PALCARE
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THE JIMMY S BILIMORIA FOUNDATION

PALLIATIVE CARE
GUIDELINES
FOR A HOME SETTING IN INDIA

DEPRESSION

INTRODUCTION

Depression is highly prevalent in patients with life-threatening illnesses and has significant impact on quality of life. It is often unrecognised, underdiagnosed and untreated due to attitudinal barriers from both clinicians and patients.

Depression, if left untreated in patients with life threatening illness, can be associated with increased symptom burden, impaired quality of life, emotional distress, and suicidal ideations/acts. Depression can negatively impact patients' interaction with their families during this critical time in which patients may be saying goodbye, thank you, or make important plans.

Depression can erode patients' autonomy thereby rendering patients, incapable of making their own decisions regarding medical treatments and personal choices. Risk of self-harm, suicide is higher among cancer patients compared to general population and can be a consequence of depression.

The causes of depression in palliative care settings are usually threats and losses associated with life-threatening illnesses. The major threats and losses are:

- Comprehension of a life-threatening illness, uncertainty of prognosis, fear and anxiety about death and dying
- Poorly controlled physical symptoms
- Undesirable effects of treatments - surgical and medical
- Loss of functional ability, independence, dignity
- Changes in social position, relationships
- Spiritual distress
- Concern about family, income, job
- Changes in body image
- Loss of libido

Other risk factors that contribute to depression are:

- Concurrent disorders
  - Infection - respiratory or urinary infection, septicaemia
  - C.N.S. disorders - primary or secondary tumour, Alzheimer's disease, cerebrovascular disease, HIV dementia
  - Hypothyroidism
  - Metabolic imbalances - dehydration, electrolyte disturbance, hypercalcaemia
  - Organ failure

- Medications - opioids, benzodiazepines, glucocorticoids, chemotherapeutic agents, anti-psychotics, antihypertensives
- Withdrawal - benzodiazepines, opioids, alcohol

- Past/family history of depression or mood disorders
- History of self-harm, substance abuse, negative life-events

ASSESSMENT

- **Assessment** must determine the underlying cause and risk factors of depression, effectiveness of treatment and impact on quality of life for the patients and their families (***refer to the Guideline - Symptom Assessment***)

- **Screening** - Patients should be screened for depression with the following two depression identification questions:
    - During the last month, have you often been bothered by feeling down, depressed or hopeless?
    - During the last month, have you often been bothered by having little interest or pleasure in doing things?
- **Assess for symptoms and signs of depression**
    - Somatic - fatigue, lack of energy, disturbed sleep, reduced appetite, psychomotor agitation or retardation
    - Psychological - sustained dysphoria, sustained low mood especially in the mornings, anhedonia (loss of interest and pleasure), diminished concentration, diminished attention, social withdrawal, feeling of hopelessness and worthlessness, excessive guilt, pessimism, blunting and suicidal ideations/acts
- Assess whether the physical symptoms/signs are caused by physical illness and treatments or due to depression
- Assessment of mental health/depression by trained mental healthcare professional, using a validated tool - Beck's Depression Inventory
- Assess risk for suicide/self-harm
- Continue ongoing assessment of effectiveness of treatment and expectations
- **Investigations** - Thyroid function tests, serum electrolytes, serum calcium

RECOMMENDATION

- Healthcare professionals should have a high suspicion of depression when patients display feelings/psychological symptoms, different from normal distress in terms of their severity, duration and quality
- Healthcare professional should use the same screening tool consistently to identify depression to be familiar with it
- Healthcare professional should know the sensitivity/specificity of the screening tool
- If there is diagnostic uncertainty as to whether the patient is having depression, adjustment reaction or sadness, the healthcare professional should re-evaluate after 1 - 2 weeks of psychological support and adequate symptom management
- Healthcare professional should refer the patients to psychologist/psychiatrist if there is diagnostic uncertainty and/or profound depression and/or overtly suicidal ideations/acts

- Healthcare professional should take into account severity and duration of functional, interpersonal and social impairment associated with depression
- If the life expectancy of the patient is less than four weeks, a psychostimulant is preferred; e.g. methylphenidate
- If the life expectancy of the patient is more than four weeks, a conventional anti-depressant may be prescribed
- In patients who are weak, old and infirm, the starting and maintenance doses of anti-depressants should be lower than the conventional doses
- When initiating SSRIs, if there is an increase in anxiety, then initiate a benzodiazepine at bedtime
- If treatment is effective, continue antidepressants for at least 6 months after the patient feels no longer depressed
- Withdraw anti-depressants gradually over 4 weeks to avoid withdrawal symptoms
- Explain to the patient and family about the medications - dosage, effect and adverse reactions

MANAGEMENT

General measures

- During screening for depression, if the answer is "yes" to any one of the depression identification questions, and the healthcare professional is trained to conduct a mental health assessment then re-assess the person's mental health using a validated tool e.g. Beck's Depression Inventory
- If the healthcare professional is not trained to conduct a mental health assessment, then refer the patient to mental health professional e.g. psychologist

Non-pharmacological measures

- Explain the problems and assure that they would be managed
- Specific psychological interventions - to be administered by psychologist/trained mental healthcare professional
    - Lower intensity psychological interventions - self-help support, designed physical activity programmes
    - Higher intensity psychological interventions (depending on prognosis) - cognitive behavioural therapy (CBT), behavioural activation (BA), Interpersonal therapy (IPT), short-term psychodynamic therapy (STPT) and counselling
- Sleep hygiene
    - Start routine sleep and wake-up times
    - Avoid smoking and drinking before going to sleep
    - Avoid heavy meals before sleeping
    - Start a routine physical activity programme as appropriate for the patient

Pharmacological measures

- ***F*irst line anti-depressant**

  If prognosis less than 4 weeks,

- Methylphenidate
  - Initiate with 2.5 - 5mg bd (at breakfast and lunch)
  - If necessary, the dose can be increased by 2.5mg bd
  - Maximum dose - 20mg bd to tid

If prognosis more than 4 weeks and if associated with anxiety, then SSRIs

- Sertraline
  - Initiate at 25 - 50mg OD; increase to 50 - 100mg OD after a week
  - If no improvement or partial improvement after 6 - 8 weeks, then increase the dose by 50mg to a maximum dose of 200mg/24 hours
  - If there is no effect, then switch to another antidepressant
- Citalopram
  - Initiate at 10mg OD; increase to 20mg OD after a week
  - If no improvement or partial improvement after 6 - 8 weeks, then increase the dose by 10mg to a maximum dose of 40mg/24 hours (maximum of 20mg/24 hours in patients with hepatic impairment, age more than 60 years, on medications - cimetidine, omeprazole and other inhibitors of cyp2c19)
  - if there is no effect, then switch to another antidepressant
- Escitalopram
  - Initiate at 5mg OD; increase to 10mg OD after a week and then to 20mg OD after another week
  - Maximum dose of 20mg/24 hours (maximum dose of 10mg/24 hours in patients with hepatic impairment, age more than 60 years)
  - If there is no effect, then switch to another antidepressant
- Fluoxetine
  - Initiate at 20mg OD; increase after several weeks gradually if there is no improvement or partial improvement
  - Maximum dose of 80mg/24 hours (maximum of 40mg/24 hours in patients with hepatic impairment, age more than 60 years)
  - If there is no effect, then switch to another antidepressant

- **Second line anti-depressant: (NASSA)**
  - Mirtazapine
    - initiate at 7.5 - 15mg hs
    - if no improvement after 6 weeks, then increase the dose to 30mg hs
    - if no improvement after 4 weeks, then consider third line options
- **Third line options**
  - Switch antidepressant
    - Typical doses of SSRIs can be switched without cross-tapering and washout period
      - Sertraline 50mg can be switched to citalopram, fluoxetine 20mg, escitalopram 10mg
      - Higher doses of SSRIs should be tapered before switching
    - Mirtazapine 15mg can be switched to citalopram, fluoxetine 20mg, escitalopram 10mg, sertraline 50mg
  - Start a trial of combination of SSRI with mirtazapine, olanzapine or quetiapine
  - Refer the patient to a psychiatrist

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