EDITORIAL

Collaborative care effective in cancer patients with depression

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INTEGRATED COLLABORATIVE CARE SUBSTANTIALLY IMPROVES OUTCOMES FOR CANCER PATIENTS WITH major depression, a UK study has found.[1]

Patients being treated at three cancer centres in Scotland were screened for depression using the HADS questionnaire, followed by a structured clinical interview using DSM IV criteria. Patients with major depression of at least four weeks' duration and a predicted survival of at least 12 months were eligible. A total of 253 patients were randomly allocated to collaborative care and 247 to usual care. The intervention was provided by trained cancer nurses under the supervision of a psychiatrist and in collaboration with the oncology team and the patient's GP.

Collaborative care consisted of: up to ten sessions over a four-month period; education about depression; brief interventions (problem solving, behavioural activation); monitoring of progress using the PHQ-9; and initiation and adjustment of antidepressant treatment as advised by the psychiatrist.[2]

'We should bear in mind the high prevalence of depression when carrying out QOF cancer reviews'

The primary outcome measure was response to treatment at four months' follow-up, defined as a 50% reduction in the SCL-20 score. This tool comprises 20 items which provide a measure of depression severity with a range of 0 to 4. Patients had to have a baseline score of at least 1.75 indicative of major depression of at least moderate severity.

Nearly two-thirds, 62% (143/231), of those receiving collaborative care but only 17% (40/231) of those receiving usual care responded to treatment; adjusted odds ratio 8.5 (95% CI:5.5-13.4, $P < 0.0001$). Moreover, at all time points, the collaborative care patients had significantly less anxiety, pain and fatigue; and significantly better functioning, health and quality of life. They also had a higher perceived quality of depression care.

These results are impressive. The effect size was large (1.13) and much bigger than the mean reported effect size for collaborative care (0.25).[3] The intervention improved on conventional collaborative care by integrating depression management with cancer care.

However, there are a couple of caveats. Patients identified by screening are often reluctant to accept treatment and we already know that screening only improves outcomes when it is linked to collaborative care.[4] The primary outcome measure was a self-completed questionnaire, not assessment by a blinded assessor and this may have biased the results.

More than half the participants in both groups were treated with antidepressants whereas very few received formal psychotherapy. This is in accordance with the British Association for Psychopharmacology guideline which recommends antidepressants as first-line treatment for cancer patients with depression of moderate severity,[4] rather than the NICE guideline which recommends a high-intensity psychological intervention, preferably group CBT.[6] Both guidelines recommend antidepressants plus CBT for those with severe depression. The findings of this study suggest that NICE should review its recommendation that collaborative care should only be considered for moderate to severely depressed cancer patients when they have not responded to first-line treatment.[5]

A linked study has found that approximately 10% of those attending cancer clinics have major depression but only a quarter of them are receiving potentially effective treatment.[7]

I think GPs have an important role in recognising depression in cancer patients and suggest that we should bear in mind the high prevalence of depression when carrying out QOF cancer reviews.[8] This study suggests that treatment is unlikely to be effective unless it incorporates some form of enhanced care. GPs may not have access to collaborative care but we can provide case management and liaise with our local oncology teams.

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