Depression and suicide in cancer patients

By Dr Nigel Dormer

The suicide rate in patients with cancer is about double the incidence relative to the general population (SMR 1.3 to 2.6) but this still represents a very small percentage of the cancer deaths (0.3% in WA). Men are at a much higher risk and represent up to 85% of the total number of suicides. However, even with the relatively small numbers of cases, the impact of a suicide is widespread. Clinicians who work with suicidal people estimate that for each person who commits suicide, there will be at least six people strongly affected by the event.

What do we know about risk factors?

The highest risk is seen in the first year after the cancer diagnosis, particularly in the first 3 months, where risk may be up to six times greater than expected. One Japanese study noted the highest rate was seen in the 3rd to 5th months, but during that study, it was common for patients to stay in hospital for the first 2-3 months after diagnosis.

Two more recent large studies in Sweden and Denmark (2005) were able to clarify the impact of cancer type and staging. The better the five-year survival rate, then the lower the suicide rate and vice versa e.g. uterine cancer had a low suicide rate to pancreatic cancer, which had the worst.

A study of 45 palliative care units in the UK and of 12 palliative care teams in Italy (not unlike our Hospice Silver Chain) demonstrated a lower rate of suicide in patients receiving palliative care, possibly in the order of 10 times.

Where does depression fit in?

Clinical depression is common in cancer patients and the symptoms can overlap with those of the cancer, particularly somatic symptoms (e.g. fatigue, anorexia, insomnia). These symptoms may be dismissed as understandable in the context of the situation – but although anxiety, grief, stress and sadness may be, clinical depression should not.

The prevalence of depression in cancer patients is between 15–25%. Moreover, an oncology outpatient study discovered that about half of the patients had a different psychiatric diagnosis: 68% had an adjustment disorder, 8% an organic mental disorder, 7% a personality disorder, and 4% a pre-existing anxiety disorder.

Factors associated with increased risk of depression are old age, a past or recent depressive episode, a family history of depression or suicide, poorly controlled pain, drug or alcohol abuse (pre-morbid vulnerability), isolation, unemployment and other chronic disease states (diabetes, CVA, PVD). Suicidal ideation and a recent suicide attempt are strong risk factors for completed suicide in this population.

Doctors should recall that medications (steroids, interferon), metabolic abnormalities (calcium, sodium), endocrine diseases (thyroid, adrenal), chemotherapeutic agents (vinblastine and vincristine) and anti-hormone agents (tamoxifen, cyproterone) can all cause depression.

Hopelessness is another independent risk factor for suicide, equal to depression. It can be characterised as a pessimistic cognitive style rather than an assessment of one's poor prognosis. Other psychological variables include spiritual well-being, quality of life, symptom distress and a perception of being a burden.

Screening for depression can be as easy as asking, "Are you depressed most of the time?" This has as high a sensitivity and specificity as more complicated self-reporting scales. Posing this question with an awareness of the various risk factors in this vulnerable group will identify most of those at risk of suicide.

Taking action

We now have better access to psychologists and other support staff. We have a range of safer anti-depressants with less side effects, and effective anxiolytic medications. The understanding of this type of prescribing rests mainly with the patient's GP, someone who may have been left in the background while all the recent activity focused on the diagnosis and treatment of the cancer.

Palliative care, with its focus on symptom control and in-home patient care and support of the family, may have the largest impact, with an inter-disciplinary team literally on the doorstep.

And on many occasions over the years I have witnessed chaplains addressing spiritual issues in distressed patients, with far greater effectiveness than anything I have prescribed! ■