Anxiety, Depressive Symptoms, and Quality of Life in Newly Diagnosed Head and Neck Cancer Patients

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ABSTRACT

Psychological distress, including anxiety and depressive symptoms, is prevalent among newly diagnosed cancer patients. Greater distress may be related to poorer quality of life (QOL). Poor QOL may impact treatment response and recovery. Here we describe a sample of newly diagnosed patients who reported on anxiety, depressive symptoms, and HRQOL upon initial presentation to a multidisciplinary head and neck clinic.

Retrospective medical record review (Oct 2012 - Feb 2013) yielded 107 patients (78 male) who provided data of interest. This cohort completed screening measures of anxiety and depressive symptoms (HADS), and health-related quality of life (UW-QOL). These data were provided during the initial clinic visit, prior to initiation of curative treatment.

Average age was 60.7 years (SD=13.2). Nineteen patients (17.8%) had laryngeal and 14 (13.1%) had tonsillar cancers. Nearly half (46.7%) exhibited clinically significant distress. Younger patients had significantly greater anxiety and depressive symptoms, but better QOL (p<.024). Patients with more advanced cancer reported poorer physical QOL (p=.016). Greater anxiety and depressive symptoms were strongly predictive of poorer QOL (p=.001; Figures 2 and 3), especially for those who scored above the cutoff for clinically significant distress (p<.001).

In this study, we describe a sample of head and neck cancer patients. Our group is beginning to explore a model of psychoneuroendocrine and psychoneuroimmune relationships in cancer (Figure 1) [8] for the first time in the head and neck population.

Here we begin with a cross-sectional examination of relationships between psychological distress and QOL upon patients’ initial presentation to a multidisciplinary head and neck clinic.

RESULTS

• Mean age was 60.7 years (SD=13.2).
• The most common diagnoses were laryngeal (n=19, 17.8%) and tonsillar cancers (n=14, 13.1%).
• Nearly half (46.7%) exhibited clinically significant distress on self-report questionnaires.
• Younger patients had significantly greater anxiety and depressive symptoms, but better QOL (p<.024).
• Patients with more advanced cancer stage reported poorer physical QOL (p=.016).
• Greater anxiety and depressive symptoms were strongly predictive of poorer QOL (p<.001; Figures 2 and 3), especially for those who scored above the cutoff for clinically significant distress (p<.001).

METHODS AND MATERIALS

Retrospective medical record review (Oct 2012 - Feb 2013) yielded 107 patients (78 male) who provided data of interest. This cohort was interviewed, and they completed measures of anxiety and depressive symptoms (HADS), and health-related quality of life (UW-QOL). Assessments were completed during the initial clinic visit, prior to initiation of curative treatment.

CONCLUSIONS

• Strong relationships between psychological distress and QOL are evident before curative treatment. This is particularly true among patients reporting clinically significant distress.
• Lower QOL may influence treatment outcomes, and may be affected by psychosocial intervention, even for the reluctant patient.
• Symptom report during interview was at times lower than scores on self-report questionnaires would suggest. Some patients may be reluctant to discuss issues with treating professionals.

DISCUSSION AND FUTURE DIRECTIONS

The high prevalence of distress and impact on QOL among patients with head and neck cancer makes a compelling case for assessment in this population at the start of treatment. However, some patients may minimize symptom report during clinical interview. Accurate symptom assessment is critical for the treating physician, as it may offer clues about disease progression or recurrence. Employing multiple modalities, including self-report questionnaires, to assess patient symptomatology, may allow patients to better inform their treating physicians.

Growing evidence suggests that distress that begins with diagnosis and continues with treatment initiates a cascade of downstream physiological effects, including endocrine activation, down-regulation of immune defenses, and cancer progression via dysregulation of circadian rhythms (Figure 1) [8]. These pathways may mediate relationships to QOL highlighted here and warrant further study.

Providing patients with a behavioral intervention at the time of treatment may help to improve their coping efforts and prevent chronic conditions, such as depression and PTSD, as well as ameliorate physiological disruption.

Future studies will continue to assess distress and will begin to understand endocrine and rest/activity rhythm disruption in this patient population. Studies will assess the impact on QOL, tumor progression and survival.

REFERENCES