmacological

- Counselling support by a social worker, psychologist, psychiatrist, or spiritual care provider can be helpful
- Cognitive behavioural therapy, of which dignity therapy is a form designed for end of life, is a common approach to counselling
- Dignity therapy is a brief focused form of therapy which is designed to address psychosocial and existential distress in patients with advanced illness
- The focus is on maintaining hope, preserving the patient's cherished roles, reducing worry about being a burden to others, and leaving a legacy

Pharmacologicals

- Most categories of antidepressants can be used in palliative care, although the time needed for efficacy (e.g. SSRIs) may limit their use in patients nearing the end of life
  - For patients with a prognosis of weeks, consider psychostimulants, which start to act immediately (e.g. **methylphenidate 5 mg in the morning and at noon**)
- Consider **duloxetine** or **venlafaxine** when neuropathic pain is present
- When polypharmacy is present, consider **citalopram, escitalopram,** or **mirtazapine**

- **Mirtazapine** is helpful if the patient has insomnia, nausea, or anorexia
- Closely monitor patients initiated on an antidepressant for adverse effects and dose titration

Class	Action	Advantageous Effects or Side Effects	Harmful Side Effects	Use in Palliative Care	Daily Dose Ranges
Tricyclics	Inhibits 5-HT and NA uptake, antimuscarinic, antihistaminic, anti-alpha 1	Co-analgesic, sedative	Constipation Dry mouth Urinary retention Hypotension Syncope Confusion	Pain Insomnia Depression	Amitriptyline 25–150 mg
Selective serotonin reuptake inhibitors (SSRI)	Inhibition of 5-HT reuptake		Sexual dysfunction Nausea and vomiting Diarrhoea QTc prolongation at higher doses Serotonin Syndrome	Depression Anxiety Obsessive- compulsive PTSD	Citalopram 10–60 mg Fluoxetine 10–80 mg Paroxetine 10–60 mg Sertraline 25–200 mg Escitalopram 5–20 mg
Selective serotonin and noradrenaline reuptake inhibition (SSNRI)	Inhibition of 5-HT and NA reuptake	Co-analgesic	Hypertension in higher doses Nausea GI tract	Severe depression Anxiety	Venlafaxine 37.5–450 mg Duloxetine 15–60 mg
Selective dopamine and noradrenaline reuptake inhibitors	Inhibition of dopamine and noradrenaline reuptake	Improves attention and concentration Reduces fatigue	Anxiety Seizures Agitation	Depression Fatigue	Bupropion 150–450 mg
Noradrenergic and specific serotonergic antidepressants	Increases 5-HT and NA activity, antihistaminic	Stimulates appetite Helps sleep Co-analgesic	Dry mouth Drowsiness Neutropenia rare	Depression, anxiety Appetite and weight gain Insomnia	Mirtazapine 7.5–60 mg
Serotonin antagonists and reuptake inhibitors	Increases 5-HT activity, anticholinergic	Helps sleep	Dry mouth, Constipation Urinary retention Drowsiness	Sleep Depression	Trazodone 50–300 mg
Psychostimulant	Increase dopamine activity	Improves alertness Rapid effect	Agitation Insomnia Anorexia Seizures Hallucinations Psychosis Arrhythmia Nightmares	Depression Opioid induced sedation	Methylphenidate 5–60 mg Modafinil 100–400 mg Dextroamphetamine 5–60 mg