

\*\*\*\*\*

## 10 Minute Consultation

### Exploring low mood in a person with cancer

**Alexandra Pitman**,<sup>1,2</sup> Macmillan Consultant Liaison Psychiatrist<sup>1</sup>; Senior Clinical Lecturer in Psychiatry<sup>2</sup>

**Sahil Suleman**,<sup>1,2</sup> Macmillan Consultant Clinical Psychologist<sup>1</sup>; Honorary Research Associate<sup>2</sup>

**Nicholas Hyde**,<sup>1</sup> Consultant Head and Neck Surgeon<sup>1</sup>

**Andrew Hodgkiss**,<sup>3,4,5,3,4,5</sup> Consultant Liaison Psychiatrist<sup>3,4</sup>; Honorary Clinical Senior Lecturer<sup>5</sup>

<sup>1</sup> St George's University Hospitals NHS Foundation Trust, London, UK

<sup>2</sup> UCL Division of Psychiatry, London, UK

<sup>3</sup> Central & North West London NHS Foundation Trust, London, UK

<sup>4</sup> The Royal Marsden NHS Foundation Trust, London, UK

<sup>5</sup> Institute of Psychiatry, Psychology & Neuroscience, Kings College London, London, UK

Correspondence to: A Pitman [a.pitman@ucl.ac.uk](mailto:a.pitman@ucl.ac.uk)

#### Box start

#### What you need to know

- Specific psychological symptoms help distinguish between pathological anxiety or depression and an expected reaction to cancer
  - Psychological, rather than biological, symptoms of depression, such as anhedonia and pronounced helplessness, hopelessness, guilt, and suicidal ideation, tend to be key diagnostic pointers to depression in patients with cancer
- Anxiety is regarded as pathological in a patient with cancer when it is disproportionate to the level of threat (such as persisting beyond 10 days after receiving bad news), and disrupts usual functioning
- Investigate and address reversible causes, such as vitamin deficiency or hypercalcaemia, and perpetuating factors, such as pain

Provide active treatment for depression and anxiety where appropriate

#### Box end

*A 54 year old man asks his doctor for a sleeping tablet. He has recently been diagnosed with a Dukes B adenocarcinoma of the rectum and seems low in mood. Although he has been given a good prognosis, has completed neoadjuvant chemotherapy, and is booked for curative surgery shortly, he expresses doubts that he will live much longer. His doctor wonders if he might be depressed or anxious, and how best to address this.*

Depression and anxiety are more common in patients with cancer, and they are associated with poorer quality of life and cancer survival. This article offers advice on how to recognise these disorders, and when to offer referral for specialist advice.

During the assessment, form an impression about whether the patient has depression:

- Is this pathological low mood or anxiety, or is this a normal response to the threat posed by cancer?
- Could this be a direct effect of a medication or the disease?

## What you should cover

### History

Explore current mood, and difficulties with sleep. Facilitate disclosure by acknowledging that some patients may feel depressed or anxious after a cancer diagnosis, even when receiving life-saving treatment.

Ask about:

- Specific psychological symptoms: Psychological symptoms are the key diagnostic pointers of depression in patients with cancer. Ask about anhedonia (loss of pleasure or interest in previously enjoyable activities), and pronounced symptoms of helplessness, hopelessness, guilt, and suicidal ideation causing severe distress or impairment, as these are very likely to be diagnostic of depression<sup>5</sup>
- Does the patient feel subjectively very low in mood or report panic symptoms? Has he ever experienced this before?

Specific biological symptoms: Is the problem specifically initial insomnia /early morning waking, or is sleep broken due to pain or recent high-dose steroids??

- Check that depressive symptoms are not a result of the biologically-mediated effects of the tumour or treatment (see infographic).<sup>4</sup> Weight loss, low energy, and poor motivation may be a consequence of cancer cachexia or chemotherapy.

How are these symptoms affecting the person's life and ability to function? Are they likely to influence his cancer treatment decisions?

- Current physical symptoms, including but not limited to pain and bowel habit. Is he anxious about other symptoms, fearing they represent cancer spread?

For patients with high levels of anxiety, it may be hard to distinguish between an anxiety disorder, an adjustment disorder, and a transient but normal response to a life-changing diagnosis. Anxiety is regarded as pathological where it is disproportionate to the level of threat (for example high beyond 10 days after receiving bad news), persists or deteriorates without intervention, and disrupts usual functioning.<sup>6</sup>

*Previous medical history* Does he have any other medical problems associated with depression? Take an alcohol history, especially as rectal cancer is associated with alcohol use. Hazardous alcohol use will worsen low mood/anxiety, and render antidepressants ineffective.

*Previous psychiatric history:* Is this a further relapse of a longstanding recurrent depressive disorder or bipolar mood disorder?

### *Risk Assessment*

There is no evidence that screening for suicidal thoughts induces suicidal ideation. Explore suicidal thoughts, which may be passive (eg. “I don’t care if I wake tomorrow or not. I wish I was dead”) or active (eg. “I am thinking of ending my life”). Ask whether the patient has begun to think of ways to end their life and whether they intend to act on this. If so, when are they planning to take action?

Risk factors for suicide in cancer include tumour site, physical functioning, and cancer prognosis, in addition to the usual risk factors for completed suicide in the general population.<sup>1</sup> Patients with head and neck tumours, multiple myeloma, or lung cancer and those with limited treatment options are a particular concern, as are men with poor social support.<sup>2</sup> Suicide risk peaks during the first month after cancer diagnosis.<sup>3</sup> Such elevated risks are apparent despite the prevalence of suicidal ideation being no higher than that in the general population.<sup>4</sup> Suicidal thoughts may arise as a catastrophic reaction to a new diagnosis, during the intense phase of treatment, or in terminal illness. A past history of severe mental illness, previous self-harm and continuing alcohol or drug misuse are further important risk factors for completed suicide.

### **Clinical examination**

Whether the aetiology is thought to be biopsychosocial or due to direct biological effects (for example due to recent anti-folate chemotherapy), a full physical screen will identify any reversible contributory causes.

In this patient’s case, as for any assessment for depression, this should include:

- Mental state examination, looking for signs of self-neglect, poor eye contact, depressed posture, agitation or psychomotor retardation, depressive cognitions, suicidal thoughts / planning / intent, depressive delusions. Test concentration and memory (after recent chemotherapy).
- Medical investigation should include reviewing full blood count, renal, thyroid and liver function tests. The oncologists will have ruled out bone or brain metastases as part of the pre-operative staging of the cancer.

### **What you should do**

The general principle when assessing a patient with cancer for depression is that, if psychological symptoms reach the threshold for a depressive disorder, this should be

diagnosed and treated. Similarly, when anxiety is noted to impair function significantly, it should be assessed against diagnostic criteria for an anxiety disorder and treated accordingly.

Further details about management are found in the accompanying **Clinical Update** but the basic approach would include:

*Address any underlying biological causes:* for example hypothyroidism independent of his cancer. Colorectal cancers have few neuropsychiatric effects. If his low mood is thought to be an adverse effect of anti-folate chemotherapy, Vitamin B12 administration may ameliorate this by correcting raised homocysteine levels, but this remains untrials.

*Psychological approaches:* group or individual cognitive-behavioural strategies to understand and cope with his depressive symptoms and wider psychological therapy approaches to explore existential issues. These may be available from a psychosocial support service embedded in local cancer services, or from local psychological therapy services such as the Improving Access to Psychological Therapies (IAPT) programme. Where specialist services are not available, Increasing Access to Psychological Therapy (IAPT) services may also have long term conditions support available to address depression and anxiety.

*Pharmacological approach:* assuming no alcohol misuse, Sertraline or Citalopram would usually be appropriate first-line agents, with a gastro-protective agent if he has previous gastritis (see General prescribing pointers in patients with cancer). However, these SSRIs occasionally cause diarrhoea. In his case, choice of antidepressant should anticipate forthcoming stoma, and Mirtazapine would be a better option due to its relatively neutral effect on bowel function.

*Psychosocial support:* local voluntary sector support groups for people with cancer, and web-based psychoeducation resources are likely to be of benefit in self-management of distress.

### **When to refer**

Referral for specialist counselling and specific psychological interventions is indicated where depression or anxiety seriously challenge coping mechanisms or give rise to persistent distress. Such interventions include anxiety management or cognitive-behavioural therapy tailored to cancer contexts, and are provided in specialist psychological support services, including specialist counsellors and clinical psychologists embedded in cancer services.

Patients with cancer treated in primary care for major depression have better response rates to antidepressants after prescribing input from a psychiatrist.<sup>8</sup> Liaison psychiatrists have

particular expertise in selecting antidepressants in the context of complex medical or surgical care, particularly in the case of treatment resistance. In hospitals where there is no specialist oncology liaison service, or where liaison psychiatry input is only available for in-patients, prescribing advice for out-patients may be sought from community-based psychiatric services.

Suicidal ideation, psychotic symptoms, mania, and confusion or severe depression of rapid onset after chemotherapy or corticosteroid administration, are all indications for urgent psychiatric referral.

---

**Box start****Desire for hastened death**

“Desire for hastened death” is the term used to describe suicidal thoughts, requests for assisted suicide, and requests for euthanasia in terminally ill patients. It is reported by 17% of inpatients receiving end-of-life cancer care and is associated with major depression.<sup>7</sup> Commonly such patients report uncontrolled pain, burdensomeness, loss of dignity, and fear of a painful death. While healthcare staff might be asked to assist death at the end, this is illegal in the UK.

- If a person asks about options for hastening their death, use their request to open up a conversation about their fears about death
- Explore modifiable contributory factors, particularly pain.
- Clarify that assistance to die cannot be provided, document the discussion, and explain your obligation to share their feelings with senior professional colleagues

---

**Box end****Box start****General prescribing pointers in patients with cancer****Avoid**

- Selective serotonin reuptake inhibitors (SSRIs) in frail elderly patients due to risk of hyponatraemia (especially in women)
- Monoamine oxidase inhibitors (MAOIs) due to the potential for interactions with opioids and anaesthetics
- Fluoxetine or paroxetine in patients receiving tamoxifen as they inhibit metabolism to its active metabolite. Venlafaxine or citalopram are advised instead
- Mirtazapine and mianserin where white cells are compromised (due to risk of agranulocytosis), and SSRIs where platelets are compromised (due to increased risk of bleeding)
- Tricyclics—particularly clomipramine, dosulepin, and high dose amitriptyline—in patients with a reduced seizure threshold. Sertraline is advised as it has a lower risk of precipitating seizures

- SSRIs in patients taking procarbazine (an MAOI), and SSRIs or serotonin and norepinephrine reuptake inhibitors (SNRIs) in patients prescribed fentanyl, tramadol, or ondansetron, due to the risk of serotonin syndrome
- SSRIs in patients experiencing chemotherapy-induced nausea, due to treatment-initiation nausea
- Psychotropics causing QTc prolongation (such as tricyclics, quetiapine) with ondansetron or with most molecularly targeted therapies (particularly vemurafenib)

### **Consider**

- Vitamin B12 for patients depressed after gastrectomy or after pelvic irradiation
- Fluoxetine for depression in the context of anti-folate chemotherapies (methotrexate or pemetrexed).
- Gastroprotective agents in patients taking SSRIs who are at increased risk of bleeding due to impaired platelet aggregation. Bleeding risk is even greater in patients with bone marrow compromise.
- Sedative antidepressants, such as mirtazapine, in underweight patients or those with insomnia
- Venlafaxine to treat depression in women taking tamoxifen for breast cancer, to exploit its dual effect in reducing hot flashes

---

### **Box end**

---

### **Box start**

#### **Education into practice**

- What questions might you include in a screen for depression and anxiety in patients with cancer exhibiting psychological distress?
- How comfortable do you feel discussing suicidal ideation in a patient offered potentially curative treatment for cancer?
- 

---

### **Box end**

---

### **Box start**

#### **How patients were involved in the creation of this article**

We interviewed a range of our patients with cancer to find out what they felt were the important aspects to address in an article about psychiatric problems in cancer. We invited a patient representative to give a personal perspective of her experiences and to review our article for its coverage of key points.

---

### **Box end**

Contributors: AP and AH conceived the article and conducted literature searches. AP drafted the article, with contributions from SS, NH, and AH. SS devised the cognitive behavioural model. All authors approved the final version of the article and agree to be accountable for all aspects of the work. AP is the guarantor.

Competing interests: We have read and understood BMJ policy on declaration of interests and have no relevant interests to declare. Our employers and Macmillan had no role in the preparation, review, or approval of the manuscript. The views expressed are those of the authors and not necessarily those of their employing trusts or of Macmillan.

- <jrn>1 Robson A, Scrutton F, Wilkinson L, MacLeod F. The risk of suicide in cancer patients: a review of the literature. *Psychooncology* 2010;19:1250-8. [PubMed](#) [doi:10.1002/pon.1717](https://doi.org/10.1002/pon.1717)</jrn>
- <jrn>2 Kendal WS. Suicide and cancer: a gender-comparative study. *Ann Oncol* 2007;18:381-7. [PubMed](#) [doi:10.1093/annonc/mdl385](https://doi.org/10.1093/annonc/mdl385)</jrn>
- <jrn>3 Johnson TV, Garlow SJ, Brawley OW, Master VA. Peak window of suicides occurs within the first month of diagnosis: implications for clinical oncology. *Psychooncology* 2012;21:351-6. [PubMed](#) [doi:10.1002/pon.1905](https://doi.org/10.1002/pon.1905)</jrn>
- <jrn>4 Smith HR. Depression in cancer patients: pathogenesis, implications and treatment (review). *Oncol Lett* 2015;9:1509-14. [PubMed](#) [doi:10.3892/ol.2015.2944](https://doi.org/10.3892/ol.2015.2944)</jrn>
- <jrn>5 Gross AF, Smith FA, Stern TA. Is depression an appropriate response to having cancer? A discussion of diagnostic criteria and treatment decisions. *Prim Care Companion J Clin Psychiatry* 2007;9:382-7. [PubMed](#) [doi:10.4088/PCC.v09n0508](https://doi.org/10.4088/PCC.v09n0508)</jrn>
- <jrn>6 Stark DPH, House A. Anxiety in cancer patients. *Br J Cancer* 2000;83:1261-7. [PubMed](#) [doi:10.1054/bjoc.2000.1405](https://doi.org/10.1054/bjoc.2000.1405)</jrn>
- <jrn>7 Breitbart W, Rosenfeld B, Pessin H, et al. Depression, hopelessness, and desire for hastened death in terminally ill patients with cancer. *JAMA* 2000;284:2907-11. [PubMed](#) [doi:10.1001/jama.284.22.2907](https://doi.org/10.1001/jama.284.22.2907)</jrn>
- <jrn>8 Sharpe M, Walker J, Holm Hansen C, et al; SMaRT (Symptom Management Research Trials) Oncology-2 Team. Integrated collaborative care for comorbid major depression in patients with cancer (SMaRT Oncology-2): a multicentre randomised controlled effectiveness trial. *Lancet* 2014;384:1099-108. [PubMed](#) [doi:10.1016/S0140-6736\(14\)61231-9](https://doi.org/10.1016/S0140-6736(14)61231-9)</jrn>