

Treatment-Resistant Major Depression and the Capacity to Terminate Care

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ABSTRACT

Of patients suffering from major depression, only around 70-80% experience remission, with the rest having only a partial response or no response at all to treatment, resulting in severe emotional distress and hopelessness. For the older patient who becomes malnourished as a result, depression may become life threatening, even if the patient is not overtly suicidal. We present the case of such a patient, who after many courses of antidepressant trials and electroconvulsive therapy, requested that treatment be terminated, along with the nasogastric feeding that had been keeping him alive. The patient knew that this course would result in his death. We propose that in this case, major depression was similar to other end stage medical disorders for which there are no curative treatments, and that the patient had capacity to terminate his care. We propose that he suffered from "terminal depression", and we review the literature on this subject.

Key Words: depression; treatment-resistant; end-of-life; elderly; ethics.

Introduction:

As patients direct the amount and invasiveness of care at the end of life, the decisions made are accepted without question only if competence is assured. When a patient suffers from depression, these end-of-life issues generally are delayed until the depression has lifted, with the implicit assumption that passive suicidal feelings and hopelessness will abate or disappear. Moreover, patients are most often considered

temporarily incapable of making such important decisions when depressed, with studies showing that in general they have more optimism after antidepressant treatment, and that this optimism also may apply to decisions about advanced directives^(i,ii).

However, the literature on the longitudinal course of depression suggests that there are a significant number of patients that either only partially respond, or do not respond at all to antidepressant therapy, despite good adherence to adequate trials. While some studies estimate the incidence to be up to 30%⁽ⁱⁱⁱ⁾, the exact figures are difficult to estimate, with most studies evaluating patients after only one trial^(iv,v). Unremitting, severe depression may lead to a dramatic reduction in quality of life, often with inability to fully return to work^(vi). Older patients may experience a decline in physical health as they decrease their food consumption and ambulation. Frail older patients may be at risk for falls, and after staying in bed for protracted periods, also may run the risk of deep vein thrombosis. Complicating this picture is the risk posed when older patients are given multiple medications, increasing the risk for delirium^(vii).

While treating such patients with all available regimens is the standard of care, there are instances when patients do not improve, and remission becomes a frank impossibility. Research suggests that some late-onset depressions, associated with abnormalities in the limbic areas of the brain^(viii), diminish the possibility of a full response to medications or electroconvulsive therapy (ECT), which require such pathways. Furthermore, it has been found that patients not responding to antidepressant therapy may be at increased risk of cognitive decline, and this deleterious effect of antidepressants should make the clinician consider discontinuing medications in older patients that have not had a treatment response^(ix).

After a patient has undergone several courses of oral medications and ECT, without therapeutic effect, we propose that the

malnourished, frail, older, depressed individual may be seen as suffering from the psychiatric equivalent of a terminal medical illness. The question then arises as to whether such a severely depressed patient has the capacity to terminate care, knowing that the outcome will hasten death. While there is literature on the termination of care in the case of a patient with a medical illness and concomitant depression, there is little that discusses this question as it pertains to depression as the primary illness.

We discuss the case of a man who had had a robust pre-morbid baseline, but after the initial onset of depression in later life, experienced a several-year period of protracted, recurrent depressive symptoms. After many different medication trials and ECT, he asked that his treatment be discontinued, knowing that because of the severely malnourished state emanating from his primary depression, death would ensue. We postulate that this case may be considered “terminal depression.” The patient’s wife consented that his case be described.

CASE PRESENTATION

Without a past psychiatric history, Mr. A first experienced a profound depression at age 59. There were no confounding medical illnesses, medications, or family stresses, and he did not present with concurrent psychosis or dementia. His prominent difficulties with poor sleep and appetite, and lack of energy, treated with citalopram and psychotherapy, led to a remission for five years after a psychiatric hospitalization, and Mr. A was able to resume his job.

Five years after this initial depression, Mr. A’s wife found that he was becoming irritable and isolative, and then he asked that she arrange funeral preparations. He no longer was able to function as the professor he had been but when his outpatient psychiatrist prescribed an increase in citalopram, he did not agree with the plan, having lost confidence in the medication on which he again became symptomatic. He then began to ask his wife whether they could afford a funeral, feeling that his mental illness was a sign that he was to die at an early age. With this depression, he became severely slowed in his motor function, (anergy) and having become paranoid that others were poisoning his food, he stopped eating. He had intrusive thoughts and during this hospitalization, the staff felt he was experiencing auditory hallucinations. A CT scan of his brain was normal. Mr. A remained alert, oriented, and fluent in his speech. Neurological examinations were unrevealing.

Within three months, Mr. A stopped eating all together, and by this time had lost 45 pounds. With extreme poverty of thought and slowness of speech, delayed after a question was asked, he was voluntarily admitted for his third hospitalization, this time to a medical/psychiatric unit. At times he refused to get out of bed to perform activities of daily living, and despite his lack of the classic waxy flexibility on physical examination diagnostic of catatonia, the magnitude of his anergy made the staff nonetheless consider the diagnosis. He described a somatic delusion about esophageal and intestinal blockage, causing him to refuse to eat or drink. An MRI of the brain was consistent only with nonspecific chronic small vessel ischemic disease. Also noted was mild global prominence of the ventricles and sulci consistent with mild cerebral tissue loss, specifying that the loss was slightly greater than expected for an

individual his age. A Mini Mental State Exam (MMSE) at time of this third admission was 29/30, missing one point for “serial 7’s”. A diagnosis of dementia was ruled out.

Mr A received a course of 16 bilateral ECT treatments during this hospitalization, with scores on the Montgomery-Åsberg Depression Rating Scale (MADRS) decreasing only from 53 to 34, reflective of continuing very severe depression. Of some benefit, he became less paranoid and began oral intake again and gained 20 pounds. The ECT did not result in demonstrable cognitive impairment.

Five months after discharge, the patient relapsed, requiring another psychiatric hospitalization.

Another medication regimen was prescribed, and while the neurovegetative symptoms improved, he continued to complain of depressed mood at the time of discharge. Given the magnitude of his functional decline from his baseline, a course of 16 ECTs was again administered. Unfortunately, his MADRS score only decreased from 45 to 33. At the time of final discharge, he was able to participate in some ward groups and activities, and he was able to leave his room for short escorted walks with his wife or with staff. He continued to exhibit constricted affect, to appear dysphoric, and he stated he felt “frustrated” for lack of overall improvement in his mood. He did not appear psychotic.

Mr. A’s wife stated that about six months later, he became “tired of seeing the psychologist and taking medications”, telling her “Enough is enough.” His refusal to take medications was again followed by refusal to eat, and another psychiatric hospitalization. His primary care provider felt that Mr. A had capacity to make his own decisions and after consulting with an ethicist, informed Mr. A’s wife that it was “ok to let him go.” Medication adherence was an issue, as Mr. A was at this point refusing to abide by a daily regimen.

He was hospitalized a fifth time, after a total weight loss of 50 lbs over the previous six months. His mental status exam was significant at this time for severe psychomotor slowing, severely constricted emotional tone, and irritability. He showed no motivation, lying in bed throughout the day. He stated he was anxious, and had no interest in watching or reading about baseball, his previous avocation.

Mr. A’s MMSE was 19/28 at the beginning of this fifth admission with trouble with concentration, recall, remembering a 3-step command, and reading and obeying commands. He was unable to draw a pentagon or to write a sentence, stating he was too weak. He did complain of autobiographical memory loss from his previous ECT treatments. His ability to perform tasks with dexterity was intact but he was unable to interpret abstractions and was concrete in thinking. However, his ability to assess the advantages and disadvantages of ECT were intact. He remembered these risks and benefits based on recall from his prior ECT experience. An MRI of the brain revealed moderate prominence of ventricles and sulci suggesting global volume loss. Again, chronic small vessel ischemic changes in the frontal lobes were noted, without change from the previous study. Also noted were more severe changes in the basal ganglia (motor area) bilaterally. Given the presence of cortical and subcortical white matter lesions, cognitive deficits, gait disturbances, and history of tremor that accompanied his late

life depression and anxiety, diagnoses of vascular dementia and vascular depression were made. While neuropsychological testing was attempted, Mr. A could not tolerate it.

With the anxiety pharmacologically treated and now in good control, he was able to get out of bed, with aid from physical therapy once or twice a day.

It was at this point that that the patient finally decided that he was no longer interested in any treatment for depression. He was able to recall that he had had several psychiatric hospitalizations, ECT with little effect, and now, feeling a burden to his wife, he felt that there was nothing left to ameliorate his low level of functioning. He no longer wanted his wife to visit. At the same time, when she did see him, she often cried at his deterioration, and now was in counseling herself. He acknowledged to one of the authors that he felt he had lost his dignity. A palliative care consultation was called, but he refused to see the team.

While he appeared to have capacity to refuse treatment, given his concomitant severe depression with somatic delusions, an ethics consultation was sought to determine if the team could abide by his wish. It was determined that the patient did indeed have capacity, and he was transferred to a skilled nursing facility, nasogastric tube (NGT) in place. He continued to demonstrate paucity of speech, with long latency of response. After three weeks at the skilled nursing facility, the patient pulled the NGT, and said “Good-bye” to his wife. He died several days later.

A complete list of his medication regimens is listed in Figure 1.

Discussion

We propose that Mr. A may be thought of as having suffered from the psychiatric equivalent of a terminal illness. Like other patients suffering from medical disorders, who do not respond even to the most up to date strategies, and who are considered “non-responders”, his prognosis became increasingly grave. As it became progressively more difficult for him to experience a sustained remission, he began to spend increasing amounts of time in hospitals. His treatments were aggressive, and while one may argue over the details of some combinations of treatments, there is no argument that he received adequate trials of several antidepressants in adequate doses, with evidence-based augmentation strategies. Furthermore, he was administered ECT twice. Nonetheless, no treatment, save citalopram at the onset of his symptoms, was helpful for a sustained period.

Mr. A was competent in his understanding that after having had many available psychiatric treatments, one viable option was to continue with enteral (tube) feeding and even more medications in an assisted living environment. Alternatively, he could have accepted ECT, which had not caused sustained remission in the past and which gave rise to autobiographical memory loss. In addition to his psychiatric diagnosis of major depression with psychosis, he may have also been suffering from the depression and demoralization often superimposed on patients in the terminal phases of medical illnesses, and which may increase the desire to die^(x,xi). Mr. A also likely suffered from mild vascular dementia,

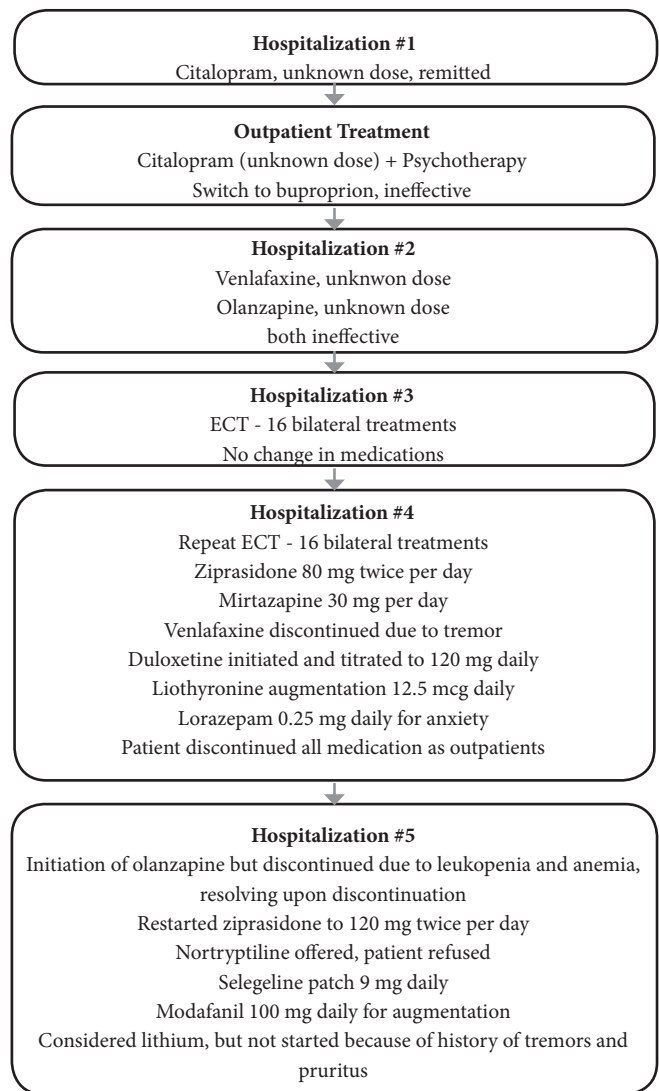


Figure 1: Treatment Course. Note all antidepressant trials lasted a minimum of 10 weeks with assured adherence by patient and his wife unless specified otherwise.

which was not thought to impact on his ability to rationally make decisions about his end-of-life care.

In the psychiatric setting, a patient who refuses treatment, or who expresses a right to die is most often considered *a priori* to suffer from a psychiatric disorder. However, studies have shown that patients with serious medical illnesses often exhibit depressed symptoms in the last month of life. It has been suggested that while such patients should be given rights to determine their care, they often are not^(xii). In the Netherlands, where physician assisted suicide has been practiced and studied for over a decade, it also has been found that patients with depression are not necessarily incompetent to make end of life decisions^(xiii). Psychiatrists have been found able to make such adjudications about competence in such circumstances on a first interview only 6% of the time^(xi).

Mr. A was a voluntarily admitted patient who, while depressed, was never suicidal during any of his admissions, and who clearly understood the ramifications of the different courses that could be taken on his behalf. He was seen as capable of making decisions

on his own behalf, despite his depression. This capability was in line with most research findings that even patients with very severe depression maintain their competence to make health care decisions ^(xiv).

This case is important because older individuals with white matter abnormalities on MRI, reflective of abnormalities in cortico-striato-limbic networks may be predisposed to chronic, refractory depression ^(viii). These networks may be seen as the “cables” required for antidepressant therapy action. Such patients are analogous to other medical patients with end-stage organ disease, refractory to known medical treatments, who wish to terminate their care. With a minority of psychiatric patients for whom there are no viable treatments left, whose oral intake, by virtue of depression, is not life sustaining, there may exist the ethical decision that no treatment is a humane option. In this case, the patient, with no history of suicidal feelings, was felt to be capable of making such an important end of life choice.

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