Oncology Nurses Ease Cancer Patients' Depression

BY JANE SALODOF MACNEIL
Southwest Bureau

TUCSON, ARIZ. — A psychiatric intervention conducted by specially trained oncology nurses significantly reduced depression for cancer patients enrolled in a clinical trial presented at the annual meeting of the Academy of Psychosomatic Medicine.

Dr. Michael Sharpe said patients who were randomized to problem-solving therapy reached lower mean scores on the Symptom Checklist–20 (SCL-20) and were more likely to achieve a 50% reduction in clinical symptoms, compared with patients given optimized usual care. The randomized group also had twice the rate of complete remission. "We can make a difference in depression in cancer patients with this kind of model," said Dr. Sharpe, a professor of psychological medicine and symptoms research at the University of Edinburgh where the 200-patient trial was done.

Depression is common but poorly managed in cancer patients, according to Dr. Sharpe. It is associated with nonadherence to cancer treatment, increased medical costs, and suicide, he said. Yet it is often not detected or, if recognized, discounted as a normal response to having cancer.

Therefore, the investigators recruited oncology nurses to integrate depression care into cancer care. A psychiatrist supervised the nurses, who coordinated drug treatment, delivered psychological treatment, and monitored patient progress.

As described by Dr. Sharpe, the psychological component was a problem-solving therapy in which the patients would list cancer and noncancer concerns. They would choose one concern to focus on with the nurse, identifying what a solution would look like and brainstorming on how to achieve it. Next, they would choose and try out a strategy.

Initially, one nurse worked full time in a pilot study testing the model, but it was "too much," so nurses worked half-time in the randomized trial, he said.

Selection and training of nurses without a psychiatric background was also a challenge. "We had a core of three nurses who did treatment, but one of them could not do it and had to leave," he said.

The trial population was drawn from a pool of patients who underwent computerized screening for depression before consultation with their oncologists. Depression diagnoses were based on subsequent structured clinical interviews of patients who scored above 14 on the Hospital Anxiety and Depression Scale.

Depression is often not detected in cancer patients, or, if recognized, is discounted as a normal response to having cancer.

DR. SHARPE

Two hundred patients were randomized: 99 to optimized usual care and 101 to optimized usual care plus the Symptom Management Research Trials (SMaRT) intervention by the oncology nurses. Dr. Sharpe noted that primary care physicians were notified of all depression diagnoses and could prescribe antidepressants to patients in both groups.

Breast cancer was the most common malignancy, accounting for more than 40% of the patients enrolled. The study population was generally female with an average age of 56 years. About two-thirds were disease free, and more than 80% were visiting oncologists for follow-up care after completing cancer therapy.

Data analysis was done at 3 months' follow-up for all 99 usual-care patients and 97 who received the added intervention (4 patients, including 2 who died, were excluded because of incomplete data).

The intervention group had lower mean SCL-20 scores, compared with the usual-care group: 1.25 vs. 1.54. More than half (53%) of the intervention group achieved a 50% clinical reduction of depression symptoms compared with about a third (34%) of the control group. Twice as many had a complete remission on the SCL-20: 29% vs. 14%. Remission rates were also significantly higher based on structured clinical interviews: 67% vs. 45%, respectively.

Although he did not report statistics in detail, Dr. Sharpe said the effects "were maintained and possibly increased" at 6 months. The next step, he said, will be to duplicate the study with more nurses and patients at multiple centers. ■

Pages 28a—28b