A nurse delivered management programme for depression in people with cancer reduces depressive symptoms compared with usual care

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**QUESTION**

**Question:** In people with cancer, is a complex depression management intervention effective in reducing depressive symptoms compared with usual care?

**Patients:** 200 adult outpatients with both cancer (mean age 56.6 years; 71% women) and DSM-IV major depressive disorder (identified by screening using the Hospital Anxiety and Depression Scale; those scoring ≥15 completed the Structured Clinical Interview for DSM-IV). Inclusion criteria: cancer prognosis of 6 months or more; major depressive disorder for ≥1 month not associated with a change of cancer or cancer management; and a score of ≥17.5 on the Symptom Checklist-20 (SCL-20) depression scale (score range 1–4, higher score indicating greater levels of depressive symptoms). Exclusions: intensive anticancer treatment, communication difficulties, poorly controlled comorbidities, and people needing or receiving specialist psychiatric care.

**Setting:** Regional cancer centre, Scotland, UK; recruitment October 2003–December 2005.

**Intervention:** The Depression Care for People with Cancer intervention plus usual care or usual care alone. Depression Care for People with Cancer: maximum 10 individual 45 min sessions, delivered by a trained cancer nurse over 3 months. Sessions were mainly in person but sometimes carried out over the telephone. Intervention comprised education about depression, antidepressant medication, problem solving exercises and instruction in coping strategies. Management of depression was discussed with the patient’s oncologist and primary care doctor. Progress was monitored by telephone 3 months after treatment sessions ended. Usual care: Each patient’s oncologist and primary care doctor was informed of the major depressive disorder diagnosis and advice on antidepressant drugs was given if requested.

**Outcomes:** Primary outcome: difference in mean score of the SCL-20 depression scale at 3 months. The SCL-20 questionnaires were mailed to participants for completion.

**Patient follow-up:** 98% at 3 months, 82% at 12 months. 98.5% included in intention to treat analyses.

**METHODS**

**Design:** Randomised controlled trial.

**Allocation:** Concealed.

**Blinding:** Unclear.

**Follow-up period:** Assessments taken at 3, 6 and 12 months.

**MAIN RESULTS**

At 3 months, the Depression Care for People with Cancer intervention reduced symptoms of depression more than usual care (adjusted difference in mean SCL-20 score: 0.34, 95% CI 0.15 to 0.53). Median baseline SCL-20 depression score for the intervention group was 2.35 (interquartile range (IQR) 2.05 to 2.75) which fell to 1.20 (IQR 0.70 to 1.70) at 3 months. Median baseline SCL-20 depression score for the usual care group was 2.25 (IQR 1.95 to 2.75) which decreased to 1.55 (0.90 to 2.00) at 3 months. Depression scores in the intervention group were also lower than depression scores in the usual care group at 6 and 12 months (intervention vs usual care at 6 months: 1.05 vs 1.51; 12 months: 1.12 vs 1.43; significance not stated).

**CONCLUSIONS**

The nurse delivered Depression Care for People with Cancer intervention to manage major depression in people with cancer is effective in reducing depressive symptoms.

**ABSTRACTED FROM**


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Depressive symptoms in cancer have been the subject of much research. Prevalence rates are estimated as high as 58% for depression spectrum disorders and 5–16% for major depressive disorder (MDD). Despite this, several studies have found that patients are not always willing to accept treatment. It has been recommended that primary care providers should use a two stage selective procedure whereby patients are screened for depressive disorder but only patients scoring above a certain threshold are selected for treatment.

Strong and colleagues performed a proof of concept study of such a two stage screening procedure in the hospital outpatient setting and offered patients with MDD collaborative care. The authors found 660 (8%) patients with MDD, a rather low percentage. Of these, 326 (49%) were not eligible for the intervention in the hospital setting. They found a small but significant increase in quality of life in the intervention group; the total average extra cost for the intervention was £334, or £5278 per QALY gained. Although there was a significant increase in antidepressant use in the intervention group, the control group also used antidepressants, and there was a lack of effective monitoring of antidepressant use. Although the findings are promising, two questions remain. Firstly, is the effort described by the authors to screen all patients justified in view of the limited effect size and the fact that 49% of patients with MDD were ineligible? Secondly, in terms of collaborative care, this is not the ultimate model; there was a remarkable lack of contact between doctors, nurses and psychiatrists.

In order to address these problems, the psychiatrist consultation liaison service in a hospital might play a role in screening and selection of patients for treatment. Also, the hospital consultant psychiatrist could prescribe the antidepressant. Such an adaptation of the model might make the process more efficient and enhance the potential cost effectiveness of collaborative care in the hospital setting for depressed patients with cancer. That could make a case to re think clinical practice.

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**Competing interests:** None.