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Is age a risk factor for depression among the oldest old with cancer?

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ABSTRACT

Introduction: Age is negatively related to depression among young and middle age patients with cancer. Nevertheless the relationship between age and depression among older patients with cancer is unclear. The goal of the current study is to assess the association of depression with increasing age among older patients with cancer. **Materials and methods:** Participants were 243 oncology out-patients, aged ≥ 65 , either receiving treatment for active disease or within 6 months of completing treatment for active disease, with a Karnofsky score ≥ 70 . Participants were grouped by age: “Younger-Old” – age 65–74 ($N = 125$); “Old” – age 75–84 ($N = 49$); and “Oldest-Old” –age ≥ 85 years ($N = 69$).

Background data included: socio-demography; cancer type/staging/treatment; Charlson comorbidity index (CCI); Eastern Cooperative Oncology Group (ECOG) performance. Psychological data included: the 5-item Geriatric Depression Scale (GDS); “Distress Thermometer” (single item); and Cancer Perceived Agents of Social Support (12-item).

Results: Depression levels were significantly higher among oldest-old participants in comparison to the old and younger-old groups: mean GDS scores were 0.93 ± 1.13 , 1.27 ± 1.41 and 3.91 ± 1.35 respectively. After controlling for all potential confounders in a hierarchical logistic regression model, age-group significantly predicted both depression and distress. Receiver operating characteristic (ROC) analysis determined age 86 as the optimal cutoff for both clinical depression and distress.

Discussion: Depression among older patients with cancer rises with increasing age, being extremely common among the oldest old. Age independently predicted depression, irrespective of medical variables, social support, or functional status. Findings highlight the importance of addressing the potentially unmet psychological needs of this rapidly growing patient population.

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1. Introduction

The interaction between global aging of the world population and the developments in detection and treatment of cancer will likely result in increased numbers of older people diagnosed and treated for cancer [1,2]. According to the United States (US) National Cancer Institute, the number of people surviving after cancer diagnosis is predicted to rise in the US from 14.5 million in 2014 to almost 19 million by 2024 [1,3]. A similar rise is expected in Europe, where the incidence of cancer is already 11 times higher among people >65 years compared to adults ≤ 65 [4,5]. Older cancer patients with high comorbidity, functional impairments, and frailty, in addition to their more resilient and robust contemporaries, are very likely to present a major challenge to oncologists,

geriatricians, and associated health care professionals caring for older people. In order to achieve optimal wellbeing and higher quality of life for these patients both their physiological and psychological needs have to be addressed.

Nonetheless, the specific psychological issues surrounding cancer diagnosis among the older population, and particularly the oldest old, have yet to be clearly defined. Existing research suggests that among the adverse psychological reactions of older patients to a diagnosis of cancer, depression was found to be one of the most common disorders, frequently associated with disability, morbidity, pain, decreased social functioning, and mortality [6,7]. Diagnosing depression among older patients with cancer may be challenging, and depressive symptoms may be overlooked more often than among people not suffering from malignant diseases of similar age [8–12].

To date, the findings concerning the relation between age and depression among older patients with cancer are conflicting. Some research has found that levels of depression in older adults (in comparison

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to younger adults) either decrease or remain constant [13–15]. This fact could be a result of greater experience of the older adults in coping with life adversities together with age-related differences in the perception of symptoms [1,16]. Hurria et al [17] also suggested that age may be a protective factor. Nevertheless distress levels among older patients with cancer (age ≥ 65) were estimated to be as high as 41% [17].

On the other hand, it is also possible that depression is under-diagnosed by the medical teams among older patients in general, and among older patients with cancer in particular. This can be explained in part by the complex physical symptomatology which serves as a barrier to accurate diagnosis of depression, as well as a common misconception that mistakenly attributes depressed mood to the aging process [12,18]. Recent research among 500 patients aged ≥ 65 using the Hospital Anxiety and Depression Scale (HADS) described low rates of depression (13%), and observed that age was not found to be associated with depression in univariate or multivariable analyses. The authors however suggested that the HADS measure used in the study may not have been sensitive enough to detect depression [19]. The combination of aging and cancer treatment-induced effects may mask basic symptoms of depression (such as fatigue, weight loss, and sleep problems), making it particularly difficult to recognize as a mood disorder [20]. Even when diagnosed, under-treatment of psychological distress among older people is also common. Advanced age was found to be associated with a lower likelihood of being referred for specialized psychosocial oncology care regardless of distress level. For example, it was found that only 22% of patients aged ≥ 70 were referred compared to 100% of patients ≤ 40 years old [21]. A large scale European study that included depression risk assessment (GDS-4) as part of a Comprehensive Geriatric Assessment indicated the 60% of the patients age 70 and above were at risk for depression. They also reported that most of the physicians were unaware of the results of the assessment, with an underestimation of depression among the older patients and extremely low intervention rates [22]. Although there is a growing appreciation of the importance of Comprehensive Geriatric Assessment of cancer patients and the importance of the inclusion of psychological measures in such assessments, results are rarely included in treatment decisions and physicians tend to overlook symptoms among older patients with cancer [23–25].

Existing research has frequently included individuals aged 50–60 years into study samples of “older patients with cancer”, further complicating an accurate understanding of the available literature. Indeed, as the numbers of oldest old people aged >85 years diagnosed with cancer and deemed to be candidates for treatment continues to rise, there is an urgent need to accurately describe the frequency of depression and psychological distress among this population.

This study aims to examine the association between age and frequency of depression among older people with cancer and to examine the influence upon this association of possible intervening variables.

2. Materials and methods

2.1. Participants, inclusion and exclusion criteria

The current sample is part of an ongoing cross-sectional Israeli study. The goal of the study is to measure the relationship between depression, distress, hope, and social support among patients with cancer (age ≥ 65 , with preserved functional status), and their spousal caregivers [13,26]. Participants were enrolled as a convenience sample, at the time of patients out-patient visit. Inclusion criteria: 1. Age ≥ 65 years old, 2. Active disease or within six months after completing their treatment for active disease, and 3. Living together with a spouse (as designated by the patient as the primary caregiver) for at least 10 years. Subjects were excluded if 1. They were receiving palliative care alone, 2. They were resident in a long term care facility, and 3. They had impaired physical functioning as measured by a Karnofsky score <70 4. They suffered major cognitive impairment (as determined by an overall global assessment reported by the study physicians).

2.2. Sample size and refusals

Three-hundred twenty patients were approached about the study. In 33 (10.3%) cases, the patients ($n = 27$) either refused to participate or the spouse ($n = 6$) refused, stating they didn't want the patient to be disturbed. We excluded 44 (13.75%) patients who were defined as “survivors” (e.g. no longer receiving treatment and >6 months after treatment and thus presumed “disease free”). The “time from diagnosis” was measured from the initial diagnosis at first presentation. In the case of patients who were initially treated, became “disease-free” and subsequently re-presented with advanced disease, the “time from diagnosis” failed to account for time spent “disease-free”. Unfortunately information was lacking concerning the period of time that patients were “disease free”. The final sample included 243 patients from outpatient clinics of two major cancer centers in Israel. The centers are partially public, tertiary hospitals, which by law provide comprehensive medical care to all Israeli citizens through the National Health Insurance in Israel.

2.3. Ethical approval and procedure

The Hadassah-Hebrew University Medical Center and the Sheba Medical Center Institutional Review Boards approved the study. After receiving approval from the Medical Ethics Review Committee and treating physicians, the patients were approached during routine medical evaluations in the outpatient clinics. Patients were interviewed individually, and each participant signed an informed consent form. Data were collected between May 2013 and January 2017.

2.4. Measures

2.4.1. Background data

Patients completed socio-demographic questionnaires. We reviewed the medical records for medical variables such as the cancer diagnosis, therapy, the Eastern Cooperative Oncology Group (ECOG) performance status grades [27] and the Charlson Comorbidity Index (CCI) [28].

2.4.2. Depression

Depression was measured using the five-item version of the Geriatric Depression Scale (5-item GDS) [24]. The scale consists of five binary items; scores of ≥ 2 are considered to be the clinical cutoff for susceptibility to depression. The internal reliability values (Cronbach's alphas) were 0.82.

2.4.3. Distress

Distress was measured using the distress thermometer, which consists of a one-item (11-point Likert-type scale) screening tool for distress in patients with cancer that has been validated among both patients with cancer and their caregivers. It is used extensively in the US, Europe, and Israel [29] and is used both as a criterion-referenced measure and as a continuous measure [30]. An Israeli validation study established a score of ≥ 3 as a clinical cutoff for distress. Since most validation studies however point to a higher optimal cutoff score, we decided to choose the conservative cutoff of ≥ 5 [30].

The distress and depression measure were highly correlated (Pearson's $r = 0.68$, $p < 0.0001$) indicating that both measure similar variables.

2.4.4. Social support

The Cancer Perceived Agents of Social Support [31] is a 12-item questionnaire combining two theoretical content facets of social support (agent of support, type of support). This scale was found to be valid and reliable for patients and spouses. The internal reliability values (Cronbach's alphas) were 0.75 to 0.96.

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