

Practical Suggestions for Dealing With Distress in the Patient With Head and Neck Cancer

Robert Buckman, PhD, MD

Dr. Buckman is a medical oncologist, Princess Margaret Hospital, University of Toronto, and Professor, Department of Medicine, University of Toronto, Toronto, Ontario, Canada.

Commentary on “Psychologic Distress and Head and Neck Cancer: Part 1—Review of the Literature” by Haman (page 155).

Haman’s review of the literature concerning psychologic distress in patients with head and neck cancers (HNC) performs a major service for everyone in clinical oncology. Her paper successfully achieves the two main objectives of any review: a clear and intelligible understanding of the background, coupled to practical approaches and strategies for improving patient care.

Using the straightforward and pragmatic definition of cancer-related distress from the National Comprehensive Cancer Network,¹ Haman examines the contributory factors that are so important in HNC, some of which are specific to those tumor sites. Many of these factors preexist before the cancer develops. Alcohol, smoking, and substance abuse are more common in patients with HNC than in the general population, and they are likely to make things worse when it comes to exacerbating distress, thereby increasing the difficulty of providing an intervention such as counseling and other psychotherapeutic supports. Simply being aware of the preexisting factors that make palliation more difficult is helpful in itself.

Added to the factors related to causation are factors related to the disease process and its treatment. Organic causes of difficulties in communication and in mental activity are obviously important: for example, regarding deterioration in mentation, cognitive abilities, or emotional stability, one should always think of cerebral metastases as a possible cause.

Correspondence to: Robert Buckman, PhD, MD, Princess Margaret Hospital, 610 University Avenue, Toronto, ON M5G 2M9, Canada; telephone: (416) 946-4501, x5759; e-mail: Robert.Buckman@uhn.on.ca

J Support Oncol 2008;6:164–165 © 2008 Elsevier Inc. All rights reserved.

Many other physical factors related to the disease and treatment conspire to make things more difficult. The tumor itself may interfere with articulation, and surgery and radiation therapy may make matters worse as well as produce disfigurement, which often affects mood. In fact, as the author of this review notes, depression in HNC patients may occur in as many as 40% of patients. Haman reviews the possible syndrome of “chemo-brain,” which produces difficulties in memory and in mentation during and after chemotherapy, as well as the potential benefits of methylphenidate. Haman also notes that pain may frequently be a factor, and pain medications can also affect mood.

With all of this in mind, a strategy is required. The algorithm presented in Haman’s review is practical and useful. It contains a small number of intervention points—six, including a self-report screen that the patient fills in before the consultation starts—and it directs the clinician to assess quickly and effectively the patient’s state and severity of distress and mood and any possible need for referral. Many of the tools and questionnaires are discussed briefly in the article.

As another welcome feature in this review, there are many plain-language examples of what we might say to the patient to assess the extent of distress and the presence of serious symptoms such as suicidal ideation. In my view, a few simple and straightforward examples are both memorable and helpful. Phrases such as “*Has the way you’ve been feeling gotten in your way at all?*” give clinicians a general idea of what can be said when they might be stuck and feel that they have no clue as to what to say.

Similarly, with sensitive areas such as suicidal ideation, a validating preamble followed by a question is helpful: “*Sometimes people feel very hopeless or have thoughts about suicide. One thing we try to do is ask patients about thoughts like that. Any times in the past couple of weeks where you’ve thought about*

hurting or killing yourself?” The language is plain and casual: the patient is highly likely to feel supported and understood and will probably answer honestly. If nothing much is forthcoming, an open question such as “*What thoughts have you had?*” might be useful.

It is also helpful to be reminded that merely asking questions like these about depression or suicide will not actually create or induce those conditions. In fact, the opposite is true: failure to ask about distress has been shown to amplify it; hence, a practical approach improves the situation—another benefit provided by a straightforward algorithm.

Another useful area is the assessment of strategies that the patient might be using to reduce distress, including, of course, alcohol and drugs. Again, a phrase such as “*Often people drink or use drugs to deal with feeling bad...*” is validating and non-judgmental and is helpful in setting up an assessment of what the patient is actually doing.

Like most cancers, HNC is genuinely a condition that affects the whole family or household. Relationships with other family members and other caregivers, sexual problems, and issues of self-esteem are also covered in this review.

A common problem when dealing with psychologic dis-

tress in any cancer, but particularly in HNC, is whether, when, and how to make a referral for counseling, psychiatric opinion, or other service. This is clearly and simply dealt with in the review, including the important point that the referral needs to be discussed with the patient. It gets things off to a bad start if the patient has no idea why the appointment has been made or what the consultant does. It is also worth remembering that patients may lack motivation or ability to find support services by themselves (true in all cancers, but particularly in HNC), so that referral may be very important. A comprehensive list of support organizations and their Web addresses is included.

In conclusion, this review is timely, practical and useful. It covers the theoretical ground succinctly and offers an approach that can be used in daily clinical practice. This is a literature review that can help us all in real, everyday clinical practice.

Reference

PubMed ID in brackets

1. National Comprehensive Cancer Network. Distress management. NCCN Practice Guidelines in Oncology 2005;v.1. Available at: http://www.nccn.org/professionals/physician_gls/PDF/distress.pdf. Accessed March 1, 2008.