

Depression: diagnosis and management in terminal illness

Xenia Bache, Jim Bolton

Depressive illness is often not recognized in terminally ill patients, because it is seen as an 'understandable' reaction. However, treating depression in such patients can significantly improve the quality of their remaining life. The diagnosis and management of depression in terminally ill patients will be discussed in this article.

Depression is a common symptom in patients with terminal illness. In such circumstances, there is a danger that depression may be seen as 'understandable' and therefore not amenable to treatment. In fact, recognizing and treating depressive illness can bring a significant improvement in a patient's quality of life, despite a poor physical prognosis, as illustrated by the case in *Table 1*. How should depressive illness be managed in palliative care?

HOW COMMON IS DEPRESSION IN TERMINAL ILLNESS?

Depression is common in patients with physical illness in general and terminal illness in particular. In a systematic review, Hotopf et al (2002) concluded that the prevalence of major depressive disorder in terminal illness is approximately 15%. An additional 30% of patients have depressed mood as part of their psychological adjustment to physical health problems.

Although depression is one of the top ten symptoms in surveys of patients with terminal illness, it is unlikely to be spontaneously mentioned by patients to medical staff (Hotopf et al, 2002). It is also the symptom that is most often unaddressed by palliative care teams (Edmonds et al, 1998).

WHY IS DEPRESSION OFTEN MISSED?

Potential barriers to health professionals making a diagnosis of depressive illness are listed in *Table 2*. A number of such reasons may apply in an individual case. A contributing factor to the difficulties in managing psychological problems in patients with physical illness is the tendency to separate health services into those that deal with either 'physical' or 'mental' disorders. This

encourages the mistaken thinking that human beings function as independent minds and bodies.

HOW IS DEPRESSIVE ILLNESS DIAGNOSED?

Illness requires ongoing psychological adjustment. An individual will have to understand their diagnosis and the impact that it will have on them. They may also have to cope with unpleasant investigations and treatments, and deterioration in their physical health. Those with terminal illness will have to come to terms with their prognosis and make practical and psychological preparations for death. In such circumstances, sadness is an appropriate response to serious illness, but when does low mood become a depressive illness that warrants specific treatment?

Adjustment reaction

Low mood is a common symptom of an adjustment reaction to the diagnosis of a terminal illness. Patients may also have similar reactions as

Dr Xenia Bache is Senior House Officer in Psychiatry and Dr Jim Bolton is Consultant Liaison Psychiatrist, Department of Liaison Psychiatry, St Helier Hospital, Wrythe lane, Carshalton, Surrey SM5 1AA.

Correspondence to: Dr J Bolton

TABLE 1.
Case study

Mr M was a 75-year-old retired taxi driver who had been diagnosed with cancer of the colon. Following a radical resection, he was found to have liver metastases and began an unsuccessful course of chemotherapy. His GP was concerned about Mr M's low mood and referred him to the general hospital psychiatry service.

Mr M reluctantly attended an outpatient appointment. His wife described how he had become withdrawn and tearful. He no longer enjoyed watching sport on TV, nor seeing his grandchildren. Mr M took little part in the interview and appeared downcast. He saw little point in being in the clinic as he had only a few months left to live.

With his wife's encouragement Mr M agreed to taking an antidepressant, and to attend further appointments to discuss his illness. After 5 weeks Mr M reported that he felt much better. Although he continued to eat poorly and have little energy, he felt more like his old self. He enjoyed visiting his grandchildren and resumed watching sport. Although he only lived for another 2 months, the quality of his remaining life had been significantly improved by treating his depression.

Details of Mr M's case have been changed to ensure anonymity.

TABLE 2.
Barriers to diagnosing and treating depressive illness in patients with terminal illness

View that depression is not a 'real' illness
Assumption by staff that depression is appropriate or understandable and therefore not responsive to treatment
Reluctance by staff to explore emotional issues, either because of time constraints or a fear that they will be unable to manage the patient's feelings
Difficulty in distinguishing the somatic symptoms of depression from those of physical illness
Assumption by the patient that his/her depressive symptoms are part of their physical illness
Belief that depression is not worth treating in patients close to death
Reluctance to prescribe antidepressants because of concern about interactions with other drug treatments
Reluctance by the patient to discuss psychological issues because staff are seen as managing physical health problems
Patient feels to blame for his/her health problems

they adjust to changes in their circumstances as their health deteriorates. This reaction reflects the psychological work needed to come to terms with a loss of physical health.

Depressive illness

In general, low mood becomes a depressive illness when it is pervasive and intense, or when it persists. Severe depression will have a significant impact on an individual's everyday functioning and may be associated with suicidal thoughts. If low mood persists for longer than expected, this may indicate that the patient has a depressive illness. Warning signs that indicate that a patient might be depressed are listed in *Table 3*.

The symptoms criteria used to diagnose a depressive illness are shown in *Table 4*. The severity of depression can be judged by the magnitude of effect that it has on an individual's day-to-day activities.

Depression has both psychological and somatic symptoms (also called biological or physical

TABLE 3.
Problems that might indicate a depressive illness

Severe or persistent distress
Failure to adjust to illness
Poor adherence to treatment
Greater than expected disability
Poor social interaction
Suicidal ideation
Sudden deterioration in general condition or coping ability not explained by physical condition

symptoms). However, in patients with severe physical illness it is often difficult to decide whether somatic symptoms, e.g. fatigue, poor appetite or sleep disturbance, are primarily caused by the illness and its consequences, or by an independent depressive illness. Psychological symptoms are therefore of greater importance than somatic symptoms when making a diagnosis of depression in physical illness (Endicott, 1984).

ARE THOUGHTS OF SUICIDE AN APPROPRIATE RESPONSE TO A TERMINAL ILLNESS?

Viewing depression as an understandable response to physical illness can also extend to associated suicidal thoughts. Although contemplating and preparing for death is part of the psychological work that patients have to do, ongoing thoughts of suicide should be considered as evidence of a depressive illness. High rates of depression have been found in patients who request euthanasia (Hotopf, 2003). Tiernan et al (2002) found that the desire for early death in terminally ill patients was associated with depressive symptoms. Enquiring about suicidal ideation should be part of all assessments for depressive illness.

SHOULD PATIENTS BE SCREENED FOR DEPRESSION IN TERMINAL ILLNESS?

As depressive illness is common in patients with terminal illness, it is important to question whether it is appropriate to screen for the disorder? A systematic review of routinely administered psychiatric questionnaires for depression and anxiety in non-psychiatric settings found little evidence that this improved patients' psychological outcome (Gilbody et al, 2001). One suggested explanation for this finding is that staff may not feel confident in dealing with emotional disorders. Screening is more effective when accompanied by staff education and the possibility of referral to another agency.

Possible screening instruments include the Hospital Anxiety and Depression Scale (Zigmond and Snaith, 1983). This is a self-rated 14-item questionnaire suitable for use with medical patients, as it excludes somatic symptoms of depression which might also be a result of physical illness. A simpler screening tool which can easily be incorporated into routine clinical practice is the single question 'Are you depressed?' (Chochinov et al, 1997). A review of validated screening tools for depression in palliative care concluded that this single question had the highest sensitivity and specificity of available instruments (Lloyd-Williams et al, 2003).

DEPRESSION AFFECTS PHYSICAL FUNCTION

Depression complicating chronic illnesses can impact on a patient's quality of life and use of health-care resources. Overall, it has been estimated that untreated depression in chronic illness may increase the cost of care by 50% (Katon, 2003). Depression can lower a patient's pain threshold and increase his/her need for analgesia. A study of older adults found that those with depression were more likely to report themselves as having a poorer physical condition (Mossey et al, 2000).

Depression is associated with increased morbidity and mortality in many chronic illnesses, including diabetes mellitus and ischaemic heart disease. This may be a result of behavioural factors, such as increased smoking and reduced exercise. In addition, patients with depression are less likely to adhere to treatments for their physical illness, and less inclined to participate in rehabilitation programmes (Katon, 2003). Depression may also have adverse physiological consequences, such as an increased propensity to arrhythmias in patients with heart disease.

Considering cancer in particular, there is a popular belief that psychological factors can influence long-term survival, with plausible immunological and neuroendocrine mechanisms for such a link. However, the evidence for this association is inconsistent (Petticrew et al, 2002; Brown et al, 2003).

WHAT ARE THE TREATMENT OPTIONS?

The management of depression should consider physical, psychological and social factors. This approach complements the holistic approach of palliative care. As well as having the skills to identify depressive illness and manage straightforward cases, staff working with terminally-ill patients should also have access to specialist mental health advice and referral.

Drug treatments

A systematic review of antidepressants in physical illness confirmed that they are both effective and tolerated (Gill and Hatcher, 1999). When choosing an appropriate antidepressant for an individual patient, possible drug interactions and the type and severity of physical illness should be considered. Looking specifically at advanced disease, Lan Ly et al (2002) concluded that the selective serotonin reuptake inhibitors are usually the preferred type of antidepressant. The tricyclic antidepressants, however, appear to have an additional analgesic effect and may be the preferred option for patients with chronic or

neuropathic pain.

Psychostimulants, such as dexamphetamine, can rapidly increase a patient's sense of well-being and stimulate their appetite. These drugs are not licensed for the treatment of depression in the UK, but are occasionally prescribed in the end stages of a terminal illness.

Psychological therapies

Basic psychological and spiritual support is often important in helping patients to come to terms with their illness and its consequences, and may be protective against depressive illness. The importance of basic education, advice, and simply providing a listening ear, should not be underestimated. For patients with mild to moderate depression, psychotherapy is as effective as antidepressant treatment. The largest evidence base is for cognitive-behavioural therapy, with specific evidence for its use in a number of physical illnesses.

Complementary and alternative therapies

There is no evidence that complementary and alternative therapies can treat depressive illness. However, they may have significant psychological benefits for patients with advanced disease. These include giving patients a sense of positive action and control in what can otherwise feel like an uncontrollable situation. Care should be taken to ensure that these therapies do not adversely interact with the patient's regular treatment, including any psychotropic medication they may be receiving.

CONCLUSIONS

A significant proportion of terminally-ill patients will develop a depressive illness. However, the belief that this is an understandable reaction contributes to depression being under-

TABLE 4.
International Classification of Diseases-10 diagnostic criteria for a depressive episode

<i>Core symptoms</i>
Depressed mood
Loss of interest and enjoyment
Reduced energy and fatigability
<i>Other common symptoms</i>
Reduced concentration
Reduced self-esteem and self-confidence
Ideas of guilt and unworthiness
Bleak and pessimistic views of the future
Disturbed sleep
Diminished appetite
<i>Severity of depression</i>
Mild: 2 core plus 2 other symptoms
Moderate: 2 core plus 3 other symptoms
Severe: 3 core plus 4 other symptoms

(World Health Organization, 1992)

recognized and under treated in such patients. The management of depression is an important element of palliative care, and can bring significant improvement in patient's physical functioning and quality of life. **HM**

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KEY POINTS

- Depression is a common symptom in terminal illness, with 15% of patients having a depressive illness.
- Depressive illness is often not recognized or treated, particularly when it is seen as an understandable reaction to a terminal illness.
- Suicidal thoughts or requests for euthanasia should be considered as possible symptoms of a depressive illness.
- A simple screening tool for depression is the single question, 'Are you depressed?'
- Antidepressants, psychological therapies and social support are all important elements in the treatment of depressive illness.
- Palliative care services should have access to specialist mental health advice and referral.

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IMAGES IN MEDICINE

Heparin-induced thrombocytopenia

Rupen Dattani

Although heparin is widely used as the anticoagulant agent of choice in surgical patients, it has several potential adverse effects. The most hazardous of these is heparin-induced thrombocytopenia and thrombosis syndrome (HITTS).

Clinical warning signs of HITTS include thrombocytopenia, any unexplained thrombotic event (venous or arterial) or skin lesions. Unlike drug-induced thrombocytopenias heparin-induced thrombocytopenia (HIT) typically presents with thrombosis rather than bleeding. Diagnosis can be

made when clinical symptoms are associated with pathologic HIT antibodies. If HITTS is suspected, heparin should be stopped immediately and alternative forms of anticoagulation commenced until resolution of thrombocytopenia. Warfarin can be considered once platelet count rises above 100×10^9 cells/litre.

Patient with a history of HITTS should never be re-exposed to heparin. Use of low molecular weight heparin (LMWH) is now becoming increasingly popular in most surgical units. Compared with unfractionated heparin, LMWH is both superior as a thromboprophylaxis agent and is associated with a much lower incidence of HITTS. **HM**



Figure 1. Magnetic resonance imaging (MRI) angiogram of the carotid arteries in a previously healthy 49-year-old woman who developed heparin-induced thrombocytopenia after receiving unfractionated heparin following an elective laparoscopic cholecystectomy. Arrow indicates Thrombus in the right internal carotid artery.

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Mr Rupen Dattani is Research Fellow, Department of Biomedical Engineering, Royal National Hospital, Middlessex, HA5 4DE

Correspondence to: Mr Rupen Dattani