

Mental Health in the Oncology Setting: General Considerations and Treatment Tips

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Presenter's disclosure of conflicts of interest is found at the end of this article.

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Abstract

Patients with comorbid mental health and substance use disorders are at greater risk for mortality and have higher cancer care costs. At JADPRO Live Virtual 2021, Lisa W. Goldstone, MS, PharmD, BCPS, BCPP, talked through general considerations in the oncology setting for persons with comorbid mental health or substance use disorders, strategies for recognizing when patients with new or preexisting mental health symptoms or disorders may benefit from treatment and/or referral, and first and second-line pharmacotherapy options.

Patients with comorbid mental health and substance use disorders are at greater risk for mortality and have higher cancer care costs. During JADPRO Live Virtual 2021, Lisa W. Goldstone, MS, PharmD, BCPS, BCPP, of the University of Southern California School of Pharmacy, discussed the need for routine screening for psychological distress for all patients, followed by treatment or referral when indicated. Dr. Goldstone also described pharmacotherapy options for patients with depressive and/or anxiety disorders.

CONSIDERATIONS WITH COMORBID CONDITIONS

According to Dr. Goldstone, when psychiatric disorders are present,

they will, “without doubt,” impact cost of care. One study of 6,598 patients treated at National Cancer Institute-designated cancer center found that more than 10% had a comorbid psychiatric disorder (Nizazi et al, 2020). The most common diagnoses were mood disorders, including depression and bipolar disorder, followed by tobacco use, anxiety, cognitive, and alcohol-related disorders.

“The average cost of cancer care was nearly \$20,000 more for persons with psychiatric comorbidities compared with those who did not have one, and there are incremental effects at higher levels of cost,” said Dr. Goldstone. “The cost of care for patients in the 90th percentile was more than \$40,000 higher.”

Patients with comorbid psychiatric disorders are also at greater risk for a cancer-specific death. A systematic review and meta-analysis of 28 observational studies found increased odds of having advanced-stage cancer at diagnosis among patients with preexisting mental illness (Davis et al., 2020). According to Dr. Goldstone, this outcome could be related to several factors.

“Health disparities do exist for persons with mental illness, so they may not be identified as quickly,” she said.

The study also found that specific disorders, including dementia (HR = 1.59), depressive disorder (HR = 1.17), psychotic disorder (HR = 1.59), and substance use disorder (HR = 1.55), were associated with a higher risk of a cancer-specific death.

“Although having a depressive disorder was associated with a lower risk of a cancer-specific death compared to some other disorders or even having a preexisting mental illness in general, it is still a greater risk than if one did not have a depressive disorder,” said Dr. Goldstone.

A systematic literature review with 17 studies and more than 280,000 patients found that persons with depression and/or anxiety with breast cancer had a higher hazard ratio in terms of recurrence, cancer-specific mortality, and all-cause mortality (Wang et al., 2020). Subgroup analyses showed poorer prognosis for those with clinically diagnosed depression and anxiety, females, patients younger than 60, and those with fewer than 5 years of follow-up.

Although having a diagnosis of either a depressive or anxiety disorder is associated with an increased risk of mortality, a retrospective study of a public health insurance database of patients diagnosed with breast cancer (N = 124,381) identified a reduction in mortality when an antidepressant is used compared with when it is not (Shim et al., 2020).

“The difference in mortality was most striking when you look at depressive disorders,” said Dr. Goldstone, who noted a hazard ratio of 2.4 with no antidepressant treatment vs. 1.31 when an antidepressant was used.

“There are some limitations to this study, but I think it speaks to the importance of not only evaluating for psychiatric disorders but also making sure we’re treating them,” she added.

MOOD STABILIZERS AND ANTIPSYCHOTICS

Dr. Goldstone noted select considerations for patients on mood stabilizers and antipsychotics. For patients on lithium, she said that providers should maintain therapy whenever possible, but they may have to reduce the dose in critically ill patients (Mehta & Roth, 2015).

“Lithium has a very narrow therapeutic index, and so it’s easily affected by changes in hydration status and sodium levels,” said Dr. Goldstone. “It’s really important to monitor lithium levels very closely whenever intake of fluids and electrolytes are restricted, and keep in mind that the prescrib-

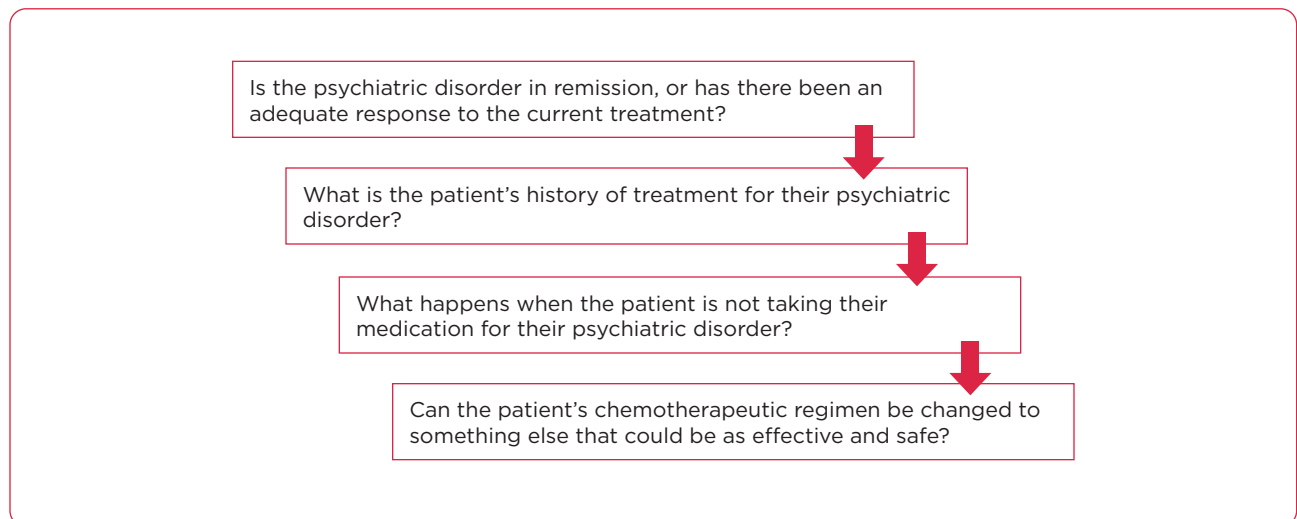


Figure 1. Drug-drug interactions and psychiatric adverse effects: What do I do?

er of the lithium may not know what’s happening in the oncology setting.”

Carbamazepine, an anticonvulsant medication used as a second-line agent in bipolar disorder, has bone marrow suppressing properties. With anti-psychotics, there is the potential for QTc prolongation, blood dyscrasias, and metabolic changes.

Figure 1 contains questions that should be asked when considering whether the psychiatric medication or oncology treatment should be changed in the event of a drug-drug interaction or adverse effects. “These are very tough decisions that are best made with the entire team, including the patient, but it’s important to know the answers to these questions so that you can have this discussion of risk vs. benefit with the patient and the other providers as part of the shared decision-making process,” said Dr. Goldstone.

IDENTIFICATION: TREAT OR REFER?

Given that a person with cancer may be at increased risk of suicide and the development of psychiatric disorders—most notably, depressive and anxiety disorders—Dr. Goldstone underscored the importance of identifying patients who are in need or in potential need of psychiatric treatment. Screening for psychological/psychiatric distress should thus be conducted at baseline and at regular intervals, she said. These screening tools include the following:

- NCCN Distress Thermometer and Problem List
- Patient Health Questionnaire (PHQ)-9
- Generalized Anxiety Disorders (GAD)-7

“An easy way to screen is just to make the screening tool a routine part of your intake paperwork that all your patients fill out,” Dr. Goldstone

said. “You could also have them fill out the screening tool in your office during the visit, but I find this takes time away from my face-to-face contact with my patients.”

“Another way to screen is doing it through your electronic health record or having your patients fill out the screening tool before they come in for appointments,” she added. Once a patient has been identified as having psychological distress, the NCCN Guidelines for Patients 2020: Distress During Cancer Care can be provided to patients as another resource.

If a provider has identified a patient with symptoms that may indicate some type of mental health disorder, the question then becomes whether to treat or to refer to a psychiatric specialist. Figure 2 contains an algorithm to help oncology providers decide whether to treat themselves or refer. According to Dr. Goldstone, many providers are uncertain about what to do if a patient reports suicidal thoughts, and in many cases, there isn’t a clear procedure to follow in the institution or the organization itself.

For this reason, said Dr. Goldstone, providers should be aware of the Columbia-Suicide Severity Rating Scale, or C-SSRS, an evidence-based tool to assess for suicide risk. The tool is available in 100 languages, with multiple versions available for different settings: <https://cssrs.Columbia.edu>.

DEPRESSION AND ANXIETY: FIRST-LINE OPTIONS

Understandably, persons with cancer can develop situational anxiety or an exacerbation of symptoms of an existing anxiety disorder because of cancer. The cancer itself, depending on type and location, may also cause anxiety.

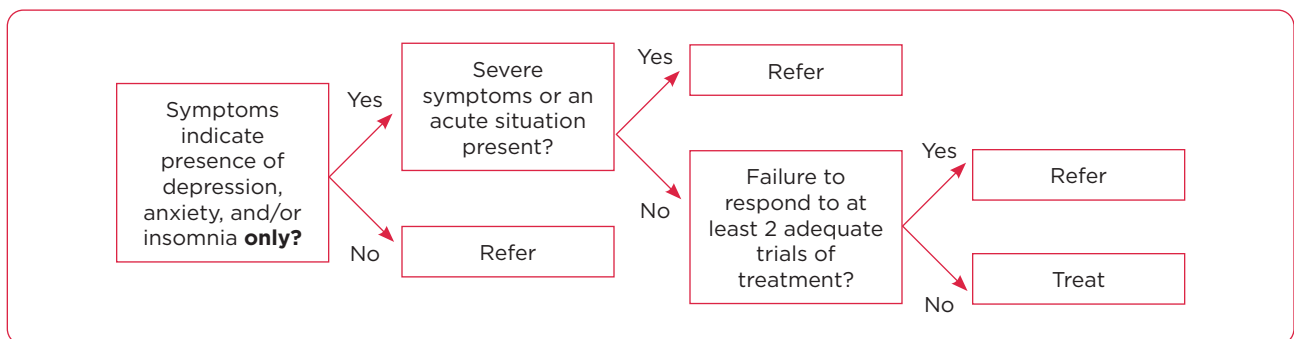


Figure 2. Treat or refer?

“There are multiple physical and psychological causes for depression, including stressors or losses resulting from a diagnosis of cancer or other medical conditions, that can develop,” said Dr. Goldstone. “Thus, multiple medication-related causes for symptoms of depression and anxiety need to be considered by oncology providers.”

According to Dr. Goldstone, this speaks to the importance of not only doing baseline screening but ongoing screening. Knowing whether the symptoms of depression and anxiety are medication related is critical as the risk vs. benefit of continuing that medication needs to be weighed against adding another medication to treat those symptoms, she said.

There are several important guidelines in psychiatry regarding first-line treatment of major depressive disorder.

The American Psychiatric Association (APA), which is considered the “gold standard for guidelines pertaining to psychiatric treatment in the United States,” recommends psychotherapy or a second-generation antidepressant, said Dr. Goldstone. Those are agents such as selective serotonin reuptake inhibitors (SSRIs), serotonin norepinephrine reuptake inhibitors (SNRIs), bupropion, and mirtazapine. With respect to psychotherapy, cognitive behavioral therapy and interpersonal psychotherapy are preferred.

The Canadian Network for Mood and Anxiety Treatments Guideline published in 2016 leans toward non-pharmacotherapy treatments in cases of mild depression, including psychoeducation, self-management, psychological treatment, and complementary therapies. Medications are only recommended in certain situations.

Finally, the Psychopharmacology Algorithm Project at the Harvard Medical School South Shore (updated in 2020) offers three options: sertraline, escitalopram, and bupropion.

“In general, SSRIs, SNRIs, bupropion, and mirtazapine are going to be your go-to agents,” said Dr. Goldstone.

With respect to generalized anxiety disorder, Dr. Goldstone recommended starting with an SSRI, such as sertraline or escitalopram, and for patients with comorbid pain, an SNRI, such as venlafaxine or duloxetine.

“I try to avoid using benzodiazepines even on an as-needed basis unless a patient has severe symptoms,” said Dr. Goldstone. “As I’ve already mentioned, patients with severe symptoms should be referred to a psychiatric or mental health specialist for treatment.” ●

Disclosure

The presenter had no conflicts of interest to disclose.

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