

Geriatric Psycho-Oncology

Barbara Lubrano di Ciccone, MD

Assistant Professor

University of South Florida

OBJECTIVE

- Identify the major psychiatric complications of cancer and its treatment
- Identify the needs of elderly patients with cancer
- Become familiar with assessment and treatment strategies for elderly with cancer

Key Points

- Overall, elderly people appear to cope better than younger people with cancer
- However, it is more difficult to assess psychiatric distress in the elderly
- Many elderly patients, especially men who have never had psychiatric treatment, are less willing to accept psychiatric treatment in the cancer setting, when needed
- Psychotherapy and psychiatric medications can be very helpful, but may need to be modified to accommodate the elderly and end of life
- Family and social resources must be taken into account to achieve successful psychiatric treatment in the elderly

Cancer and the Elderly

- By 2030, 20% of the population will be over the age of 65
- 60% of people diagnosed with cancer are 65 years or older
- 70% of all cancer deaths occur in those 65 and older
- 25% of elderly patients with distress will go unnoticed
- Coping with cancer at older ages is particularly difficult because of other life cycle events and losses
 - Retirement, widowhood, death of peers
 - Loss of hearing, sight, and mobility.

Evaluation of older patients

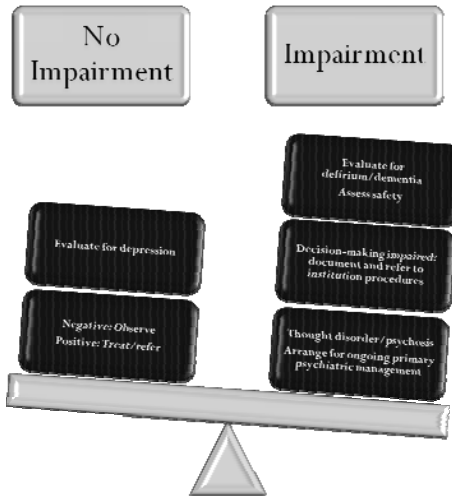
More emphasis needs to be given to the following domains

- **Functional status**
- Co-morbidities and concomitant medication use
- Nutrition
- **Cognition**
- **Social Support**

Treatment decision-making

- Older Patients are less likely to receive standard cancer treatment due to difficulty tolerating toxic cancer therapy
- Factors affecting treatment include:
 - Functional status
 - Co-morbid medical conditions
 - Nutritional status
 - Social support
 - Psychological status
 - Capacity

Evaluation of elderly with dementia in cancer: MMSE, Neurological exam and neuropsychiatric testing



Oncology evaluation of the older patient

- Need to compare the “chronological” age with the “functional” age
- Current widely used tools are the Karnofsky Performance Status (KPS) and the Eastern Cooperative Oncology Group (ECOG) can be misleading.

The KPS and the ECOG

- 100: NI, no complaints, no evidence of disease
 - 90: Able to carry on NI activities; minor signs of or sxs of disease
 - 80: NI activity with effort
 - 70: Cares for self, unable to carry on NI activities
 - 60: Requires occasional assistance
 - 50: Requires considerable assistance and frequent medical care
 - 40: Disabled
 - 30: Severely disabled, hospitalization is required
 - 20: Very sick, death not imminent
 - 10: Moribund, fatal process
 - 0: Dead
- 0: NI activity
 - 1: Symptomatic; fully ambulatory
 - 2: Symptomatic, in bed < 50% of time
 - 3: Symptomatic: in bed > 50% of time
 - 4: 100% bedridden
 - 5 Dead

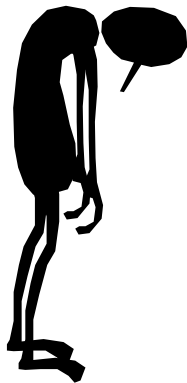
Assessing for mood disorders



Normal Responses to cancer

- Initial shock and disbelief, followed by a period of turmoil, anxiety, depression, irritability and neurovegetative symptoms.
- Symptoms are usually self limited and resolve over days to weeks with support of family, friends and doctors. Other interventions are not required. Hypnotics or anxiolytics can be helpful.

When it becomes a problem?



- When depressive or anxious symptoms don't improve after few weeks and the high level persist over weeks to months, is maladaptive, impairs social and/or occupational functioning.
- Emergence of suicidal ideations, request for PAS (Physician Assisted Suicide)

Communication Issues

- Shorter visits are less likely to contain “empathic opportunities”
- Patients do not get an opportunity to express their emotions.
In some instances, patients are seen by the resident, fellow or midlevel providers, which leaves the physician with a briefer encounter.
- Women are more comfortable expressing emotions than men
- Most physicians are comfortable with addressing patient’s emotions, however, they may not be comfortable with recognizing emotions when they occur.
- Elderly patients usually require longer visit time.
Schedule accordingly.

Suggested questions for the assessment of depressive symptoms

- Many people find themselves dwelling on thoughts of cancer.
What kind of thoughts do you have?
- Do you find yourself ever thinking I brought this on myself, God is punishing me? How often? Do you believe these thoughts are true?
- In spite of these thoughts, are you still able to go on with your life and find pleasure in things. Or are you so preoccupied that you cannot sleep, or feel hopeless?

Be prepared to answer your patients' questions

- What I have done wrong?
- Is it my fault?
 - I did not: exercise, eat healthy, stop smoking, pay attention to my depression, anxiety or stress, stop smoking or drinking.
 - I was not good to my partner or children
- Am I being punished?
- Am I dying?
- Don't avoid talking about death with your patient

Screening tools for Depression in Cancer Patients

- Single Item Interview assessing mood: "Have you been depressed most time for the past two weeks?"
- Two-item interview assessing depressed mood and loss of interest in activities
- Visual analog scale for depressed mood
- Beck depression inventory-13 item.

- Chochinov et al, 1997, American Journal of Psychiatry

During the past week, how distressed have you been?

Please indicate your level of distress on the thermometer and check the causes of your distress.

Extreme Distress

No Distress

Practical problems

- Housing
- Insurance
- Work/school
- Transportation
- Child care

Family problems

- Partner
- Children

Emotional problems

- Worry
- Sadness
- Depression
- Nervousness

Spiritual/religious concerns

- Relating to God
- Loss of faith
- Other problems

Physical problems

- Pain
- Nausea
- Fatigue
- Sleep
- Getting around
- Bathing/dressing
- Breathing
- Mouth sores
- Eating
- Indigestion
- Constipation/diarrhea
- Bowel changes
- Changes in urination
- Fevers
- Skin dry/itchy
- Nose dry/congested
- Tingling in hands/feet
- Feeling swollen
- Sexual problems

Brief Screening tool and Problem List

Emotional Crises In Cancer: Palliative Care Continues Throughout

- Diagnosis and Initial Treatment
- Completion of treatment
- No evidence of disease—Damocles' Syndrome
- Recurrence of disease; more treatment; spiritual and existential concerns
- Advancing disease—pain, fatigue
- Hospice and Terminal Stages
- Death

Depression

- Estimates in the elderly as high as 50%
- Risk of depression plateaus from the ages of 65 to 75 but then increases again with advancing age
- Risk factors:
 - loss of spouse
 - functional disability
 - inadequate emotional support; other life stresses or losses
 - uncontrolled pain and advanced illness
 - poor physical condition
 - previous history of depression
 - family history of depression or suicide
 - medications known to cause depression

Medical Conditions Causing Depression in Cancer Patients

- Metabolic Abnormalities
 - Hypercalcemia, Hypomagnesemia
 - Sodium and Potassium imbalance
 - Low B12 or folate
 - Thyroid problems
 - Adrenal dysfunction
 - DM, Insulinoma
 - Anemia
- Oat Cell Carcinoma, Pancreatic carcinoma, CNS tumors, Lymphoma, Leukemias
- Uncontrolled PAIN

Medications that can cause depression

- Steroids
- Anticonvulsants
- Baclofen
- Benzodiazepines
- β blockers
- Metronidazole
- Narcotics
- NSAIDs
- Phenylephrine
- Reserpine
- Trimethoprim-Sulfamethoxazole
- Interferon
- Tamoxifen
- Leuprolide
- Vincristine
- Vinblastine

Mood disorder with depressive features due to cancer

- Attend to whether organic factors underlie the depressive syndrome
- Rule out the presence of delirium, and if present precludes the Dx of depression
- Cancer affecting the CNS and Pancreatic carcinoma
- Every cancer patient must be evaluated for medical, endocrine and neurologic factors.
- If the mood d/o is believed to result from the GMC or medications, attempt to treat these first.

Who is at a higher risk?

- Patients with poor physical condition
- Advanced stages of disease
- Inadequate pain control
- Hx of depression
- Significant life stressors or losses

(Massie and Popkin, 1998; Newport and Nemeroff, 1998)

Diagnosing Depression in the Elderly

- Sleep, appetite, and energy are less reliable symptoms in cancer patients
- Elderly more likely to have somatic symptoms
- Cognitive symptoms of depression such as hopelessness, worthlessness, guilt and suicidal thoughts may be very significant
- Rule out organic causes or mimics
 - Pain, fatigue, metabolic, endocrine, substance use and withdrawal and Demoralization

Critical Symptoms of Depression in the Cancer Patient

- Hopelessness
- Excessive guilt
- Worthlessness
- Feeling one is being punished
- Suicidal ideation

Pain

- In a study conducted by Walsh et al. (2000) found that over 80% of elderly advanced cancer patients reported daily pain.
- Within the hospice setting, over 40% of older patients reported SEVERE pain
- Cancer pain has been associated with depression among older people in institutional and outpatient settings.

Bernabei R, Gambassi G, Lapane K et al. *Jama* 1998; 279:1877-82
Heim HM, Oei TP, *Pain* 1993; 13:116-37

Suicide and Cancer

- Cancer patients are at 2-3 X greater risk for suicide than the general population.
- Rates of SI range from 1%-16% depending on the stage, type/setting
- Poor prognosis, delirium, uncontrolled pain, depression, hopelessness increase the risk for suicide.

Risks Factors for Suicide in Cancer Patients

(From Miller and Massie, The Cancer Journal, Vol 12 NO 5, September 2006)

- **Related to mental status**
 - Suicidal ideations
 - Lethal Plans
 - Depression and Hopelessness
 - Delirium and disinhibition
 - Psychosis
 - Loss of control and impulsivity
- **Related to history**
 - Previous suicide attempt
 - Psychopathology
 - Substance abuse
 - Recent losses
 - Poor psychosocial support
 - Older male
 - Family history of suicide
- **Related to cancer**
 - Uncontrolled pain
 - Advanced disease and poor prognosis
 - Fatigue
 - Site of cancer (H&N, lung, GI, GU, Breast)
 - Medications side effects (steroids)

Reasons for Patient Requests for Assisted Suicide

- Discomfort other than Pain 79%
- Loss of Dignity 53%
- Fear of uncontrolled Sxs 52%
- Pain 50%
- Loss of Meaning in life 47%
- Being a burden 34%
- Dependency 30%

Meier, et al NEJM 1998; 338:1193

Depression: Treatment

- Psychopharmacology: SSRI's and others
 - Be mindful of drug-drug interactions, i.e. SSRI's (in particular Paroxetine, Fluoxetine and Sertraline) with concomitant use of Tamoxifen.
 - Psychostimulants—work faster, but be aware of side effects
 - Choosing medication based on additional actions or on side effect profile to maximize benefits
 - Mirtazapine to help sleep and appetite
 - Tricyclics to help with neuropathic pain
 - Bupropion, Fluoxetine to help fatigue
 - Start at lower doses for elderly
 - Psychotherapeutic techniques: Supportive Therapy, Cognitive-Behaviorally Oriented Therapy, Group Therapy, Meaning-Centered Therapy; Dignity Therapy
- titrate slowly

Before Starting Psychotropics

- ✓ liver and renal functions
- ✓ cognitive function
- ✓ other medications and possible interactions
- ✓ for alcohol use
- ✓ EKG
- Start low and go slowly

Psychotherapeutic Issues

- May need to decrease length of sessions
- May need to focus on physical and psychological symptom interplay and relief
- May need to be flexible with therapy style:
 - Education
 - Support
 - Cognitive-behaviorally oriented
 - Insight-oriented
- With men, may need to have spouse in session

Demoralization



- Demoralization: A state of hopelessness, loss of meaning, and existential distress recognizable in palliative care settings. It is associated with chronic medical illness, disability, bodily disfigurement, fear of loss of dignity, social isolation, and feelings of dependency on others. (Kissane et al. 2001)
- 7-14% of patients have high demoralization in the absence of MDD

Diagnostic Criteria for Demoralization Syndrome

- A. Symptoms of existential distress: meaninglessness, pointlessness, hopelessness
- B. Sense of pessimism, stuckness, helplessness, loss of motivation to cope differently
- C. Associated social isolation, alienation or lack of support
- D. Phenomena persist over more than two weeks

Kissane D, 2001

Predictors of Shorter Survival

Particularly after recurrence:

- Helplessness, hopelessness, depression
- Social alienation
- High anxiety
- Fatalism, stoicism

Anxiety: Diagnosis

- ? Normal reaction to stressful events
- ? Component of pain, delirium or depression
- ? Related to medical causes:
 - Respiratory distress or Pulmonary embolus
 - Medications—steroids, anti-emetics
 - Metabolic disturbances
- ? Prior anxiety disorders
 - Panic disorder; Obsessive Compulsive Disorder
 - Post-traumatic stress disorder

Anxiety: Treatment

Psychotherapy

- Cognitive behavioral, supportive, insight oriented psychotherapies
 - Reframing, progressive relaxation, guided imagery, meditation, hypnosis
 - Understand the illness in context of life continuum
- In-person or telephone counseling

Pharmacotherapy

- Benzodiazepines:
 - Sedation and confusion
 - Increased risk of falls
 - Paradoxical agitation
- Buspirone—not immediately effective
- Neuroleptics—low dose often effective
 - Good alternative or addition to benzodiazepines

Delirium

- Disturbance in level of consciousness, attention, thinking, perception and memory
- Develops over short period of time
- Fluctuates during course of day
- Common in advanced cancer patients
- Risk factors include cognitive impairment, advanced age and co-morbid medical illness
- Distinguish from dementia and other cognitive disorders

Delirium

- Often involves multiple etiologies
 - Direct effect of cancer/paraneoplastic syndrome
 - Medications and chemotherapy
 - Narcotic analgesics
 - Hypnotics
 - Steroids
 - Chemo agents, immunotherapeutic agents, anti-infectious agents
 - Electrolyte imbalance
 - Infection

Delirium: Management

- Correction of underlying cause(s)
 - i.e., electrolytes, infection, stopping causative agents
- Environmental structure
 - Calendar, lighting, familiar people and photos
- Medications
 - Neuroleptics: main pharmacologic intervention
 - Typicals: Haloperidol, Chlorpromazine (Thorazine)
 - Atypicals: Olanzapine (Zyprexa), Risperidone (Risperdal), Quetiapine (Seroquel), Ziprasidone (Geodon), Aripiprazole (Abilify)
 - Benzodiazepines: NOT effective alone; useful in combination with a neuroleptic like haloperidol for rapid sedation

In summary:

- Treatment choice can be a complex issue
- Overall, older patients cope better than younger ones
- They often do not express their loneliness or depression so that these symptoms go unnoticed
- It is necessary to distinguish depression or anxiety from delirium
- About 25% of older patients with distress are not recognized or treated
 - Need to make appropriate use of screening tools

... and finally

- Patients with cancer over 65 years of age and older are the fastest growing segment of the U.S. population and suffer significant psychological distress
- It is important to recognize and treat mood symptoms, but traditional methods may need to be modified
- Family and social supports are important sources in diagnosing and treating psychiatric issues in the elderly