

Depression and Anxiety in Oncology: The Oncologist's Perspective

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Depression and anxiety frequently occur in oncology patients and have a significant impact on patient quality of life, health care utilization, and even disease outcome. Depression and anxiety are eminently treatable, and therefore psychiatric assessment and appropriate intervention should form an integral component of management strategy in patients with cancer. It is essential that patients are recognized at an early stage, so that resources can be targeted effectively at those most at risk of developing psychiatric morbidity. Evaluation techniques that can identify signs or symptoms of depression and anxiety and can be incorporated into the program of a busy oncology clinic or in the primary care setting are therefore needed. Diagnosis of depression and anxiety may be facilitated by using primary screening tools, such as the Hospital Anxiety and Depression Scale questionnaire, and by considering factors such as family psychiatric history, levels of family support, and degrees of pain suffered by the patient. In this article, the issues surrounding diagnosis of depression and anxiety in cancer patients and the benefits of early intervention are considered from the point of view of the oncologist.

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The overwhelming majority of patients with cancer will understandably undergo some degree of emotional distress, particularly on initial diagnosis. Fear, worry, and sadness are therefore recognized by health care professionals as normal reactions. According to current estimates, however, approximately 25% of cancer patients meet diagnostic criteria for major depression or anxiety disorders.^{1,2} These disorders cannot be considered a "normal" reaction and have a severely detrimental effect on the quality of life of the patient. They can also lead to patients' failing to comply with treatment for their disease and are associated with prolonged hospital stays in cancer patients.^{3,4} Furthermore, some studies have suggested that depression and anxiety can have a direct bearing on prognosis and mortality among cancer patients.⁵⁻⁷

Most patients diagnosed with clinical depression or anxiety can be effectively treated. It might therefore be expected, with 1 in 4 cancer patients suffering from clinically

significant anxiety or depression, that psychiatric therapy would feature prominently in the management of these patients. However, clinical depression and anxiety in cancer patients are frequently not recognized by health care givers, and many patients remain untreated. Moreover, even when a problem is recognized, physicians may be unsure how to treat it or may believe that treatment will have little effect. This article reviews current understanding of depression and anxiety in cancer, considers how these disorders may be diagnosed, and highlights the benefits of treatment, from the perspective of the oncologist.

ANXIETY AND DEPRESSION IN PATIENTS WITH CANCER

Cancer patients as a group are particularly vulnerable to depression and anxiety. The diagnosis of a life-threatening condition such as cancer will inevitably cause fear and uncertainty, even when the prognosis is relatively optimistic. The symptoms, particularly the pain, associated with cancer can contribute to depression, as can the side effects of treatments, particularly radiotherapy and chemotherapy. Specific cancers may also be associated with altered body image or function, such as mastectomy in breast cancer or loss of voice in laryngeal carcinoma, and these carry with them particular implications for psychiatric morbidity. Screening and diagnosis of psychiatric morbidity, with appropriate intervention, are likely to be most effective early in the disease process. However, psychiatric disorders may also be apparent long after initial diagnosis of cancer, with up to 30% of long-term survivors of cancer reported to suffer chronic, clinical anxiety.⁸

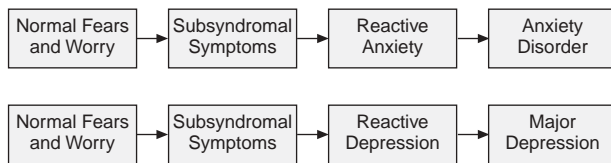
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Figure 1. Primary Types of Distress: Progression From Normal Fears and Worry to Anxiety and Depression



Patients with cancer will suffer a spectrum of psychiatric symptoms ranging from normal fear and sadness to major depression and anxiety disorders (Figure 1). Frequently, major depression and anxiety coexist. Ideally, clinicians should aim to prevent, or at least minimize, progression from the first, "normal" phase to pathologic disorder.

An important factor in helping to reduce anxiety and depression in cancer patients is the level and quality of information supplied to the patient by clinicians and other health care professionals. Communication between patient and doctor and the encouragement of patients to express their feelings about the disease have been shown to significantly reduce psychiatric morbidity.^{9,10} The level of support that the patient has from family and friends is also important. Those patients who are well supported are at significantly lower risk of developing clinical depression and anxiety.^{11,12}

PAIN AND DEPRESSION

Not surprisingly, cancer patients who suffer pain are more likely to develop psychiatric disorders. Investigators have consistently found an association between pain levels and mood disorders in cancer patients¹³⁻¹⁵ as well as in other patients.¹⁶⁻¹⁹ The evidence indicates that, as might be expected, depression arises as a consequence of pain rather than the other way around,²⁰ although it is less clear whether relief of pain, where it can be achieved, may be sufficient to lift the associated depression. Early in the course of the disease, many patients may suffer pain, and intervention at this stage may help prevent the emergence of psychiatric morbidity. Those cancer patients who continue to report chronic pain, however, can be considered good candidates for investigation of symptoms of depression and anxiety and appropriate treatment.

Notwithstanding the above considerations, a significant proportion of cancer patients will develop clinically important depression and anxiety. It is vital that effective strategies for screening and diagnosis are in place so that these patients can benefit from appropriate intervention.

IDENTIFYING DEPRESSION AND ANXIETY IN PATIENTS WITH CANCER

Diagnosis of depression and anxiety in cancer patients is by no means straightforward, and there are a number of

Table 1. Reasons for Underdiagnosis of Depression and Anxiety in Cancer

Lack of time during office visit
Misinterpretation of depression and anxiety as expected "normal" reaction
Symptoms of depression and anxiety attributed to cancer
Focus on medical problems
Therapeutic nihilism

Table 2. Risk Factors for Anxiety and Depression

Organic mental disorders
Poorly controlled physical symptoms
Poor communication between staff and patient
Past history of mood disorder
Lack of support from family and friends

barriers to recognition (Table 1). Cancer patients are seen by general practitioners, surgeons, and oncologists, rather than psychiatrists, and there will be a natural focus on medical problems. Some feelings of sadness and anxiety will be expected on diagnosis of cancer, and so symptoms of psychiatric illness may be missed, being considered by both physicians and patients as a normal reaction. Many of the symptoms and signs of depression, including fatigue, reduced concentration, sleeplessness, and loss of appetite, can also be caused by cancer or its treatment, particularly chemotherapy or radiotherapy. Even when the symptoms are recognized, an impression may still persist that psychiatric intervention will not work and that addressing the cancer itself will solve the psychiatric problems.

The greatest barrier to diagnosis is probably lack of time. Average oncology clinics in the United Kingdom may allow only 10 to 15 minutes per patient, a period in which all of the physical problems need to be addressed. It is not realistic to expect oncologists, at such an interview, to screen all patients for symptoms of clinical anxiety and depression and to be able to distinguish those symptoms from direct effects of the cancer or treatment. A robust diagnosis of clinical depression or anxiety, a detailed and structured interview, or even more than 1 interview is usually required. It is vital, however, that some form of screening is implemented, so that patients with depression and anxiety can be diagnosed at an early stage, when depression and anxiety are seen most frequently and when treatment will be most effective.

Given the logistical constraints, it is essential that resources are targeted to those patients most at risk of developing clinical depression or anxiety and that effective screening strategies are in place. A number of specific risk factors for anxiety and depression have been identified in cancer patients (Table 2). Patients with a past history of mood disorder and patients known to lack support of friends and family^{11,12} are particularly vulnerable and can be considered good candidates for diagnostic testing and intervention. Initial diagnosis can be best achieved by a

simple, patient-administered questionnaire, such as the Hospital Anxiety and Depression Scale (HADS).²¹ The HADS has proved an invaluable tool in identifying psychiatric morbidity and is particularly suited to the oncology setting, as it has been specifically designed to exclude physical symptoms. The HADS has also had reported patient uptake rates of up to 90%.²²

BENEFITS OF INTERVENTION

Treatment for anxiety and depression in cancer patients will undoubtedly improve quality of life and is likely to lead to improved general health and compliance with treatment.^{3,4} Furthermore, there is a recognized "medical-offset" effect of antidepressant therapy, in which patients receiving therapy show markedly reduced utilization of other medical services, frequently sufficient to outweigh any economic cost of the antidepressant treatment.²³ In a study of medical-offset effects in a range of medical conditions, Thompson et al.²⁴ demonstrated significant reductions in health care utilization, specifically in cancer patients receiving antidepressant therapy.

A number of studies demonstrate a significant effect of depression on the outcome of cancer. Herrmann et al.⁷ showed a significant association of mean HADS scores with mortality in a population of 445 medical inpatients. Although the group consisted of patients with a range of medical conditions, the subgroup of patients with cancer suffered the highest mortality, and this mortality was also significantly associated with depression. Similarly, depression has been linked to higher mortality in other tumors including cancer of the breast²⁵ and lung.^{6,26} Fawzy and Fawzy²⁷ have also demonstrated a significant beneficial effect of early psychotherapeutic intervention on tumor recurrence and patient survival in melanoma patients.

The benefits of early psychiatric intervention on prognosis of cancer may occur primarily through improved general health and diet and better treatment compliance, but there is evidence to suggest that the physiologic processes influencing cancer cell growth may also be affected. Research reviewed by Musselman and Nemeroff²⁸ convincingly demonstrated that depression is associated with changes to the immune²⁹⁻³¹ and endocrine systems; psychotherapeutic intervention in melanoma patients can also promote enhanced activity of cytotoxic lymphocytes and natural killer cells.⁵

The evidence therefore indicates that treatment of depression and anxiety in cancer patients is likely to have beneficial effects, not just in terms of patient quality of life or palliative care, but also in the fight against the disease.

MANAGING DEPRESSION AND ANXIETY IN PATIENTS WITH CANCER

The choice of therapy for depression or anxiety is largely the province of the psychiatrist and is considered,

for cancer patients, in a complementary article elsewhere in this supplement.³² From the point of view of the oncologist, the need is to establish the importance of these disorders and their treatment within strategies for cancer care and management. It is essential that physicians understand how early intervention can result in considerable benefits in terms of patient quality of life, disease prognosis, and even health care costs.

Modern cancer care involves a multidisciplinary team, including general practitioners, surgeons, oncologists, psychiatrists, hospital and community nursing staff, and support staff. General practitioners and specialist oncology nurses are likely to have the most contact with the patient and so are best positioned to identify patients at risk of, or suffering from, clinical psychiatric problems. The entire health care team, however, can play a role in ensuring that depression and anxiety are recognized and treated in cancer patients, and there is currently a substantial need for increased awareness in this area through education of health care professionals. Furthermore, it is essential that patients are aware that depression and anxiety are genuine illnesses that can be treated. In many cases, a stigma remains attached to psychiatric disorder, and some patients may feel that undergoing treatment for anxiety and depression somehow suggests that the symptoms of cancer, including pain and disability, are not genuine.

CONCLUSIONS

Depression and anxiety are seriously disabling conditions that affect up to 25% of cancer patients. These disorders are eminently treatable, but failure to recognize depression or anxiety, or underestimation of their importance, means that many patients do not receive treatment that could have a significant beneficial impact on their quality of life or even on their disease outcome. In the primary care facility or the oncology clinic, straightforward procedures such as the HADS questionnaire are available; these procedures can help identify clinical psychiatric symptoms and distinguish them from overlapping symptoms arising from patients' tumor or treatment. Early diagnosis and intervention can result in significant improvement in patient well-being and disease outcome and may also reduce long-term health care costs. Improving diagnosis of depression and anxiety in these settings through education and screening programs is thus an important, achievable goal for professionals caring for patients with cancer.

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