

## Depression Management Tips for Healthcare Professionals

**Guiding Principles:** Depression is common in advanced cancer and requires attention.

### Step 1. Top underlying treatable causes and diagnosis:

- Patients are screened for depression and suicidality routinely utilizing the MySymptom Report (MSR) electronic patient-reported outcome (ePRO) questionnaire in Connect Care. Review the following areas on the MSR related to depression:
  - Depression score on the electronic Edmonton Symptom Assessment System – Cancer revised [(e)ESAS-r Cancer]
    - Mild (1-3)
    - Moderate (4-6)
    - Severe (7-10)
  - Screening question for suicidality embedded after Depression rating item
    - Patients are asked to answer “Yes/No” to “I have thoughts of harming or killing myself”
  - Emotional domain on the MyPersonal Needs (MPN) checklist –patients select emotional concerns pertinent to their unique situation
  - Note: paper format of MSR questionnaire does not include the MPN checklist, but does include the Depression symptom rating item and screening question for suicidality
- Depression and demoralization are often due to multiple interactions between disease-related, individual and psychosocial factors
- Major Depression (present in ~30%):
  - Psychological symptoms (e.g. depressed mood, feelings of worthlessness, guilt, hopelessness, anhedonia, suicidal ideations) are more useful in diagnosis in cancer patients compared to somatic symptoms (e.g. anorexia, fatigue, weight loss, insomnia)
- Assess for early or hypoactive delirium using tools such as:
  - Confusion Assessment Method (CAM),
  - Blessed Orientation-Memory-Concentration (BOMC) test)
- Simply asking ‘Are you depressed?’ may help
- Consider ruling out secondary causes (e.g. hypothyroidism, anemia, medications (e.g. interferon), sleep disorders, nutritional deficiencies)
- Assess for suicidality
  - Review patient answer to “I have thoughts of harming or killing myself” on both the paper and electronic MSR questionnaires
- Address possible concomitant underlying contributors:
  - Poor symptom control (e.g. pain, dyspnea)
  - Drugs: Corticosteroids, Interferon

### Step 2a. Non-pharmacological management:

- All levels of distress, mild-to-severe, should be addressed
- Persons with advanced cancer often prefer psychological over pharmacologic treatment

- Non-pharm therapies may be used alone for mild to moderate distress, and are also used in conjunction with pharmacological therapies for severe distress.
- Assessment includes coping strategies, response to illness, expectations of healthcare providers
- Encourage activity, engagement in valued interests
- Group therapies useful for feeling less alone, being understood, sense of community, sharing information
- Mindfulness interventions alleviate depression and anxiety
- Evidenced based 3 – 6 session Managing Cancer and Living Meaningfully (CALM) psychological intervention for individuals and a close other, flexibility in meeting times, supports resolution of practical and existential issues that face those with metastatic disease
- Dignity Therapy can be useful for demoralized patients
- Supportive Therapies: Supportive-expressive groups, Individual Psychotherapy
- Complementary therapies: Relaxation Therapy, Meditation, Massage, Aroma, Reiki, Therapeutic Touch, Art, Imagery
- Patient information: <https://myhealth.alberta.ca/health/pages/conditions.aspx?Hwid=hw30709>

### Step 2b. Pharmacological options:

- Major depression may require both non-pharmacological and pharmacological treatment
- Consider concomitant methylphenidate for rapid onset (hours to days) either if short prognosis or until regular antidepressant takes effect; give 5 mg (2.5 mg if very **frail**) test dose in morning (discontinue if severe anxiety, tremors, agitation, confusion, severe tachycardia); then 5 mg po bid (0800 & 1400); increase q1-3d by 2.5 mg per dose to 20 mg po bid; if given in combination with SSRI/SNRI, after initial 3-4 weeks, taper and discontinue in 1-2 weeks.
- Citalopram: start 10 mg po daily; increase q5-7d to maximum 40 mg daily (**Elderly**: Maximum 20mg daily)
- Escitalopram: start 5 mg po daily; increase q5-7d to maximum 20 mg daily (**Elderly**: Maximum 10mg daily); usual effective dose 10-15 mg
- Mirtazapine (good for insomnia too as sedating at doses < 15 mg qhs): start 7.5-15 mg po qhs; increase q7-14d; usual dose 15-45 mg
- **Elderly**: Time to effect with medication changes can be 10-12 weeks. So, consider titrate q2-4 weeks
- Drug monitoring: Check electrolytes for risk of SIADH (SSRI); ECG for prolonged QTc interval (SSRI/Mirtazapine) – especially if 2 or more drugs with effect on QTc interval

### Step 3. When to refer to specialists:

- Psychiatrist:
  - If depression symptoms worsening despite above treatment
  - Significant history of depression or other psychiatric illness that predates latest episode
  - Severe depression with risk of harm to self and/or others
- Palliative care:
  - Concomitant physical symptoms (like pain) that are difficult to control

- Existential distress requiring involvement of multidisciplinary team (social worker, rehabilitation, spiritual care)

For more detailed information on Depression visit: <https://www.cancercareontario.ca/en/symptom-management/3986>

#### **End of Life Considerations:**

- In untreated patients, consider use of methylphenidate (1<sup>st</sup> line) IF affecting quality of life and prognosis is longer than few days

**NOTE:** Guidelines do not replace individualized care and clinical expertise.

#### **References:**

1. Inouye SK, van Dyck CH, Alessia CA, et al. Clarifying confusion: the confusion assessment method. A new method for detection of delirium. *Ann Intern Med* 1999;113:941-8.
2. Chochinov HM, Wilson KG, Enns M, Lander S. 'Are you depressed?' Screening for depression in the terminally ill. *Am J Psychiatr*. 1997;154:674-676.
3. The Pallium Palliative Pocketbook: a peer-reviewed, referenced resource. 2<sup>nd</sup> Cdn ed. Ottawa, Canada: Pallium Canada; 2016.
4. Cancer Care Ontario Depression Algorithm. <https://www.cancercareontario.ca/en/symptom-management/3986>
5. Kerr CW, Drake J, Milch RA, et al. Effects of Methylphenidate on Fatigue and Depression: A Randomized, Double-Blind, Placebo-Controlled Trial. *J Pain Symp Mgmt* 2012; 43(1):68-77
6. MacQueen GM, Frey BN, Idmail Z, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) 2016 Clinical Guidelines for the Management of Adults with Major Depressive Disorder. Section 6. Special Populations: Youth, Women, and the Elderly. *Can J Psychiatry* 2016; 61(9):588-603
7. Bultz BD, Groff SL, Fitch M, Blais MC, Howes J, Levy K et al. Screening for distress. The 6th vital sign: A Canadian strategy for changing practice. *Psycho-oncology* 2011; 20: 463-469.
8. Akechi T, Okuyama T, Onishi J, Morita T, & Furukawa TA (2008). Psychotherapy for depression among incurable cancer patients. *Cochrane Database Systematic Review*, (2):CD005537
9. Goodwin PJ, Leszcz M, Ennis M, Koopmans J, Vincent L, Guther H, Drysdale E, Hundleby M, Chochinov HM, Navarro M, Specia M, & Hunter J (2001). The effect of group psychosocial support on survival in metastatic breast cancer. *New England Journal of Medicine*, 345(24): 1719-1726.
10. Carlson LE. Mindfulness-based interventions for coping with cancer. *Ann N Y Acad Sci*. 2016 Jun;1373(1):5-12
11. Lo C, Zimmermann C, Rydall AC, Walsh A, Jones JM, Moore MJ, Shepherd FA, Gagliese L, & Rodin G (2010a). Longitudinal study of depressive symptoms in patients with metastatic gastrointestinal and lung cancer. *Journal of Clinical Oncology*, 28(18): 3084-3089
12. Rodin G, Lo C, Rydall A, Shnall J., Malfitano, C., Chiu, A., Panday, T., Watt, S., An, E., Nissim, R., Li, M., Zimmerman, C., and Hales, S. Managing Cancer and Living Meaningfully (CALM): A Randomized Controlled Trial of a Psychological Intervention for Patients With Advanced Cancer. *Journal of Clinical Oncology*, 2018; 36, 1 - 17.
13. Chochinov HM, Hack T, Hassard T, Kristjanson LJ, McClement S, & Harlos M (2005). Dignity therapy: A novel psychotherapeutic intervention for patients near the end of life. *Journal of Clinical Oncology*, 23(24): 5520-5525
14. Grassi L, Nanni MG, Rodin G, Li M, Caruso R. The use of antidepressants in oncology: a review and practical tips for oncologists. *Ann Oncol*. 2018 Jan 1;29(1):101-111. doi: 10.1093/annonc/mdx526.

15. Prescott AT, Hull JG, Dionne-Odom JN, Tosteson TD, Lyons KD, Li Z, Li Z, Dragnev KH, Hegel MT, Steinhauser KE, Ahles TA, Bakitas MA. The role of a palliative care intervention in moderating the relationship between depression and survival among individuals with advanced cancer. *Health Psychol.* 2017 Dec;36(12):1140-1146. doi: 10.1037/hea0000544.



*Vision:* Improving quality of life for Albertans with advanced cancer.