

PSYCHO-ONCOLOGICAL APPROACH TO BREAST CANCER PATIENTS

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Summary

Nearly three-quarters of patients with breast cancer have some form of depression. The main cause of the depression is fear, often lifelong, concerning the diagnosis of cancer itself, eventual recurrence, appearance of metastases, final outcome of the disease, but also the possible surgical mutilation of the patient and possible genetic transmission of malignant disease to the offsprings. The high incidence of mental disorders in patients with malignant diseases requires the inclusion of psychiatrist in the therapy team. This could ameliorate the patients quality of life and influence the kind of therapy applied, as well as the final outcome of the disease.

KEY WORD: *psycho-oncology, liaison psychiatry, breast cancer, mental disturbances*

PSIHO-ONKOLOŠKI PRISTUP OBOLJELIMA OD RAKA DOJKE

Sažetak

Gotovo tri četvrtine oboljelih od karcinoma dojke ima neki oblik depresije. Depresija je najčešće uzrokovana strahom, često cjeloživotnim, zbog dijagnoze maligne bolesti, kao i zbog stalne mogućnosti povrata bolesti i neizvjesnog ishoda liječenja. Eventualna kirurška mutilacija bolesnika, kao i mogući genetički prijenos maligne bolesti na potomstvo, također mogu uzrokovati strah i depresiju kod bolesnika. Budući da je pojavnost psihičke promijenjenosti kod oboljelih od malignih bolesti velika, smatra se da je uključenost psihijatra u liječenje bolesnika s malignim bolestima neophodna. Time se omogućuje bolja kvaliteta života bolesnika i povoljniji ishod liječenja.

KLJUČNE RIJEČI: *psiho-onkologija, liaison psihijatrija, rak dojke, mentalni poremećaji*

INTRODUCTION

Mental disturbances are not rare in female breast cancer patients, and it is known that they can also have a significant impact on the selection and course of treatment, as well as the outcome of the illness itself. The literature thus states that 70% breast cancer patients have depressive disorders and more than half of them comply with the diagnosis of psychic disturbance. Most frequent psychic disturbances are adjustment disorders (68%), major depressive episodes (13%) and delirious conditions (8%) (1). It is a known fact that de-

pressive condition has an unfavourable impact on the outcome of the illness, and some people think it triggers the cancer occurrence. The results obtained by a meta-analysis of 31 prospective studies have shown that the mortality increase is 25% in patients with depressive disorders and as much as 39% in patients with major depressive disorders (2).

FACTORS AFFECTING THE PROBLEM

A few factors can seriously shake the psychic stability of female patients with a diagnosed breast cancer. Already the knowledge that a person suf-

fers from a malignant tumour is an extreme psychic stress for her. The basic emotion that appears is the fear of death, also fear of disability, frequently a lifelong fear of appearance of recurrence, metastases or a malignant tumour located somewhere else. The expected mutilation, except for the noticeable deformity, is an additional psychic burden because female patients think that they lose their attraction, especially sexual attraction, which frequently implies huge difficulties for single women to find partners, and thus to have children, and the fear of leaving and loss of family for married women. Therapeutic protocols frequently include a lengthy treatment, the consequences and complications of which (fatigue, exhaustion, hair loss, haemorrhage, changes in irradiated skin, hormonal imbalance and other) additionally psychologically exhaust female patients. Mental condition can also deteriorate due to brain metastases and associated illnesses and disorders (uraemia, encephalopathy, electrolyte disorders and other).

PREVALENCE AND TYPES OF DISTURBANCES

The dominant fear and depression, sometimes there are also anger and self-accusation, even suicidal ideas. Although suicidal ideas are relatively frequent, the current suicide incidence is only somewhat higher than in the general population. Suicidal tendencies are facilitated by depression and despair, poorly controlled pain, feeling of helplessness, disinhibition within the scope of organ syndrome, exhaustion, anxiety, pre-existing psychopathology (drugs abuse, character pathology and other), difficult family situation and positive family anamnesis to suicide. Delirious conditions are not rare in terminal stages of illness, and they can be developed as the consequence of metabolic encephalopathy, failure of vital organs, electrolyte disorders, hypoxia, nutritive deficiency, infection (especially in immunosuppressed disorders), as well as endocrine disorders.

THERAPY

Individual approach

Patients are nowadays loaded with information from the Internet, which substitutes conver-

sations with a physician, and which is often uncritically interpreted by patients. This is why they literary plead for someone to whom they could entrust their fears and who could psychically uplift them. Which is why mental support is necessary from the very moment of diagnosis to the end of treatment, and to many even afterwards, whereby a psychiatrist has a significant role in the medical team.

Unfortunately, both physicians and patients frequently see depression as an expected and normal reaction to the announced diagnosis, which is why depression is often unrecognized and untreated (3-8). It would be desirable that a psychiatrist is present as early as when announcing the diagnosis, which has until now most often been done by a surgeon that would also perform the surgery on a patient. His or her role is primarily to perform a surgery well, and to inform the patient about the nature of the surgery. Owing to the nature of his or her work, this conversation with the patient is usually short, while at that moment the patient needs a longer conversation, explanation, empathy and encouragement. The patient needs to be receive the diagnosis, but also needs to be encouraged the patient. A physician should avoid reprovingly shaking his or her head and asking the patient where she has been until now and how could she let the tumour spread so much. On the other hand, she needs to be given hope in the treatment, describe the possibilities of plastic surgery and reconstruction to her, possibly with a video, and announce a lengthy treatment, its possible complications and consequences, and help her to accept the proposed treatment modes from the team. Of course, no psychiatrist is needed for something like that, but he or she should be there to make the best judgment of the patient's reaction, and based on it to help in the establishment of the most adequate therapy.

Psychosocial approach

In addition to the individual psychotherapeutic approach (psychological interventions to reduce depression and anxiety), psycho-social approach (inclusion of the family) is also important. Group psychotherapy would also be used because the confrontation with the similar healed patients could stimulate the positive attitude to such illness. If possible, such patients should return to their work environment as soon as possible,

whereby they would be less focused on their illness.

Pharamceutical approach

A psychiatrist will decide upon the administration of psychopharmaceuticals depending on the seriousness and type of disorder. A systematic review of 24 randomized controlled trials of either pharmacologic or psychotherapeutic interventions for cancer patients with depression or depressive symptoms has recently concluded that depression in cancer patients is responsive to antidepressant medication treatment, although some studies reported high dropout rates and some failed to report adverse events and tolerability (9). Studies have proven impacts of selective inhibitors of serotonin storage; primarily paroxetine (10) and fluoxetine (11). In the treatment of comorbid neuropathic pain in addition to depression, the choice is venlafaxine, and tricyclic antidepressants (amitriptyline and desipramine) and bupropion (12-14). Mirtazapine has proven especially efficient in female patients with cachexia (15). Tolerability of the above stated antidepressants is frequently very good. The length of the treatment is, by all means, strictly individual, and sometimes, although rarely, also life-long.

CONCLUSION

Mental disturbances in breast cancer patients are the consequence of stress due to the diagnosis of malignant disease, fear of surgical mutilation's consequences on a personal as well as on a family level, frequently premature and sudden menopause caused by a hormonal therapy or oophorectomy, consequences of chemo- or radiotherapy, etc. Very often a life-long fear of disease recurrence, or of appearance of metastasis are present by the patients. Since different mental disorders are common in breast cancer patients, (although often neglected), we think that a psychiatric approach is obligatory in the team that decides upon breast cancer patients treatment.

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