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Depression in patients with advanced illness: An examination of Ontario complex continuing care using the Minimum Data Set 2.0

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Background: The importance of assessing and treating depression in dying patients has been documented in the literature, with variations on prevalence estimates from 15% to 30%. There is also evidence to suggest that depression has the greatest impact on quality of life of any symptom at any stage of illness, and in particular in the terminal phase. Depression is associated with physical impairment, cognitive decline, pain and increased mortality. In addition, other research suggests that depression is the strongest predictor of requests for hastened death, but that these requests subside with appropriate treatment. Most studies to date have focused on patients with malignant disease, with little known about the prevalence of depression in patients in end stages of their life with non-malignant conditions. The difficulty of defining the "end-stage" of an illness has been a methodological limitation of previous work. Because previous research has used self-report or interview measures to detect depression, only those who are cognitively intact have been included. This has led to a paucity of information about the psychological state of patients with cognitive impairment at end stages of their illness. This research was designed to address these gaps in knowledge. The aim of the study was to determine the prevalence of potential depression, its recognition and treatment and associated characteristics in a hospital population, using an empirically defined definition of advanced illness.

Methods: All data were obtained from the Ontario (Canada) provincially-mandated MDS 2.0 form for chronic care. Advanced illness was determined using an empirically derived algorithm, the Changes in Health End-stage disease, and Signs and Symptoms (CHESS) scale. Scoring is based on the presence of the presence of vomiting, dehydration, weight loss, leaving 25% of food uneaten and shortness of breath, end-stage disease, decline in cognition, and decline in ADL function. The MDS-embedded Depression Rating Scale (DRS) was used to measure psychological well-being and a score of 3 or greater indicated potential depression.

Results: Of 3,081 patients, 552 scored 4 or greater on the CHESS. Excluding comatose patients, a total of 524 were designated as having AI. These patients showed moderate levels of cognitive impairment and high levels of physical impairment. Twenty-nine percent of patients with AI scored greater than 3, making them nearly twice as likely to be potentially depressed as other patients (OR 1.8, 95% CI 1.5-2.2). However, these patients were less likely to have received antidepressants (28.9% vs 38.2%), even among those with a diagnosis (45.3% vs 58.4%). On average depressed patients were older, reported less contact with family and friends and had been in hospital longer than non-depressed patients. Depressed patients also reported more pain and delirium. Patients with cancer were substantially less likely to be depressed (AOR 0.37, 95% CI 0.2-0.6). Further investigation revealed that cancer patients were more likely to be treated for depression and to be recognised as being within the terminal phase of illness.

Commentary: The scientific merit of this research is clear as evidenced by the sample size, trustworthiness of data collection method used, careful attention to measurement, and psychometric properties of the instruments used. This paper provides new information about the prevalence of potential depression in patients with advanced disease. The empirical definition of advanced disease is a particular strength of this research allowing helpful comparisons across diagnostic groups. The study also provides insights into the psychological experience of patients with cognitive impairment, addressing a notable gap in the literature. Moreover, the findings provide useful direction to clinicians who may underestimate the psychological depression of patient sub-populations that to date, have not been measured (ie, cognitively impaired, non-malignant disease groups, long-term hospitalised patients, older patients without family support).

Reviewer

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Professor Linda Kristjanson is The Cancer Council WA Chair of Palliative Care and in this role she directs the WA Centre for Cancer & Palliative Care. Professor Kristjanson is also the Director of Hospice Research for Silver Chain Hospice Service in Western Australia and was chosen as the 2002 Australian Telstra Business Woman of the Year for her entrepreneurial work in health and science. Professor Kristjanson has received competitive research funding from local and national organisations in Canada, the USA and Australia. During her research career Professor Kristjanson has received more than \$18m in research grants and has published more than 120 refereed papers and book chapters. In 2004 Professor Kristjanson was appointed by the Minister of Health to the Australian Primary Health Care Research Institute and she now holds the position of Deputy Chair of this Institute. She is also a member of the National Health & Medical Research Council.