

Are We Missing Out on Something?

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Abstract

Suicide risk is very high in the patients suffering from advanced cancer. Around 60% of patients with advanced cancer suffer from cancer related pain and this further accentuates the risk of psychiatric disorders as well as suicide. A fifty year old male who was a known case of carcinoma of floor of mouth, post chemotherapy and post radiotherapy came in the outpatient clinic with complains of throat pain which increased on swallowing. On further probing, it was revealed, that he consumed poison in the recent past while being agitated and upset with the severe throat pain. The recent radiotherapy had only made the pain worse. Cancer pain is an important symptom which should be adequately addressed while reviewing patients in the palliative care / oncologist clinic.

Keywords: Continuum of care, hopeless, palliative physician, quality of life

INTRODUCTION

Advanced cancer patients suffer till death, not only physically but also emotionally. The prevalence of depression in advanced cancer patients has been found to be 5%–26%.^[1] In a recent study, advanced cancer has been associated with poor performance status.^[2] It has also been reported that desire for hastened death is higher in patients suffering from advanced cancer and depression.^[3] Suicides in cancer patients has been to be reported high as compared to general population constantly in the past. This case depicts the story of a patient being treated for oral cancer suffered from severe mental distress and made a suicide attempt.

CASE REPORT

A 55-year-old male who was a known case of cancer of floor of mouth came to the outpatient department with complaints of difficulty in swallowing and burning sensation in the oral cavity for the past 3 months. The pain was insidious in onset, burning, and stinging in nature and radiating to the earlobe. The patient reported that he had not taken his meals properly for the past 10 days and appeared very distressed. He reported restriction in mouth opening and alteration of taste for the past 3 months. He, therefore, was not on any medications as oral intake was very poor. He revealed that he had consumed lice poison (pyrethrins) 5 days back, while feeling hopeless due to his pain.

The patient was diagnosed 1 year ago, when he presented in the head and neck clinic with an ulcer in the floor of his mouth for 6 months. He had also noticed swelling in the neck for the same duration. The patient noticed a change in voice for the past 1 month, and he also reported that recently a painful ulcer had developed inside his right cheek. He was evaluated by a biopsy which revealed moderately differentiated squamous cell cancer.

Patient was planned for palliative radiotherapy and received five fractions recently. His previous radical radiotherapy session was in September 2017.

The patient reported that he developed severe ulceration and burning sensation in his mouth after his radiotherapy.

The patient had been a follow-up case of pain clinic since 2016 and was started on morphine 4 h along with adjuncts such as paracetamol and gabapentin, and the dose was subsequently increased after the period when he received radiotherapy. He was late to his follow-up this time, admitted that due to some personal issues, he could not come on time.

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On speaking with him alone, he confessed that he consumed the poison when he was alone and was suffering from intolerable pain. He repeatedly ensured that there was no emotional distress that he suffered other than the pain. He was thankful to God that his family members were very supportive. There were no attempts like this in the past.

On discussion with his eldest son who was accompanying him, his statements echoed with what his father had told. He was upset that his father resorted to poisoning himself because of the pain and requested painkillers. He told that he has never left his father's side since then.

A personal history showed that the patient was a smoker for the past 40 years, 1 pack/day. He was an alcoholic for the past 40 years and had a consumption of about 50 ml every day. The patient also reported disturbed sleep for 6 months.

A history showed that the patient was a diabetic, diagnosed 6 months ago. He was not on any antidiabetic medication.

A psychosocial history showed that the patient had four children, of them two were married. Two girls who were married lived with their families in the same town. The patient had a supporting wife; both the husband and the wife lived with their two sons and their families in the same house. The family knew about the diagnosis and were involved actively in the treatment since the diagnosis of the disease.

On examination, the patient seemed anxious, avoided eye contact, and was teary during the whole conversation. He was conscious, oriented, and alert. There was mild pallor. There was an ulceroproliferative growth 6 cm × 5 cm in the floor of the mouth on the undersurface of the tongue with restricted mouth opening, admitting only two fingers. There were areas of white patches involving the buccal mucosa and the tongue. There were intermittent areas of erythema over the buccal mucosa as well as the lips. There was no bleeding. There were multiple ulcers present on the floor of the mouth, the buccal mucosa, and the hard palate. Oral mucositis WHO grade IV was present. The oral hygiene was poor. There was halitosis.

The patient was admitted in the ward and he was started on morphine infusion. The intravenous infusion was titrated according to the patient's response. He was advised triple gargle (concoction containing syrup Benadryl, lignocaine viscous, and sodium bicarbonate is an indigenous preparation used in low-income countries for oral hygiene) six times a day and was instructed to maintain proper oral hygiene. The patient was counseled on a daily basis and his mental functioning was noted on the basis of being able to perform his daily activities, and his spiritual and psychosocial pain was addressed. A psychology consult in this patient was not deemed necessary as the suicide attempt was due to pain and the patient when admitted in ward was under full supervision, while being titrated with pain medication.

The patient was seen on follow-up visit after 2 weeks and was found to be feeling better. He seemed pain free. He reported

that he was more functional after the discharge and felt happy about himself and his family.

DISCUSSION

Cancer pain affects almost 60% of cancer patients. Cancer pain may significantly impair the quality of life and restrict the social well-being of the patient. In head and neck cancer patients, the pain may have multiple components due to the dense nerve supply in that area. Not only the disease process but also various treatment modalities may be related to innumerable side effects which may cumulatively affect the patient's quality of life.

Articles ranging from 1979 to 2017 have all stated that the diagnosis of advanced cancer plays a definitive risk factor for suicide in these patients.^[4,5] In a recent report published by Memorial Sloan Kettering hospital, a definite suicide risk, associated with the diagnosis of cancer was identified. This risk was found to be higher after treatment completion. This is evident in the present case scenario too.^[6]

There are numerous psychosocial factors which are responsible for higher risk of depression and therefore suicide in cancer. The suicide risk in head and neck cancer may be specifically related to the disfigurement associated with head and neck cancer. According to a study published in 2010, the journey to diagnosis and treatment in head and neck cancer patients is very traumatizing.^[7] There are specific phases that have been identified where the patients are at increased of suicide.^[8] The three phases are acute survival, extended survival, and permanent survival. The extended survival period may be associated with increased risk of depression due to radiation treatment-induced pain, xerostomia, mucositis, and fatigue. The present case scenario fits into the extended phase of treatment. In a study performed in July 2013, the mood scores after 1, 3, and 5 years of radiation treatment were evaluated with the help of "University of Washington Quality Of Life Instrument."^[9] The patients who were somewhat to extremely depressed had disproportionately low use of antidepressants which depicted the high prevalence of depression in treated cases of head and neck cancer patients. The patients who were at higher risk of depression were with the gastrostomy tube, tracheostomy tube, and continued smoking.

Development of certain coping strategies can be helpful for the patients, in facilitating the development of acceptance about the diagnosis as well as understanding the logistics of the treatment. In an interview-based study performed on advanced cancer patients and their care givers, certain coping strategies in the cancer patients were outlined, namely "everyday pragmatism," "self-awareness," "communication," and "relying on others."^[10] These strategies were found to be helpful in tiding over the everyday challenges faced by these patients, as well as dealing with episodic crisis.

The recent report from Memorial Sloan Kettering suggests that PHQ-9 should be used for the screening of the patients

suffering from advanced cancer. They also suggest that burdening the patient with several questions can be prevented by screening method, in which the first two questions are asked first to screen.

CONCLUSION

It is important to have a great clinical suspicion of depression while treating patients who suffer from advanced cancers, especially head and neck. It is crucial to effectively address the pain or worrisome symptoms by the palliative care team, as the symptoms may not be directly injurious to their health, but may impair the patient psychosocially. They should be advised to develop coping strategies that not only help the patient navigate through the troublesome journey of diagnosis till treatment but also are helpful for the care givers also. Also, for certain patients, a questionnaire format may be adopted to emphasize on the psychological effects of pain.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

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