FAST FACTS AND CONCEPTS #146
SCREENING FOR DEPRESSION IN PALLIATIVE CARE
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Background  Depression is a significant symptom for approximately 1 in 4 palliative care patients and is especially common in patients with metastatic cancer (see Fast Fact #21). Up to 80% of the psychological symptoms that occur in cancer patients go unrecognized and untreated. One reason for this is the difficulty in diagnosing depression in palliative care patients (see Fast Fact #7). In the primary care literature a number of brief screening instruments such as PRIME-MD are used to identify depression. However, the symptoms associated with depression in primary care (weight loss, loss of energy, fatigue, insomnia) also occur in patients without depression who have a life-threatening disease. Thus, there has been interest in developing a brief scale that can accurately identify depression in the palliative care population. This Fast Fact reviews that literature on depression screening tools.

Single question screening: 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 and a positive predictive value of 1 (Chochinov 1997). Adding a second question about anhedonia (the absence of pleasure from the performance of acts that would normally be pleasurable), “Have you found that little brings you pleasure or joy over the last two weeks?”, reduced the specificity and positive predictive value. Unfortunately, follow-up studies using a single question regarding mood in other palliative care populations have shown a sensitivity of roughly 55 percent and a specificity of 75 percent.

A four-item algorithm asks questions about energy level, anhedonism, depressed mood, and psychomotor retardation/agitation. In a study of hospice patients in Australia this tool had a sensitivity between 62 and 72%, specificity of 75 to 89% and positive predictive value of between 68 and 89% (Robinson 2005).

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).

Other studies have examined 10-20 question depression instruments that have been validated in other patient populations. The Edinburgh Postnatal Depression Scale (Lloyd-Williams 2000), a self-assessment scale consisting of ten items each rated on a 4 point scale, had a sensitivity of 70% and specificity of 80% in patients with metastatic cancer receiving palliative care. The Hospital Anxiety and Depression Scale (Lloyd-Williams 2003) is a 14 item scale with separate sub-scales for anxiety and depression. In a group of patients with metastatic cancer, summing the two subscales gave a sensitivity of 77%, specificity was 89% and a positive predicted value of 0.48. Two more recent articles reported lower sensitivity and specificity in patients with advanced metastatic disease.

Summary and Recommendations
• Clinicians should have a high clinical suspicion for depression—especially in patients who exhibit feelings of hopelessness, worthlessness, guilt, anhedonia, sustained periods of feeling sad, and/or those with suicidal ideation and/or suicidal plans.
• The literature does not suggest that any of the above scales are clearly superior for helping to diagnose depression in a population of palliative care patients.
• Depression screening scales may be helpful in individual cases to provide the clinician with additional data in formulating a diagnosis; if used, it is suggested that clinicians be familiar with the sensitivity/specificity data for one scale and consistently use that scale so as to gain clinical familiarity.
• Psychiatric consultation is indicated in cases of diagnostic uncertainty and/or when patients present with profound depression and/or are overtly suicidal.
Definitions (Further resources available at: [http://www.musc.edu/dc/icrebm/diagnostictests.html](http://www.musc.edu/dc/icrebm/diagnostictests.html).)

- **Sensitivity:** The fraction of those with the disease correctly identified as positive by the test.
- **Specificity:** The fraction of those without the disease correctly identified as negative by the test.
- **Positive predictive value:** The fraction of people with positive tests who actually have the condition.

References


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