Depression and Anxiety

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Objectives

- By the end of the session, the learner should be able to:
  - Discuss the diagnosis of depression and anxiety in palliative care patients and the confounding factors that play a part
  - Discuss common treatments of depression and anxiety and their side effects
  - Be able to assess for suicide risk
  - Discuss barriers to treatment

Psychological Distress

- Psychological suffering adds significant stress to the dying process for terminally ill patients and their families.
- Common psychiatric problems near the end of life include depression, anxiety, delirium, and suicidal ideation.

Psychological Distress

- Medication side effects, physical impairments, dependency, bereavement, and family dysfunction can lead to psychological distress.
- Many patients describe a decrease in their capacity for pleasure, sense of meaning in their lives, and ability to make connections with others.

Psychological Distress

- Psychiatric distress can increase pain.
- Major risk factor for suicidal ideation.

Psychological Distress

- All patients facing or contemplating the end of life are “depressed”
- The clinician’s inability to recognize and treat depression
- Fear of upsetting the patient
- Stigma
- Drug-drug interactions with psychotropic agents
- Clinicians may feel a sense of hopelessness

Bars to Treatment
Diagnosing major depression can be complicated by the overlap of symptoms. Clinicians often rely more on the psychological or cognitive symptoms of depression.

Endicott suggests substituting more psychological symptoms for the somatic symptoms:

- Instead of...
  1. Change in appetite/weight
  2. Sleep disturbance
  3. Fatigue, loss of energy
  4. Diminished ability to think or concentrate

- Use...
  1. Tearfulness, depressed appearance
  2. Social withdrawal, decreased talkativeness
  3. Brooding, self-pity, pessimism
  4. Lack of reactivity, blunting

Other studies have suggested anhedonia and feelings of hopelessness, worthlessness, and guilt are more accurate indicators of depression in medically ill individuals.

Patients who are not depressed, tend to refocus their interests to those that are less physically or mentally demanding without losing interest.

The reported prevalence of MDD in individuals with cancer varies from 3 to 38%.

In general, rates are higher in populations with advanced cancer, greater levels of disability, and/or unrelieved pain.
The reported prevalence of depression in terminally-ill cancer patients is between 13 and 26 percent. These rates are significantly higher than one month prevalence rates of depression in the general North American population, which range from 1.6 to 4.9 percent.

Within non-cancer populations:
- 27% of patients with end-stage renal disease and those seeking to discontinue dialysis
- 20 to 40% of those with Parkinson disease
- 35% of patients with advanced multiple sclerosis
- 22 to 46% of patients with advanced heart failure
- 23 to 52% of those with end-stage AIDS

Younger cancer patients have higher rates of depressive disorders. Gender is not consistently reported to be a risk factor for depression in cancer patients.

A past history of depression is a risk factor for major depression in cancer patients. The presence of uncontrolled symptoms, particularly pain, is a major risk factor for depression and suicide among patients with cancer.

The incidence of depression also depends upon the patient's particular illness.
- head and neck
- pancreatic cancers
Psychiatric symptoms may precede the physical symptoms of pancreatic cancer by several months.

Existential concerns - unfulfilled ambitions, the meaning of life, maintaining dignity at the end of life
Existential suffering and deep personal anguish are some of the most distressing experiences that occur in the dying.
The relationship between existential distress and depressive syndromes among the terminally ill is not well studied. In one study, existential distress (ie, concerns related to loss of meaning in life) showed a high correlation with depression.

A study of palliative care inpatients found that a single question, "Are you feeling down, depressed or hopeless most of the time over the last 2 weeks?" correctly identified patients with 100 percent sensitivity and specificity.

Chochinov 1997

The four question Brief Case Find for Depression asks questions about sleep, depressed mood, life satisfaction, and ability to overcome difficulties. In a study of oncology and palliative care patients this tool had fair agreement with longer depression screening instruments.

Jefford 2004

The literature does not suggest that any of the above scales are clearly superior. A positive depression screen should indicate the need for a more detailed assessment of mood.

Why do we need to identify depression?
Decreases the amount of pleasure and meaning in life.
Takes away hope and peace at the end of life.
Causes suffering and increases physical pain.
Associated with an increased risk of suicide.
Diminishes overall quality of life and complicates symptom control, resulting in more frequent admission to inpatient care settings.

Many terminally ill patients suffer from more modest symptoms of depression.
Minor depression and adjustment disorder

Minor depression requires fewer symptoms to qualify for a diagnosis.
Adjustment disorder with depressed mood is a maladaptive reaction to an identified stressor in excess of a normal and expectable reaction.

Distinguishing between normal sadness and a major depressive episode has significant implications.

<table>
<thead>
<tr>
<th>Depression</th>
<th>Sadness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feels outcast and alone</td>
<td>Able to feel intimately connected to others</td>
</tr>
<tr>
<td>Feeling of permanence</td>
<td>Feeling some day this will end</td>
</tr>
<tr>
<td>Rumination of &quot;irredeemable&quot; mistakes</td>
<td>Able to enjoy happy memories</td>
</tr>
<tr>
<td>Extreme self-loathing</td>
<td>Sense of self worth</td>
</tr>
<tr>
<td>Constant and unremitting</td>
<td>Comes in waves</td>
</tr>
<tr>
<td>No hope/interest in the future</td>
<td>Looks forward to things</td>
</tr>
<tr>
<td>Enjoys few activities</td>
<td>Retains capacity for pleasure</td>
</tr>
<tr>
<td>Suicidal thoughts/behavior</td>
<td>Will to live</td>
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</table>

Mr. B, a 47-year-old, married, father of two, was diagnosed with end-stage colon cancer several months ago. He was referred for a mental health evaluation by his oncologist after he inquired as to the possibility of euthanasia should his condition worsen.

His initial presentation was unremarkable, as he smiled occasionally and showed no overt sadness or distress.

However, he explained that he has increasingly felt himself to be a burden to his wife, who has been forced to care for him in addition to their young children.

He described feelings of guilt, based largely on what he characterized as an inadequate life insurance policy that although substantial was not sufficient to prevent his wife from needing to resume work after his death.

He had begun to discourage friends and family members from visiting him, explaining that he does not want to be seen in such a debilitated condition although he acknowledged that these visits no longer brought him pleasure.

Mr. B also revealed that although he was once an avid sports fan, he has lost all interest in watching sporting events on TV and no longer reads the newspaper.
Case
He initially attributed these changes to problems concentrating but later indicated that he is simply not interested in these activities that were once a central focus of his attention.

Differential Diagnosis
It is crucial that clinicians consider alternative diagnoses for the presentation as misdiagnosis may prevent patients receiving appropriate treatment.
- delirium
- dementia
- Parkinson's disease
- hypothyroidism
- uncontrolled pain
- cerebral metastases
- adverse drug reactions

Contributory Factors
It is also important to consider contributory factors, which if addressed might alleviate the patient's depressive symptoms.
- Biological (e.g. hypercalcemia, uncontrolled physical symptoms, drugs causing depression – e.g. steroids)
- Psychological (e.g. spiritual distress, anger relating to diagnostic delay)
- Social (e.g. family conflict, isolation, poor living conditions).

Treatment
Major depression in palliative care or terminally-ill patients is treatable.
The first step in treating depression is to relieve uncontrolled symptoms, particularly pain.

Treatment
Good palliative care is of itself a key strategy for preventing and alleviating depression at the end of life.
A recent RCT published in the New England Journal of Medicine showed that metastatic lung cancer patients who received early palliative care had improved mood and quality of life, as compared with those receiving standard oncological care.

Treatment
The more favorable side effect profile of newer antidepressants (e.g. selective serotonin reuptake inhibitors (SSRIs) and serotonin-norepinephrine reuptake inhibitors (SNRIs)) has facilitated their use in the elderly and medically ill.
These agents are relatively benign and well tolerated so clinicians should have a low threshold for initiating therapy.
Mild depression
Characterised by a small number of symptoms with limited impact on the patient's everyday life

First-line treatment
- Refer to specialist palliative care for symptom control and psychosocial support
- Assess quality of relationships with significant others; facilitate communication
- Consider a guided self-help programme
- Consider a brief psychological intervention (e.g. problem-solving therapy, brief CBT)

If symptoms persist...
- Consider a guided self-help programme
- Consider a brief psychological intervention (e.g. problem-solving therapy, brief CBT)

Moderate depression
Characterised by a larger number of symptoms which make it difficult for the patient to function as they would normally

First-line treatment
- Do all recommended for mild depression
- Initiate antidepressant medication and/or psychological therapy

If symptoms persist...
- Assess compliance to treatment
- Consider combining antidepressant treatment and psychological therapy
- After 4 weeks of antidepressant treatment, consider raising the dose of antidepressant or switching to a different drug

Severe depression
Characterised by a large number of symptoms which make it very difficult for the patient to carry out everyday activities. There may be psychotic symptoms, food and/or fluid refusal, or severe and persistent suicidal ideation

First-line treatment
- Do all recommended for mild depression
- Initiate antidepressants and psychological therapy
- Consider using a hypnotic or sedative in sleep disturbed or very distressed patients

If symptoms persist...
- As for moderate depression
- Consider using an antidepressant
- Reassess and possibly revise the diagnosis

Psychostimulants have a faster onset of activity and are the preferred initial option for palliative care patients whose life expectancy is less than two to four months or for those in need of urgent treatment.

All patients should have a complete medical evaluation.
- Toxins created by a tumor
- Possibly autoimmune reactions
- Viral infections
- Nutritional deficiencies

Depression can also represent an adverse effect from certain treatments:
- Glucocorticoids
- Chemotherapy drugs
- Radiotherapy to the brain or head and neck.
If depression persists specific therapy is warranted. Treatment should be tailored to the individual needs of the patient.

Treatment

Psychosocial interventions
- individual or group psychotherapy
- hypnotherapy
- cognitive-behavioral therapy
- existential therapy
- self-help groups

There are no randomized trials that specifically address the benefit of psychotherapy for palliative care patients with depression, and few that address pharmacologic treatment.

The single most important aspect of psychotherapeutic support for depressed terminally-ill patients is the therapeutic alliance between the patient and the primary medical caregiver.

Supportive Therapy

Support adaptive coping mechanisms, minimize maladaptive ones, and decrease adverse psychological reactions.
The main components are active listening, supportive verbal interventions, and occasional interpretation.

Clinicians should elicit from the patient his or her concerns about death and the dying process. Patients should be encouraged to talk about their lives and experiences, fears about the impact of illness on family members, and past experiences of coping with loss.
Supportive Therapy

- Patients should be encouraged to freely talk about or ask questions about their prognosis.
- Reassurance is useful when it is based on a specific understanding of the individual’s status and is not clinically unrealistic.

Supportive Therapy

- Can be provided by any provider.
- Sometimes, supportive psychotherapy alone is sufficient to treat depression.

Cognitive Behavioral Therapy

- Focuses on distorted thoughts that adversely affect mood.
- These approaches explore patients’ beliefs about their diagnosis and its treatment and attempt to elicit irrational or unhelpful thoughts that lead to feelings of helplessness and hopelessness.
- Therapy then leads to the correction of these maladaptive thoughts along with providing new coping skills.

Existential Therapy

- Existential therapies may represent an option for some patients who confront daily choices that affect quality of life, and who often have questions about the meaning, purpose, and value of life.
- Such therapy can improve spiritual wellbeing, lessen sadness and depression, and sustain or enhance a sense of meaning, peace, and purpose at the end of life.

Psychopharmacology

- As with psychotherapy, there is a general lack of high-quality evidence regarding the effectiveness of antidepressants in patients with major depression who are receiving end of life care.
- Randomized trials and meta-analyses document the efficacy of antidepressants in depressed patients with physical illness, including those with “life-threatening” physical illness.

Psychopharmacology

- A systematic review of antidepressants for treatment of depression in palliative care, which included 25 placebo-controlled randomized trials, demonstrated significant benefit of treatment over placebo within four to five weeks, with continued improvement over time.
- Though there is no evidence that any particular antidepressant is preferable for palliative patients.
Psychostimulants (e.g., dextroamphetamine, methylphenidate, and modafinil)
SSRIs (e.g., sertraline, citalopram) [fluoxetine on WHO EML]
Tricyclic (TCAs) and tetracyclic antidepressants [amitriptyline on WHO EML]
Serotonin-norepinephrine reuptake inhibitors (SNRIs)
Serotonin modulators (e.g., nefazodone, trazodone, and vilazodone)
Atypical antidepressants (e.g., bupropion, and mirtazapine)
Monoamine oxidase inhibitors (MAOIs), which are rarely used in palliative care due to side effects

Psychostimulants are an important option for treatment of depression at the end of life because they take effect quickly.

For palliative care patients, the factors that influence the choice of initial agent in addition to side effect profile are:
  - the available time frame for treatment
  - coexisting medical problems and symptoms
  - and pharmacologic properties

While patients with an anticipated life expectancy of several months can afford to wait one or two weeks for a TCA or SSRI to begin working those with a shorter remaining lifespan do better with rapidly-acting psychostimulants.

Psychostimulants are useful for the treatment of depressive symptoms who are weeks from death. Patients may experience improvement in mood and energy within 24 to 48 hours of starting treatment.

Elderly patients and those with cardiovascular disease should avoid drugs that cause orthostatic hypotension.
SSRIs are preferred for patients with slowed intestinal motility or urinary retention, as well as those who have stomatitis or chronic dry mouth secondary to chemotherapy or radiotherapy.
Psychopharmacology

- Side effects may sometimes be used to the patient's advantage.
- The depressed patient who is experiencing agitation or insomnia may benefit from the more sedating antidepressants.
- Patients with fatigue or psychomotor slowing may do better with compounds that have the least sedating effects.

Psychopharmacology

- The TCAs have analgesic properties and they potentiate the effects of opioid analgesics.
- Patients who are experiencing pain, particularly neuropathic pain, may benefit from these agents alone or in combination with other drugs.

Psychopharmacology

- Liquid formulations are available for some antidepressants and may be preferred for patients who cannot swallow pills.
  - Fluoxetine
  - Sertraline
  - Citalopram
  - Escitalopram
  - Paroxetine

Psychopharmacology

- SSRI side effects:
  - Jitteriness
  - Restlessness
  - Anxiety
  - Agitation
  - Headache
  - Sexual dysfunction
  - Gastrointestinal symptoms
  - Insomnia

Psychopharmacology

- Fluoxetine was shown to significantly improve quality of life and depressive symptoms in patients with advanced cancer in two of the only controlled trials carried out in this population.
- The clinical use of fluoxetine is limited by its long half-life and drug-drug interactions because it inhibits hepatic drug metabolizing enzymes such as cytochrome P450.

Psychopharmacology

- Most other SSRIs reach steady state levels in 4 to 14 days.
- However, this is counterbalanced by the fact that a missed dose can lead to an unpleasant withdrawal syndrome.
- This does not tend to happen with sertraline.
- The initial SSRI dose for patients with advanced or end-stage medical illness should be about one-half that used in otherwise healthy patients.
Although TCAs are still used, they are not as well tolerated as SSRIs because of their sedating and autonomic effects.

TCA side effects:
- dry mouth
- blurred vision
- constipation
- urinary retention
- tachycardia
- orthostatic hypotension
- impaired memory, confusion or delirium

Desipramine and nortriptyline are less anticholinergic than other tricyclics. A few TCAs have well-established therapeutic plasma levels and generally better tolerance profiles, such as desipramine and nortriptyline.

SNRIs can be helpful for depression with or without pain. Side effects are generally the same as the SSRIs but vitals signs must be monitored as these can increase blood pressure and pulse and can have withdrawal symptoms with only one missed dose.

Mirtazapine has been shown to be effective for improving multiple symptoms, depression, and quality of life in patients with advanced cancer. At lower doses (7.5mg or 15mg) it is sedating and can help with sleep. It can also stimulate appetite. These side effects decrease as the dose is increased. Mirtazapine Soltab

Trazodone is also very sedating but can cause g grogginess in the morning. It can also lower blood pressure and be very drying. Priapism in males.
Bupropion is not the first drug of choice for the treatment of depression.
- The energizing effects of bupropion are similar to the stimulant drugs.
- It is contraindicated for cancer patients with CNS disorders, due to its association with increased incidence of seizures.

Bupropion does not treat anxiety and can make it worse.
- Common side effects are headaches, anorexia, and insomnia.

Psychostimulants can help when dysphoric mood is associated with opioid-related sedation, severe psychomotor slowing, and even mild cognitive impairment.
- Stimulants are often energizing and improve overall performance on neuropsychological testing in the medically ill.
- Stimulants at low doses can stimulate appetite, promote a sense of well-being, and relieve feelings of weakness and fatigue in cancer patients.

Stimulant side effects:
- agitation
- insomnia
- anxiety
- tremor
- Cardiac decompensation can occur in those with heart disease.
- Confusion or delirium may occur.

Modafinil has less sympathomimetic effects than amphetamines and is often a good choice for older patients.
- It has been associated with a mild increase in blood pressure and should be used cautiously in people with a history of arrhythmias or heart disease.

In grief, the predominant affect is feelings of emptiness and loss.
- In MDD, it is persistent depressed mood and the inability to anticipate happiness or pleasure.
The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves. The waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of MDD is more persistent and not tied to specific thoughts or preoccupations. Grief may be accompanied by positive emotions and humor.

Grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations seen in MDD. In grief, self-esteem is generally preserved, whereas in MDD, feelings or worthlessness and self-loathing are common.

Thoughts of death and dying are focused on the deceased and “joining” the deceased. In MDD, such thoughts are focused on ending one’s own life because of feeling worthless, undeserving of live, or unable to cope with the pain of depression.

Occasional thoughts of suicide occur quite frequently among the terminally ill. Consideration of assisted suicide and euthanasia is not uncommon among terminally ill individuals.

Studies of terminally ill cancer and AIDS patients have demonstrated that the desire for hastened death is much more common in the context of a severe depression. Hopelessness is a more powerful factor in driving desire for death. Some proportion of suicidal statements may reflect a cry for help in which the patient is trying to convey the magnitude of her or his distress.

In the assessment of suicide, it is important to recognize that the risk of suicide increases if:
- the patient reports ideation (i.e., thoughts of suicide)
- plus a plan (i.e., description of the means)
- Risk continues to increase to the extent that the plan is lethal.
Factors to consider in assessing lethality include:
- availability of the means
- reversibility of the means
- proximity to help

It is essential to determine whether the underlying cause is a depressive illness or an expression of the desire to have ultimate control over intolerable symptoms.

In a review of psychiatric consultation data from Memorial Sloan-Kettering Cancer Center, one-third of suicidal cancer patients had major depression, and 50 percent were diagnosed with an adjustment disorder with features of both anxiety and depression at the time of evaluation.

Prompt identification and treatment of major depression is essential in lowering the risk for suicide in cancer patients. The assessment of hopelessness is not straightforward in the patient with advanced disease with no hope of cure.

Establishing rapport is of prime importance.
The clinician must believe that talking about suicide will not cause the patient to attempt suicide.
Talking about suicide legitimizes concerns and permits patients to describe their feelings and fears.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Assessment</th>
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<tbody>
<tr>
<td>Most people with cancer have passing thoughts about suicide, such as, “I might do something if it gets bad enough.”</td>
<td>Acknowledge normality by opening with a statement recognizing that a discussion does not increase risk.</td>
</tr>
<tr>
<td>Have you ever had thoughts like that? Any thoughts of not wanting to live or ending your illness might have your own?</td>
<td>Level of risk</td>
</tr>
<tr>
<td>Do you have thoughts of suicide? Have you thought about how you would do it? Do you intend to harm yourself?</td>
<td>Level of risk</td>
</tr>
<tr>
<td>Have you ever been depressed or made a suicide attempt? Has it been a suicide attempt?</td>
<td>History</td>
</tr>
<tr>
<td>Have you ever been treated for other psychiatric problems? Has it been psychiatrically hospitalized before getting diagnosed with cancer?</td>
<td>History</td>
</tr>
<tr>
<td>Have you had a problem with alcohol or drugs?</td>
<td>Substance abuse</td>
</tr>
<tr>
<td>Have you lost anyone close to you recently? (Family, friends, others with cancer)</td>
<td>Stressor</td>
</tr>
</tbody>
</table>

Assessment, Evaluation, and Management of Suicidal Patients
National Cancer Institute
Suicide

- Involve as much of a patient's support system as possible.
- All contributing symptoms should be aggressively controlled.

Suicide

- Many patients experience substantial benefits from simply discussing their concerns with a clinician.
- It is imperative that clinicians approach end-of-life topics in a nonjudgmental manner.
- Prolonged suffering (or fear of prolonged suffering) caused by poorly controlled symptoms can lead to feelings of desperation and hopelessness.

Suicide

- Patients close to the end of life may be unable to maintain a wakeful state without high levels of emotional or physical pain.
- This frequently leads to suicidal thoughts or requests for aid in dying.
- Such patients may require sedation to ease their distress.

Suicide

- It may be important to limit access to potentially lethal medications for patients considered at risk for suicide.

Suicide

- Strategies to lessen suicidal risk include:
  - Frequent contact to reassess suicidal risk and symptom control
  - Avoid having the patient spend long periods of time alone
  - Regular delivery of medications for effective management of poorly controlled symptoms
  - Use medications that work rapidly to alleviate distress

Anxiety

- Similar to depression, clinicians often assume that anxiety inevitably accompanies the terminal phase of an illness.
- Anxiety may arise in response to illness-related stressors, may be a chronic condition, or may arise from iatrogenic sources.
- Anxiety is quite common and can reduce a patient’s tolerance for physical distress, especially pain, and decrease overall functioning.
The reported prevalence of anxiety among advanced cancer patients is 18 percent.

Because of the overlap between anxiety and depressive syndromes, distinguishing between these two disorders is not always easy.

Symptoms of anxiety and depression often overlap with delirium. Patients with delirium often present with symptoms of anxiety, irritability, and motor restlessness, and delirious patients are frequently mislabeled as “anxious”.

Delirium usually involves substantial cognitive impairment, such as disorientation and memory impairment, anxiety does not.

The similarities between depression and anxiety are also found in screening as somatic symptoms often overlap with the anxiety diagnosis.

There is little research trying to disentangle the symptoms to assess for actual anxiety.

Symptoms of anxiety can be manifestations of the underlying disease or side effects of medications

- sweating
- shortness of breath
- gastrointestinal distress
- heart palpitations

Hypoxia, sepsis, poorly controlled pain, and adverse drug reactions such as akathisia, or withdrawal states often present as anxiety.

Benzodiazepine withdrawal also can present first as agitation or anxiety.
Generalized Anxiety Disorder

- Excessive anxiety and worry, occurring more days than not for at least 6 months, about a number of events or activities.
- The individual finds it difficult to control the worry.
- The anxiety and worry are associated with 3 or more of the following 6 symptoms:
  - Restlessness or feeling keyed up or on edge
  - Being easily fatigued
  - Difficulty concentrating or mind going blank
  - Irritability
  - Muscle tension
  - Sleep disturbance

Anxiety Screening

- When patients are cognitively intact, the use of instruments specifically designed to identify and quantify anxiety can be helpful.

- The HADS is a brief (14-item) self-report measure that assesses cognitive symptoms associated with depression and anxiety. This avoids the confounding influence of physical symptoms.

- The State Trait Anxiety Inventory (STAI) is considerably longer but allows for the differentiation of stable, chronic forms of anxiety from those that are transient or situational.

Case

- Ms. U, a 59-year-old divorced, Hispanic woman who was recently hospitalized because of end-stage breast cancer, was referred for evaluation because of her “bizarre” behavior.
- Specifically, Ms. U was observed sitting in a chair in her room all night long, often sobbing uncontrollably, and refused requests by nursing staff or her physician to sleep in her bed.
Case

The evaluating psychologist initially suspected that Ms. U’s behavior might be due to uncontrolled pain that she reported having, but her behavior was unchanged even after her pain medications were increased to the point of pain relief.

Case

Upon interview, Ms. U revealed her fear that she would die if she went to bed. She believed that she could stave off death indefinitely by remaining awake and in her chair. She also reported feelings of “panic” whenever she thought of dying, was preoccupied with fears about how her son would fare after her eventual death, and became tremulous and short of breath whenever she discussed these fears.

Case

Although her beliefs sounded almost psychotic, Ms. U’s awareness that her beliefs were irrational (although she insisted that she felt better when she remained in the chair) coupled with her general anxiety and nervousness around a number of related issues supported the conclusion that her behavior was driven by anxiety.

Treatment

According to a Cochrane Database Systems Review in 2012, there remains insufficient evidence to draw a conclusion about the effectiveness of drug therapy for symptoms of anxiety in adult palliative care patients. Treatment recommendations are made from studies on non-palliative care populations.

Treatment

SSRIs, SNRIs and TCAs have been shown to decrease anxiety symptoms.
- Pros: anxiety prevention, usually once a day
- Cons: weeks to work, side effects

Treatment

Patients with GAD can be treated with cognitive behavioral therapy (CBT), a serotonergic antidepressant, or both.
- No difference in efficacy has been found between CBT and serotonergic antidepressants.
Benzodiazepines are considered the mainstay of pharmacological therapy for acute anxiety. Good quality evidence to support the role of benzodiazepines in the treatment of anxiety associated with terminal illness is limited. Diazepam and Lorazepam are included in WHO EML.

Lorazepam can be administered subcutaneously and can be administered as a continuous infusion with other medicine. Lorazepam solution can also be administered via the oral route with rapid onset and ease of administration.

Some benzodiazepines can lead to elevated methadone peak levels via common cytochrome P450 3A4 oxidation pathways in the liver. Oxazepam, lorazepam, and temazepam have fewer P450 interactions and are better choices for patients taking multiple medications, on methadone, or with compromised liver function. Oxazepam and temazepam only come as oral capsules.

Side effects of benzodiazepines include:
- Impairment of psychomotor performance
- Cognitive decline or amnesia
- Dependence and withdrawal symptoms after long-term treatment
- Rebound anxiety after short-term treatment

Benzodiazepines with shorter elimination half-lives (e.g., alprazolam, lorazepam, and oxazepam) are more likely to produce acute withdrawal on abrupt cessation after prolonged use.

Benzodiazepines with longer elimination half-lives (e.g., clorazepate, diazepam, and clonazepam) usually produce more delayed and somewhat attenuated withdrawal symptoms.
Buspirone has been shown in several randomized trials to reduce symptoms of anxiety in patients with GAD.

Buspirone’s time to onset is similar to the antidepressants’ average of four weeks.

It has a weaker anxiolytic effect than benzodiazepines.

Side effects: dizziness, headache, drowsiness, nausea

Pregabalin is sometimes used to treat GAD.

The doses for pregabalin range from 50 to 300 mg.

Side effects include sedation and dizziness.

Tolerance, withdrawal, and dependence are possible.

Depression is the most common mental health problem encountered in palliative medicine, yet it is underdiagnosed and undertreated.

Individuals who suffer from depression are at high risk of suicide and suicidal ideation.

Failure to diagnose and treat depression impairs the quality of life of dying patients, and adds to their burden of suffering.
Major depression in terminally-ill patients is treatable. The first step in treating depression is to relieve uncontrolled symptoms, particularly pain. Most experts recommend combining supportive psychotherapy with judicious use of antidepressant medication.

SSRIs, SNRIs, TCAs and Psychostimulants are all possibilities. The starting dose should be approximately one-half that used in non-terminally ill patients, and then slowly and carefully titrated.

Assessment of suicide is paramount! Talking about suicide does not increase the risk. Just because you are ill, does not mean you should be depressed. Depression and anxiety should be treated.

Questions??

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References


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