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About Depressive Disorders in Cancer Patients

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ABSTRACT

Cancer is a leading cause of death, but it turns from a terminal illness to more of a chronic illness with periods of remission and exacerbation of symptoms. This perspective has broadened the scope of care from treating the disease alone to managing cancer-related symptoms including mental disorders. Among the nosological forms of comorbid mental pathology in cancer patients, affective disorders (depression and anxiety) predominate. This predomination is most distinct in long-term cancer survivors. Receiving a fatal diagnosis, going through treatment protocols, interruption of life plans, learning to live with limitations, changes in lifestyle, social role, body image and self-esteem and financial and legal concerns can cause depression in many patients, as can side effects from the treatment itself. Still, not everyone with cancer becomes depressed. Normally, a patient's initial emotional response to the crises faced during cancer is brief, extending over several days to weeks, and may include feelings of denial, disbelief, despair, sadness and grief. More severe symptoms of depression are of clinical concern because of their association with marked distress, more prolonged hospital stays, physical disorders, poorer treatment compliance and adherence to therapy, disability, lower quality of life, increased desire for hastened death and completed suicide. If untreated, depression has been shown to negatively influence the underlying cellular and molecular processes that facilitate the progression of cancer. Higher rates of depressive symptoms in cancer have been found toward the end of life and in specific cancers, such as lung, pancreatic, gastric and oropharyngeal ones. Depressive symptoms occur on a continuum, with non-pathologic sadness at the milder end, minor or sub threshold depression in the middle and major depression at the more severe end of the spectrum. The most common form of depressive symptomatology in people with cancer is an adjustment disorder with depressed mood, sometimes referred to as reactive depression which may be under-recognized and undertreated. Cancer-related depression can exist before the diagnosis of cancer or may develop after the cancer is identified. While there is no evidence to support a causal role for depression in cancer, it may impact the course of the disease and a person's ability to participate in treatment. Emergence of depression in cancer patients may be understood as a final common pathway resulting from the interaction of multiple disease-related, individual and psychosocial factors. There is mounting evidence that tumor cell burden and treatment-induced tissue destruction, which release pro-inflammatory cytokines that alter neurotransmitter and neuroendocrine function, may contribute to depressive symptoms in cancer patients with, captured under the rubric of cytokine-induced depression. The diagnosis of depression is difficult due to the problems inherent in distinguishing biological or physical symptoms from symptoms of illness or toxic side effects of treatment. Suicidal statements may range from an off-hand comment resulting from frustration or disgust with a treatment course to a reflection of significant despair and an emergent situation. If the suicidal thoughts are believed to be serious, a referral to a psychiatrist or psychologist should be made immediately and attention should be given to the patient's safety. A critical part of cancer care is the recognition of the levels of depression present and determination of the appropriate level of intervention, ranging from brief counseling or support groups to medication and/or psychotherapy. At least one half of all people diagnosed with cancer will successfully adapt. Pharmacotherapy for depression in patients with advanced cancer should be guided by a focus on symptom reduction, irrespective of whether the patient meets the diagnostic criteria for major depression. The optimal antidepressant for specific patients can be determined by each patient’s depressive symptom profile and potential dual benefit for depression and cancer-related symptoms such as anorexia, insomnia, fatigue, neuropathic pain and hot flashes. Because of both their adverse effect profiles and risk for lethality in overdose, tricyclic/heterocyclic antidepressants, monoamine oxidase inhibitors and reversible inhibitors of monoamine oxidase A are rarely used in patients with cancer. Timely and precise diagnosis and appropriate treatment of depression is required in an effort not only to increase quality of life but also to reduce adverse effects on cancer course, length of hospital stay, treatment adherence and efficacy and possibly prognosis and survival.

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