

## ASSESSMENT AND MANAGEMENT OF ANXIETY

- As anxiety may have many different origins, assessment may be complex
- Attempt to differentiate between primary anxiety and:
  - Delirium
  - Depression
  - Bipolar disorder
  - Medication side effects
- Look for reversible causes of anxiety such as:
  - Insomnia
  - Alcohol
  - Caffeine
  - Medications (e.g. increased doses of beta-agonists and methylxanthines for the management of dyspnea)
- To help clarify these issues, it is often valuable to elicit input from others who have knowledge of or contact with the patient: family, friends and other members of interdisciplinary team
  - Delirium
  - Depression
  - Bipolar disorder
  - Medication side effects

### Non-pharmacological Management of in Anxiety Advanced Illness

- The majority of patients will be receptive to compassionate exploration of the specific issues that are causing or exacerbating their anxiety
- Some patients may have concerns that are unlikely to resolve with medication but will benefit from counseling and supportive therapy. These include:
  - Concerns about finances
  - Family conflicts
  - Future disability
  - Dependency
  - Existential concerns
- Involve other appropriate disciplines such as nursing, psychology, social work, and chaplaincy
- Complementary and alternative medical approaches may help some patients
- Issues of grief and loss are important dimensions to understand, particularly in evaluating anxiety and psychological distress. They are applicable earlier in the course of the illness for both patients and family members

### Pharmacological Management of Anxiety: General Considerations

- When it appears that pharmacological therapy will be beneficial as part of a total plan of care for anxiety, benzodiazepines are generally the medication class of choice
- Choose an agent based on the desired half-life
  - Longer half-life medications have a more sustained effect, but may accumulate
  - Shorter half-life medications may have a greater risk of withdrawal and rebound anxiety
- Whichever medication is chosen, start with low doses and titrate to effect and tolerability

### Benzodiazepines

#### Long half-life benzodiazepines

- diazepam 2–10 mg po q hs to q 8h
- clonazepam 0.25–1 mg po q d to bid

#### Moderate half-life benzodiazepines

- lorazepam 0.25–2 mg po, sl q 6h

#### Short half-life benzodiazepines

- alprazolam 0.125–0.5 mg po q 6h
- oxazepam 10–30 mg po q 4–6h

#### Cautions and Side Effects

- Benzodiazepines may worsen memory, particularly in the elderly
- They may also cause confusion in patients with preexisting cognitive impairment
- When discontinuing benzodiazepines, taper them slowly

#### **Atypical antidepressants: Examples of Drugs in this Class**

- mirtazipine
- nefazodone
- trazodone

#### **When to Use Atypical Antidepressants in the Treatment of Anxiety**

Consider using atypical antidepressants for patients with:

- Mixed anxiety and depression
- Chronic anxiety
- Panic disorder
- If only a hypnotic effect is needed, trazodone is a useful alternative (25–100 mg po q hs)

### **ASSESSMENT AND MANAGEMENT OF DELIRIUM**

- The diagnosis needs to be distinguished from:
  - Anxiety
  - Depression and
  - Dementia (which is slowly progressive, usually irreversible, and commonly associated with unaltered consciousness until very late in its course)
- A tool such as the Folstein mini-mental status exam can be used for more definitive assessments

#### **Management of Delirium in Advanced Illness: General Considerations**

- Management of delirium begins by first evaluating the benefits vs. burdens of seeking and treating reversible causes
  - For some patients, it may be most efficacious to try to treat the delirium rather than search for the underlying cause
- In all cases, it makes sense to review the medication list and try to relate changes in medication to the onset of the symptoms
  - If medications are felt to be responsible, consider removing those that are nonessential
- General treatment measures are frequently beneficial
  - If the patient must be in the hospital, try to ensure that family and caregivers are present as much as they can be
  - Reduce excessive stimulation, and regularly orient and assure the patient of his or her safety regularly
  - Familiar surroundings are more likely to be calming. If possible, discharge the patient home with the necessary supports in place, e.g., home hospice

## Neuroleptics

- If medications are needed, neuroleptics may be helpful
- Monitor for extrapyramidal adverse effects, e.g., dystonia or akathisia

### haloperidol

- 0.5–1 mg po, iv, sc q 1h prn, titrate until settled, then q 12 to q 6h to maintain
- Total daily doses of 1–20 mg or more may be needed
- Less sedating than chlorpromazine

### chlorpromazine

- 10–25 mg po/iv q 4–6h for sedating neuroleptic
- Low doses are ideal for nighttime sedation, especially with day-night reversal, and/or in the elderly
- Delirium may worsen in some patients because of chlorpromazine's anticholinergic effect
- It also lowers the seizure threshold

## Atypical Neuroleptics

- Cause less dystonia and akathisia than typical neuroleptics
- Risperidone may be better in demented or agitated delirium
  - risperidone 0.5–1 mg q 12 and titrate
- Sedating atypical neuroleptics (eg, olanzepine, quetiapine) are alternatives to chlorpromazine, though they have been less extensively used or studied in this population
  - olanzepine 2.5–7.5 mg po q 12h
  - quetiapine 75–100 mg po q 12h

## Management of Terminal Delirium

- Management is focused on:
  - Symptomatic control
  - Relief of the distress of both patient and family
- Benzodiazepines or sedating neuroleptics are usually effective at settling the patient

## Evaluating Treatment

- Patients on medication for delirium should be monitored carefully and regular meetings arranged to discuss their progress
- If there is a negligible or only partial response:
  - Reevaluate the diagnosis
  - Consider adjusting the dosage
  - Try a different medication
  - Inquire of family members and caregivers about adherence to medication
- If delirium persists, seek advice from, or refer to, a specialist

## ASSESSMENT AND MANAGEMENT OF DEPRESSION

### What Symptoms to Look for and How to Assess

- Somatic symptoms (e.g., changes in appetite, weight, energy level, libido, or sleeping) are almost invariably present in patients with advanced illness. Because of this, such symptoms are less reliable diagnostic indicators of depression in this population than they are in the general population
- Psychological and cognitive symptoms of depression should therefore be the focus in assessment of depression in patients with advanced illness. The most reliable criteria include:

- Persistent dysphoria
  - Anhedonia (loss of pleasure or interest)
  - Feelings of helplessness, hopelessness, and worthlessness
  - Loss of self-esteem
  - Feelings of excessive guilt
  - Pervasive despair
  - Bothersome ruminations about death
  - Thoughts of suicide or requests to hasten death
  - Pain not responding as expected
  - Sad mood with flat affect
  - Anxiety, irritability, or unpleasant mood
- The screening question, "Do you feel depressed most of the time?" is a highly sensitive and specific question in this population
  - Where possible, include the observations of family, friends and other members of the health care team as they may provide considerable information to add to the history
  - More specific screening tools (such as the Beck inventory for depression) for the identification of depression are available. If you are having difficulty determining the presence or extent of a patient's depression, use colleagues as resources. For instance:
    - You may need the assistance of a child psychologist, child life specialist, or social worker if the patient is a child or adolescent
    - Ask an experienced psychiatrist for assistance as appropriate

### **Assessment of Suicidality - Common Questions and Answers**

- Who should be assessed for risk of suicide?
  - All patients with depressive symptoms should be assessed for their risk of suicide
- Why should I be so concerned about suicidal thoughts? Aren't these normal in patients with advanced illness?
  - Suicidal thoughts are an important sign of depression, even in patients with advanced life-threatening illness
- Won't talking about suicide put the idea in my patients' minds?
  - No, in fact, open discussion of suicide may reduce the risk. It is a myth that asking about suicide will "put the idea into someone's head." To the contrary, allowing patients to discuss the thoughts they are having may reduce the likelihood they will actually commit suicide. This is particularly true when the physician acknowledges their feelings and desires, and addresses the root causes of their distress. What should I do if I think my patient is suicidal?
  - Patients with recurrent thoughts of suicide or serious plans should be considered at high risk. Immediate consultation with a mental health specialist with experienced in this area is indicated

### **Management of Depression in Advanced Illness**

#### **Techniques for Treating Depression: An Overview**

To treat depressed patients who are living with life-threatening illness, use a combination of supportive psychotherapy, cognitive approaches, behavioral techniques and antidepressant medication

**Psychotherapeutic interventions:** Individual or group counseling have both been shown to reduce depressive symptoms. In addition to formal sessions with psychiatrist, psychologists, or other mental health professionals, nurses, social workers, and chaplains may also be able to conduct both formal and informal sessions, depending on their training.

**Cognitive approaches:** Time spent talking with patients about their feelings and reframing their ideas may be very helpful. These approaches can be used by the primary physician, as well as other colleagues.

**Behavioral interventions:** Relaxation therapy, distraction therapy with pleasant imagery, etc. have been shown to reduce depressive symptoms in patients with mild to moderate levels of depression. Complementary and alternative medical approaches may be useful adjuncts.

**Antidepressant medications:** A variety of medications that will be discussed below work with all severities of depression. They work better than psychotherapy alone in severe depression.

### **Counseling Goals in the Treatment of Depression**

## General Tips for Supportive Counseling

- Look for opportunities to weave supportive counseling that uses aspects of brief supportive psychotherapy into routine interventions
- Include family members whenever possible
- Refer seriously depressed or anxious patients for formal psychotherapy

## Goals of Supportive Counseling

- Improve patient understanding
  - During the discussions, to provide the patient with an improved understanding of his or her:
    - Prognosis
    - Potential treatments
    - Outcomes
  - In this way, the interaction itself may be therapeutic
- Encourage new perspectives
  - Giving patients information and helping them to gain an improved understanding of the situation they face may help them to develop different perspectives on their:
    - Perceptions
    - Expectations
    - Needs
    - Fears and fantasies about illness and death
- Help establish/re-establish patient's sense of self-worth and meaning
  - Discuss short-term goals
  - Identify and reinforce the patient's previously demonstrated:
    - Strengths
    - Successful coping techniques
- Introduce new coping techniques
  - Inform patients about techniques such as:
    - Relaxation
    - Meditation
    - Guided imagery
    - Self-hypnosis
  - Educate the patient and family members about modifiable factors that contribute to anxiety and depression

## Pharmacological Management of Depression: General Considerations

- The time available for treatment will strongly influence the choice of medication for initial therapy
  - When reversal of depression is an immediate short-term goal, a rapid-acting psychostimulant is the best choice
  - If a response in 2 to 4 weeks is acceptable, an atypical antidepressant or SSRI may be an appropriate choice
- With all antidepressant medications, dosing should "start low and go slow"
  - Titrate the dose to effect and tolerability
  - Warn patients about possible adverse effects and assure them that these will usually ameliorate within a few days
- If patients are not responding as expected, seek consultation with an experienced colleague, such as a psychiatrist
- See the Medication Table for information about specific drugs and dosages

## Psychostimulants

### Basic Information and Examples of Drugs in this Class

- The psychostimulants are often underappreciated for their antidepressant qualities
- Drugs in this class include:
  - Methylphenidate
    - Usually started at 5 mg in the morning and at noon, and then titrated to effect
    - An extended-release formulation taken once in the morning may improve tolerability
  - Dextroamphetamine
  - Pemoline

### **Advantages of Psychostimulants**

- Act quickly (within days). Some patients report increased energy and an improved sense of well-being within 24 hours
- Produce minimal adverse effects
- Can be used alone or in combination with other antidepressants
- May be continued indefinitely as their antidepressant effect persists over time
- Tolerance to the antidepressant effect does not appear to develop
- May also be used to diminish opioid-induced sedation
- Their potential as adjuvant analgesics has been reported

### **Disadvantages of Psychostimulants:** May produce

- Tremulousness
  - Anxiety
  - Anorexia
  - Insomnia
- These adverse effects should be monitored
  - If discontinued, psychostimulants should be tapered off slowly

### **Selective Serotonin Reuptake Inhibitors (SSRIs): Examples of Drugs in this Class**

- fluoxetine
- paroxetine
- sertraline
- citalopram

### **Advantages of SSRIs**

- Highly effective (70% of patients report a significant response)
- Low doses may be sufficient in advanced illness
- Once-daily dosing is possible
- Cause less constipation, sedation, and dry mouth than the tricyclic antidepressants

### **Disadvantages of SSRIs**

- Latency (require 2-4 weeks to take effect)
- Nausea may be worse than with tricyclics

### **Tricyclic Antidepressants: Examples of Drugs in this Class**

- amitriptyline
- clomipramine
- desipramine
- doxepin

- imipramine
- nortriptyline
- protriptyline
- trimipramine

### **Issues to Consider before Using Tricyclics**

- Not recommended as first first-line therapy to manage depression unless they are being used as adjuvants to control neuropathic pain
- Titration to achieve an adequate dosage may take 3 to 6 weeks, delaying the onset of therapeutic action
- Anticholinergic adverse effects (eg, dry mouth, constipation, orthostatic hypotension, blurred vision, urinary retention, delirium) and cardiac conduction delays (proarrhythmic) are all seen with some frequency
- If a tricyclic antidepressant is to be used, the secondary amines nortriptyline and desipramine are preferable as they tend to have fewer side effects

### **Atypical Antidepressants**

- This diverse group of older and newer medication is growing quickly. Examples include:
  - Mirtazapine
  - Bupropion
  - Nefazodone
  - Trazodone
  - Venlafaxine
- Their precise role in patients with advanced disease is being studied

### **Non-Pharmacologic Management**

- Although this module focuses on equipping physicians with the medical knowledge, attitudes, and skills to manage depression, this does not exclude the role of non-pharmacological management of depression
- Use appropriate colleagues and team members to help address the emotional and spiritual issues that overlap and influence clinical depression
- Complementary and alternative methods may be useful adjuncts for some patients. It is beyond the scope of this module to discuss these in detail
- Issues of grief and bereavement may be important. Although these topics are discussed in Module 12: Last Hours of Living, the concepts are also applicable in the context of evaluating and managing depression. See Module 16: Social and Psychological Considerations for more information on non-pharmacological approaches to the treatment of depression and anxiety.

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