



Mini Review for Depression among Cancer Patients



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Abstract

Anxiety and depression, complications of cancer, are prevalent but often overlooked mental illnesses. But about 15 to 25 percent of people with cancer-a rate two to three times that of the general population - develop a clinically significant depression that can affect their ability to function daily, including going through treatment. Much research has also shown that the most common psychological states with cancer patients are anxiety and depression. Psychotherapy, cognitive behavioral therapy and mindfulness-based therapies are effective treatments. Psychopharmacological treatments have been shown to be effective treatments for anxiety and depressive disorders.

Keywords: Cancer; Anxiety; Depression; Psycho-Oncology; Psychopathological conditions

Introduction

Psychological distress is a common problem associated with cancer. Anxiety and depression are common psychological symptoms in cancer patients [1,2]. Depression, anxiety and cancer-related fatigue (CRF) often accompany the diagnosis of cancer and its treatment. CRF is now recognized as one of the most common and distressing adverse effects of cancer and cancer treatment [3-5]. Up to 38% of people diagnosed with cancer also present with clinically significant levels of depressive and anxiety symptoms in the first five years after diagnosis [6,7] and these persist despite recovery from cancer [8-10]. Some research also suggests that depressive and anxiety symptoms are associated with higher cancer mortality [11-13]. Metastases and cancer pain have also been associated with higher levels of depression [14]. The prevalence of depression in patients with high levels of pain compared with low pain levels is significantly higher; one study observed that depression occurred in 33% of those in high amounts of pain, compared with 13% in those with low levels of pain, suggesting that pain may be a causative factor in depression [15]. Considering the possible bidirectional relationship between cancer and depressive and anxiety symptoms, it is important to integrate psychological support to cancer treatment [7,16,17]. Emotional distress in cancer patients is associated with a reduction in overall quality of life among patients, and has a negative impact

on compliance levels with medical treatment, and carries an elevated risk of mortality, so emotional distress is recognized as the sixth vital sign in cancer care Linden et al. 2012 [18] Moreover, patients with cancer and co- morbid depression have worse anxiety, pain, fatigue, and functioning than do other patients with cancer, and are more likely to have suicidal thoughts Walker et al. [19]. Despite the effect distress has on daily functioning, distress in cancer patients is often overlooked and under-treated Ng et al. [20].

Discussion

Anxiety and depression are the most common psychological symptoms in patients with cancer, irrespective of disease stage, primary cancer site and phase of treatment. Symptoms may range from nonpathological states, such as concerns, worry, sense of uncertainty, sadness and increased levels of hopelessness, to specific psychiatric syndromes (i.e., anxiety and depressive disorders). After diagnosis - the first potential trigger - the pain, fatigue and insomnia that can result from the cancer itself or as side effects of treatment can lead to or worsen depression. Several medications that are used to treat cancer can exacerbate depression, including hormonal therapies such as tamoxifen for breast cancer or steroids used in conjunction with chemotherapy.

Interferon, which is used to treat melanoma and some other cancers, is so notorious for inducing depression that anti-depressant medication is often prescribed proactively. Clinical depression is prevalent among cancer patients with rates ranging between 13 and 40% [21]. Several authors have suggested that psychological variables may have a stronger effect on disease progression and mortality in early stages of cancer [22]. Although we observed a somewhat stronger effect in studies on early stages than on mixed and later stages of cancer, these differences did not reach statistical significance, perhaps due to the paucity of samples on early stage (k=6) and late stage (k=14) cancer. At present, the most parsimonious conclusion is that depression's influence on mortality is independent of disease stage. Similarly, comparable associations were found for leukemia/lymphoma, breast cancer, brain cancer and lung cancer. The most parsimonious explanation is that depression's influence on mortality is independent of site.

Spiegel D, Giese-Davis [23], identify three reasons why depression may enhance mortality risk in cancer patients. First, depression may have a pathophysiological effect via neuroendocrine and immunological functions that influence mortality (e.g. dysregulation of the hypothalamic-pituitary-adrenal axis, especially diurnal variation in cortisol and melatonin). Second, depressed patients may be less likely to adhere to preventive screening procedures, cancer treatments or recommendations for maintaining health. This is a significant and challenging problem, underlining the need to improve communication between physicians and patients; the role of oncologists in both screening and motivating patients to be referred and to accept the recommended treatment is extremely important. In a review on this subject, McCarter et al. [24] found a paucity of evidence for strategies to improve rates of referral to psychosocial support and treatment and stressed the need to establish a strong evidence base supporting the implementation of comprehensive distress screening protocols [25]. Screening and early, efficacious treatment for those manifesting significant symptoms of anxiety or depression hold the potential to reduce the human cost of cancer, not only for patients and survivors, but also for those who care for and about them. Strong patient/physician rapport will help to assess the patient's experience of depression and anxiety and determine the most appropriate treatment strategy [26].

Conclusion

Clinicians may not be able to prevent some of the chronic or late medical effects of cancer. But they have a vital role in preventing or reducing emotional fall-out at diagnosis and thereafter. Consider the case of depression. It is important for clinicians to understand the difference between nonpathological fluctuations in anxious or depressive states, which are not intense and are short-lived emotional responses to life challenges, and the more specific and impactful psychopathological conditions, such as anxiety and/or

depressive disorders. More studies are necessary to understand the predictors and barriers to mental health and psycho-oncology service utilization among patients with cancer and a diagnosis of anxiety or depression.

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