Provider Education: Depression and Cancer

Did you know...

That people with cancer have higher rates of depression? How about that people with depression have higher rates of cancer? And when depression and cancer are together, the patients tend to have a worse prognosis.

❖ Studies suggest that 15-25% of cancer patients (1) have depression compared with 7% of the general population (2).

❖ 73% of these patients don’t receive treatment and 5% see a mental health provider (3).

❖ Medical professionals tend to dismiss symptoms of depression in cancer patients as an understandable reaction to having a potentially terminal illness or as side effects of their treatments. They also believe that antidepressants won’t work in this situation.
  ➢ A normal emotional response to a new cancer diagnosis generally subsides after days to weeks. During this time the patient often has feelings of disbelief and denial. If mood changes persist over weeks to months and include other symptoms, this may indicate that the patient is depressed.

Why?

❖ Cancer can be the stressor that causes someone to go into a major depressive episode, especially if they have a history of depression (1).

❖ Depression can be secondary to a medical condition, including conditions related to cancers like nutritional deficiencies (B12), endocrine disturbances (thyroid, adrenals), primary brain tumors or brain metastases, and others (2).

❖ It can also come on secondary to medication use, some of which include chemotherapies, immunotherapies, and steroids (2). The side effects of medications may also mimic depressive symptoms.

❖ In people with chronic depression, persistently elevated cortisol levels can suppress the immune system, particularly natural killer cells. These cells are essential for early tumor eradication and when they are compromised, cancer is more likely to develop. Once cancer is present, these cells fight metastasizing cells and the primary tumor (4).

❖ Patients may not be able to precisely describe the symptoms they are experiencing or may attribute them to something different than the root cause. Often times what patients think is anxiety or depression is really fear, and that can be treated differently.

❖ When they feel depressed, patients tend to be less likely to show up for appointments, comply with treatments, choose potentially life-saving measures, and take care of themselves in general.
What can you do?

❖ Don’t dismiss their depressive symptoms..they can benefit from treatment!
  ➢ Compare mood symptoms to how they were in the past. Many patients that present with depression after a cancer diagnosis were depressed all along but it may or may not have been diagnosed.
  ➢ Ask the patient if they identify more with feelings of depression, anxiety, or fear. The difference between anxiety and fear is that there is something specific they worry about with fear, which in these patients may be death, or leaving family. These are all treated differently so it is important to separate them out.
❖ While everyone should undergo depression screening, be sure to screen your cancer patients.
  ➢ The Commission on Cancer requires oncologists to perform a distress screen at certain intervals in a patient’s care. They don’t, however, always take action on the result they get. This can be found in the scanned documents section of their chart and you can view it to help get an idea of the patient’s mental health.
  ➢ The survivor document is another resource that includes if the patient used mental health services during the course of treatment or if there might be a future need for depression screening or treatment.
❖ Prescribe antidepressants when you feel it is appropriate.
  ➢ Oncologists prefer that the primary care provider prescribes and manages antidepressant medications. If they sense a potential need for intervention, they will try to call or email the PCP to let them know.
❖ Address patients’ sleep problems.
  ➢ Oncologists see this in many of their patients for various reasons, and improving sleep may be what they need to help improve their mood and make them feel better overall.
  ➢ Determine the nature of the sleep disturbance and what their baseline was before the cancer. It could be caused by the treatment or psychiatric condition like mania, depression, anxiety, or fear. These should be treated differently.
❖ Encourage exercise and lifestyle changes that could improve mood and coping skills.
  ➢ Steps to Wellness is the oncology rehabilitation program that helps patients safely exercise and provides resources about other healthy habits that is free for 12 weeks.
  ➢ UVM offers 8 week long mindfulness courses as well as shorter options.
❖ Suggestions from psychiatry for when to refer (from Dr. Rabinowitz):
  ➢ If the depression does not improve after trials of 2 different medications at the appropriate dose (depends on med) and for the appropriate duration (4-8 weeks).
  ➢ If the patient is suicidal or psychotic on top of their depression, refer right away.
  ➢ If you have a feeling of being in over your head, even if you are too worried to admit it, ask for help.
  ➢ If you suspect that the patient does not have much longer to live and want them to be more comfortable in terms of mood symptoms without needing to wait for an SSRI or other medication to kick in; psychiatry is more comfortable trying other medications like stimulants in this setting.
  ➢ Note: Don’t be afraid to send someone to the ED if they have an acute change in mood and there isn’t another provider available to help. They will be kept safe there and will be connected with medical care when it becomes available.
**Extra Information**

**There are very few known interactions between cancer drugs and antidepressants. One notable one is that the use of fluoxetine, paroxetine, and sertraline (CYP2D6 inhibitors) can decrease the efficacy of tamoxifen in treating breast cancer, so they should be avoided. Other interactions may exist.**

<table>
<thead>
<tr>
<th>Class of Medication</th>
<th>Specific Clinical Uses</th>
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<tbody>
<tr>
<td>SSRI</td>
<td>Most commonly used in cancer patients because they are the safest and best tolerated</td>
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<tr>
<td>SNRI</td>
<td>Helpful with pain and hot flashes</td>
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<tr>
<td>Bupropion</td>
<td>Helpful with fatigue</td>
</tr>
<tr>
<td>Mirtazapine</td>
<td>Helpful with insomnia, cachexia, nausea, and in elderly patients</td>
</tr>
<tr>
<td>Trazodone</td>
<td>Helpful for insomnia and anxiety</td>
</tr>
<tr>
<td>TCAs</td>
<td>Generally not first-line, but helpful with insomnia and headaches</td>
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<tr>
<td>MAOIs</td>
<td>Used for treatment-resistant depression</td>
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<tr>
<td>Psychostimulants</td>
<td>Adjunctive treatment for patients with fatigue, controlling mood symptoms more quickly</td>
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<tr>
<td>Buspirone</td>
<td>Adjunctive treatment for anxiety</td>
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<tr>
<td>Antipsychotics*</td>
<td>Fear of something specific (ex. dying)</td>
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*Many primary care providers are uncomfortable starting antipsychotics, and patients may also be uncomfortable because of the stigma of the medication. If you feel that the patient is experiencing fear as their primary mood disturbance, a referral to psychiatry to address it with antipsychotics may be appropriate. If you feel comfortable treating on your own, a low dose (.25mg) risperidone is a good place to start.

References: