



Research Report

Depression in advanced cancer – Assessment challenges and associations with disease load



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ABSTRACT

Background: Patients with advanced cancer commonly experience multiple somatic symptoms and declining functioning. Some highly prevalent symptoms also overlap with diagnostic symptom-criteria of depression. Thus, assessing depression in these patients can be challenging. We therefore investigated 1) the effect of different scoring-methods of depressive symptoms on detecting depression, and 2) the relationship between disease load and depression amongst patients with advanced cancer.

Methods: The sample included 969 patients in the European Palliative Care Research Collaborative-Computer Symptom Assessment Study (EPCRC-CSA). Inclusion criteria were: incurable metastatic/locally advanced cancer and ≥ 18 years. Biomarkers and length of survival were registered from patient-records. Depression was assessed using the Patient Health Questionnaire (PHQ-9) and applying three scoring-methods: inclusive (algorithm scoring including the somatic symptom-criteria), exclusive (algorithm scoring excluding the somatic symptom-criteria) and sum-score (sum of all symptoms with a cut-off ≥ 8).

Results: Depression prevalence rates varied according to scoring-method: inclusive 13.7%, exclusive 14.9% and sum-score 45.3%. Agreement between the algorithm scoring-methods was excellent (Kappa=0.81), but low between the inclusive and sum scoring-methods (Kappa=0.32). Depression was significantly associated with more pain (OR-range: 1.09–1.19, $p < 0.001$ –0.04) and lower performance status (KPS-score, OR-range=0.68–0.72, $p < 0.001$) irrespective of scoring-method.

Limitations: Depression was assessed using self-report, not clinical interviews.

Conclusions: The scoring-method, not excluding somatic symptoms, had the greatest effect on assessment outcomes. Increasing pain and poorer than expected physical condition should alert clinicians to possible co-morbid depression. The large discrepancy in prevalence rates between scoring-methods reinforces the need for consensus and validation of depression definitions and assessment in populations with high disease load.

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Abbreviations: EPCRC-CSA, European Palliative Care Research Collaborative-Computer Symptom Assessment Study; PHQ-9, Primary Care Evaluation of Mental Disorders Patient Health Questionnaire, mood module, PRIME-MD PHQ-9; OR, Odds ratio; MDD, major depressive disorder; KPS, Karnofsky Performance Scale; CRP, C-reactive protein; HgB, hemoglobin; BMI, Body Mass Index; HCP, health care personnel; SCID, structured clinical interviews for DSM; BPI, Brief Pain Inventory

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1. Introduction

Incurable cancer disease is often referred to as advanced cancer (American Cancer Society, 2014). Around 40–50% of all new cancer cases will enter advanced stages of their disease (National Institutes of Health, 2010; Cancer Research UK, 2014). Patients with advanced cancer disease typically experience a high disease load accompanied by an increased number and severity of symptoms as well as functional decline as the disease progresses (Maltoni et al., 2005; Teunissen et al., 2007a; Walsh et al., 2000).

Major depression in these patients is common, with average prevalence rate estimates of around 15% based on clinical interviews (Hotopf et al., 2002; Mitchell et al., 2011). The estimates range between 5% and 30%, mostly reflecting differences in assessment methods and sample heterogeneity (Mitchell et al., 2011). Being able to assess depression accurately in these patients is important because depression is linked to a range of negative effects (DiMatteo et al., 2000), including poorer health status, reduced quality of life (Pinquart and Duberstein, 2010) and shortened survival (Lloyd-Williams et al., 2014; Pinquart and Duberstein, 2010). Despite this, depression is frequently overlooked or underestimated in the clinic (Passik et al., 1998), thus hampering adequate treatment and care (Rayner et al., 2009).

Identifying depression in patients with advanced cancer can be challenging for clinicians without mental health training because of the multiplicity of symptoms, the functional decline and the lack of consensus regarding how to define and assess depression in these patients (Hotopf et al., 2002; Mitchell et al., 2012b; Wasteson et al., 2009). This is reflected in the large variability of descriptions of depression characteristics in studies of depression in patients with advanced cancer (Janberidze et al., 2014b). Further, the assessment methods of depression used also vary considerably (Mitchell et al., 2012b; Wasteson et al., 2009). In a review of 202 studies of depression among palliative cancer patients, 106 different assessment methods were used (Wasteson et al., 2009). Few studies defined depression according to standard diagnostic criteria, the current “gold standard”, e.g. the DSM (APA, 2013) or ICD-systems (WHO, 1992).

Whether the standard diagnostic criteria for depression are appropriate for use in cancer patients has been debated for decades because symptom criteria for depression overlap common symptoms of cancer and its treatment, e.g. fatigue, appetite loss and sleep disturbances (Akechi et al., 2003; Bukberg et al., 1984; Chochinov et al., 1994; Endicott, 1984; Rayner et al., 2011a). To reduce the problem of symptom-overlap, the DSM-5 states that symptoms due to a general medical condition should be ignored (APA, 2013). Correctly attributing symptoms to the cancer or to the depression can, however, be particularly challenging in multi-symptomatic

advanced cancer patients in the context of a busy clinical setting (Chochinov, 2001; Lloyd-Williams and Friedman, 2001).

Suggestions have been made to remove (Bukberg et al., 1984; Rayner et al., 2011a; Zimmerman et al., 2006) or to substitute (Endicott, 1984) the somatic depression symptoms when assessing depression in the medically ill. Others have argued for the retention of the somatic symptoms as they can be diagnostically useful (Mitchell et al., 2012a; van Wilgen et al., 2006) and seem to have little effect on prevalence rates, at least when levels of depressive symptoms are high (Chochinov et al., 1994; Kathol et al., 1990; Mitchell et al., 2012a; van Wilgen et al., 2006).

The lack of consensus is also reflected in recommended screening procedures (Andersen et al., 2014; Hewitt et al., 2006; Rayner et al., 2011b). The recently published ASCO guidelines (Andersen et al., 2014) recommend using the Patient Health Questionnaire (PHQ-9). It corresponds item-by-item to the nine DSM-5 diagnostic criteria for major depressive disorder (five psychological and four somatic symptoms (Spitzer et al., 1999)). Further, a sum-scoring of all symptoms and applying a cutoff of ≥ 8 to detect depressed cases is recommended. On the other hand, the European EPCRC guidelines for depression screening in palliative care suggest prioritizing the psychological, or cognitive/affective, depression symptoms because the somatic symptoms may be caused by the cancer or its treatment (Rayner et al., 2011b). The divergent recommendations might reflect different perceptions of the effect of disease load between cancer patients in general and cancer patients with advanced disease and high disease load.

Yet, the potential effect of somatic disease load on detecting depression in cancer patients is rarely considered (Chen and Chang, 2004; Mitchell et al., 2012a; Rayner et al., 2011a; Rodin et al., 2009; Smith et al., 2003; Teunissen et al., 2007b). A recent review demonstrated that core medical characteristics were unsystematically and inconsistently described in studies of depression in patients with advanced cancer (Janberidze et al., 2014b). This may in part be due to the lack of standardized systems for assessing disease load in patients with advanced cancer in general (Maltoni et al., 2005). Candidate markers of disease load are factors known to

Table 1
Description of the three depression scoring-methods: symptoms included and scoring-method.

Depression symptoms included	Depression scoring-method		
	Inclusive	Exclusive	Sum-score
1. Anhedonia ^a	+	+	+
2. Depressed mood ^a	+	+	+
3. Sleep-problems ^b	+	–	+
4. Fatigue ^b	+	–	+
5. Weight/appetite change ^b	+	–	+
6. Feelings of worthlessness/guilt ^c	+	+	+
7. Poor concentration ^c	+	+	+
8. Psychomotor retardation/agitation ^b	+	–	+
9. Thoughts of self-harm/suicidal ideations ^c	+	+	+
Scoring-method	Algorithm: five symptoms must be endorsed, including at least depressed mood or anhedonia	Algorithm: three symptoms must be endorsed, including at least depressed mood or anhedonia	Sum: scores on each symptom (0–3) are summed and a cut-off score of ≥ 8 is applied

Notes: Symptoms reflect the DSM-5 criteria used to diagnose major depressive disorder (APA, 2013).

^a Main or cardinal depression symptom.

^b “Somatic depression symptoms”.

^c “Psychological depression symptoms”.

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