

Anxiety and Depression in Patients with Cancer. A Case Report

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Abstract

Depression is among the leading causes of disability worldwide, leading in some cases, to suicide and it is considered to be the disease of the millennium. Clinical depression is a common disease, and yet frequently overlooked, source of suffering among patients with cancer. Anterior studies

indicate that the rate of depression in cancer patients is thought to be up to three times higher than in the general population. Depression decreases the quality of life, compromises the outcomes, and results in increase the rates of mortality from cancer.

Clinical case: We identify a 50-year-old woman diagnosed with bilateral ovarian high-grade serous carcinoma. The imaging investigations revealed multiple metastases (cT3bN1bM1b – TNM classification). This stadium made the patient to be a candidate only for palliative chemotherapy. At first visit at the oncological specialist, the patient was worried about her health condition, but after discussing with the medical oncologist about the treatment and side effects of chemotherapy, the patient gained confidence. During a routine chemotherapy infusion, the patient reports some special side effects like increase feeling of “going through the motions” as if in a trance-like state, episodes of sudden tearfulness, and feeling like she is “out of control”.

After the finish of the chemotherapy infusion, at the interview, the patient reports feeling safe, denies any self-harm or self-injurious thoughts, denies use of illicit substances and alcohol. She says that the impact of hair loss is very depressive for her. In these conditions, the oncologist decide to discuss an initial treatment plan with her that includes individual counseling. Individual counseling helps the patient to complete her palliative therapies and increase her confident after the post-chemotherapy CT exam result. However, there is progression of her disease after 6 months. After this exam, she becomes despondent and is struggling to complete daily activities. She reports specific symptoms for depressive disorder: sleeping poorly and lacking appetite, and no longer enjoys spending time with her friends and family or pursuing her interests. She is preoccupied with death and has difficulty concentrating, but fortunately denies any suicidal ideation or death wishes.

It was started the second line chemotherapy protocol. At this time the patient shows abandonment behavior, autolytic thoughts and drug ingestion triggered by acute family conflict, requiring psychiatric re-assessment and specialist treatment.

Conclusion: Depression remains an under-recognised comorbidity in cancer patients, with major implications on patient suffering, mortality and healthcare expenditure. Depression in cancer is markedly different from depression in healthy individuals, and involves a unique symptomatology.

Keywords: Anxiety; Depression; Ovarian Cancer; Oncology; Psycho-Oncology.

1. Introduction

Depression is among the leading causes of disability worldwide, leading in some cases, to suicide. Clinical depression is a relatively common, and yet frequently overlooked, source of suffering among patients with cancer (Mitchell et. al., 2011).

The rate of depression in cancer patients is thought to be up to three times higher than in the general population. Depression leads to a poorer quality of life, compromises patient outcomes, and results in higher rates of mortality from cancer (Lemogne et. al., 2013). Despite its clear impact on patients, depression continues to be under-diagnosed and inadequately treated. There are many reasons for this, ranging from the underestimation of depressive symptoms by clinicians, their widespread presence in the context of cancer, the entanglement of depressive symptoms with those associated with cancer and its treatment, or, indeed, the difficulty of clinicians in exploring emotional symptoms.

Concurrent with advances in cancer treatment, the importance of the psychosocial care of individuals with cancer has been increasingly recognized. In 2008, the Institute of Medicine in Washington, D.C. (US) published *Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs*, which documented under-detection and failure to optimally manage psychiatric disorders and psychosocial needs in patients with cancer and their families (Graves, 2009).

The onset and progression of psychological distress in patients with cancer, including patients with ovarian cancer, is not likely to be an acute threat that passes quickly but a chronic one with peaks and troughs of severity that occur during key stages of the cancer journey.

Ovarian cancer is the seventh most commonly diagnosed cancer among women in the world. There were nearly 300,000 new cases in 2018 and 184,000 deaths worldwide annually (Bray et. al., 2018).

2. Case Presentation

In September 2017, a 50-year old woman with past medical history of hypertension presented for an outpatient clinic evaluation with a growing lump as large as 35/20/15 mm in her left supraclavicular fossa; she had had the mass for 2 months, which on biopsy was diagnosed as a metastatic papillary tumor. She underwent gastroenteroscopy being negative for the tumor and a thoracic computed tomography showing multiple mediastinal lymph node metastasis. Finally, abdominal computed tomography showed a pelvic mass measuring 46/23 mm and retroperitoneal enlarged lymph nodes. The serum cancer antigen 125 (CA125) level was 315,6 U/ml. The patient had a gynecological oncology consultation and underwent exploratory laparotomy. The histopathology confirmed papillary serous carcinoma of both ovaries. Subsequently, she was referred to the Department of Medical Oncology for consultation. The final diagnosis was papillary serous carcinoma of the ovaries, International Federation of Gynecology and Obstetrics (FIGO) Stage IVB (pT3bN1bM1b). Because of the metastases status, the patient was a candidate for a combination of palliative chemotherapy consisting of Carboplatin AUC 6 and Paclitaxel 175 mg/m² q3w. At first administration of chemotherapy, she was worried about her health condition, but after discussing with the medical oncologist about the treatment and side effects of chemotherapy, the patient gains confidence. During a routine chemotherapy infusion, the patient reports an increased feeling of episode sudden tearfulness, and feeling like she is “out of control”. During the interview, the patient reports feeling safe, denies any self-harm or self-injurious thoughts, denies use of illicit substances and alcohol and says the impact of hair loss depresses most. The oncologist discusses an initial treatment plan with her that includes individual counseling.

Individual counseling greatly helps and she completes her palliative therapies and is confident after the post-chemotherapy CT exam result (mediastinal lymph nodes and pelvic mass were markedly decreased in size). Carboplatin plus Paclitaxel chemotherapy was administered for 6 cycles and CA125 level returned to normal. On follow-up (6 months), the patient’s serum CA125 level was increased to 115.3 U/ml and a PET/CT scan was obtained. Fluorine-18 fluorodeoxyglucose positron emission tomography associated with computed tomography (PET/CT) images revealed areas of increased metabolic activity in the peritoneal cavity, left axillary and left supraclavicular lymph node metastases (Figure 1).

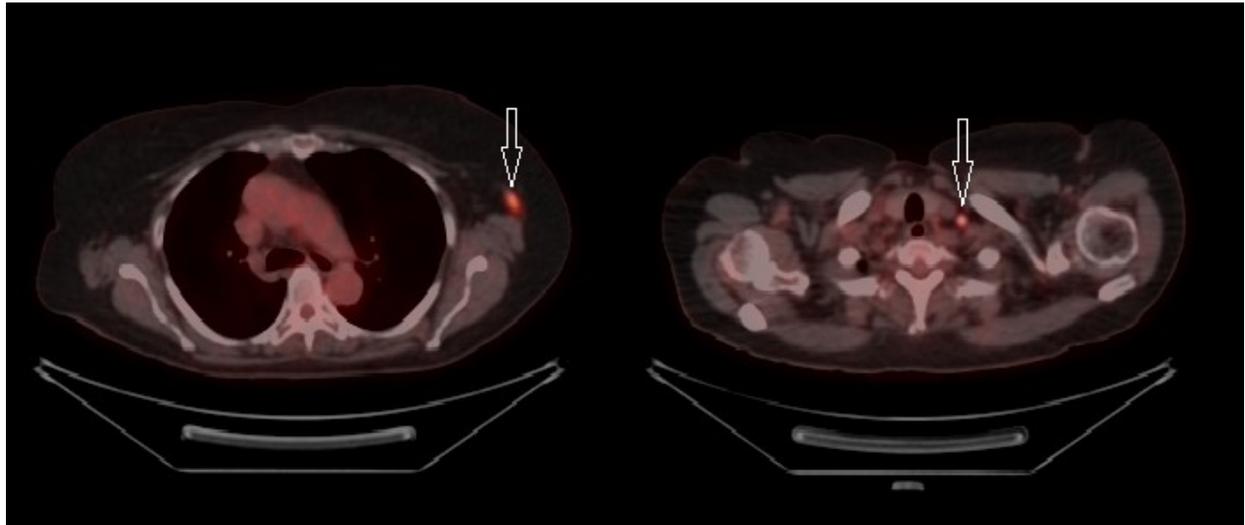


Figure 1: Fluorine-18 fluorodeoxyglucose positron emission tomography associated with computed tomography images revealed an area of increased metabolic activity in the left axillary and left supraclavicular lymph nodes (arrows).

At this time, she becomes despondent and is struggling to complete daily activities. She reports sleeping poorly and lacking appetite, and no longer enjoys spending time with her friends and family or pursuing her interests. She is preoccupied with death and has difficulty concentrating, but denies any suicidal ideation or death wishes. The oncologist discusses a treatment plan with her that includes individual counseling and psychiatric consultation. The patient starts antidepressant treatment.

In March 2018, during a second-line chemotherapy infusion, the patient shows abandonment behavior, autolytic thoughts and drug ingestion triggered by acute family conflict, requiring psychiatric re-assessment and specialist treatment.

3. Discussion

Ovarian cancer is the seventh most commonly diagnosed cancer among women in the world and in 75% of patients has already reached an advanced stage at the time of diagnosis (Narod, 2016). In the present case, the patient initially presented with supraclavicular lymph node metastasis. The disease had already progressed to stage IVB. Such cases have been rarely reported and usually have poor outcomes.

Depression is among the leading causes of disability worldwide, leading in some cases, to suicide. Clinical depression is a relatively common, and yet frequently overlooked, source of suffering among patients with cancer (Mitchell et. al., 2011).

In two-thirds of cancer patients who experience depression, the distress may be related to cancer treatments or symptoms, may be situational, or may be addressed with problem-solving (Vodermaier et. al., 2009).

Patients highly value their relationships with their oncologic providers, and positive support and encouragement are also meaningful interventions.

At different times during treatment and recovery, people with cancer may be fearful and anxious. Finding out that they have cancer or that the cancer has come back causes the most anxiety and fear. Depression, anxiety, and other emotional problems can nearly always be helped with individual counseling, group support, cognitive behavioral or interpersonal therapy (Antoni, 2013; Condratovici, 2018). Medications should be recommended for more severe symptoms (Li et. al., 2012). In the confusion and stress that come after a cancer diagnosis, the emotional problems of people with cancer and those around them can often become fairly serious before they are recognized.

4. Conclusion

Depression remains an under-recognised comorbidity in cancer patients, with major implications on patient suffering, mortality and healthcare expenditure. Depression in cancer is markedly different from depression in healthy individuals, and involves a unique symptomatology.

Consent

Written informed consent was obtained from the patient for publication of this case report and any accompanying images.

References

- Antoni, M. (2013). Psychosocial intervention effects on adaptation, disease course and biobehavioral processes in cancer. *Brain, Behavior, And Immunity*, 30, S88-S98. doi: 10.1016/j.bbi.2012.05.009.
- Bray, F., Ferlay, J., Soerjomataram, I., Siegel, R., Torre, L., & Jemal, A. (2018). Global cancer statistics 2018: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. *CA: A Cancer Journal For Clinicians*, 68(6), 394-424. doi: 10.3322/caac.21492.
- Condratovici, C. P., Ilie, M., Mihai, M., Condratovici, A. P., Chihai, J., Baci, G. (2018). Anxiety associated with visit to the dentist. *Romanian Journal of Oral Rehabilitation*. 10(2), 86-90.
- Graves, K. (2009). *Cancer care for the whole patient: meeting psychosocial health needs*. Written by the Committee on Psychosocial Services to Cancer Patients/Families in a Community Setting Board on Health Care Services. Institute of Medicine. The National Academies Press, Washington, DC. 2008. 429pp. Price: \$46.95 (US), £24.99 (UK). ISBN: 978-0-309-11107-2. *Psycho-Oncology*, 18(3), 305-306. doi: 10.1002/pon.1478.
- Lemogne, C., Consoli, S., Melchior, M., Nabi, H., Coeuret-Pellicer, M., & Limosin, F. et. al. (2013). Depression and the Risk of Cancer: A 15-year Follow-up Study of the GAZEL Cohort. *American Journal Of Epidemiology*, 178(12), 1712-1720. doi: 10.1093/aje/kwt217.
- Li, M., Fitzgerald, P., & Rodin, G. (2012). Evidence-Based Treatment of Depression in Patients With Cancer. *Journal Of Clinical Oncology*, 30(11), 1187-1196. doi: 10.1200/jco.2011.39.7372.
- Mitchell, A., Chan, M., Bhatti, H., Halton, M., Grassi, L., Johansen, C., & Meader, N. (2011). Prevalence of depression, anxiety, and adjustment disorder in oncological, haematological, and palliative-care settings: a meta-analysis of 94 interview-based studies. *The Lancet Oncology*, 12(2), 160-174. doi: 10.1016/s1470-2045(11)70002-x.
- Narod, S. (2016). Can advanced-stage ovarian cancer be cured?. *Nature Reviews Clinical Oncology*, 13(4), 255-261. doi: 10.1038/nrclinonc.2015.224
- Vodermaier, A., Linden, W., & Siu, C. (2009). Screening for Emotional Distress in Cancer Patients: A Systematic Review of Assessment Instruments. *JNCI Journal Of The National Cancer Institute*, 101(21), 1464-1488. doi: 10.1093/jnci/djp336.