Depression – significance, assessment and treatments

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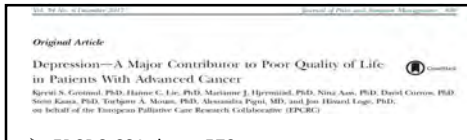
Nordic Course Palliative Medicine 2019

Outline

- Depression disorder – significance
- Assessment
  - Classification
  - Other symptoms – use of ESAS
  - Assessment in practice
- Treatments
  - General aspects
  - ADs
  - Psychotherapy
- Conclusions
  - The black dog

QOL - main predictor in palliative setting?



Original Article

Depression—A Major Contributor to Poor Quality of Life in Patients With Advanced Cancer

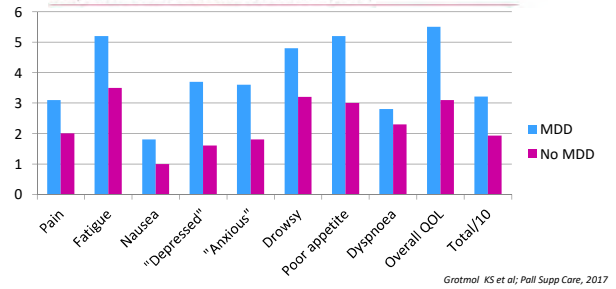
Kjersti S. Grotmol, PhD, Haisse C. Lie, PhD, Marianne J. Hjermstad, PhD, Nina Aass, PhD, Daniel Corcoran, PhD, Stein Kaasa, PhD, Torbjørn Å. Mosge, PhD, Alessandra Pigni, MD, and Jon Håvard Loge, PhD, on behalf of the European Palliative Care Research Collaborative (EPCRC)

- EPCRC-CSA data - 572 pts.:
  - Missing data: blood samples / MMSE
- Poor QOL – "predictors":
  - CRP ↑
  - Short survival-time
  - Functional status ↓
  - Pain ↑
  - **Depression severity (5 psychological items PHQ9)**
    - ✓ Depression severity: 6.7% of observed variance (30%)
- Cross-sectional design limits

Grotmol KS et al; J Pain Sympt Manage, 2017

Patients with advanced cancer and depression report a significantly higher symptom burden than non-depressed patients

Kjersti Steen Grotmol, PH.D.[1,*], Hanne C. Lie, PH.D.[2,3,4,*], Jon Håvard Loge, PH.D.[1,3,5], Nina Aass, PH.D.[6,7], Dagny Faksvåg Haugen, PH.D.[8,9], Patrick C. Stone, M.D.[10], Stein Kaasa, PH.D.[5,6,7] and Marianne Jensen Hjermstad, PH.D.[1,5] on behalf of the European Palliative Care Research Collaborative (EPCRC)



Grotmol KS et al; Pall Supp Care, 2017

The use of antidepressants in patients with advanced cancer—results from an international multicentre study

- EPCRS-CSA-data (N=1048), PHQ-9
- Depression: inclusive DSM-scoring (all criteria)
- 14% used ADs – not adjuvant for pain
  - 25% had PHQ-depression
  - The 75% - improved?
- **25% of «depressed» received ADs**
- Cross-sectional design limits
  - What happens around next corner?
- **Underdetection & undertreatment** = the rule
- **Why?**

Janberidze et al; 2014

Assessment & classification

Depression – several meanings

- Depression used as a term for:
  - Depressed mood – a symptom
  - Loss of pleasure (anhedonia) – a symptom
  - A colloquial term – feeling down, blue,…
  - What is measured by different assessment tools
    - ✓ i.e. HADS-depression (Hospital Anxiety and Depression Scale)
  - **A disorder of affect**

    - a syndrome as defined by the DSM-IV / ICD-10

    - I.e. Depression Disorder

Some principles of psychiatric classification

- Same psychic symptom in several conditions
  - As for all symptoms!
  - Symptoms also in normal reactions such as depressed mood in sadness
  - Construct validity of psychiatric diagnoses disputed by some
    - ✓ Do the classes actually exist? Continuous phenomena – depressed mood
    - ✓ Boundaries between disorders (are the "clusters" valid?)
- Some core criteria for counting as disorders
  - Symptom constellation – group of symptoms – i.e. clusters
  - Symptom load – how much of each symptom - i.e. intensity
  - Duration
  - Functional consequences

Original Article
MEDICINE

Depression assessment and classification in palliative cancer patients: a systematic literature review

Palliative Medicine
23(8) 719–753
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DOI: 10.1177/0269216309106978
pmj.sagepub.com
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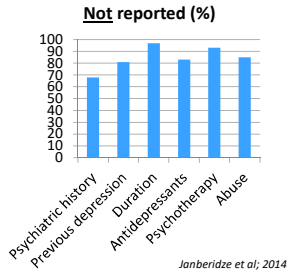
- Part of EU-funded project (EPCRC)
- Review on depression assessment
  - 202 papers 1966-2007
  - 106 different assessment methods
  - **76 used Hospital Anxiety and Depression Scale (HADS)**
  - 65 used methods unique to one study
  - 27 used structured interviews – gold standard
- Stable pattern over time-periods
- Makes comparisons impossible – research limited clinical value

Wasteson et al; 2009

How Are Patient Populations Characterized in Studies Investigating Depression in Advanced Cancer? Results From a Systematic Literature Review

Core variables – seldom assessed in literature

- 59 studies on depression & pall.care / advanced cancer (2007-2011)
- Not disorder ≠ symptom
- Core variables <u>not</u> reported
  - Functional consequences
  - Ca. disease/treatment
- 50% used HADS
- **Cancer - similar practice?**



Janberidze et al; 2014

Depression – some general aspects

- A symptom - continuous
- A syndrome – categorical
  - Psychiatric disorders – diagnostic systems (ICD10 / DSMV)
    - ✓Depression Disorders
    - ✓Adjustment disorders
- Depression and anxiety <u>symptoms</u> co-occur
  - In "normal" emotional reactions
  - In adjustment disorders – "more than anticipated"
  - Anxiety – also a common symptom among depressed *(Brenne 2013)*
- **Psychiatric disorders = syndromes**
  - Defined symptoms (criteria) + duration + functional consequences
  - Cachexia also a syndrome

What is depression disorder?

DSMV-criteria depression disorder:
-Symptom-threshold + duration + functional decline

- **Symptom overlap – a special challenge in pall care**

Criteria [1]	Type of symptom
1. Lowered mood [2]	Psychological
2. Anhedonia * [2]	Psychological (?)
3. Anorexia / weight loss	***Somatic***
4. Insomnia / hypersomnia	***Somatic***
5. Psychomotor agitation / retardation	***Somatic***
6. Fatigue	***Somatic***
7. Feeling of guilt	Psychological
8. Lowered concentration	Psychological (??
9. Recurrent thoughts of death / suicide	Psychological

[1]: **5 or more criteria present for last 14 days and a change from previous functioning**
[2]: **Major criteria - one must be present**
*: **Anhedonia = lacking ability to feel pleasure of stimuli that usually gives pleasure**

Depression – symptom and disorder

-confusing literature

- Depressed mood observed in several disorders
  - Depressive episode (major / minor)
  - Adjustment disorders
  - Personality disorder (dysthymia)
  - Normal reactions – grief
  - Seasonal Affective Disorder (SAD)
  - + …….
- Depression as disorder ≠ depression as symptom
  - Often not kept separate – clinic & research
- Dep. disorder moderately prevalent in oncology / pall. care
  - Major depression: 14,3% (95% CI 11,1–17,9) *Mitchell A, Lanc Onc 2011*
  - Any mood disorder: 38,2% (95% CI 28,4–48,6) *Mitchell A, Lanc Onc 2011*

Palliative and Supportive Care (2013), **11**, 491–501.
© Cambridge University Press, 2013 1478-9515/13 $20.00
doi:10.1017/S1478951512000909

Depressed patients with incurable cancer: Which depressive symptoms do they experience?

What do the pts. tell us?

Also part of EPCRC-CSA-study

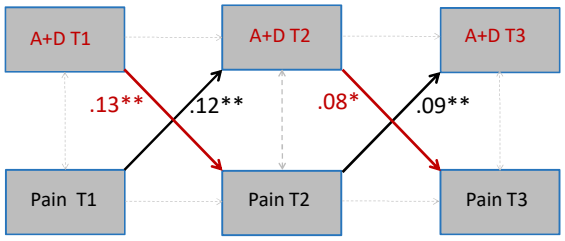
30 pts. on antidepressants – qualitative study

- Lowered mood & anhedonia
- Restless, constantly focused on disease, sleep disturbance, guilt & thoughts of death as a solution
- **Appetite & weight, fatigue & concentration inseparable from disease**
- "New" symptoms: despair, anxiety & withdrawal

Brenne et al; 2013

Pain & distress (A+D symptoms) – correlated over time

-Controlled for age, gender & pain treatment



* = $p < 0.05$ ** = $p < 0.01$

Grotmol KS et al; unpublished data 2017

The Edmonton Symptom Assessment System: Poor performance as screener for major depression in patients with incurable cancer

Palliative Medicine
2016, Vol. 30(6) 587–598
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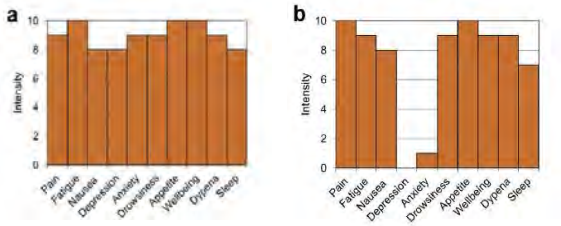
sagepub.co.uk/journalsPermissions.
DOI: 10.1177/0269216315620082
pmj.sagepub.com
SAGE

Brenne et al; 2016

- PHQ-9 MDD as the standard
  - EPCRC-CSA-study (N=969)
- ESAS-depression item = poor screener
  - Cut-off ≥2: sensitivity=.69, specificity=.60
  - Cut-off ≥4: sensitivity=.51, specificity=.82
  - Wording? Confusing *(Bruera E, Hui D; 2017)*
- Performance not improved by adding anxiety-item
- Different conclusions by others but versus distress:

BAGHA S.M., MACEDO A., JACKS L.M., LO C., ZIMMERMANN C., RODIN G. & LI M. (2013) *European Journal of Cancer Care* **22**, 60–69
The utility of the Edmonton Symptom Assessment System in screening for anxiety and depression

Depression – modulates ESAS- scores



- Anxiety and abuse may also exert similar effects

Bruera E, Hui D; 2017

SPØRRESKJEMA OM HELSEN DIN-9

72883

(Norwegian version of the PHQ-9)

THIS SECTION FOR USE BY STUDY PERSONNEL ONLY.

Were data collected? **No** ☐ *(provide reason in comments)*

If **Yes**, data collected on visit date ☐ **or** specify date: _____ (DD-Mth-YYYY)

Comments:

Only the patient (subject) should enter information onto this questionnaire.

I løpet av de siste 2 ukene, hvor ofte har du vært plaget av ett eller flere av de følgende problemene?	Ikke i det hele tatt	Noen dager	Mer enn 7 dager	Nesten hver dag
1. Lite interesse for eller glede over å gjøre ting	0	1	2	3
2. Følt deg nedfor, deprimert eller fylt av håpløshet	0	1	2	3
3. Vansker med å sovne eller med å sove natten gjennom uten å våkne - eller å sove for mye	0	1	2	3
4. Følt deg trett eller slapp	0	1	2	3
5. Dårlig appetitt eller å spise for mye	0	1	2	3
6. Vært misfornøyd med deg selv eller følt deg mislykket - eller følt at du har sviktet deg selv eller familien din	0	1	2	3
7. Vansker med å konsentrere deg om ting, slik som å lese avisen eller se på TV	0	1	2	3
8. Beveget deg eller snakket så langsomt at andre kan ha merket det? Eller motsatt - følt deg så urolig eller rastløs at du har vært mye mer i bevegelse enn vanlig	0	1	2	3
9. Tanker om at du like gjerne kunne vært død eller på annen måte ville skade deg selv	0	1	2	3

SCORING FOR USE BY STUDY PERSONNEL ONLY

_0_ + _____ + _____ + _____

=Total Score: _____

Hvis du har opplevd ett eller flere av de problemene som nevnes, i hvor stor grad har problemene gjort det vanskelig for deg å utføre arbeidet ditt, ordne med ting hjemme eller å komme overens med andre?

Ikke vanskelig i det hele tatt	Litt vanskelig	Veldig vanskelig	Ekstremt vanskelig
☐	☐	☐	☐

Assessment of depression – summary

- Interview – the "gold standard"
  - Structured: SCID, CIDI, MINI, ……
  - Semi-structured: **MADRS**
  - Clinical
- Patient-reported instruments – i.e. Questionnaires
  - Many
  - Assess different depression symptoms
  - Assess present symptom intensity + thresholds for "case definitions"
  - Cases poor/moderate concordance with cases defined by ICD/DSM
    - ✓ Unless high level of intensity
  - PHQ-9 includes DSM-criteria. Therefore preferable at present

Treatments

Treatment – general aspects
-patient-centred care in practice

- Is the patient suffering from a depression disorder?
  - Or dying? Or sad? Difference between sadness and dep. disorder?
  - Will benefit from treatment? What can she/he expect from treatment?
  - What type of treatment is feasible? Functional status / expected survival
- What is the patients' perception of the problems?
  - Information from there –public misconceptions about depression
  - Depression is often bad news; shame, guilt, negativism, lack of faith…
  - SPIKES protocol can be relevant
- Involve in decision(s) – shared decision making
  - Reduce shame and guilt by information, acceptance of strain & normalisation
  - Scepticism towards ADs – negotiate, test-period… - after personalised info.

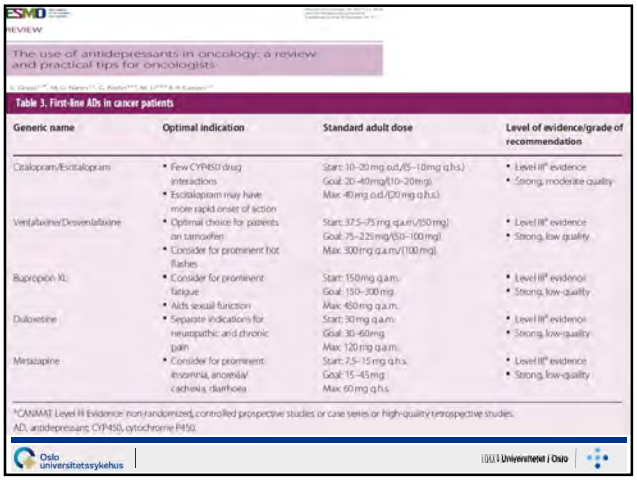
Treatment – aspects to consider

- Often other symptoms/ other diseases
  - 1. Priority: Treat physical symptoms first
  - Symptoms co-occur: Pain – depression / anxiety – dyspnoea
  - Optimal practice?
- Who is best in position to treat and provide follow-up?
  - Palliative Care Physician? GP? Psychiatrist?
  - Pro's & con's?
- Psychotherapy feasible?
- Re ADs: Other symptoms / Side-effects / interactions
  - Are side-effects positive or negative? i.e. sedation, anxiety, CIPN..
  - Pharmacokinetics – i.e. old/frail patients
  - Risk for interactions

Antidepressants to cancer patients during the last year of life—a population-based study

- A national registry-based study
  - Norwegian prescription database + Statistics Norway + Cancer Registry
  - >17 000 deaths from cancer 2005-2006
- 22% at least one prescription vs 6% in gen. pop
  - M/F=19%/25% - equal prevalence
  - Higher prescription rate with longer disease duration
  - Rate increased towards death
  - 10% ADs prescribed last month of life
- Same drugs as in general population!
  - 50% prescribed by GPs

Brelin et al; 2013



ESMO REVIEW

The use of antidepressants in oncology: a review and practical tips for oncologists

Table 3. First-line ADs in cancer patients

Generic name	Optimal indication	Standard adult dose	Level of evidence/grade of recommendation
Citalopram/Escitalopram	• Few CYP450 drug interactions • Escitalopram may have more rapid onset of action	Start: 10–20 mg o.d./(5–10 mg q.h.s.) Goal: 20–40 mg/(10–20 mg) Max: 40 mg o.d./(20 mg q.h.s.)	• Level III[a] evidence • Strong, moderate quality
Venlafaxine/Desvenlafaxine	• Optimal choice for patients on tamoxifen • Consider for prominent hot flashes	Start: 37.5–75 mg q.a.m./(50 mg) Goal: 75–225 mg/(50–100 mg) Max: 300 mg q.a.m./(100 mg)	• Level III[a] evidence • Strong, low quality
Bupropion XL	• Consider for prominent fatigue • Aids sexual function	Start: 150 mg q.a.m. Goal: 150–300 mg Max: 450 mg q.a.m.	• Level III[a] evidence • Strong, low-quality
Duloxetine	• Separate indications for neuropathic and chronic pain	Start: 30 mg q.a.m. Goal: 30–60 mg Max: 120 mg q.a.m.	• Level III[a] evidence • Strong, low-quality
Mirtazapine	• Consider for prominent insomnia, anorexia/cachexia, diarrhoea	Start: 7.5–15 mg q.h.s. Goal: 15–45 mg Max: 60 mg q.h.s.	• Level III[a] evidence • Strong, low-quality

[a]CANMAT Level III Evidence: non-randomized, controlled prospective studies or case series or high-quality retrospective studies.
AD, antidepressant; CYP450, cytochrome P450.

Cochrane Database Syst Rev. 2018 Apr 23;4:CD011006. doi: 10.1002/14651858.CD011006.pub3 [Epub ahead of print]

Antidepressants for the treatment of depression in people with cancer.

Ostuzzi G[1], Matcham F, Dauchy S, Barbui C, Hotopf M.

Author Information

AUTHORS' CONCLUSIONS:

Despite the impact of depression on people with cancer, the available studies were very few and of low quality. This review found very low certainty evidence for the effects of these drugs compared with placebo. On the basis of these results, clear implications for practice cannot be deduced. The use of antidepressants in people with cancer should be considered on an individual basis and, considering the lack of head-to-head data, the choice of which agent to prescribe may be based on the data on antidepressant efficacy in the general population of individuals with major depression, also taking into account that data on medically ill patients suggest a positive safety profile for the SSRIs. To better inform clinical practice, there is an urgent need for large, simple, randomised, pragmatic trials comparing commonly used antidepressants versus placebo in people with cancer who have depressive symptoms, with or without a formal diagnosis of a depressive disorder

Choosing an antidepressant

- Old meta-analysis – revised 2010 *(Gill D, Cochrane 1999)*
  - Mianserin: best effect and least drop-outs
  - Less dropouts than SSRIs / TCAs – side-effects *(Gill D, Cochrane 99)*
  - SSRI's: side-effects from GI
- Revised 2010: 51 studies; 4 on cancer *(Rayner L, Cochrane 2010)*
  - SSRI & TCA similar effect - Mianserin/Mirtazapin: few studies
  - **EPCRC Guideline: https://www.kcl.ac.uk/cicelysaunders/attachments/depression-guidlines/the-management-of-depression-in-palliative-care.pdf**
  - Expert opinion: **Mirtazepin**
- In practice:
  1. If TCA already: increase from 25-50mg to 50-100 (150)mg
  2. New treatment:
     a. Mianserin (Tolvon©): 30 mg increase to 90 (120)mg
     b. Mirtazepin (Remeron©): 15mg (30mg) increase to 45mg (60mg)
  3. Sedative and hypnotic effects warranted in most cases

Contents lists available at ScienceDirect
Cancer Treatment Reviews
journal homepage: www.elsevierhealth.com/journals/ctrv

Systematic or Meta-analysis Studies

Psychotherapy for depression among advanced, incurable cancer patients: A systematic review and meta-analysis

Toru Okuyama[a,b], Tatsuo Akechi[a,b], Lisa Mackenzie[c,d], Toshi A. Furukawa[e,a]

- Minor depression in general population
  - Counselling, physical activity, social activities, stimulate self-help, reduce stressors…..
- Moderate/major DD in general population
  - CBT & ADs
- Psychotherapies in pts. with advanced ca.:
  - Different types; CBT, mindfulness, meaning-centred, CALM…
  - *Conclusions:* Low quality evidence suggests that psychotherapy is moderately more effective for the amelioration of symptoms of depression among advanced, incurable cancer patients than the control conditions. There is insufficient high-quality evidence supporting the effectiveness of psychotherapy for patients with clinically diagnosed depression.

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Guideline #19-4; Section 1

A Quality Initiative of the
Program in Evidence-Based Care (PEBC), Cancer Care Ontario (CCO)

The Management of Depression in Patients with Cancer: Guideline Recommendations

M. Li, E.B. Kennedy, N. Byrne, C. Gerin-Lajoie, E. Green, M. R. Katz, H. Keshavarz, S. M. Sellick, and the Management of Depression in Patients with Cancer Expert Panel

Figure 2. Delivery of intervention corresponding to the Stepped Care Model.

[1]Complex depression includes depression that shows an inadequate response to multiple treatments, is complicated by psychotic symptoms, and/or is associated with significant psychiatric comorbidity or psychosocial factors. Stepped care algorithm adapted from NICE CG91, p.110 [1].

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Ontario
Cancer Care Ontario
Action Cancer Ontario

Guideline #19-4

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The Management of Depression in Patients with Cancer

M. Li, E.B. Kennedy, N. Byrne, C. Gerin-Lajoie, E. Green, M. R. Katz, H. Keshavarz, S. M. Sellick, and the Management of Depression in Patients with Cancer Expert Panel

Report Date: May 11, 2015

Guideline 19-4 is comprised of three sections: Page

For information about this document, please contact Dr. Madeline Li, through the PEBC. Via: Phone: 905-527-4322 ext. 42822 Fax: 905 526-6775 E-mail: pcope@cancercare.on.ca

For information about the PEBC and the most current version of all reports, please visit the CCO website at http://www.cancercare.on.ca/ or contact the PEBC office at: Phone: 905-527-4322 ext. 42822 Fax: 905 526-6775 E-mail: pcope@cancercare.on.ca

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JOURNAL OF CLINICAL ONCOLOGY | ASCO SPECIAL ARTICLE

Screening, Assessment, and Care of Anxiety and Depressive Symptoms in Adults With Cancer: An American Society of Clinical Oncology Guideline Adaptation

Barbara L. Andersen, Robert J. DeRubeis, Barry J. Gurman, Jessie Grunert, Victoria L. Champion, Mary Jane Massie, Jimmie C. Holland, Ann H. Partridge, Kate Nail, Mark R. Somerfield, and Julia H. Rowland

ABSTRACT

Purpose
A Pan-Canadian Practice Guideline on Screening, Assessment, and Care of Psychosocial Distress (Depression, Anxiety) in Adults With Cancer was identified for adaptation.

Methods
American Society of Clinical Oncology (ASCO) has a policy and set of procedures for adapting clinical practice guidelines developed by other organizations. The guideline was reviewed for developmental rigor and content applicability.

Results
On the basis of content review of the pan-Canadian guideline, the ASCO panel agreed that, in general, the recommendations were clear, thorough, based on the most relevant scientific evidence, and presented options that will be acceptable to patients. However, for some topics addressed in the pan-Canadian guideline, the ASCO panel formulated a set of adapted recommendations based on local context and practice beliefs of the ad hoc panel members. It is recommended that all patients with cancer be evaluated for symptoms of depression and anxiety at periodic times across the trajectory of care. Assessment should be performed using validated, published measures and procedures. Depending on levels of symptoms and supplementary information, diverging treatment pathways are recommended. Failure to identify and treat anxiety and depression increases the risk for poor quality of life and potential disease-related morbidity and mortality. The guideline adaptation is part of a larger survivorship guidelines series.

Conclusion
Although clinicians may not be able to prevent some of the chronic or late medical effects of cancer, they have a vital role in mitigating the negative emotional and behavioral sequelae. Recognizing and treating effectively those who manifest symptoms of anxiety or depression will reduce the human cost of cancer.

J Clin Oncol 32:1605-1619. © 2014 by American Society of Clinical Oncology

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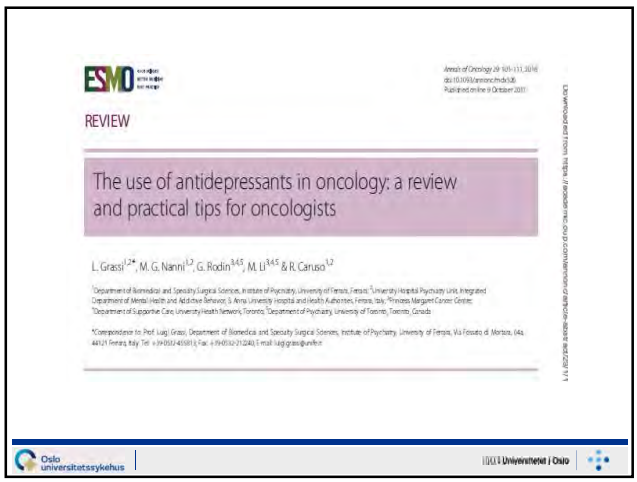

The Management of Depression in Palliative Care

CLINICAL GUIDELINES

https://www.kcl.ac.uk/cicelysaunders/attachments/depression-guidlines/the-management-of-depression-in-palliative-care.pdf

Conclusions

- Symptom ≠ disorder
- Explore by interview
  - Evt. supported by Questionnaire/ interview guide (MADRS)
  - Open-ended start
- ESAS responses - be aware of depression when:
  - High levels of many symptoms
  - High symptom levels but no anxiety/depression
  - "Refractory symptoms"
- Involve patient in diagnostic evaluation / treatment discussion
- Choose treatment in accordance with patient's wishes & prognosis
- ADs best documented – learn 2-3
  - Monitor effects / side-effects by PROMs

Thank you for your attention

The black dog WHO:
https://www.youtube.com/watch?v=XiCrniLQGYc

Case 1 – question 1 *(Kristina Johansson, Uppsala U. Hospital)*

A 53 years old woman with cervical cancer is accepted as an out-patient at the Palliative care unit. She has liver-, lung- and brain metastases and due to this she can't live alone with her adolescent son, so she lives in a nursing home.

On the first visit from the Palliative care unit, she is very quiet and the team has to wait a long time for her answers. She doesn´t make eye contact. She has no pain or any other symptoms except some nausea and insomnia. She has refused the radiation therapy for her brain metastases that was suggested.

How to proceed?

Case 1 – question 2 *(Kristina Johansson, Uppsala U. Hospital)*

The patient had a history of depression and had been admitted once to a psychiatric ward in her early twenties. When she was diagnosed with cervix cancer and received high doses of cortisone three years ago, she had a psychotic episode triggered by depression so severe that she had to be treated with ECT.

Diagnostic reasoning?

Case 1 – question 3 *(Kristina Johansson, Uppsala U. Hospital)*

To ease the symptoms from her brain metastases, she received cortisone prescribed from the Oncology clinic. The symptoms were mostly confusion and changed behaviour.

So, the patient had a history of depression and cortisone triggered psychosis, meanwhile she also had brain metastases who was treated with cortisone due to confusion. She had no medical treatment for depression.

Treatment options?

Case 1 – question 4 *(Kristina Johansson, Uppsala U. Hospital)*

The Palliative care unit decide to treat the patient with Mirtazapine for depression management and improved sleep, as well as with Olanzapine due to nausea, and for the antipsychotic effect.

After ten days, the patient had no longer delayed answers and could participate in a conversation. Her sleep had improved and she had no nausea. She wanted to try and live with her son again and plans for this was on there way when she suddenly developed high fever and died at the nursing home. The fever was thought to be secondary to known abscesses and fistulation between liver metastases and colon.

Reflections?

Case 2 – question 1 *(Ogmundur Bjarnason, Reykjavik, Iceland)*

70 year old male diagnosed with fibrotic lung disease (idiopathic pulmonary fibrosis) in 2014. End-stage respiratory failure from early 2017. History of osteoarthritis and overweight but no psychiatric history. Considerable impairment at start-up in palliative home-service in mai 2017. Expresses wish to die. Mild overdose (4 times daily dosage of Contalgin) in september 2017.

How to address an explicit death wish?

Diagnostic reflections?

Case 2 – question 2 *(Ogmundur Bjarnason, Reykjavik, Iceland)*

Admitted to scheduled 10-day respite care at palliative unit (PU) because of this and obvious strain on spouse. Restates death-wish but appears not overtly depressed. Reluctant to recieve care and leaves the unit after 3 days. Admitted to PU again in december 2017, then barely able to speak from dyspnea and pracitally bed-ridden. Asks for help to end his life, appears irritable and dissatisfied. Reluctant to eat. Expresses long standing grief over his declining health and thoughts of beeing a burden on his wife and family.

Further examinations?

Diagnosis?

Case 2 – question 3 *(Ogmundur Bjarnason, Reykjavik, Iceland)*

Antidepressiv medication already initiated. Recieves proper care, urin catheterization, increase in morfin-dose and low-dose benzodiazepine, counselling with priest and attending physician. Appears in two weeks time considerably more affective stable, positive and content in expression, in spite of steadily declining physical state. Gains appetite and enjoys his favorite treat – doughnut with a glass of milk – 3 times aday until succumbing to pneumonia.

Reflections?