Supportive Care of the Patient With Pancreatic Cancer: Role of the Psycho-Oncologist

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Many people who are diagnosed with pancreatic cancer react with a normal level of sadness. In others, however, depression represents a concomitant illness, perhaps with a biologic basis. Regardless of their origin, these mood

**Introduction**

Patients with pancreatic cancer, known for its frequent diagnosis at an advanced stage, rapid progression, extremely low survival rate, and associated pain, are intuitively expected to present with depression and anxiety, based on the logic that feelings of hopelessness, helplessness, sadness, and grief would be common and even "normal" in these patients. Corroborating this notion, several studies have reported that depression and anxiety occur in as many as 50% of patients with carcinoma of the pancreas [1-3]. Although sadness is a normal situational reaction to pain and potential loss for many people with pancreatic cancer, for others depression is a concomitant illness. Many reports have noted an excessive comorbidity between depression and pancreatic cancer, as compared with other types of cancer [1,4-6]. Even more striking, psychiatric symptoms appear in approximately 50% of these patients before the diagnosis of cancer is made and somatic symptoms are noted [2,3,7]. In fact, psychiatric symptoms have been reported to occur up to 2 years prior to the onset of abdominal symptoms in some pancreatic cancer patients [4], and it has been suggested that the presence of depression, anxiety, insomnia, restlessness, or agitation may sometimes aid in the earlier diagnosis of this usually late-detected cancer [3,7]. This sequence of events suggests that pain, knowledge of a cancer diagnosis, or worry over unexplained physical symptoms cannot be the sole etiologic basis for psychiatric symptoms in many patients. Rather, it implies the existence of neuropsychiatric causes, such as tumor-based biologic pathogeneses [3]; such factors potentially involve adrenocorticotropic hormone, parathyroid hormone, thyrotropin-releasing hormone, glucagon, serotonin, insulin, or bicarbonate [3,8]. The role of the psycho-oncologist is to distinguish between normal emotional reactions to having advanced cancer and symptoms of comorbid psychiatric illness, perhaps with a biologic basis, which warrant more extensive treatment [9].

**Diagnosing Depression**

Depression is often overlooked in people with advanced pancreatic cancer because anorexia, weight loss, loss of energy, insomnia, loss of libido, and fatigue are more likely to be symptoms of the cancer than of a depressive syndrome [9]. Therefore, a diagnosis of major depression in cancer patients relies more on psychological symptoms, such as dysphoric mood for 2 or more weeks, hopelessness, helplessness, and a sense of worthlessness or despair, than on somatic complaints. In particular, anhedonia (total loss of interest or pleasure; not to be confused with a mere reduction in the number of pleasure-providing activities) and suicidal ideation are dependable diagnostic markers for depression in patients with pancreatic cancer. When these cognitive or ideational symptoms are present, a family history of depression or a history of alcoholism, drug abuse, or two or more previous depressive episodes (particularly if the first episode was before age 25 or after age 50) increase the risk and further substantiate the diagnosis [9].

**Treating Depression**

For cancer patients whose sadness and grief are normal emotional reactions to the grim medical situation that they are facing, depressive symptoms resolve gradually within 7 to 10 days with
support from family, friends, clergy, and others. The medical team can assist by providing clear medical information and a treatment plan that offers hope—if not for a cure, perhaps for control of pain and suffering. For pancreatic cancer patients, this treatment plan may include surgical resection, neoadjuvant or post-resection therapies, multimodality chemoradiation with or without surgery, enrollment in clinical trial protocols, or the assurance that physical and psychological symptoms will be addressed (ie, the patient will not die alone or in pain).

Intervention beyond that provided by empathic physicians, nurses, social workers, and clergy is usually not required unless symptoms of emotional distress are sustained, intolerable, or interfere with functioning [9]. However, prescribing a hypnotic or low-dose antidepressant to permit normal sleep and/or a benzodiazepine to reduce daytime anxiety can assist the patient through crisis periods and facilitate adaptation.

For patients who meet the Diagnostic and Statistical Manual-IV (DSM-IV) criteria for mood disorders or adjustment disorders, a combination of supportive psychotherapy (in the form of either individual or group counseling), cognitive-behavioral techniques (such as relaxation and distraction with pleasant imagery), and antidepressants has been shown to decrease psychological distress and depressive symptoms [9-11].

**Psychopharmacologic Interventions**

Psychopharmacologic interventions are the centerpiece of treatment of severe depression [10] and especially merit a trial in patients whose depressive mood disorder has a hormonal or neuropsychiatric complication, such as disruption of serotonin synthesis. Tricyclic antidepressants are the most commonly used antidepressants in cancer patients because of their analgesic properties and side effects that can alleviate cancer symptoms. For example, tricyclics with sedating properties, such as amitriptyline or doxepin, can be helpful in patients with agitation or insomnia [9,10]. If a patient does not respond to a tricyclic or cannot tolerate its anticholinergic side effects, a second-generation tricyclic (eg, trazodone), heterocyclic (eg, amoxapine or maprotiline), or serotonin-selective antidepressant (eg, fluoxetine [Prozac], sertraline [Zoloft], or paroxetine [Paxil]) can be used. Trazodone is strongly sedating and can be used at bedtime for insomnia.

Serotonin-selective reuptake-inhibiting antidepressants have fewer sedating and autonomic effects than the tricyclics, but because they can be associated with nausea, weight loss, and anorexia, their usefulness may be limited in patients with pancreatic cancer [10]. In addition, psychostimulants, such as dextroamphetamine, methylphenidate, and pemoline (Cylert), can also be used for managing depression or advanced cancer-related fatigue and can have a dramatic impact on patients’ functioning [10]. Psychostimulants have been shown to improve attention and concentration, and low doses may stimulate appetite, promote well-being, improve feelings of weakness and fatigue, and reverse the sedating effects of opioids used for pain management [10].

**Crisis Intervention**

For the person without an extensive psychiatric history who is undergoing the crises inherent in coping with pancreatic cancer, reducing symptoms of distress is the key to facilitating better adjustment. The goal of the psycho-oncologist performing crisis intervention therapy is to restore the patient's baseline (precancer) psychological functioning by using hypnosis, relaxation therapy, and other psychotherapeutic techniques and modalities that reduce pain and distress. Crisis intervention focuses on solving concrete, daily-life problems, including teaching specific coping skills (eg, how to take analgesics correctly), emphasizing past strengths, and mobilizing inner resources [9]. Referrals to such "low-tech" interventions as support groups and cancer survivor networks are often successful because for some patients less stigma is attached to participating in such groups than to seeing a psychologist or psychiatrist. Suggestions of coping techniques are sometimes better received from other patients than from mental health professionals.

**Summary**

Psycho-oncologists who care for pancreatic cancer patients can attest that depression and anxiety are neither inevitable nor untreatable in this population. Regardless of whether the depression and anxiety accompanying a patient's pancreatic cancer are the normal results of anticipatory grief, pain, and distress or are comorbid psychiatric conditions, these mood disorder symptoms are controllable using supportive psychotherapy, cognitive-behavioral techniques, crisis intervention, and/or psychopharmaceuticals.
References:

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