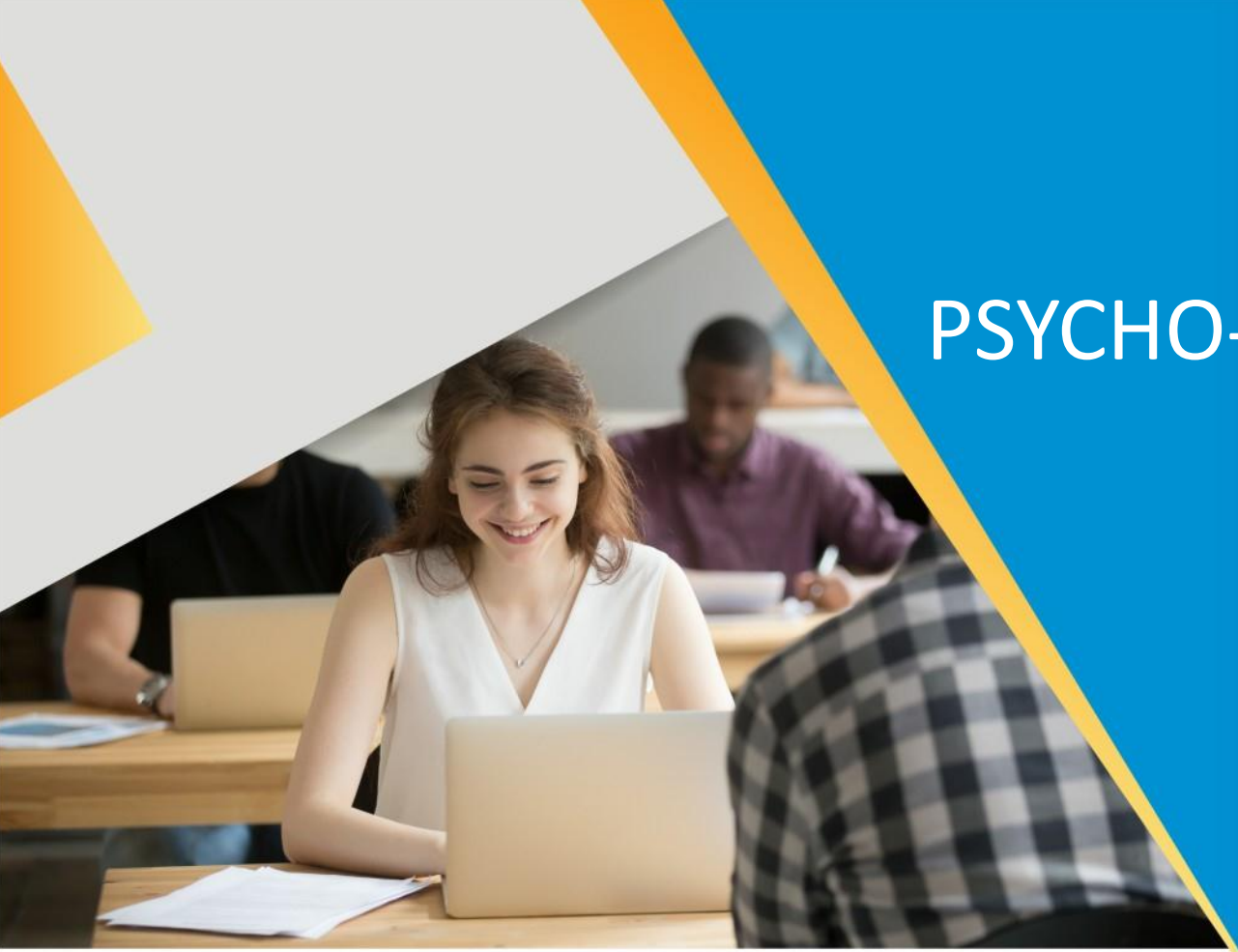


PSYCHO-ONCOLOGY

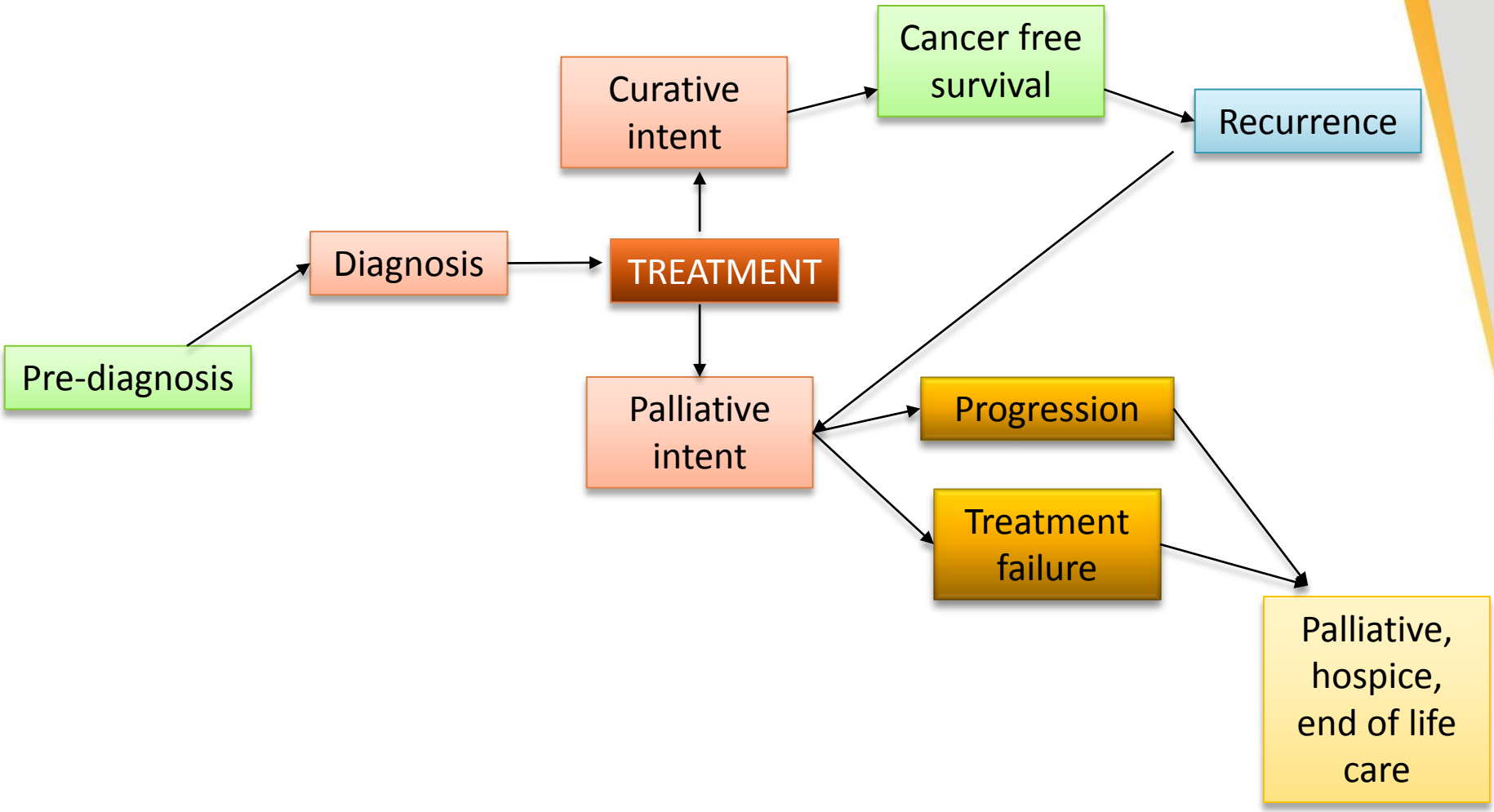
DR. JAYITA DEODHAR

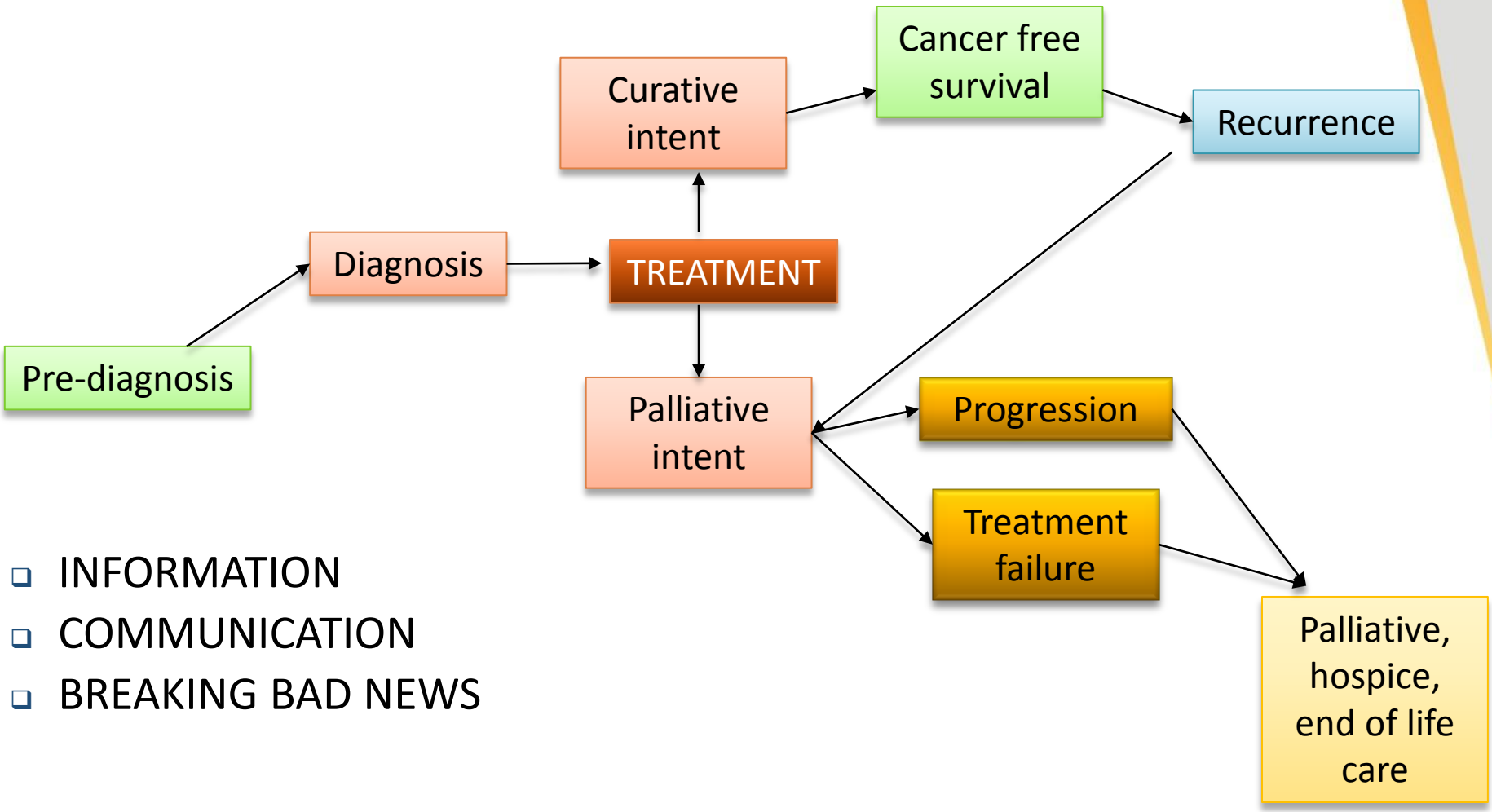
PROF & PHY (PSYCHIATRY)

AD HOC OFFICER IN CHARGE, DEPT OF PALLIATIVE MEDICINE

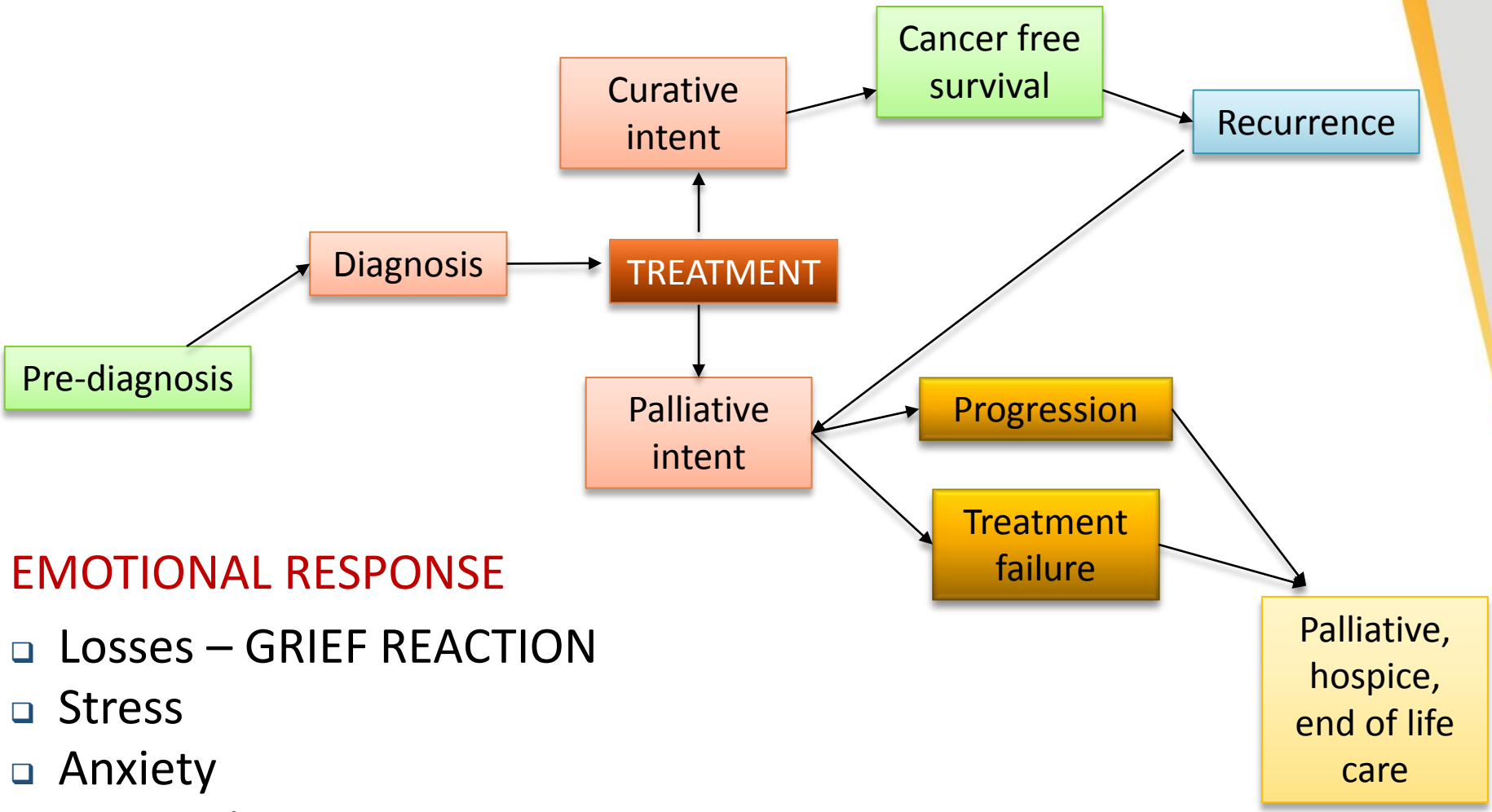
TATA MEMORIAL HOSPITAL

MISSING LINK


Pre-diagnosis
Diagnosis
TREATMENT
Curative intent
Cancer free survival
Recurrence
Palliative intent
Progression
Treatment failure
Palliative, hospice, end of life care



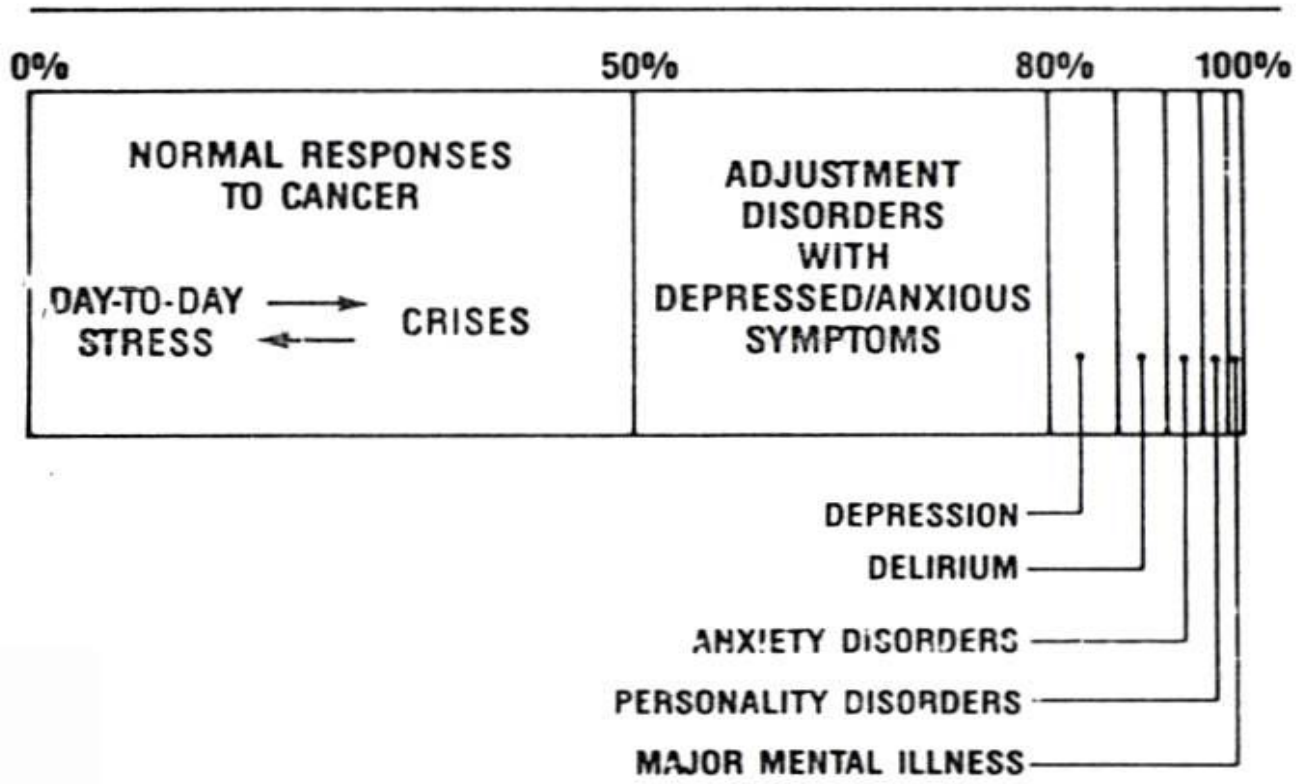
- INFORMATION
- COMMUNICATION
- BREAKING BAD NEWS



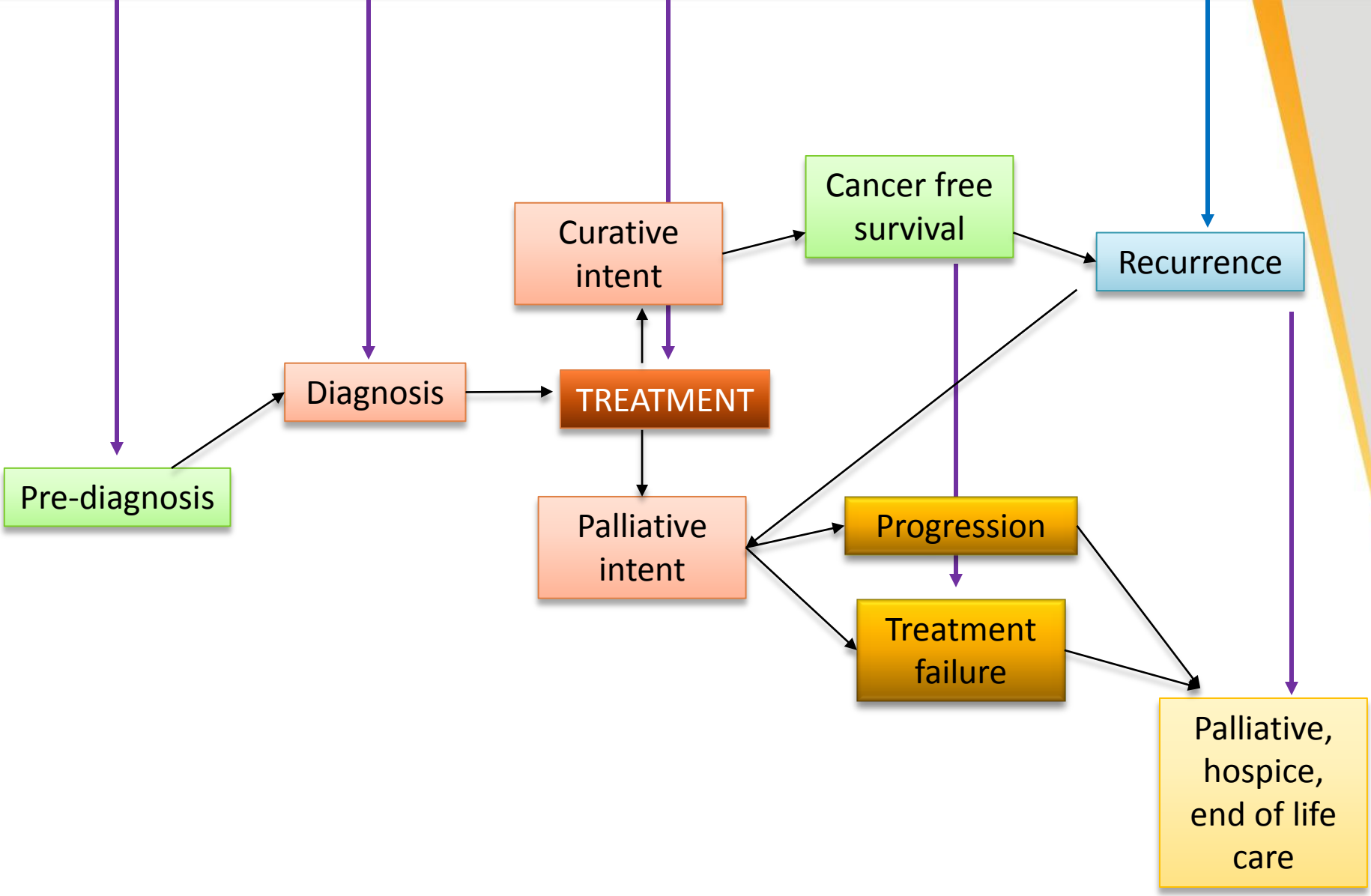
EMOTIONAL RESPONSE

- Losses – GRIEF REACTION
- Stress
- Anxiety
- Depression

DIAGNOSIS – Normal, distress or disorder?



NEW OR PREEXISTING?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- Derogatis' PSYCOG (1983): DSM-III
  - 11% prior psych diagnosis
  - 89% response to cancer
- 47% Psychiatric Disorder Rate
  - 13% major depression
  - 68% adjustment disorder (anx, dep)
  - 8% delirium

Adjustment disorders

- 16-42% in cancer patients
- Course – 21% developed major depression within 5 years
- Treatment – relaxation, individual therapy
- Use of medications if required

DEPRESSION

- Rate 2-3 times higher than in general population, as that associated with other serious medical illnesses (Caruso et al 2017)
- Pooled mean prevalence in a meta-analysis 8-24% (diff cancer, diff stages) (Krebber et al 2015)
- DSM defined – 14.9% MDD, 19.4% Adjustment Disorder (Mitchell et al, 2011)
- Negative impact on treatment adherence, quality of life, subjective severity of physical symptoms
- Cancer types associated with depression – oropharyngeal, pancreatic, lung and breast
- Diagnosis

RISK FACTORS FOR DEPRESSION

Individual

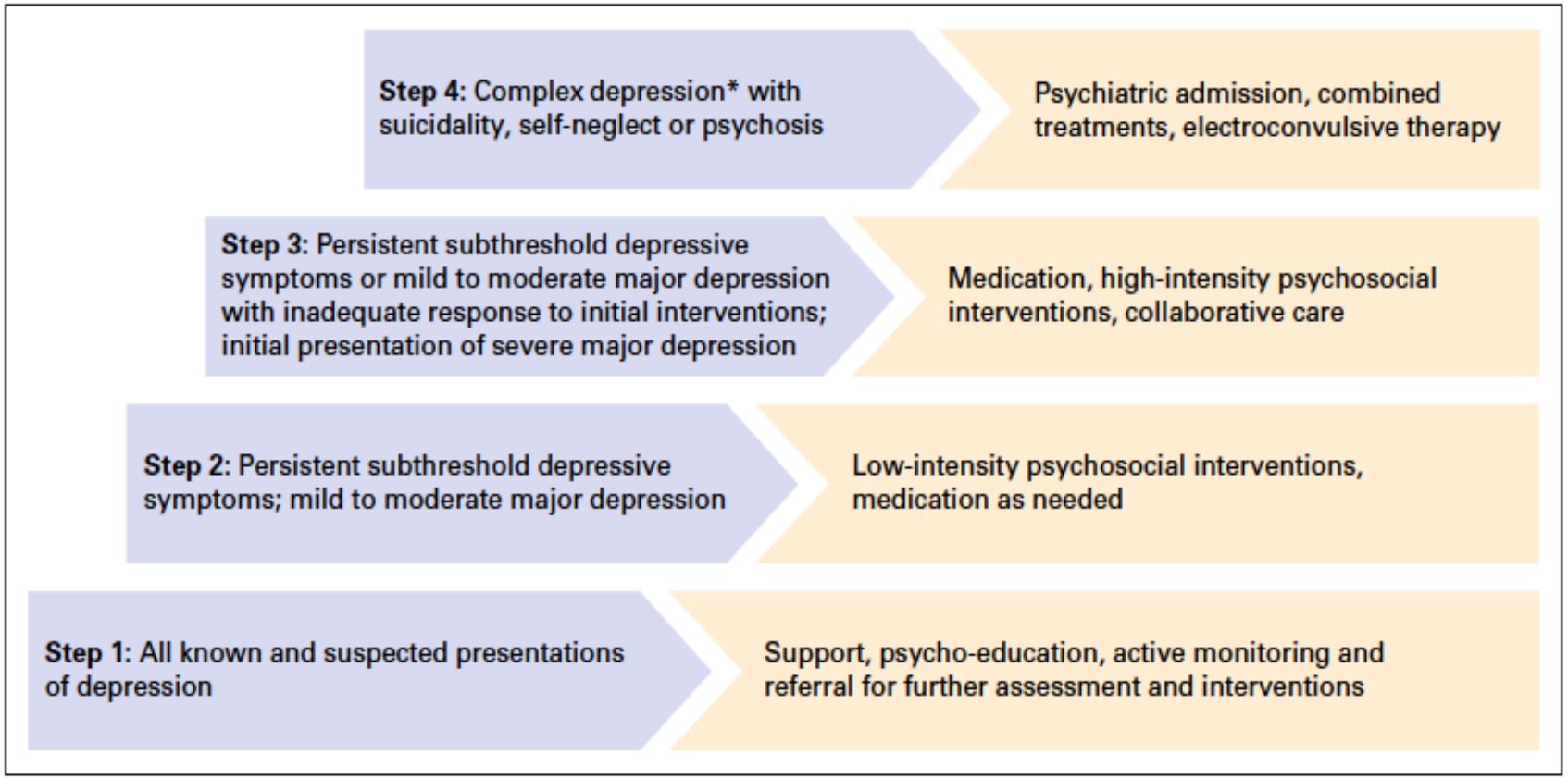
- Family or personal history, personality and coping

Interpersonal and social

- Stressful LE, lack of social support, low SES

Biological - type, stage, uncontrolled physical symptoms, inflammatory factors, treatment related

TREATMENT FOR DEPRESSION – STEPPED CARE APPROACH



ANTIDEPRESSANTS

- SSRIs –
  - Escitalopram
  - Fluoxetine, Paroxetine – CYP2D6 inhibition – avoid with Tamoxifen
- SNRIs – Venlafaxine/desvenlafaxine
- NaSSA- Mirtazapine
- TCAs – neuropathic pain
- Psychostimulants –

ANXIETY

PSYCHIATRIC Agitation, depression, delirium	ORGANIC Cardiac causes, metabolic, hypoxia, sepsis, pain, drug withdrawal
EXISTENTIAL Dependency, disfigurement, death	IATROGENIC Drug side-effects

ANXIETY

- Often comorbid with depression
- BDZ
- Alprazolam – mixed cancers in RCT
- Clinical practice – Lorazepam, clonazepam
- Close monitoring of adverse effects

DELIRIUM

- Neuropsychiatric diagnosis
- 25-85% in palliative medicine, higher in end of life
- Usually irreversible in end of life

Other concerns

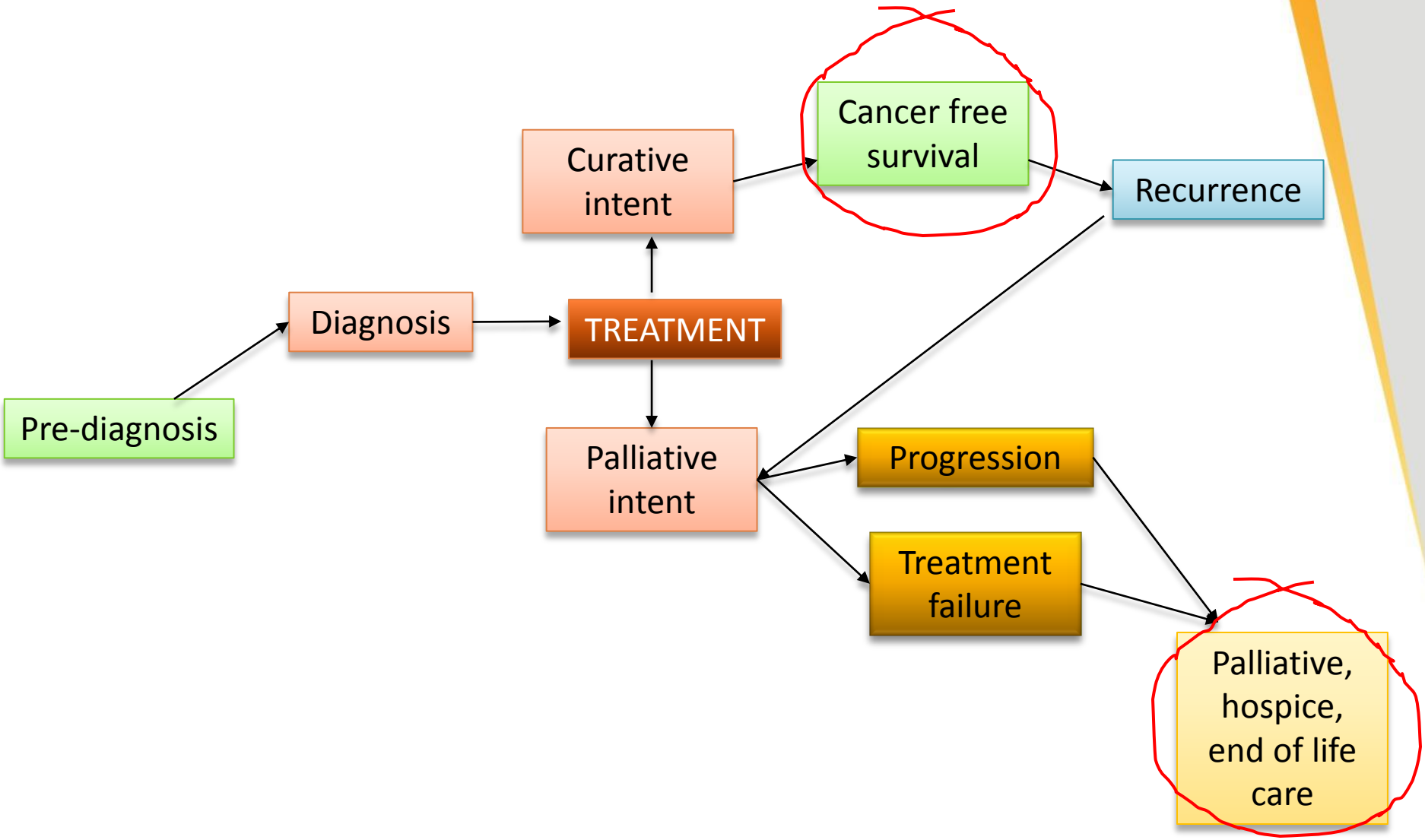
- Body image and sexuality
- Fear of cancer recurrence

- Substance use disorders
- Psychotic and Bipolar affective disorders – pre-existent or new

EVIDENCE BASED PSYCHOLOGICAL INTERVENTIONS IN CANCER CARE

- Supportive expressive
- Educational
- Cognitive behavioural
- Stress reduction
- Problem solving
- Expressive arts based

- Specialised psychotherapies – Meaning centred therapy, Dignity therapy, CALM – RCTs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SURVIVORS – ARE THEY OUT OF THE WOODS?

Clinical Ascertainment of Health Outcomes Among Adults Treated for Childhood Cancer

Melissa M. Hudson, MD
Kirsten K. Ness, PT, PhD
James G. Gurney, PhD
Daniel A. Mulrooney, MD, MS
Wassim Chemaitilly, MD
Kevin R. Krull, PhD
Daniel M. Green, MD
Gregory T. Armstrong, MD, MSCE
Kerri A. Nottage, MD
Kendra E. Jones, MS
Charles A. Sklar, MD
Deo Kumar Srivastava, PhD
Leslie L. Robison, PhD

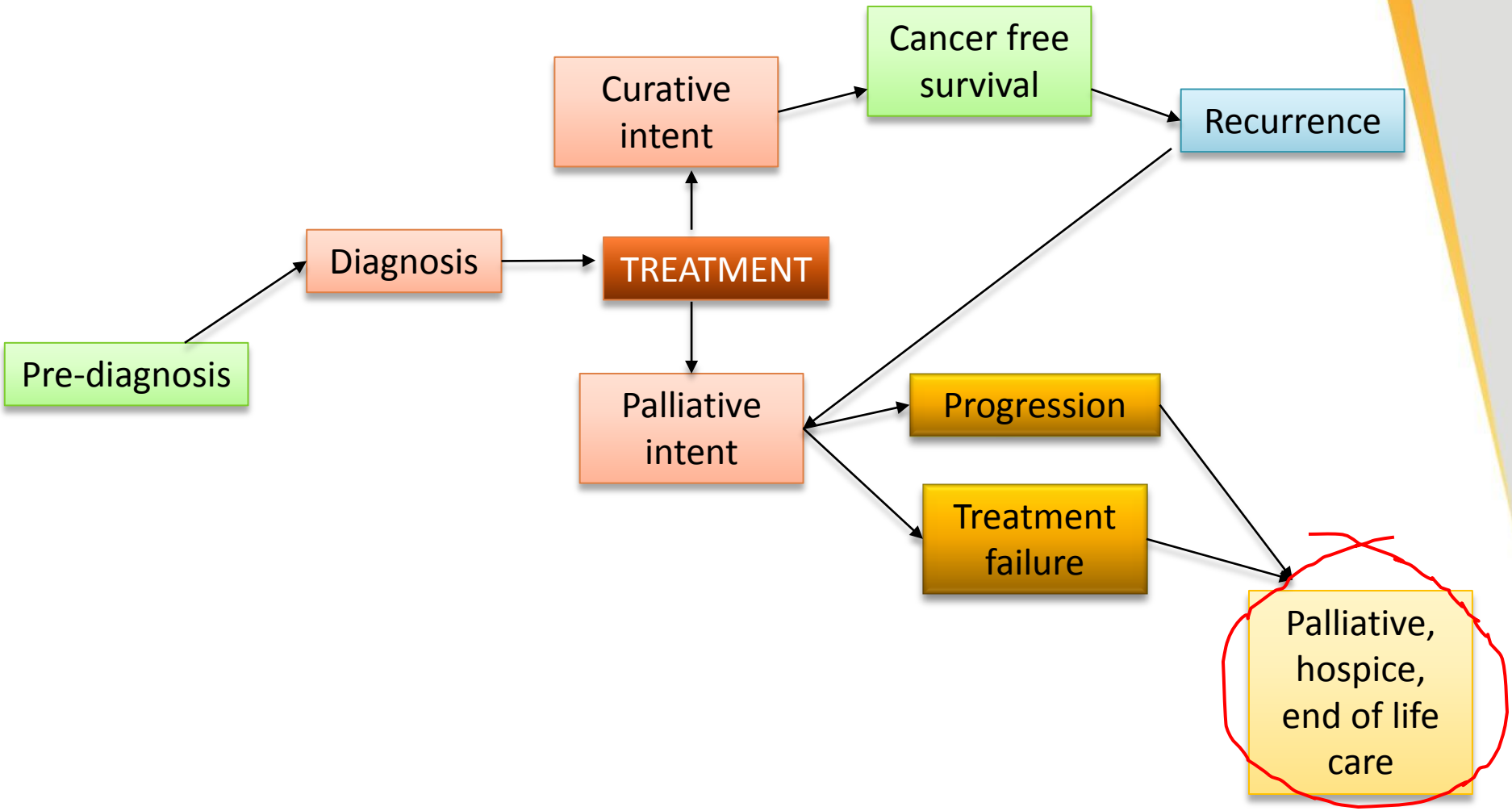
Importance Adult survivors of childhood cancer are known to be at risk for treatment-related adverse health outcomes. A large population of survivors has not been evaluated using a comprehensive systematic clinical assessment to determine the prevalence of chronic health conditions.

Objective To determine the prevalence of adverse health outcomes and the proportion associated with treatment-related exposures in a large cohort of adult survivors of childhood cancer.

Design, Setting, and Participants Presence of health outcomes was ascertained using systematic exposure-based medical assessments among 1713 adult (median age, 32 [range, 18-60] years) survivors of childhood cancer (median time from diagnosis, 25 [range, 10-47] years) enrolled in the St Jude Lifetime Cohort Study since October 1, 2007, and undergoing follow-up through October 31, 2012.

Main Outcomes and Measures Age-specific cumulative prevalence of adverse outcomes by organ system.

Results Using clinical criteria, the crude prevalence of adverse health outcomes was highest for pulmonary (abnormal pulmonary function, 65.2% [95% CI, 60.4%-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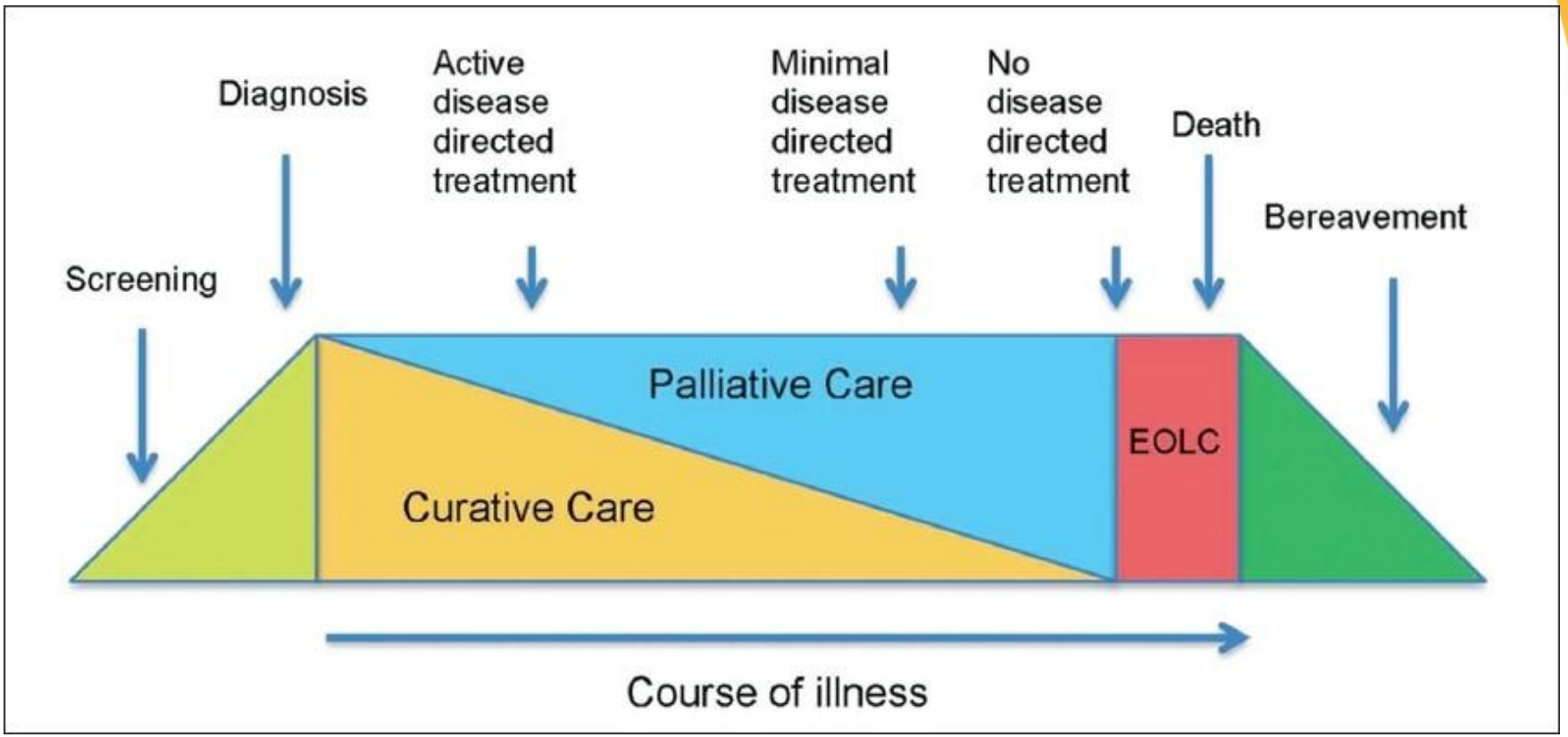
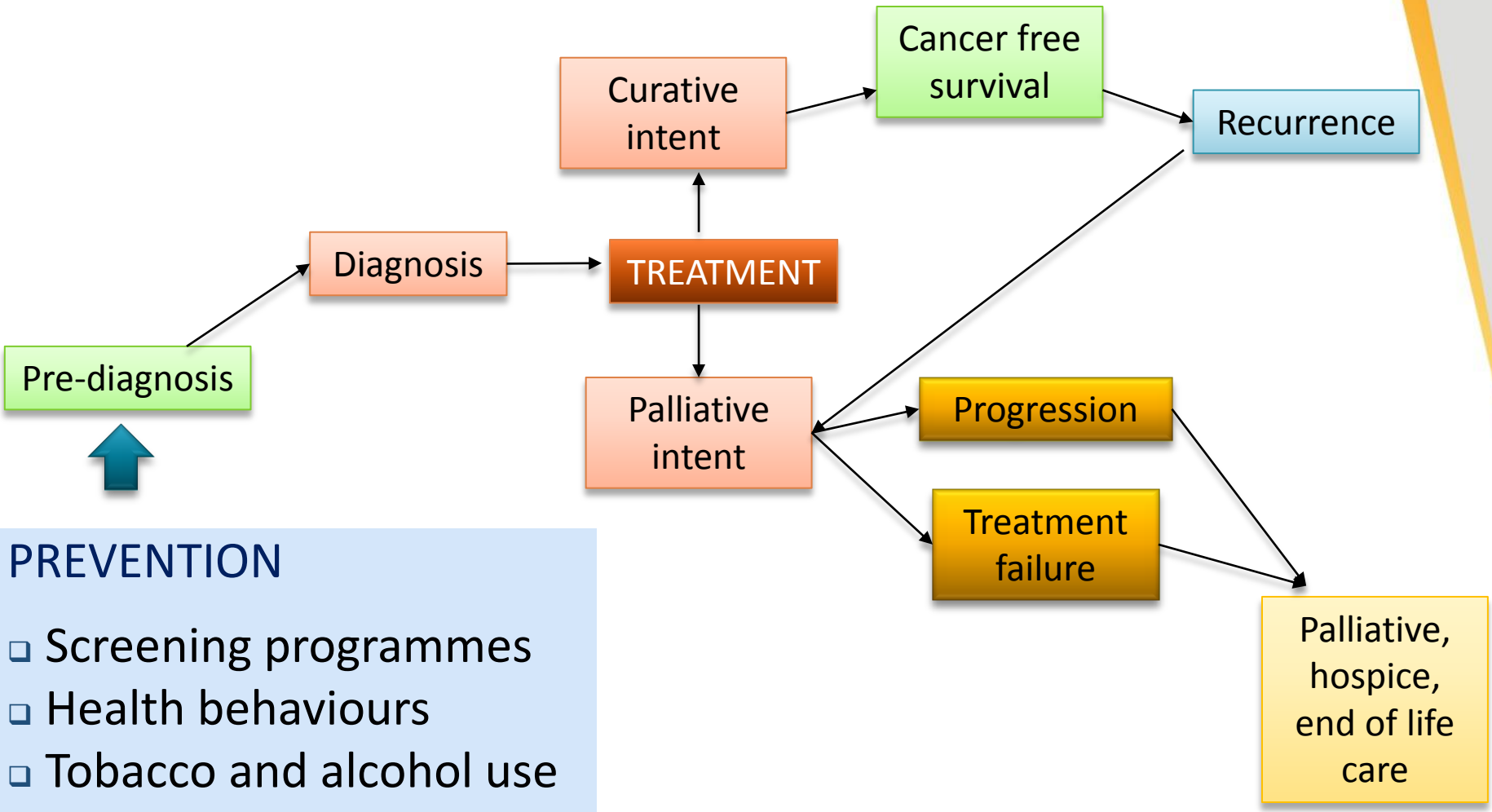

Diagnosis
Active disease directed treatment
Minimal disease directed treatment
No disease directed treatment
Death
Bereavement
Screening
Palliative Care
EOLC
Curative Care
Course of illness

Universal concepts…….influenced by culture

- Existential
- Spiritual
- Meaning in life
- The other side of the coin – Post traumatic growth, Resilience



PREVENTION

- Screening programmes
- Health behaviours
- Tobacco and alcohol use
- Genetic counselling

STAFF STRESS AND BURNOUT

- Loss of commitment, negative attitude to patients and staff and self, role dissatisfaction
- Oncology/ICU/Mental health > Palliative care professionals
- Importance of self-care

OUR ROLE

- Person-centred approach
- Bio-psychosocio environmental approach
- Predisposing, precipitating and perpetuating factors

Progress has been made in recent years for integrating psychosocial care into routine cancer care, but more work is needed.