Screening for and Treating Depression

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Assessment and Treatment of Depression in Patients Undergoing Maintenance Dialysis

By Rajnish Mehrotra, MD

Patients who need dialysis for the treatment of ESRD have a high burden of disease because they have numerous coexisting illnesses (such as diabetes and congestive heart failure), high health care utilization with frequent hospitalizations and high rates of readmission, and a very high daily pill burden. The dialysis regimen adds further to this burden, because patients have to make significant changes in their day-to-day lives, including in their diets, to accommodate the treatment schedules and minimize risks to their health. Patients have further challenges in coping with the numerous demands imposed by a diagnosis of ESRD if they also suffer from depression. The ability to cope may be even more decreased with the added stress of a transition in care.

Unfortunately, comorbid depression is very common: a large number of studies from around the world using a variety of assessments seem to suggest that anywhere from one-quarter to one-third of all patients needing dialysis support have significant depressive symptoms (1). A greater severity of depressive symptoms is associated with higher risks for hospitalization and death (2). There is a significant body of evidence that a large part of the health risk associated with depression in dialysis patients arises from their inability to adhere to the prescribed dialysis regimen, diet, and/or medications (3). This observation raises hope that, if patients with depression can be identified early and offered adequate treatment, their depressive symptoms will improve and they will better adhere with their treatment, resulting in better health outcomes.

Unfortunately, few studies have examined whether treatment methods recommended for patients without kidney disease are effective for patients with kidney failure who need dialysis, and none have tested whether such treatment reduces the need for hospitalization or risk for death. Despite this lack of evidence, the Centers for Medicare & Medicaid Services has instituted financial incentives to dialysis facilities linked to screening all Medicare beneficiaries undergoing dialysis for the presence of depression and instituting a plan of care. So what do we know about this issue to allow us to implement this policy imperative in a manner that is safe and effective?

There are many ways to screen for the presence of depression, but it is important to keep some caveats in mind. First, survey instruments like Patient Health Questionnaire (PHQ)-2, PHQ-9, or others, are only meant for screening and identifying patients who need further evaluation and should not be used to make a diagnosis of depression (4). Although a formal diagnosis of depression should only be made using a structured clinical interview, treatment decisions in some patients may be appropriate even without such additional assessment. Second, we must also recognize that many of the symptoms experienced by patients with depression are the same symptoms caused by kidney failure (e.g., fatigue, loss of appetite, and difficulty sleeping). At least 20% of patients who screen positive for depression on survey instruments do not have the disease, and treatment, particularly with antidepressant medications, would be inappropriate (4). For many of the survey instruments, the cutoff score for the diagnosis of depression in patients treated with dialysis is higher than that for patients without kidney disease. Even when the patient's score is above this higher cutoff score, some patients' symptoms result from their kidney failure and other coexisting illnesses, not from depression.

Even though there is limited evidence to date for health benefits from treatment of depression, lack of evidence is not the same as lack of benefit, and treatment should be offered to selected patients. Even today, a diagnosis of depression has stigma attached with it, and many patients are unwilling to accept the label and/or treatment even when offered. Hence, tremendous clinical skill is needed to communicate the results of diagnosis and options for treatment.

Treating depression

There are two major ways to treat depression in patients without kidney disease—cognitive behavioral therapy (a special form of psychotherapy) or antidepressant medications. Two clinical trials have shown that cognitive behavioral therapy is effective for improving depressive symptoms in patients who need dialysis, regardless of whether delivered one on one or in a group setting (5,6). There is virtually no high-quality data to determine if antidepressant drugs are effective in improving depressive symptoms in dialysis patients. However, there is one small study that has compared cognitive behavioral therapy with antidepressant drug therapy for patients with ESRD and found them to be equally effective (7).

To better inform clinical practice, the ASCEND Study is a multicenter, randomized, controlled clinical trial supported by the Patient Centered Outcomes Research Institute that is presently underway in three cities in the country (Albuquerque, NM; Dallas, TX; and Seattle, WA) (8). Patients are screened for the presence of depressive symptoms using the Beck Depression Inventory II. If the diagnosis is formally confirmed, the patients are offered to be randomized to cognitive behavioral therapy while undergoing dialysis or antidepressant drug therapy each for a period of 12 weeks (8). The results of the study are likely to be available in early 2018 and, it is hoped, will provide better guidance to clinicians.

In summary, even though depression is common among patients undergoing dialysis, little is known regarding how to best treat such patients. The public policy is premature for the level of guidance that we have from research studies. Treatment decisions must be made using our best clinical judgment until better evidence becomes available.

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