

## Commentary to the Article Entitled “Cancer Pain, Anxiety and Depression in Admitted Patients in a Tertiary Care Hospital – A Prospective Observational Study”

The article entitled “Cancer pain, anxiety and depression in admitted patients in a tertiary care hospital – A prospective observational study” raises many important issues regarding the coexistence of depression and anxiety in patients suffering from cancer pain. A systematic review and meta-analysis in 2011 by Mitchell *et al.* reported on the prevalence of major depression (15%), minor depression (20%), and anxiety (10%) in patients treated for cancer.<sup>[1]</sup> These figures are higher than the population estimates of past-year depression (5%) and anxiety (7%), and signify the importance of physician awareness about these issues.<sup>[2]</sup> Interestingly, these figures show variance with cancer type, with major depression affecting an estimated 13% of patients with lung cancer, 11% of those with gynecological cancers, 9% in breast cancer, 7% in colorectal cancer, and 6% in genitourinary cancers.<sup>[3]</sup> Similarly, the highest levels of anxiety are reported in lung, gynecological, and hematological cancers.<sup>[4]</sup> Depression in cancer has been attributed to differing prognoses, and degrees of body image disruption associated with each tumor type, as well as specific tumor-related and treatment-related neuropsychiatric side effects.<sup>[5]</sup>

Evidence suggests strong associations between pain and depressed mood with each being a risk factor for the other. Different patterns and sites of pain can be seen in men and women; age differences suggest that pain prevalence increases with age up to 85 years and then decreases. Pain assessment is hampered by many communication issues, including cognitive ability and sociocultural factors. Although subjective, patient self-report is the most valid and reliable indicator of pain and it may be necessary to ask questions about pain in different ways in order to elicit a response.<sup>[6]</sup> Pain scales should be utilized alongside the clinical skills of the member of the multidisciplinary team, and a clinical assessment should be carried out. The most common self-report assessment tools for pain include Multidimensional Pain Inventory, McGill Pain Questionnaire, Pain Rating Index, and Brief Pain Inventory (and in some cases: interRAI [collaborative network of researchers] Long-Term Care Facilities, Standardized Evaluation of Pain, Oswestry Disability Index, and 36-Item Short Form). Physician-recorded diagnosis, structured interviews, body map diagrams, simple checklists, multiple-choice questions, and Likert scales designed specifically for research can also be used to assess pain.<sup>[7]</sup> The Numerical Rating Scale or verbal descriptors can be used with people who have mild-to-moderate cognitive impairment. For people with

severe cognitive impairment, the Pain Assessment in Advanced Dementia and the Doloplus-2 are recommended.

Here, the authors have observed similar findings in a subset of subjects from an Indian cancer center. The authors’ statements concerning the proportions and associations between cancer pain, anxiety, and depression can be agreed upon. We should, however, be careful about the limitations of this study and should await results from a bigger cohort. Along the way, all of us caring for such patients should be mindful of the harmful effects of depression and anxiety on the quality of life and survival; of cancers, such as pancreatic and lung, which release chemicals that are thought to cause depression; and about certain cancer treatments, such as chemotherapy and corticosteroids, which can be associated with depression. Important to remember in this regard is that depression in cancer patients receiving end-of-life care is no more prevalent than in patients living actively with cancer. Sometimes, antidepressants seem to be an easy solution, but we should be aware that antidepressants can worsen existing cancer symptoms and interact with chemotherapy agents: sertraline and citalopram tend to have the least interactions and are generally well tolerated as first-line agents.<sup>[8]</sup> Although not a comprehensive review on this subject, this article is a step in this direction and hopefully will coordinate the efforts with those of the other groups around the world who are working on this topic among Indian cancer patients.

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