



## PALLIATIVE CARE CASE OF THE MONTH

### “Are you depressed?” Screening for Depression in Palliative Care Yael Schenker, MD

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**Case:** Mr. P. is a math professor with a history of depression and lupus anticoagulant. He presented six months ago with mesenteric ischemia necessitating a bypass graft. Since that time, he has spent most of his time in the hospital with a series of complications, including overwhelming infection, graft thrombosis, small bowel necrosis, and delirium. He has undergone multiple abdominal surgeries. He receives total parenteral nutrition and broad spectrum antibiotics without a clear stopping point. Prior to admission he took escitalopram for depression, however this was stopped during his hospital stay due to concerns for an interaction with his antibiotics. Palliative care is consulted when Mr. N begins saying that he is tired of being in the hospital and feeling down.

On initial visit, Mr. N is awake and conversant. He has a flat affect. He screens negative for delirium. His pain is well-controlled with a fentanyl patch. He has chronic low-level nausea. He describes feeling afraid to have additional surgeries because he is worried about more complications. He feels like he will never get better. He is worried about dying and “not being around for his family.”

**Discussion:** Prevalence of depression in palliative care:

Mood disorders are common among patients receiving palliative care. Up to 50% of patients with incurable conditions have a psychiatric diagnosis. [1] Prevalence estimates for depression vary widely, in part due to the challenges of diagnosing the disease in seriously ill populations. In a survey administered to 381 patients receiving palliative care for cancer in Canada, 13% had a diagnosis of major depression (as compared to estimates of 1.8% to 4.9% among general community residents). [2] In other studies, prevalence of depression among palliative care patients with cancer ranges between 7% and 49%. [3]

Screening for depression in palliative care:

Consensus guidelines recommend a heightened awareness and attention to depression in palliative care populations. [4] Clinicians should be aware of key depressive symptoms, including feelings of hopelessness or worthlessness, persistent poor mood, loss of interest in activities, and suicidal ideation. Physical clues to depression in palliative care patients may include slumped posture, little movement, flat affect, and reduced emotional range.

Certain groups of palliative care patients are at higher risk of depression. These include patients with a prior history of depression, significant life stressors, poor social support, uncontrolled pain, poor functional status, and advanced disease at diagnosis. [4]

When assessing for depression, clinicians must be aware that symptoms of depression can overlap with symptoms of serious illness or medical treatments (for example, fatigue and poor appetite). For this reason, experts recognize prioritizing cognitive/affective symptoms over physical symptoms of depression in palliative care populations. [4]

Depression may also be difficult to differentiate from other disorders that are commonly found in palliative care. When assessing for depression, clinicians should consider alternative explanations for observed symptoms, including hypoactive delirium, dementia, hypercalcemia, hypothyroidism, brain metastases, uncontrolled pain, and adverse drug reactions (for example, steroids).

An additional challenge is differentiating depression from normal sadness among patients with serious illness. Several key differences may be useful. Depression tends to be constant, unremitting, and associated with a feeling of permanence. Sadness may fluctuate and be associated with a sense that things will change. Depression is associated with feeling outcast and alone, while patients who are sad may be able to intimately connect with others. Depression may involve rumination and regret, extreme self-deprecation, self-loathing, no hope or interest in the future, little enjoyment of activities, and suicidal thoughts or behaviors. In contrast, patients who are sad may enjoy happy memories and a sense of self-worth, look forward to things, retain a capacity for pleasure, and have a will to live. [4]

Screening Tools:

Routine screening for depression is recommended in palliative care populations. However, there is no consensus about the best screening tool and evidence is lacking that routine screening impacts depression outcomes. Interestingly, in a recent Delphi study, experts rated “informal routine asking” about mood as more useful than any specific screening tool for depression in palliative care. [5]

When screening for depression, it is suggested that clinicians be familiar with the sensitivity and specificity data for one scale and use that scale consistently to gain familiarity. [6] Sensitivity refers to the percentage of patients with depression who will be correctly identified as having depression by the scale.

*Personal details in the case published have been altered to protect patient privacy.*

For palliative care consultations please contact the Palliative Care Program at PUH/MUH, 647-7243, beeper 8511, Shadyside Dept. of Medical Ethics and Palliative Care, beeper 412-647-7243 pager # 8513, Perioperative/ Trauma Pain 647-7243, beeper 7246, UPCI Cancer Pain Service, beeper 644-1724, Interventional Pain 784-4000, Magee Women’s Hospital, beeper 412-647-7243 pager #: 8510, VA Palliative Care Program, 688-6178, beeper 296. Hillman Outpatient: 412-692-4724. For ethics consultations at UPMC Presbyterian-Montefiore and Children’s page 958-3844. With comments about “Case of the Month” call Dr. Robert Arnold at (412) 692-4834.



(Discussion Continued)

Specificity refers to the percentage of patients without depression who will be correctly identified as not having depression by the scale. The following three tools are recommended for palliative care populations. Screening should occur frequently, as the psychological state of patients with serious illness may be unstable and change quickly. A negative screen on any of these tools may be helpful in identifying patients who are not depressed. A positive screen indicates the need for a more in depth evaluation.

Single-item question: "Are you depressed?"

Sensitivity for this question ranges from 0.42-0.86 and specificity ranges from 0.74-0.92. [4] In an initial study, this question had perfect sensitivity and specificity, but subsequent studies have failed to replicate these results. [7]

Two-item screen: "During the last month, have you been bothered by feeling down, depressed, or hopeless?" During the last month, have you been bothered by having little interest or pleasure in doing things?" Sensitivity for this tool ranges from 0.91-1.00 and specificity ranges from 0.57-0.86. [4]

Hospital Anxiety and Depression Scale. This is a 14-item scale for anxiety (7 items) and depression (7 items) that was designed for use in seriously ill populations and therefore excludes somatic symptoms. Sensitivity for this scale ranges from 0.68-0.92 and specificity ranges from 0.65-0.90. [4] Of note, a number of different cut-offs have been explored for diagnosing anxiety and depression using the HADS in different populations. Typically, a score of 8 or above out of 21 signals significant symptoms.

**Resolution of the case:** When asked about his mood, Mr. P endorses feeling down. When asked if he is depressed, he says "it's situational, I just feel horrible." He reports feeling better when he is able to go down the hall in his wheelchair, but recently his wheelchair taken away and he has not been strong enough to walk with the physical therapists. He also notes that he enjoys visits from his wife in the evening and on weekends. The palliative care team recommends scheduled haldol for nausea. They request that a new wheelchair be sent to Mr. P's room and encourage family members and staff to push him in the halls. The social worker helps him to choose a Valentine's Day present for his wife from the gift shop. His mood is brighter on subsequent visits. The clinical psychologist is asked to see him but he declines therapy, noting that he is feeling much better.

His fluctuating symptoms, ability to enjoy family visits, appreciation of relationships, improved mood with improved control of nausea, and negative screen with the single-item question all suggest against a diagnosis of depression. It is recommended that his psychological symptoms continue to be closely monitored.

#### References:

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