Depression is under detected in cancer

Maguire reported that up to 80% of psychological and psychiatric conditions of cancer patients was undetected. Barriers to identification of depression in cancer patients include the following: non-reporting by cancer patients; doctors' failure to recognise depression in cancer; both patients and doctors regard depression as 'appropriate'; difficulty in differentiating depression from other psychological conditions; attributing signs and symptoms to cancer; and fear of stigmata of psychiatric illness.

Depression is under treated in cancer

Depression is also under treated in cancer patients. In one study on 1046 hospice patients, 10% of patients were given antidepressants, but 76% of them were started during the last 2 weeks of life. Barriers to treatment of depression in cancer include the following: lack of awareness of the condition; lack of competence or confidence in treating the condition; and the pre-conceived idea that psychological treatment is better than the drug treatment; drug treatment is started too late at life to achieve any therapeutic effect; and the attitude of therapeutic nihilism i.e. nothing works at this stage.

The impact of depression on cancer

The impact of depression on cancer patients can be considered in two aspects, in terms of severity and in terms of prevalence. Depression can have an impact on both the emotional and the medical course of the cancer patients. The impact on the emotional course of cancer has been recognised and manifested as erosion of QOL, amplification of symptoms, undermining the will to live, increase the desire to hasten death, associate with interest or quest for euthanasia, and suicidal ideation. Depression is also thought to have a negative impact on the medical course of cancer, including cancer incidence, cancer progression and cancer mortality. The current evidence available, however, is still divided. Nonetheless, 6 out of 30 studies on cancer incidence showed positive correlation, and 15 out of 24 studies on cancer progression showed positive association.

Prevalence of depression in cancer

The prevalence of depression as quoted by studies is variable. In a systematic review of the prevalence of depression in 2002, 10 out of 46 studies reviewed used the diagnostic criteria of depression in their studies. The prevalence of depression in these studies ranged from 5% to 26%, with a median of 15%. Other studies have employed single items for depressive mood, Hospital Anxiety Depression Scale, and other miscellaneous questionnaires for screening depression. When using HADS, the prevalence of ‘depression’ (a depression subscore >10) had a median of 29% (IQR 19.5-34.24%). However, in this review, many studies were of small sample size with high non-responding rates.

Some factors may affect the prevalence, and hence account for its variability. The group of patients being studied, the type of cancer, the timing of assessment along the trajectory of illness, and finally how the condition is being diagnosed.

Diagnosis and screening of depression

In diagnosing depression, the Diagnostic and Statistical Manual of Mental Disorders was regarded as the gold standard. In DSM-IV, a patient is diagnosed to have depression if he/she suffers from a 2 week period of depressed mood or loss of interest or pleasure (anhedonia) AND the presence of 5 or more of the following: depressed mood, anhedonia, psychomotor retardation or agitation, feeling of worthless or guilt, thoughts of death or suicide, fatigue or loss of energy, weight or appetite change, sleep changes, and difficulty in concentrating.