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Depression in Cancer Patients: Diagnostics, Screening and Treatment

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Abstract

Depression affects more than a third of cancer patients. It occurs at different critical moments : diagnosis, relapse, treatment failure. It is caused by biological factors related to the disease as well as therapeutic and psychological factors, leading to difficulties in adaptation. The diagnosis is not easy and the phenomenology is specific. On the other hand, discussions of mental health seem redundant or nuanced to doctors and patients. Treatment of this disorder can improve the quality of life of patients and the quality of care provided, in particular by promoting compliance with treatment. Depression is treated with antidepressants or psychotherapy. A combination of these two treatments is indicated for the most severe cases. Also, the specific symptoms of depression in oncology make detection more uncertain and require rigorous evaluation. The aim of this article is to better understand the specific semiology of depression in the field of oncology.

INTRODUCTION

Depression is common in cancer patients, but it is underrecognized and undertreated. Depression is more common in these patients than in the general population. However, we were surprised by the large differences in the incidence of depression reported in the literature. This variability depends on criteria such as the type or stage of the cancer, but also involves methodological differences in establishing a diagnosis. It is reasonable to assume that 5 to 15% of our patients suffer from major depressive disorder. In addition, 10 to 15% of them have an attenuated form of the syndrome (Stagno et al, 2005, pp.350-53). However, depression can lead to decreased quality of life, poor adherence to medications, longer hospital stays, and decreased overall functioning. Depression can also affect survival (Berney,et al.

Depression, «it's a cancer of the soul» reports a patient with CANCER (Stagno et al, 2005, pp.350-53). This reflection shows to what extent depression and its stigmatization can produce untold suffering to the point of being likened to cancer, a disease that is still very stigmatized in terms of physical and psychological suffering. However, in common clinical practice, there are some paradoxes:

• On the one hand, cancer patients suffer physically and spontaneously talk to their caregivers about their physical pain.

• On the other hand, patients suffering from psychological distress do not spontaneously talk to their caregivers about their moral distress. They will tend to deny or minimize their depression (Stagno et al, 2005, pp.350-53).

Many reasons can explain this state of affairs: a lack of awareness and education of both caregivers and patients about the problems of depression, a diagnosis still experienced as a sign of "weakness" and therefore making people feel guilty and stigmatising, an overload of oncology consultations with a lack of time to devote to the emotional difficulties of patients and those around them.

Given the impact that depression has on both quality of life and self-esteem, as well as on basic functions or treatment compliance, it is necessary to try to characterize the clinical specificities of depression in a patient with cancer (Hoffman& Weiner, 2007, p.2853).

Barriers to Diagnosis and Treatment

Various obstacles stand in the way of identifying and treating depression. First, we must mention the restraint of clinicians who consider the patient's mood swings as borderline and ultimately normal manifestations in the context of a serious illness. Perhaps fearing intrusion when it comes to approach a patient's experience.

The patient may also have a form of reluctance to consider considerations that are not directly related to his cancer treatment in the time allotted to him, or that he does not imagine can alleviate his suffering (Guex, 1995).

Another obstacle is the lack of clinical data, forcing clinicians to rely on recommendations designed for physically fit people and not necessarily applicable to people with cancer.

Finally, there is a diagnostic barrier; there is no consensus on the definition of depression in this population.

Risk Factors: Depression and Suicide

Multiple factors increase the risk in these patients of developing a depressive disorder. We have grouped them in box 1 (Stagno et al, 2005, pp.350-53). From these elements, we understand that there is no linear causal link between cancer and depression but that multiple mediation factors are involved, which can themselves be influenced or treated. It is estimated that cancer patients have a risk of suicide twice as high as the general population. Feelings of hopelessness, loss of control and isolation are certainly vulnerability factors for acting out and must be actively sought out during an assessment(Stiefel & Razavi, 1994, p.223).

According of Stiefel and Rasavithis is the main risk factors for depression in cancer patients :

• Family history of depression.

• Personal history of depression.

• Disadvantaged socio-economic situation.

• Stage (advanced cancer).

• Type of cancer (for example: pancreatic cancer,lung).

Psychosocial stressors (mourning, divorce).

• Prolonged or chronic pain.

• Abuse of alcohol and other psychotropic drugs.

PHENOMENOLOGY

Multiple diagnostic questions arise when generally accepted diagnostic criteria for the general population are applied to cancer patients. If we refer to Table 1, we see that many symptoms are somatic in nature, so their effectiveness in patients with physical health problems is questionable. Signs or symptoms, such as weight loss, fatigue, difficulty concentrating, and difficulty sleeping, are from a medical condition and may also be a side effect of treatment. Several attitudes have been proposed for the management of its ambiguous symptoms. The DSM-V recommends ignoring these signs and symptoms if they are directly related to a medical condition. This advice is actually difficult to apply, and the distinction is difficult.

Moreover, by reducing the number of criteria, we run the risk of missing a large number of truly depressed patients, with only the most depressed being recognized as such. Remember that five out of nine criteria must be present. Of these nine, at least four are attributable to cancer. The current tendency is to overfish by retaining these somatic symptoms, risking seeing an artificial increase in the prevalence of depression in this population. Another cardinal symptom must also be discussed in this context: loss of interest and pleasure in activities. Patients give up many activities because of their physical decline. On the other hand, they tend to refocus their field of interest putting an end to activities that suddenly after the announcement of the disease. If, however, the loss of interest leads to a lack of compliance or significantly disrupts social, family and friendly relationships, it can be considered a symptom of the depressive lineage.

Table 1. DSM-V criteria for major depression and substitute signs proposed by Endicott (1984).

Symptoms	Substitutes
• Depressed mood for most of the day	
• Marked decrease in interest and pleasure in all or almost all activities,	
most of the day	
• Weight gain or loss (more or less than 5% of body weight in one month) decrease or increase in appetite	Depressed appearance
• Insomnia or hypersomnia	Social withdrawal, talk less

• Restlessness or psychomotor retardation	
• Fatigue or loss of energy	Complaint, self-pity, pessimism
• Feelings of worthlessness, excessive or inappropriate guilt	
• Decreased concentration, indecisiveness	Lack of responsiveness, can hardly to be stimulated
• Recurrent thoughts of death, suicidal ideation or plan, suicide attempt	

Source : (Berney, et al, 2000, p. 278)

PSYCHOTHERAPY

Individual psychotherapy is especially necessary if adaptation to the disorder in the form of depression is difficult. It is believed to occur when personal resources or those of those around them are exhausted. Psychotherapy is a space in which the patient can take refuge and live a relationship that takes into account his rhythm, his resource constraints and his mode of operation. His personal pace was slowed by physical deterioration, sometimes conflicting with the agenda of oncologists tasked with acting on physical conditions in a relatively short period of time. Psychotherapy spaces allow patients to free themselves from the contingency of "doing". He could hold his breath and approach his experience with a certain calm. Suspended action facilitates the transition from a form of disease-induced numbness to integrating the diagnosis into one's biography(Stiefel et al, 1999).

The depressed patient can make the link between his current experience and previous events, thus recovering the sense of the continuity of his life. His illness becomes tolerable. He can also understand the reasons for his depression that cancer as such does not explain alone.

Physical illness raises the specter of addiction. Patients may feel out of control over their lives, and they face their own vulnerability and the risk of becoming hopeless or giving up. They may fail in the two tasks imposed on them: coping with illness and treatment, and making changes in their lives. These changes occur at the identity and person level as well as at the relationship level. While accepting the status of patient, he must encourage those around him to rehabilitate and establish a satisfactory link with his doctor, who will then become a very important person. Psychotherapy is helpful for patients who are unable to perform these tasks.

The psychiatrist's intervention framework is more flexible than in traditional treatments for healthy patients. He must be able to intervene urgently in moments of crisis (recurrence, hospitalization, unfavorable evolution, etc.). He may also have to abandon his "benevolent neutrality" and go beyond a dual relationship by intervening with relatives or caregivers. He then behaves like a kind of "auxiliary self" whose mission is to face the obstacles imposed by the disease.

MEDICAL TREATMENT

Although the effectiveness of antidepressant drugs is recognized and widely used in the treatment of depression, few methodologically sound studies have been devoted to the population under consideration. These few studies relate to several families of molecules (TCA, SSRI, psychostimulants). Despite the small number of studies and the methodological problems, antidepressants seem a priori effective (Stiefel&Razavi, 1999, pp.371-72).

Tricyclics and serotonin reuptake inhibitors seem to have comparable efficacy. The latter, however, have a more favorable side effect profile. Most of the side effects attributed to them are due to their action on central and peripheral serotonergic receptors. These side effects are rather transient and dose-dependent. Overdose is also less of a problem. This is a significant advantage in patients with hepatic metabolism sometimes slowed down due to disease or drug interactions. Between the different SSRIs, the adverse effect profile is similar but not identical. Fluoxetine causes more harm than other SSRIs due to a stronger activating effect, a long half-life inducing a later steady state and a longer elimination period, as well as a decrease appetite and initial weight loss that can be problematic.

Mianserin, a heterocyclic antidepressant, a selective 5HT-2 receptor blocker, with analgesic properties, has also shown good efficacy in the treatment of depression.

Similarly, the side effect profile appears to be favourable.

SNRIs (serotonin and norepinephrine reuptake inhibitor) such as venlafaxine, SNaRIs (postsynaptic serotonin and norepinephrine reuptake inhibitor) such as nefazodone, NaSSAs (specific serotonergic and noradrenergic antidepressants) such as mirtazapine, NDRIs (norepinephrine and dopamine reuptake inhibitors), such as bupropion,

MAOIs (reversible monoamine oxidase inhibitors) such as moclobemide, trazodone finally, although indicated in the treatment of depression, have been the subject of few studies. They are nevertheless used in current oncological practice, especially after the failure of more conventional molecules and when very specific effects are sought, for example trazodone for its sedative effect, mirtazapine for its hypnotic effect at low doses, bupropion for its activating effect and the absence of an effect on sexuality.

COMBINED TREATMENT

Thanks to the drugs, we obtained a symptomatic improvement which confirmed our idea. Not wanting to disqualify these treatments, it seems to us that depression cannot be reduced to a stable set of signs and symptoms. Its expression is influenced by the personality of each patient, which is itself the result of a series of biographical, biological, genetic and environmental factors. Psychotherapeutic approaches offer an opportunity to combat depression by promoting personality changes. By doing so, it not only reduces symptoms but also improves overall function(Voellinger, et al. 2003, p.185).

Specificities of Depression in Oncology: Difficulties in Making the Diagnosis

It is not uncommon to have dysthymia or adjustment disorders during treatment, sometimes compared to depression, and sometimes even having symptoms in the foreground. The presence of depressive symptoms does not indicate a diagnosis of depression. Moreover, not all symptoms require a medical response, although chemotherapy and/or psychological support may sometimes be essential(Nezelof & Vandel, 1998, p. 59).

However, the presence of these symptoms indicates malaise, distress, discomfort and should be considered. It is necessary to evaluate the adaptive capacities of a subject experiencing painful or depressive emotions and the resources at his disposal, as well as the confusion that they can cause.

Faced with the seriousness of the oncological diagnosis, caregivers and those around them can sometimes be tempted to over-rationalize mood disorders. Added to this, depressive disorders in oncology are rarely reported spontaneously, because what prevails in everyone's eyes, treated as caregivers, is «to have good morale», which, according to some patients, would «ensure the 70% cure(Nezelof & Vandel, 1998, p. 60).

On the Patient Side, Reluctance to Mention or Recognize Symptoms

The disease will reveal and shake patients in all their bodies, relationships, temporal and identity markers, leading them to experience a deep existential crisis that forces them to develop new stents. The self-image is deeply disturbed and the resurrection of a narcissistic wound is often more painful than the illness itself. In addition to the pain of death, patients have multiple fears: fear of pain, fear of physical decline, fear of treatment and its disabling effects, fear of being a burden on those around them, and even fear of being watched. The patient will be more or less affected with different states, depending on his referring doctor, his team, what to do to recover. Hence the famous ban of the type «you have to have the morale to heal»

Thus, the famous injunction is alive and well in our services and guides the behaviors and expectations of each of the protagonists. It is also not uncommon for patients to be convinced that what they are feeling does not concern the oncologist. We therefore find ourselves in a context of global suffering which operates in the person a dysfunction and a tear at the same time physical, psychological and spiritual. Suffering is like a cry, but voiceless, «which is the word of a subject who seeks himself in the tearing of the body, it is most often veiled, hidden, made inaudible under the noise and the commotion triggered by the pain (Vasse, 1983, p.30).

Most often masked, suffering is not revealed because it is incommunicable by the subject who carries it and impossible to hear by the listener. When a person talks about their suffering, they are someone else, as if separated from themselves. Suffering touches what is of the intimate order, and although constituting one of the ways of talking about it, to say something about one's suffering is risky, since the subject, directly implicated, then speaks of it way too general or way too intimate. Emotional disorders (depression), themselves, can also prevent their expression, such as shame, withdrawal, psychic slowing down. This is also the case for certain coping mechanisms, and more particularly in the case of emotional repression. Also, in this context, how to talk about oneself during relatively short consultations and already so dense in medical information communicated, expected, upsetting?

Screening for Depression

Through dialogue, the oncologist can help his patient to address and express his difficulties. He must identify the aspects that indicate his moral suffering, carry out an active identification of the symptoms and evaluate the repercussions of

the disease and the treatments on the psychosocial level. He can use questionnaires to detect psychological suffering and, if necessary, depressive disorders in his patients. One of the advantages is to save time and optimize referral to a psycho-oncologist, clinical psychologist or psychiatrist.

Two options are available to the oncologist:

Either ask the following open-ended question : «How is your morale lately?» » or more closed questions such as: « during the last 15 days, have you felt moments of dejection, sadness, loss of hope? "During the last 15 days, have you been worried about a loss of ability to be interested, to take pleasure in your usual activities?" (Chochinov et al, 1997, pp.674–6).

Either carry out a brief screening using a self-assessment scale HADS ("HospitalAnxietyDepressionScale"), commonly used in oncology, because it is administered quickly in a few minutes, without somatic items and therefore validated in the detection of anxiety-depressive disorders. Others So-called heteroevaluation scales for measuring depressive disorders could be used but remain more in the domain of specialists or research (BDI, MADRS, Hamilton) and appear less discriminating in oncology, because they include precisely these somatic elements that can artificially increase scores (Love,et al, 2004, p.526). Certain consequences of depression not diagnosed in time can alert the oncologist because of the implications in terms of oncological prognosis: delay in diagnosis of cancer and failure to adhere to care (Durdux, 2010,p.36).

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