Depression in advanced cancer – a hidden symptom

Mari Lloyd-Williams

Mari Lloyd-Williams MD, MRCGP, Consultant in Palliative Medicine, The Leicestershire & Rutland Hospice

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One third of the population in the UK will develop cancer during their lifetime, and one quarter will die from the disease. Whilst the development of palliative care has helped to improve the management of physical symptoms, there are still considerable issues in the diagnosis and treatment of psychological symptoms, especially depression. Depression not only makes the palliation of physical symptoms more difficult, but also has a negative effect on the quality of life for patients, and frequently on the patients' interactions with family and friends. How much of a problem is depression for patients with advanced cancer, and how effective are we as physicians in detecting and treating depression?

Prevalence of the problem

In a study which evaluated the care giver's perception of symptoms in the last year and week of life[1], perceptions of the patient feeling low were reported by 69% of relatives. A more recent study suggested that 50% of patients with breast cancer had symptoms of depression in the last few weeks of their life[2]. It is also recognised that psychiatric disorders occur more frequently in cancer patients than in the general population. It is estimated that 50% of patients will have no significant psychiatric symptoms, 30% will have what is defined as an adjustment reaction and 20% will have a formal psychiatric diagnosis (the most common being depression). For a quarter of all patients admitted to a palliative care unit, depression will be a significant symptom[3].

Although depression can occur in any patient, young age is an important factor in the development of psychiatric morbidity[4]. Similarly, depression can occur at any time during the cancer illness, but the 'crisis points' of a cancer illness, ie initial diagnosis, failure of treatment and relapse, all trigger further psychological distress and are peak times when psychiatric morbidity may occur. Up to 80% of the psychological and psychiatric morbidity which develops in cancer patients goes unrecognised and untreated[5]. A reason for this low rate of detection is thought to be due to nondisclosure by patients who may either feel that they are wasting the doctor's time or that they are in some way to blame for their distress and therefore choose to hide it[6]. In a review of depression in terminal illness, Brugha[7] highlights the mistaken belief that terminal illness invariably causes depression, and suggests that doctors caring for terminally ill patients may not be confident in eliciting psychological and psychiatric morbidity.

Possible aetiology and diagnosis

The aetiology of depression in cancer and terminal illness is unknown. It has been suggested that the emotional impact of a cancer diagnosis, side effects of treatment, progression of cancer with associated disability and symptoms, and cerebral dysfunction associated with carcinomatosis are all important factors[8]. Goldberg and Cullen[9] believed that the five psychosocial factors leading to significant depressive symptoms were disruption of key relationships, dependence, disability, disfigurement and approaching death.

There are no universally accepted criteria for diagnosing depression in the medically ill, and it is often difficult for physicians to distinguish between what can be called appropriate sadness as a patient's life is ending and identifiable depression. In the physically healthy population, depression is diagnosed if patients have a persistent low mood and at least four other symptoms including fatigue and loss of energy, significant weight loss, insomnia or hypersomnia. In patients with advanced cancer, such physical symptoms are almost universal and there has been considerable controversy as to whether they should be included and their importance in diagnosing depression. Several of the screening tools used in patients with early treatable cancer (eg the Hospital Anxiety and Depression Scale) enquire about symptoms, for example feeling slowed down and not enjoying previously pleasurable activities. Patients with advanced cancer respond negatively to these questions as a result of their illness, and therefore such tools cannot be recommended for screening in this population.

Treatment of depression in patients with advanced cancer

There is also considerable variation in the management of depression in these patients once it is diagnosed. The principles of treatment with antidepressant medication in cancer patients should be the same as in any other patient. However, a recent study

suggested that antidepressants are only prescribed for a minority of patients who may benefit from them[10]. With terminal cancer, there are also several misconceptions regarding the prescribing of antidepressant drugs. These views include patients not meriting psychotropic medication as they have an obvious reason for being depressed (ie having advanced cancer), the belief that psychological treatments such as counselling should be offered in lieu of pharmacological treatment and that drugs are not compatible with such therapies. In addition, terminal patients may have other coexisting pathologies which increase the risk of side effects, but newer antidepressant drugs are usually better tolerated. Finally, there is unfounded concern over addiction and dependence. In a study of patients with cancer referred to liaison psychiatry services[11], antidepressants were prescribed for 67% of patients with 80% showing a good clinical response to treatment with few side effects. All antidepressants take approximately three weeks to work, but treatment initiated early can be beneficial. Side effects, however, may be exhibited within the first few days making compliance a problem.

Second and third generation selective serotonin re-uptake inhibitors are now available and are less toxic and better tolerated. Psychostimulants such as dexamphetamine give patients a sense of overall well being, increase appetite and elevate mood. They work by promoting the release of biogenic amines and are administered early in the day to avoid insomnia. They are generally safe, have a rapid onset of action and their beneficial effects in the management of depression in patients with advanced cancer have been reported[12], but care needs to be taken in patients with multiple organ failure. Psychostimulants are frequently prescribed in the United States, but seldom in the UK. Further research is needed both to look at more effective means of screening for depression in patients with advanced cancer and also to determine whether some patients would benefit more from psychostimulants rather than conventional antidepressant medication.

Conclusions

Depression is the most common psychiatric illness in patients with terminal cancer. Patients who are depressed may also have physical symptoms which are difficult to palliate and which may improve as their depression is appropriately treated. Psychological and psychiatric morbidity can be a major source of distress to terminally ill patients and to their relatives and friends. Many effective antidepressants are available – the major barrier to effective treatment is the physician's failure to make the diagnosis.

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Address for correspondence: Dr Mari Lloyd-Williams, Consultant in Palliative Medicine, Leicestershire & Rutland Hospice, Groby Road, Leicester LE3 9QE