

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:

- Screen using: Putting Patients First (PPF) ESAS Depression scores useful (Mild 1-3; Moderate 4-6; Severe >7)
- Depression and demoralization are often due to multiple interactions between disease-related, individual and psychosocial factors
- Major Depression (present in ~30%):
 - a. 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),
 - Mini Mental State Exam (MMSE) or,
 - Blessed Orientation-Memory-Concentration (BOMC) test
 - See '[Palliative Care Tip: Depression or Delirium](#)' for more info
- 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 (also check patient reported 'Thoughts of ending my life' on PPF - Canadian Problem Checklist)
- Address possible concomitant underlying contributors:
 - a. Poor symptom control (e.g. pain, dyspnea)
 - b. Drugs: Corticosteroids, Interferon

Step 2a. Non-pharmacological management:

- All levels of distress, mild-to-severe, should be addressed
- Persons with advanced cancer often prefer psychologic 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 (1st line) IF affecting quality of life and prognosis is longer than few days

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

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