DEPRESSION IN HEAD AND NECK CANCER

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INCIDENCE

- Depression is a common complication in patients with Head and Neck cancers.
- In various studies incidence of 20-50%
- Compare to 15-25% rate in all cancers

THE PROBLEM

- Depression is challenging to diagnose in patients who are ill or experiencing great stress
- Depression in under-diagnosed and under-treated

Depression may be present at the time of diagnosis.

RISK FACTORS FOR DEPRESSION

- h/o depression in patient or family
- Pain
- Advanced cancer
- Physical impairment
- Lack of family support
- h/o suicide attempt in patient or family
- Alcohol dependence/drug abuse

EFFECTS OF DEPRESSION ON TREATMENT FOR CANCER

- Depression is the #1 predictor of whether a patient will complete treatment
- Contributes to a low QOL
- Higher level of fatigue
- Low motivation affects rehabilitation
- Higher suicide rates

What is depression?

MOOD disorder which is persistent over time and has a variety of disabling symptoms

SYMPTOMS OF DEPRESSION

- Depressed or down mood most of the day, on most days
- Loss of pleasure or interest in usual activities
- Poor appetite
- Sleeping too little or too much
- Tiredness

SYMPTOMS-cont'd

- Feeling or worthlessness
- Excessive guilt
- Poor concentration
- Preoccupation with death, death wish, apathy about living, suicidal thoughts

- At least 5 symptoms persist for at least 2 weeks

SUICIDE

- Head and Neck cancers account for 2-4% of all cancers
- Suicide in head and neck cancer patients account for 20% of suicide in all cancer patients
- Men at higher risk
- Older patients in 6^{th} and 7^{th} decades
- Advanced illness and poor prognosis

Suicide risk factors

- Delirium
- Loss of control, sense of helplessness
- Exhaustion of physical, emotional, spiritual, financial and familial resources
- PAIN-uncontrolled pain is leading cause of SI and morbidity
- Pre-morbid psychopathology-dependent and dissatisfied
- SI, patient or family h/o suicide

WHY IS DEPRESSION OVERLOOKED?

- OVERLAPPING SYMPTOMS of fatigue, sleep disturbance, loss of appetite
- SIDE EFFECTS of medication and cancer treatment
- BUSY time

MISCONCEPTIONS

- All patients with cancer are depressed or should be
- Depression in cancer patients is normal
- Treatment will not help

Sadness and grief are normal reactions to a life threatening crisis.

Depression is not.

When to suspect depression

When the initial reactions of disbelief, denial and despair don’t lesson as the patient adjusts to the diagnosis

When to suspect depression

- Neglectful self care
- Inability to function as spouse, parent or employee
- Passivity, disengagement
- When there is nothing to look forward to

A 1998 study in *Laryngoscope* reported that patient's who reported low QOL were often depressed.

ASK

- This same study showed a lack of correlation between the physician's rating and the patient's self-report or depression

- YOU HAVE TO ASK

CONSIDER SCREENING FOR DEPRESSION

- Early detection and treatment is key to successful care
- Multiple screening tools with high sensitivity, specificity and predictive value
- Best if part of a Psychosocial Intervention program

PREVENTION?

- University of Nebraska completed a pilot study in 2005 where patients who were given Celexa had a reduction of the rate of depression to 15% compared to 50% of the placebo group
- A current study is looking at Lexapro

RANGE OF INTERVENTION

- PSYCHOSOCIAL SUPPORT AS A PART OF TREATMENT
- BRIEF COUNSELING
- SUPPORT GROUPS
- PSYCHOLOGICAL/PSYCHIATRIC CARE

INTERVENTION-cont'd

- Depends on the degree of functional impairment and duration and severity of symptoms
- COMBINATION therapy is most effective=pharmacotherapy and other therapy

MEDICATION

- Most antidepressants are equally effective
- Newer antidepressants have less side effects
- SSRI's are first line
- Ritalin may help fatigue and low energy as well as depression

ANTIDEPRESSANT SELECTION

- Target distressing symptoms
- Avoid troublesome side effects
- Start low and increase slowly

INSOMNIA OR AGITATION

- mirtazapine
- trazadone
- tricyclics
- paroxetine
- citalopram
- sertraline

TIRED/LOW ENERGY

- Buprorion, fluoxetine, duoloxetine, venlafaxine, ecitalopram, sertraline, methylphenidate

- Methyphenidate/Ritalin

  -low energy, poor appetite, depression

  -rapid onset of action

  -well tolerated

ADJUNCTIVE CARE

-TREAT INSOMINIA SEPARATELY IF NEEDED

-MANAGE PAIN

PSYCHIATRIC REFERRAL

- No improvement in 2-4 weeks
- Worsening symptoms
- Difficulty with side effects
- Depression interferes with treatment
- Serious symptoms/suicidal

SUMMARY

- Incidence is high
- Patients with depression don’t do well
- Identify patients at risk and suffering
- Ask and screen
- Prevention may be possible
- Psychosocial intervention
- Psychopharmacologic

Summary

- Psychosocial intervention
- Psychotherapy
- Psychopharmacology

When in doubt,

CONSULT or REFER!

THANK YOU