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Features of Mental Disorders in Patients with Cancer of the Oropharyngeal Region

Kamola D. Khasanova[1], Denis P. Kim[2], Ulugbek Kh. Alimov[1], Mirza A. Gafur-Akhunov[3]

[1]Department of Psychiatry and Psychotherapy of the Center for the Development of Professional Qualifications of Medical Workers, Tashkent, Uzbekistan
[2]Department of Psychiatry and Narcology, Tashkent Medical Academy, Tashkent, Uzbekistan
[3]Department of Oncology with the Course of Functional Diagnostics of the Center for the Development of Professional Qualifications of Medical Workers, Tashkent, Uzbekistan

Abstract Malignant neoplasms are often combined with mental disorders of the depressive and anxiety spectrum, which aggravate the course and prognosis of the underlying disease. The article discusses the problems associated with the identification of comorbid emotional disorders in cancer patients, analyzes the diagnostic value of psychometric methods for assessing the symptoms of anxiety and depression. It is concluded that further development of topical issues of diagnosis, therapy and prevention of anxiety and depressive conditions in cancer patients requires the integration of scientific and practical activities of oncologists, psychiatrists, and psychotherapists.

Keywords Anxiety and depressive disorders, Cancer, Psychotherapy

1. Introduction

Despite the huge variety of causes that can cause organic brain damage (infections, intoxication, trauma, tumors, vascular diseases, etc.), there is a significant similarity between the manifestations of various organic diseases. According to epidemiological studies, somatogenic, psychogenic or combined mental disorders are found in almost half of cancer patients [1]. Such combined forms of diseases require an integrated approach to diagnosis and treatment with the involvement of a psychiatrist, psychotherapist. Most often, patients with malignant neoplasms have borderline anxiety and depressive disorders. Depression of varying severity is detected in 20-30% of cases (range 1-77%) [2,3]. Anxiety symptoms are present, according to different authors, in 24-38% of patients. In addition, anxiety and depression show a high level of comorbidity, forming mixed conditions, the percentage of which in different types of cancer ranges from 9.3 to 20.2. Concomitant anxiety and depressive disorders have a negative impact on the course and prognosis of the underlying disease - they reduce compliance to treatment. reduce the effectiveness of chemotherapy, inhibit the reverse development of the tumor process, prevent the restoration of the comorbid level of social adaptation and increase the likelihood of suicide and early death [4,5,6]. The reason for the underestimation of anxiety-depressive states in cancer patients is also the poor awareness of patients and their families about the symptoms of mental disorders and an increased risk of their occurrence in cancer. Along with this, oncologists themselves rarely prescribe psychotropic drugs. They are mainly used as antimimetic and analgesic agents.

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2. Materials and Methods

We carried out clinical studies of patients on the basis of the Tashkent regional branch of the Republican Specialized Scientific and Practical Medical Center of Oncology and Medical Radiology for the period 2019-2020. The object of the study was 107 patients, in the age range 28-64 years (mean age 46.5 ± 11.5 years). In the course of selection, the indicators of patients were determined that met the criteria of our study. Treatment in a hospital for stage III-IV oropharyngeal cancer, and, accordingly, the use of combined methods of medical intervention (surgical, remote-beam), as well as methods of drug therapy and psychotherapeutic treatment. All patients received voluntary consent to participate in the study. The diagnosis was made in accordance with the International Statistical Classification of Diseases and Problems Associated with Health (10th revision, 1995) according to the criteria of the heading "Malignant neoplasm of the oropharyngeal region". At the same time, we also determined the criteria for exclusion from the study: concomitant mental illnesses of an endogenous nature, severe somatic illnesses in the stage of exacerbation. A clinical and psychological method was applied to all patients, including direct examination of patients: clinical

interview, questionnaire survey, dynamic observation and interview. The psychological status was studied in the process of talking with patients and analyzing the characteristics of their behavior, with their own clinical observations and anamnestic information obtained as a result of interviewing patients. The indicators for determining the indicators of the conversation were the following characteristics of the patient: age, intellectual level, marital status, the degree of spread of the malignant tumor. At the same time, in the course of the study, the need for a clinical conversation was identified in order to examine a cancer patient. It should be noted that the correct application of this method in many cases determines the success of further experimental psychological research. It should be borne in mind that the inevitability of surgical intervention, as the only possible solution to the problem, in most cases is perceived negatively by patients, moreover, in relation to psychological examination.

Primary attention was paid to changes in the mental activity of patients. The focus of the conversation did not change at different stages of the examination, but its structure underwent changes in accordance with the course of the disease. Also, attention was paid to the study of premorbid personality traits, to determine the correct assessment of the socio-psychological adaptation of patients. When studying anamnestic data and objective information, attention was paid to the presence of hereditary burden in the family, concomitant somatic pathology, family relationships. In the course of a detailed analysis of the data of a direct interview, follow-up information, clinical case histories, the clinical and dynamic picture of the disease, as well as the effectiveness of the therapy, were studied. The follow-up period was characterized by a predominant focus on the second part of the clinical conversation. The aim was to obtain additional information about the nature of the restoration of labor activity.

Our research shows that all possible contacts with patients presuppose, without fail, certain elements of psychocorrection (hope for the success of treatment, restoration of the previous social status). Clinical conversation with cancer patients was not limited to the framework of psychological research, but also acted as a method of psychocorrection during the period of patients' stay in the hospital.

In order to objectively assess the data obtained, we used the defining psychodiagnostic techniques. The Hospital Anxiety and Depression Scale (HADS) is a rapid screening for assessing the level of anxiety and depression in general medical practice. It has a high discriminant validity for two disorders: anxiety and depression.

3. Results

One of the objective indicators of the social and personal characteristics of an individual is the state of interpersonal relations in the family. Thus, a study of marital status revealed that 80 (74.8%) patients were married, 20 (18.7%) were divorced, and 7 (6.5%) were widowers. Our study showed that the level of education in the surveyed contingent is as follows: secondary specialized education - in 80 (74.8%) patients, higher - in 27 (25.2%) patients. Analyzing the indicators of employment, we found that 50 (46.7%) patients were able-bodied, 47 (43.9%) of them were declared temporarily disabled, 10 (9.4%) patients were disability pensioners due to cancer.

During the survey, we established the following indicators. After visiting the doctor, 33 (30.8%) patients experienced fear and despair, 59 (55.1%) patients felt anxiety and anxiety, 18 (16.8%) patients were sure that their disease was malignant, 47 (43, 9%) partially recognized the malignant nature of the disease (with various reservations); 15 (14.0%) denied the presence of cancer, 27 (25.2%) patients had an uncertain attitude towards the diagnosis. At the same time, the patients used specific psychological defense mechanisms to mitigate the psychological trauma received from the information about the severity and possibly fatal outcome of the disease. These protective mechanisms include such as rationalization, denial, alienation, repression, etc.

The perception of their illness influenced the formation of the attitude to treatment: in 48 (44.8%) patients - active; in 47 (43.9%) - unstable; and passive was observed in 12 (11.3)% of patients.

Next, we analyzed the spectrum of concomitant diseases in somatic status in the examined patients and found that 83 patients (77.6%) had such diseases as hypertension, varicose veins, chronic gastritis, cholecystitis, osteochondrosis, etc. hereditary burden of cancer showed that 42 (39.2%) patients had a hereditary burden of cancer. The duration of the disease, in our opinion, is one of the main clinical characteristics. In the study group, the maximum duration of the disease ranges from 0 to 9.0 years, the average duration is 6.1 + 0.3 years.

4. Discussion

As can be seen from the above results, 68 (63.5%) of the examined patients experience subclinically severe depression, 14 (13.1%) were diagnosed with clinically severe depression. In the clinical picture of depressive symptoms, the predominant symptoms were depressed mood, tearfulness, depression, melancholy, and apathy. In 25 (23.4%), severe symptoms of depression were absent. Subclinical anxiety was diagnosed in 62 (57.9%) patients, clinically expressed anxiety in 25 (23.4%) patients, and in 20 (18.7%) patients there were no pronounced anxiety symptoms.

"Hospital Anxiety and Depression Scale (HADS)" 68 (63.8%) of the surveyed patients experience subclinically severe depression, 14 (13.1%) - clinically diagnosed with depression. In 62 (57.9%) patients, subclinically pronounced anxiety was determined, and in 25 (23.4%) patients, clinically pronounced anxiety was diagnosed.

Among the clinical manifestations of the anxiety state, tension, confusion, emotional lability and irritability prevailed. Based on the clinical and psychological examination, significant intergroup differences in the level of clinical manifestations of anxiety and depression were established.

Having studied the dynamics of anxiety-depressive disorders depending on the stage of the tumor, it was noted that anxiety and depression accompany a cancer patient throughout the entire course of the disease, gradually increasing from subclinical disorders at the diagnostic stage to psychotic depressions with symptoms of substitution in terminal states. Loss of hope for recovery, growing pessimism, depression, passivity, "reconciliation" with fate and indifference are more often observed in the last phases of the response, pre-terminal and terminal stages of the disease. The longest is the stage of somatized depression, within which symptoms of "irritable weakness", autonomic lability, and hypochondriacal mood are observed [7,8].

5. Conclusions

Obviously, depression negatively affects the course of the disease and significantly worsens the quality of life of patients. In addition, depression is an unfavorable prognostic factor for the outcome of cancer, and its significance increases in the later stages [9]. Depression has a negative impact - worsens 5-year survival. Depression, feelings of helplessness and hopelessness can affect the development and prognosis of cancer through a later first visit to the doctor, low compliance. It should be borne in mind that depression can be a consequence of cancer (for example, due to the activation of cytokines) or anticancer therapy (for example, as a side effect of immunologically active substances) and may not be an independent predictor. In this case, depression may be a sign of a worsening prognosis. It is obvious that the solution of the urgent problem of diagnosis and treatment of anxiety-depressive disorders in cancer patients will be possible provided that the scientific and practical activities of oncologists, psychiatrists and psychotherapists are integrated.

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