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## Depression and the Terminally Ill

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### Introduction

Depression can be an isolating, often debilitating illness. It causes a considerable amount of suffering for people with life threatening illness. Many health care providers believe that depression is a “normal” reaction when facing illness or death—a perspective that contributes to this problem being both under recognized and under treated. Untreated depression has an enormous impact on a person’s quality of life, and could deprive people and their families of precious time. The incidence of depression ranges from 25-77% in terminally ill patients. The good news is that depression at end of life, when recognized, can be effectively treated.

### Assessment

The difficult part of diagnosing depression is that the physical symptoms of depression (decreased energy, sleep disturbance, change in appetite, fatigue and difficulty concentrating) can also be attributed to medical illness, especially in those with advanced disease. Endicott suggested using the criteria of depressed mood, marked disinterest or lack of pleasure in family and friends and feelings of worthlessness and hopelessness to replace the neurovegetative signs. The single question “Are you depressed?” has been shown to be a reliable indicator of depression in the terminally ill. Risk factors for depression include a prior history of depression, lack of social support, unmanaged symptoms (especially pain), history of substance use, spiritual distress, use of medication with depressive side effects and decreasing functional status. Some cancers, including oral, pharyngeal, lung and pancreatic, have a strong correlation with depression.

A suicide assessment is essential for all persons with depression. Factors such as uncontrolled pain, emotional suffering, feelings of helplessness and despair, history of substance abuse, psychiatric disorder or previous suicide attempt, family history of suicide, social isolation, and recent death of a loved one are associated with higher risk for suicide. It is essential to assess the seriousness of suicidal intent by asking people if they have they considered taking their own life and whether they have a plan. For individuals with depression and at risk for suicide, it is important to include a psychiatrist as part of the team caring for the person.

### Intervention and Treatment

Appropriate pharmacological and nonpharmacological treatment should be incorporated into a person’s care. Simply prescribing antidepressants, without ongoing contact, can be experienced by the patient as abandonment. Optimal therapy for depression is often a combination of supportive psychotherapy, cognitive behavioral techniques, and pharmacologic management. Antidepressant medications can be effective in the treatment of depression in advanced illness. There are several different classes of antidepressant medication. Prognosis may play an important role in determining the type of medication chosen. Selective serotonin reuptake inhibitors (SSRIs) are the mainstay of treatment and have fewer side effects than older medications such as tricyclic antidepressants (TCA). SSRIs take several days to weeks to achieve therapeutic effect. Tricyclic antidepressants (i.e. desipramine or nortriptyline) have side effects such as orthostatic hypotension and anticholinergic side effects that make it difficult for the elderly population. Other types of antidepressants

include selective serotonin norepinephrine reuptake inhibitors (SNRIs) such as venlafaxine or duloxetine, or other atypical antidepressants such as bupropion or mirtazapine. In addition, SNRIs and mirtazapine have been shown to have beneficial effects in the treatment of neuropathic pain. The terminally ill patient with depression may do best with a rapid acting psychostimulant. The effect of methylphenidate is often seen in a few days and has the beneficial side effects of counteracting opioid sedation, improving appetite and cognitive function, and counteracting feelings of weakness and fatigue. Psychotherapy consists of active listening with supportive comments and occasional interpretations, as well as helping the person understand, manage, and work through her feelings related to the underlying disease. Treated depression allows individuals the opportunity to focus on other issues such as reestablishing a sense of value and self worth. The goal is to help people find meaning and enjoyment in the remaining portion of their lives.

### Conclusion

Early detection and ongoing assessment of depression are important for individuals at the end of life. It requires an interdisciplinary approach to support the person during this time. Treatment of depression with both pharmacological and nonpharmacological interventions can improve quality of life, allowing people to focus on other emotional and spiritual issues.

### Journal Watch

- The [current issue](#) of *Supportive Care in Cancer* [Aug 2007;15(8)] is devoted to complementary and alternative medicine. (Open access)
- Schofield P, et al. [Complementary therapies for pain management in palliative care](#). *Journal of Community Nursing*. Aug 2007;21(8) (free full text)
- Lorusso D, et al. Pegylated liposomal doxorubicin-related palmar-plantar erythrodysesthesia ('hand-foot' syndrome). *Annals of Oncology*. 2007 Jul;18(7):1159-1164.
- Liben S, et al. Paediatric palliative care: challenges and emerging ideas. *The Lancet*. In Press, Corrected Proof, online 17 August 2007.
- Hopkinson JB. How people with advanced cancer manage changing eating habits. *Journal of Advanced Nursing*. 2007;59(5):454-462

### Resources on the Web

- [Minimize Chemotherapy-Induced Hand-Foot Syndrome](#) (Medscape news report on Lorusso article in Journal Watch section)
- Lohr L. [Gabapentin effective for chemotherapy-induced nausea](#). *Hem/Onc Today* 2007;8(8):14.
- [Integrative Oncology Practice Guidelines](#)—July 2007 (Society for Integrative Oncology)
- [Methylnaltrexone reduces opioid-induced constipation](#) (*Oncology News International*; requires free registration)
- [Fitness plays a key role in battling cancer](#)
- Resources from [National Coalition for Cancer Survivorship](#)
  - [CanSearch™ Next Steps: Your Life After Cancer](#) (Guide to Online Post-Treatment Cancer Resources)
  - [Palliative care and symptom management](#)

### Palliative Care Calendar & CE

#### Yale

- Sep 29, 7:30am – 2:00pm. Challenges in Adult & Pediatric Oncology Nursing Practice. 6<sup>th</sup> Annual YNHH Oncology Nursing Conference. Contact: Janet Brown [janetbrown777@aol.com](mailto:janetbrown777@aol.com).
- Oct 20, 9:00am – 5:15pm. [Pain Management Through Music Therapy](#). Anlyan Center.

#### Connecticut

- The Connecticut Coalition of End-of-Life Nurse Educators has scheduled four offerings for 2007 based on the End-of-Life Nursing Education Consortium (ELNEC) curriculum. Open to all clinicians; CNE's available. Contact: Pat Trotta, (203)379-4763; [patricia.trotta@cancer.org](mailto:patricia.trotta@cancer.org).
  - Sep 15, 8:30am – 12:30pm. **Pain & Symptom Management**. Hartford Hospital
  - November 10. **Cultural and Ethical Issues at End of Life**. UConn Medical Center, Farmington.
- Sep 21, 10:30am – 2:00pm [The Connecticut Coalition to Improve End-of-Life Care](#) will hold its [Annual Meeting & Luncheon](#), Middletown. Presentation by Harold Schwartz, MD: **The Future of the End-of-Life: Reflections on the Right to Die Post-Schiavo**. Click for [brochure](#).

#### Elsewhere

- Oct 4-7 & May 8-11. Northampton, MA. [Advance Practice Certificate Program in End of Life and Palliative Care 2007-2008](#) (for Social Workers). Contact: [kim.buckelew@bhs.org](mailto:kim.buckelew@bhs.org).
- Oct 12-14. Cambridge, MA. [Practical Aspects of Palliative Medicine: Integrating Palliative Care into Clinical Practice](#)

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