Identify, Treat Depression in Cancer Patients

BY JANE SALODOF MACNEIL
Southwest Bureau

SANTA FE, N.M.—Clinical depression is common in cancer patients and can affect outcomes of cancer therapy if not treated.

About 13% of cancer patients develop a major depressive disorder within 2 years of diagnosis, Karen Weihs, M.D., said at a psychiatric symposium sponsored by the University of Arizona. Some cancers have much higher rates, according to Dr. Weihs, a psychiatrist at the university, in Tucson.

"Depression really is an overrepresented phenomenon, even compared to other kinds of illness," she said, describing the likelihood of depression as more than twice the experience in patients diagnosed with heart disease (Arch. Intern. Med. 2005;165:1260-6).

A recent monograph reported depression to be most prevalent in patients with oropharyngeal (22%-57%), pancreatic (33%-50%), breast (1%-46%), and lung (11%-44%) cancers (J. Natl. Cancer Inst. Monogr. 2004;32:57-71). Depression was also common for patients with colon cancer (13%-25%), gynecological cancer (12%-23%), and lymphoma (9%-19%).

Depressed breast cancer patients have higher mortality than those who are not treated, according to Dr. Weihs. One study put their relative risk at 1.42 (J. Am. Geriatr. Soc. 2004;52:106-11).

Often depression is accompanied by symptoms of post-traumatic stress disorder, though not the full syndrome, she added. About 75% of depressed breast cancer patients will have intrusive memories 19 months after diagnosis.

Along with cancer type, she cited disease severity (threat of early death), pain, declining physical status, and the effects of cancer treatment as general risk factors for depression. Changing from caregiver to care receiver can cause distress, she said, and patients with a history of depression are vulnerable.

Physical and psychological symptoms are more common with chemotherapy, according to Dr. Weihs. One study found clinical depression in 28% of women who underwent chemotherapy and mastectomy but only 17% of women who had mastectomy without chemotherapy (J. Natl. Cancer Inst. 2004;96;376-87).

Cytokines probably play a role in cancer-related depression, she said, noting that pancreatic tumors are characterized by high cytokine release. Depressed cancer patients have elevated cytokines compared with cancer patients who are not depressed, she added.

Some cancer drugs may promote depression. Dr. Weihs noted that procarbazine inhibits dopamine beta-hydroxylase, while vincristine and vinblastine decrease conversion of dopamine to norepinephrine.

In addition, higher depression rates have been reported in women on tamoxifen: 15%, versus 3% in a control group (Breast Cancer Res. Treat. 1993;27:277-81).

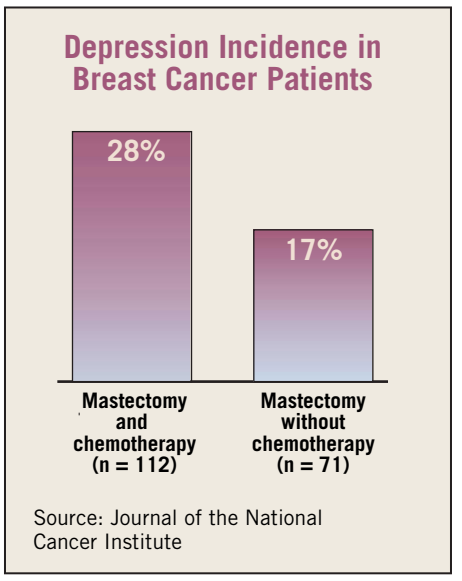
Interferon-α, used to treat malignant melanoma and renal cell cancer, has been linked to major depressive disorder in 21%-58% of patients, she added. Increasing dosage and duration increases risk.

Most of what is known about depression and cancer comes from breast cancer studies, according to Dr. Weihs. While most enrolled well-educated white women, she noted that high point prevalence of depression has also been found in low-income, Hispanic women (J. Clin. Oncol. 2005;23:3052-60).

Distinguishing clinical depression from grief over a cancer diagnosis is challenging, especially in patients with a terminal prognosis. "For people who don't see a lot of cancer patients, it is hard to know what is disproportionate," said Dr. Weihs.

She recommended approaching cancer patients on a mental health continuum. Many will function well at diagnosis, she said, and some who react poorly improve over time. About 12% deteriorate and need intervention. Accordingly, Dr. Weihs suggested staging depression in cancer patients as follows:

- Prior history that recurs with the cancer.
- First episode occurs during acute treatment for cancer.
- Related to medication or a medical complication.
- Starts after acute treatment in survivorship phase.



Few studies have tested antidepressants in cancer patients, but Dr. Weihs said the results were consistent: Treatment reduces depression scores on standard measures. One caveat is that paroxetine (Paxil) should not be given to patients who are taking tamoxifen, as it may inhibit the drug's activity.

She also recommended psychosocial interventions, including education, behavioral therapy, and individual and group psychotherapy for cancer-related distress. Psychostimulants should be reserved for patients with short life expectancy, as tolerance is not a risk and rapid action is needed, Dr. Weihs said. ■

Psychosocial Factors Linked to Carpel Tunnel Syndrome

BY DIANA MAHONEY
New England Bureau

BOSTON — Patients diagnosed with carpel tunnel syndrome are more likely to be anxious and depressed and to have lower levels of mental and physical health functioning and job satisfaction, compared with individuals without the common wrist condition, Jason Goodson said at the annual meeting of the Society of Behavioral Medicine.

Findings in a study suggest that brief assessments of psychosocial functioning when evaluating patients for carpel tunnel syndrome (CTS) might be useful for understanding and treating the condition, as well as for improving the prognosis, Mr. Goodson said at the annual meeting of the Society of Behavioral Medicine.

The case-control study compared the psychosocial functioning of 87 patients diagnosed with CTS (based on clinical symptoms and electrodiagnostic confirmation) with that of 74 gender-matched control patients from the same orthopedic clinic. All of the study participants completed self-report questionnaires that included measures of depression, anxiety, somatization, health locus of control, job satisfaction, and mental and physical functioning.

Univariate analyses showed that the CTS patients had significantly higher levels of anxiety, depression, and other health locus of control beliefs. They had significantly lower levels of job satisfaction and mental and physical health functioning, said Mr. Goodson of Utah State University, Logan.

Measures of job satisfaction and physical health functioning were statistically significant predictors of CTS in a multiple logistic regression analysis, with adjusted odds ratios of 0.92 and 0.70, respectively, noted Mr. Goodson, who conducted the study under the direction of M. Scott DeBerard, Ph.D.

Previous studies have identified biologic and work variables as risk factors for CTS, but potential psychosocial variables have received less attention, Mr. Goodson said. And those studies that do exist "have frequently used nonspecific measures of psychosocial functioning, such as general distress, rather than specific measures, such as anxiety, depression, and somatization, he said, noting that the specific measures have more relevance when it comes to designing interventions.

By assessing patients psychosocial functioning when evaluating CTS, clinicians can refer patients who are struggling emotionally for appropriate mental health care to enhance coping resources and improve their ability to understand and manage the associated pain and disability. Cognitive-behavioral therapy and stress management are among the techniques that have shown promise for mitigating the emotional pain of the condition, Mr. Goodson said. ■

Sense of Dignity Drives Will to Live Among Terminally Ill Patients

BY HEIDI SPLETE
Senior Writer

Existential issues were significantly correlated with the will to live in a study of 189 end-stage cancer patients.

Harvey Max Chochinov, M.D., professor of psychiatry at the University of Manitoba (Canada), and his colleagues examined the simultaneous influences of existential, psychiatric, and physical issues on the will to live in terminally ill patients (Psychosomatics 2005;46:7-10).

In a multiple regression analysis, each of the existential issues assessed—hopelessness, sense of dignity, and being a burden to others—was significantly correlated with the will to live.

In addition, psychiatric issues such as depression, anxiety, and concentration were significantly associated with the will to live. Social variables—including support from family friends and health care providers, and patient satisfaction with this support—also were significantly correlated with the will to live.

Physical issues, particularly dyspnea, appetite, and appearance, were significantly correlated as well, but to a lesser degree than were existential, psychiatric, and social issues.

The patients, who were recruited from two Canadian palliative care facilities, shared information about their end-of-life experiences, which were rated on a symptom distress scale developed for cancer patients and an index of independence in activities of daily living. The mean age of patients was 69 years, and almost half were men. The most common cancers were lung (29%), gastrointestinal tract (26%), genitourinary system (16%), and breast (15%).

In a univariate analysis, hopelessness was highly predictive of suicidal ideation, as was a feeling of being a burden to others and a wish to die with dignity. The inclusion of dignity in the model suggests that patients who lose their sense of self and feel that their lives are no longer valued have less will to live. "It would appear that losing one's sense of meaning and purpose—experiencing life as having become redundant or futile—is an important existential underpinning of the loss of will to live among the dying," Dr. Chochinov and his associates noted.

Although the study was limited by its focus on cancer patients, the results highlight the need to examine the factors driving terminal patients' wills to live in order to provide appropriate palliative care. The study was supported in part by the National Cancer Institute of Canada. ■