

Depression Management During Cancer Treatment

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Case Study

C.D. is a 28-year-old woman with acute myelogenous leukemia that currently is in remission. Over the past six months, she received induction and consolidation chemotherapy that was complicated by febrile neutropenia and hospitalization. C.D. is married and has a 14-month-old son. She was employed as a media specialist but has not worked since she went on maternity leave approximately 15 months ago. She has been admitted to the adult bone marrow transplant unit for a matched sibling allogeneic stem cell transplant. She has no other health problems. Her medications on admission include the antidepressant escitalopram oxalate 10 mg that was started by C.D.'s local oncologist. C.D. states, "He just thought I needed it. I'm not really sure why."

On admission, C.D. describes herself as positive: "Let's get started. The sooner I get this over with, the sooner I can get home to my family." She lives in a city about three hours from the medical center, and her husband has to work to maintain health insurance and support the family. C.D.'s 22-year-old sister is staying in her home to care for her young son. C.D. tolerates her high-dose chemotherapy without complications other than moderate nausea.

On transplant day +7, she develops mucositis that worsens over the next few days to the point that she cannot swallow. She is started on total parenteral nutrition but is not able to swallow pills, including the oral escitalopram. C.D. spends much of her time sleeping, but she is compliant with requests to walk daily with a physical therapist. On day +12, C.D. is found crying in bed. She complains of feeling miserable and missing her husband and son. The psychiatric clinical nurse specialist (PCNS) is called to meet with C.D. to evaluate her for depression.

Clinical Problem Solving

What are the symptoms of depression in someone who is in the midst of cancer treatment?

The commonly recognized signs of depression include sleep disturbance, weight and

appetite changes, cognitive changes (i.e., concentration or memory), feeling sad, crying, irritability or agitation, fatigue, diminished interest or pleasure in activities, feelings of guilt and worthlessness, and recurrent thoughts of death or suicide (American Psychiatric Association, 2000). In patients with cancer, many of these symptoms are not reliable indicators because they also can result from medication and treatment side effects; therefore, the most reliable indicators of depression are the psychological symptoms the patient is experiencing—guilt, hopelessness, or worthlessness. Suicidal thoughts also may be present (Block, 2000; Bowers & Boyle, 2003). Healthcare providers also should consider the timing and duration of symptoms. To be diagnosed with major depression, symptoms must be present every day, for a great part of the day, for two weeks or more. An adjustment disorder with depressed mood can be diagnosed in response to an identified stressor (e.g., cancer diagnosis, treatment, hospitalization, separation from family) when the predominant symptoms include depressed mood, tearfulness, or feelings of hopelessness.

The prevalence of depression in patients with cancer ranges from 15%–50%, but most cases represent adjustment disorders rather than major depressive disorders (Block, 2000; Massie, 2004). Because adjustment disorders are linked to a psychosocial stressor, the symptoms generally improve within six months of the resolution of the stressor. If the symptoms persist beyond six months, the patient should be evaluated for another disorder.

In talking with C.D., the PCNS observes a tearful but organized conversation in which C.D. vacillates between "feeling sorry for myself" and saying, "I know I will get through this. It's just very hard!" She is particularly troubled because her family is not able to visit more often. Her husband must work, her father is disabled and cannot travel, and her sister is caring for her young son. C.D. understands these facts but misses her family terribly. She talks daily by telephone with her husband and sister, and friends from work and church call or write regularly.

What is an appropriate treatment plan at this point for C.D.?

In considering a plan of care, the PCNS notes that at day +12 C.D. is confronting a very difficult time of transplant. Typically patients are very motivated to begin when first admitted to the hospital; their decision making is behind them, and they want to proceed as quickly as possible. They often have few physical symptoms during the early days of chemotherapy and feel that they are doing something active to fight the cancer. The stem cell infusion often is celebrated as a new beginning with a new immune system, but over the next week, the situation often changes. Patients may develop physical symptoms and become very uncomfortable. Side effects of the disease or treatment may interfere with patients' ability to use their usual coping strategies. For example, patients may not be able to concentrate to read or watch movies and may be too sedated or uncomfortable to visit with family. Waiting for engraftment is a time of heightened emotional and physical vulnerability; as a result, patients often become discouraged at this stage in treatment (Andrykowski & McQuellon, 2004).

C.D. has been off the antidepressant for five days. She is unable to swallow pills, and even swallowing liquids is very difficult. After venting her concerns, C.D. is able to recognize the positive events to which she is looking forward (e.g., seeing her son) and remains compliant with her daily treatment regimen. She smiles when staff members joke with her. C.D., the PCNS, and the treating team decide to monitor C.D.'s symptoms further. A sleep plan is created to allow her four hours of undisturbed sleep at night, and

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Digital Object Identifier: 10.1188/06.ONF.33-35

a chaplain is consulted to meet her spiritual needs and to visit with her because her family has limited visiting opportunities. The PCNS arranges to visit every other day to monitor the depressive symptoms and listen if C.D. needs to vent or discuss any concerns. Psychotherapy is not indicated in patients such as C.D., who are too ill to commit to a contract of self-exploration. Instead, supportive counseling is indicated to help the patient feel empowered to get through each day, control what she can (e.g., her schedule), and let go of what she cannot control (e.g., her white blood cell count). The major goal is to help C.D. comply with the treatment regimen (Neuser, Grigelat, Quabeck, Beelen, & Schaefer, 1990). She likely also will benefit from the relationship opportunity, validation of her feelings, and education about coping strategies.

The interventions are carried out, but on day +17, C.D. is more irritable. She tells the

PCNS that she has had time during the past few days to reflect on her situation and is very angry. She has missed so much of her son's young life because of her hospitalizations. She has always been a "good citizen and a decent person," so she questions why she was singled out for the disease. She states, "I am going through all this, but there's no guarantee that I'll make it. My son may lose his mother, and it won't even matter to him because he barely knows me. He thinks my sister is his mom. He wouldn't miss me!" On further questioning, C.D. denies suicidal intent but acknowledges that she has been thinking more about her death during the past two days. She says that she feels worthless as a mother. The nurses report that C.D. has been reluctant to get up and shower or walk, requiring much more encouragement than in the past. Her ability to swallow still is impaired, but C.D. agrees to attempt to take her 10 mg dose of

escitalopram in liquid form with a planned dose escalation to 20 mg in five days. The social worker arranges for C.D.'s husband to visit that weekend and bring recent photos of their son.

What must be considered when using antidepressant medication in patients undergoing cancer treatment?

In C.D.'s case, she came to treatment already on an antidepressant. Therefore, the first question is whether the medication was effective. Because C.D. was vague about the symptoms the medication was prescribed to treat, the drug's efficacy is difficult to determine. Ideally, practitioners should be able to ascertain the target depressive symptoms leading to antidepressant treatment and monitor the response. The next step would be to look at the dosage. C.D. was receiving a low dose and reporting no side effects, so her dose could be increased to determine

Clinical Highlights: Depression Management During Cancer Treatment

Definition: Depression most commonly is recognized as a mood or feeling that occurs in response to disappointment or loss. Clinical depression is a biologic disorder with many facets, including mood, cognitive, physical, and behavioral manifestations, that vary in degree from mild to severe. In the medical setting, depression frequently is unrecognized; in the oncology setting, it sometimes is viewed erroneously as an expected accompaniment to a cancer diagnosis. Depression is classified as major depression, an adjustment disorder with depressed mood, or dysthymia, a chronic but milder form of depression (American Psychiatric Association, 2000).

Prevalence: Depression is the most common psychiatric disorder, with a 15% prevalence rate in the general population. Although prevalence rates vary considerably, the rate increases two to three times in patients with medical illness (Fisch, 2004). In a review, Pirl (2004) concluded that major depression affects 10%–25% and adjustment disorders affect an even higher percentage of patients with cancer (Massie, 2004).

Risk factors: Patients with previous histories of depression or substance abuse, as well as those with multiple stressors or losses, are at higher risk for developing depression during cancer diagnosis and treatment. Zabora, Brintzenhofszoc, Curbow, Hooker, and Piantadosi (2001) explored the prevalence of psychological distress among various disease groups and found a high rate among patients with lung, pancreatic, and brain cancers. They also found that distress was highest in patients younger than age 30 or patients

80 years of older. Massie (2004) described depression as being highly associated with oropharyngeal, pancreatic, breast, and lung cancers. High symptom distress, pain, disability, and the absence of perceived social support are related to higher depression rates. Advanced illness and a history of medical noncompliance are other risk factors.

Differential diagnosis: The expected sadness and frustration experienced with cancer sometimes are mistaken for depression. Grief is a normal reaction to the losses associated with a cancer diagnosis, and grief and depression often are confused. Delirium also is a condition that may mimic depression in its early presentation. Some of the medications commonly used to treat cancer may precipitate depression-like symptoms. Patients can become tearful, irritable, and display sleep and appetite changes while taking corticosteroids, interferon, or antiestrogens.

Treatment: Depression is a treatable disorder. Antidepressant medications are effective for treating most patients, and the selective serotonin reuptake inhibitors usually are tolerated best, with fewer sedating and autonomic side effects. Nonpharmacologic treatments, including individual counseling and support groups, also are effective for mild to moderate depression. Emphasis should be placed on activities that help people feel in control, such as relaxation, exercise, journal writing, and yoga.

Screening: High-risk patients must be identified to provide early intervention. Many tools are available for this purpose, and evidence suggests that simply asking patients the question, "Do you feel depressed most of the time?" is useful (Schwartz, Lander, & Chochinov, 2002). The National

Comprehensive Cancer Network (2005) established standards of care for distress management, including the standard that "all patients should be screened for distress at their initial visit, at appropriate intervals, and as clinically indicated, especially with changes in disease status" (p. DIS-8). Failure to detect and treat distress that includes depression can jeopardize treatment outcomes, increase healthcare costs, and adversely affect patients' quality of life.

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whether a therapeutic response could be achieved.

When selecting an antidepressant, clinicians should ascertain whether a history of successful treatment with a particular antidepressant exists for the patient or a blood relative. In antidepressant-naïve patients, successful treatment in a first-degree relative is an indicator for primary consideration when other patient characteristics are the same (Schwartz, Lander, & Chochinov, 2002). A second consideration is the side-effect profile for the particular drug. Selective serotonin reuptake inhibitors (SSRIs) most often are used because they have the fewest side effects and drug interactions. None of the SSRIs currently is available in an IV formulation. If a patient is unable to swallow, consistent medication administration becomes problematic. However, many SSRIs are available in liquid form, which may be tolerated better by patients with a compromised gastrointestinal tract.

Sometimes patients or family members express reluctance to take antidepressant medication. A stigma often is associated with depression and its treatment, which may increase patient and family concerns. In addition, patients may believe that they already are taking too many medications and do not want to add any others. Education about antidepressant medication is important and should include the desired therapeutic benefit and time frame anticipated to see a benefit, as well as dosage, side effects, and contraindications. Patients should be informed that untreated depression could erode their self-concept and sense of control. Depression is known to worsen distress, anxiety, pain, and fatigue and adversely affects compliance with treatment.

Patients also must be educated about antidepressant cessation, because abrupt discontinuation can lead to withdrawal-like effects. These effects, called antidepressant discontinuation syndrome, can include general somatic symptoms (e.g., lethargy, headache, tremors, sweating), sleep disturbance, gastrointestinal symptoms, disequilibrium, sensory symptoms (e.g., paresthesias, numbness, electric shock-like sensations), and affective symptoms (e.g., irritability, anxiety, agitation, depressed mood) (Schatzberg et al., 1997; Shelton, 2001).

When should a psychiatrist be consulted?

Consult a psychiatrist when the onset of depressive symptoms is acute or severe, if depressive symptoms increase, or when suicidal risk is present. A consult also is warranted if a patient does not experience a clinical benefit after an adequate amount of time (approximately six weeks) on an adequate dose of an antidepressant. A psychiatrist should be consulted if psychotic or manic symptoms are present and lithium or neuroleptic treatment is contemplated.

C.D. resumed taking escitalopram 10 mg oral concentrate, and by day +22, she was able to swallow escitalopram 20 mg tablets. Her hospital course was uncomplicated, and on day +30, she was discharged to the outpatient clinic for daily follow-up. The PCNS continued to monitor her weekly, and C.D. reported that she was feeling much better. She now believes she can resume her role of mother to her son, her crying has stopped, and she is beginning to have an appetite. On day +62, C.D. asks if she can stop taking escitalopram. She reports that she feels emotionally well and believes she is taking too many medications.

When can antidepressant medication be discontinued?

Once a patient has recovered completely from a depressive episode, medication should be continued for another six months to preserve remission and prevent relapse. For patients who have had previous episodes of depression or are otherwise at high risk for a recurrence, antidepressant medication should be continued longer, entering a maintenance phase of therapy ("Practice Guideline," 2000; Shelton, 2001).

C.D. agrees to continue escitalopram and follows up regularly at an autologous bone marrow transplant clinic. On day +100, C.D. is discharged to her home and is scheduled to return to the clinic in two months. In the interim, she will be seen by her local oncologist. Her local physician is informed that C.D.'s escitalopram can be tapered over a course of several weeks and discontinued in four months if no depressive symptoms appear. C.D. also receives information about

support groups in her community and is encouraged to seek individual counseling as she transitions from being a patient to a survivor.

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Do You Have an Interesting Clinical Experience to Share?

Do you have a challenging clinical scenario on which you would like an expert to comment? If so, please send your scenario to *Oncology Nursing Forum* Associate Editor Lori Williams (lori.williams@prodigy.net) or Susan Moore (smoore46@yahoo.com). If you have specific questions you would like the expert to address, include those as well. The associate editor will contact you about possibly featuring your scenario as a "Clinical Challenge."