Original Article

Psychological Distress In Egyptian Patients With Cancer

Hussein Gaballa[1], Salwa Erfan[2], Mohamed El-Sayed[3], Nelly Ali Eldin[4], Wael Abdel Gawad[5].

[1]Department of Medical Oncology, National Cancer Institute, Cairo University,[2]Department of Psychiatry, Kasr Al Aini School of Medicine, Cairo University, [3]Department of Radiation, National Cancer Institute, Cairo University, [4]Department of Statistics and Cancer Epidemiology, National Cancer Institute, Cairo University and [5]Department of Surgical Oncology, National Cancer Institute, Cairo University.

Date received: 5/10/2008
Date accepted: 16/11/2008

Background: Psycho-social distress of different severity can occur at different phases of malignant diseases. Possible sources are variable and include loss of physical integrity, loss of control, and fear of relapse or death, difficult treatment decisions.

Aim of this study: is to estimate the prevalence of mental distress in Egyptian patients with malignant diseases using the Hospital Anxiety And Depression Scale as a screening tool and to correlate the findings with patient's and disease characteristics.

Subjects & Methods: One hundred and sixteen patients with various malignancies (Solid and hematological) and 93 controls (No malignancy or a household patient with malignancy) were included. Arabic translated and validated version of the scale had been used with permission of the publisher.

Results: For both hematologic and solid malignancies, the mean depression score was higher in patients compared with controls (p=0.009). 43 patients (37.5%) had moderate and high scores respectively compared with 21 (22.5%) in the control group. There was no significant difference in the mean anxiety scale. In the whole group of patients, both depression and anxiety scores were higher among females than males (10.0±4.1 vs 8.5±4.1 and 10.3±3.8 vs 8.4±4 respectively, p 0.05 and 0.02 respectively). There was no significant correlation between scores and age, marital status, family history of cancer, the type of treatment (solid vs metastatic) or with response rate (CR+PR vs SD+PD) although higher scores were found in those with progressive disease compared with others. Both scores were higher in patients receiving steroids as a part of their treatment compared with those who did not (p=0.02) for depression, (p=0.09) for anxiety. Subgroup analysis by type of malignancy showed no difference in both scores between hematological and solid tumors. Females with hematological malignancies showed higher anxiety score (p=0.06). However, patients with solid tumors had higher proportion of patients in the moderate and severe categories when anxiety score is concerned (p=0.004). For those with hematological malignancies, both the anxiety and depression scores were higher in those receiving steroids (p=0.05 and 0.02 respectively), and non-responding patients (p=0.04 for both scores).

Conclusion: patients with cancer had significantly higher mental distress compared with normal people. Adoption of screening methods is a practical solution if advantages and drawbacks are considered.

Keywords: Malignancy, Cancer, Scoring, Distress.

Abbreviations:
HADS: hospital anxiety and depression scale.
CR: complete remission.
PR: partial remission.
SD: stable disease .
PD: progressive disease

Egypt. J. Psychiatry, June 2009; 29(2): 71-78

INTRODUCTION

Psycho-social distress in cancer patients is defined to encompass a broad spectrum of unpleasant emotional experiences of a mental, social or spiritual kind that range from normal feelings of vulnerability, sadness and fear to severely restricting problems depression, anxiety disorders, panic, social isolation and spiritual crisis (Institute of Medicine, 2007).

Psycho-social distress of different severity can occur at different phases of the illness. Patient's reactions can encompass normal fears, worry and, sadness but may also include severe psychosocial problems and disorders that must be accurately identified, diagnosed and properly treated. Possible sources are variable and include maladaptive coping styles to the diagnosis of life threatening condition, with feeling of helplessness, hopelessness and an attitude of passiveness (Newport and Nemeroff, 1998; Stark and House, 2000), loss of physical integrity, loss of control, fear of relapse or death, difficult treatment decisions, family conflicts, important tasks within social and occupational activities or functional roles. However, distress may also arise as a result of treatment as inadequate treatment of physical symptoms as pain, fatigue, sleeplessness, and factors seen in those with advanced disease as metabolic disorders, undersupply

of oxygen and cognitive disorders. Substance induced mental disorders can also be caused by medications as interferons or methotrexate. Furthermore, previously existing psycho-social distresses may be worsened by cancer or its treatment (Capuron, et al. 2000; Jacobsen and Jim, 2008).

A broad spectrum of methods is available for psychosocial assessment. Standardized methods defined by objectivity and reliability include: clinical interviews, questionnaires, psychological tests, psycho-physiological tests, psycho-neuro-immunological or psycho-neuro-endocrinological tests (Berard, et al. 1998; Lynch, 1995; De Haes, et al. 1990). In routine clinical practice when patients can be often seen very briefly, screening using questionnaire can be used for such assessment. Those who exhibit a notable cut-off value on the screening equal to moderate or severe distress can undergo more detailed assessment by the psycho-social team. Although prevalence estimates vary widely, evidence suggests that anxiety and depression are among the most common symptoms experienced by cancer patients (Peter, 2004).

The Hospital Anxiety and Depression Scale (HADS) was designed as an instrument for detecting anxiety and depression in the settings of outpatient and later on inpatients (Zigmond and Snaith, 1983). The majority of research on depression in cancer patients has used the HADS, with much of this research focused on identifying the prevalence and the optimal cutoff scores for depressed patients with cancer. Often this has been done in combination with the clinical interviews. HADS had been translated and validated into many languages including Arabic language (Herrmann, 1997; Bjelland, et al. 2002).

Aim of this study is to estimate the prevalence of mental distress in Egyptian patients with malignant diseases using the Hospital Anxiety and Depression Scale as a screening tool and to correlate the findings with patient's and disease characteristics

PATIENTS AND METHODS

One hundred and sixteen patients with various malignancies (Solid and hematological) and 93 controls (No malignancy or a household patient with malignancy) were included. Arabic translated and validated version of the scale had been used with permission of the publisher. The questionnaire had been explained to the patient, their consent to participate in the study was abtained. The tool is a 14-item self-report measure comprising 7 anxiety items and 7 depression items from which separate anxiety and depression sub-scale scores are calculated.

Briefly, patients completed the questionnaire composed of statements relevant to either generalized anxiety or 'depression. The scale was completed by nurses or physicians for the majority of patients.

Each item in the questionnaire had been answered by the patient on a four point (0–3) response category so the possible scores ranged from 0 to 21 for anxiety and 0 to 21 for depression. Previous analysis of scores enabled provision of information that a score of (0-7), (8-10), (11-15) and (16-21) on either subscales represents normal, mild, moderate, and severe range of mood abnormality.

STATISTICAL METHODS

SPSS package was used for data management. T test and Mann Whitney tests were used for comparing means when appropriate. Chi square tested proportion independence. Assuming no deviation from normality, simple linear regression analysis was done. Depression and anxiety scores were the dependent variables and age, sex, marital status, presence of CNS disease, and previous brain irradiation as the independent variables. P value of 0.05 is considered for significance.

RESULTS

Patients' characteristics:

This study involved 116 patients with malignancies (Solid and hematological tumors) as well as 93 patients with no malignancies or caring for a patient with malignancy of any kind. Cancer patients were comparable with regards to age and sex to their controls. Mean age of patients was 42.4±15.1 years compared to 40.70±13.4years in controls, p=0.39. Females represented 59.5% of cancer cases and 46.2 of the control group, p=0.06. Eighty five percent of cancer cases had no family history of malignancy. None had previous history of psychiatric disease or medication while 18% (Mainly patients with hematological malignancies) were on steroids. Seventy five and 78% of both groups were married and had off-springs. Table (1, 2) summarizes patients' characteristics and their comparison with controls.

Table 1: Patients' characteristics:

		Count	Col %
Sex	Female	69	59.5%
	male	47	40.5%
Marital status	No	28	24.1%
	Widow	1	0.9%
	Yes	87	75.0%
FH	No	99	85.3%
	Yes	17	4.7%
On steroids	No	95	81.9%
	Yes	21	18.1%
On adjuv	No	78	67.2%
	Yes	38	32.8%
Metastatic	No	56	48.3%
	Yes	60	51.7%
Response	CR	61	52.6%
	PD	15	12.9%
	PR	23	19.8%
	SD	17	14.7%
Previous brain irradiation	No	109	94.0%
	Yes	7	6.0%

Table 2: Control group vs Cancer patients:

	Control	Cancer cases	P
Age			
Range			0.3
mean	40.7 + 13.3	42.4 + 15	
Sex			
Male	43/93	69/116	0.06
Female	50/93	47/116	
Marital status			
Married	71/93	87/116	0.5
unmarried	22/93	29/116	

HADS Scores:

For both hematologic and solid malignancies, the depression score ranged from 2-21 with a mean of 9.4±4.2 and for the control group it ranged from 2-14 with a mean of 8.1±2.9. The difference was statistically significant (p=0.009). Forty three patients (37.5%) had moderate and high scores respectively compared with 21 (22.5%) in the control group, (Table 3).

Table 3: HAD scores in the whole group of patients:

	Groups	Number	Mean+SD	P
Depression score	Cancer cases	116	9.4+4.2	
	Controls	93	8.1+2.9	0.009
Anxiety score	Cancer cases	116	9.57+4	
	Controls	93	9.9+3.1	0.5

On the other hand, the anxiety score for patients with malignancy ranged from 1-21 with a mean of 9.5±4 and for the control group was from 3-14 with a mean of 9.9±3.1 with no statistical significant difference (p=0.5). Forty four patients (37.9%) had moderate and high scores respectively compared with forty three (46.2%) in the control group.

Patients with solid tumors had a mean depression and anxiety scores of 9.8±3.5 and 9.8±3.4 respectively, compared with 8.8±5.0 and 9.0±4.7 in those with hematological malignancies. The difference in both parameters was not statistically significant (p=0.2 and 0.3 respectively), (Table 4).

Table 4: Depression and anxiety score in both subgroups:

	Diagnosis	N	Mean	Std. dev.	P
Depression score	Solid	70	9.83	3.526	0.2
	Hematological	46	8.8	5	
Anxiety score	Solid	70	9.89	3.483	0.3
	hematological	46	9	4.751	

Correlation of HADs with different parameters:

In the whole group of patients, both depression and anxiety scores were higher among females than males (10.0±4.1 vs 8.5±4.1 and 10.3±3.8 vs 8.4±4 respectively, p=0.05 and 0.02 respectively), however, this was not shown in the control group. There was no significant correlation between both scores and age, or the marital status, yet the scores were higher in older age in the control group. Furthermore, no significant differences were found when scores were correlated with family history of cancer, the type of treatment (Solid vs metastatic) or with response rate (CR+PR vs SD+PD) although higher scores were found in those with progressive disease compared with others. Both scores were higher in patients receiving steroids as a part of their treatment compared with those who did not (11.3±5.0 vs 9.0±3.9 (p=0.02) for depression, 10.9±4.0 vs 9.2±3.9 (p=0.09) for anxiety), (Table 5).

Table 5: Correlation of HADS with patients' and disease's criteria:

	No (%)	Depression Mean+SD	P	Anxiety Mean+SD	P
Sex					
Male	47/116 (40.5)	8.51+4.18	0.05	8.49+4.05	0.02
Female	69/116 (59.5)	10.04+4.139		10.3+3.878	
Marital status					
Married	87/116 (75)	9.38+4.2	0.8	9.8+4	0.2
Single	29/116 (25)	9.5+4.2		8.7+3.9	
Family history					
Positive	17/116 (14.6)	10.5+3.4	0.2	10.3+3.6	0.2
Negative	99/116 (85.4)	9.2+4.3		9.4+4	
Response					
CR+PR	84/116 (72.4)	9.1+4	0.04	9.4+4	0.06
PD+SD	32/116 (27.5)	11+4.4		10.9+3.5	
Treatment					
Adjuvant	38/116 (32.7)	8.9+3.4	0.4	9.6+3.2	0.8
Metastatic	78/116 (67.3)	9.6+4.5		9.5+4.3	
Steroids					
Receiving	21/116 (18.1)	11.3+5	0.02	10.9+4	0.09
Not receiving	95/116 (81.9)	9+3.9		9.2+3.9	

Subgroup analysis by type of malignancy showed no difference in both scores between hematological and solid tumors (p=0.2 and 0.3 for depression and anxiety scores respectively). In patients with solid tumors, although the mean value of both depression and anxiety scores were higher among females than males (10.1±3.7 vs 8.8±2.4 and 10.1±3.5 vs 9.2±3.4 respectively) yet it was not statistically significant. However, females with hematological malignancies showed higher anxiety score compared to males (11.4±5.2 vs 8.2±4.3) with a borderline significance (p=0.06). Classifying patients into normal, mild, moderate, and severe showed no significant difference in proportion of patients among solid and hematologic malignancies when depression score is concerned (p=0.2), However, patients with solid tumors had higher proportion of patients in the moderate and severe categories when anxiety score is concerned (p=0.004)

For those with hematological malignancies, both the anxiety and depression scores were higher in those receiving steroids compared with those not receiving it and the difference was statistically significant (p=0.05 and 0.02 respectively).

Furthermore, non-responding patients with hematological malignancies, showed a statistically significant higher scores for both anxiety and depression than patients who achieved complete or partial remission (p=0.04 for both scores), (Table 6).

Table 6: Correlation of the HAD score with different factors in both disease categories:

	Solid		Hematologic	
	Dep. Scale	Anxiety scale	Dep. Scale	Anxiety scale
Sex				
Male	8.7+2.3	9.2+3.3	8.3+4.7	8.1+4.3
Female	10+3.7	10+3.5	9.8+5.7	11.5+5
P	0.2	0.4	0.6	0.06
Response				
CR + PR	10.1+3.2	10.3+3.5	8.2+4.8	8.5+4.6
PD + SD	9.3+3.9	9.1+3.9	12.6+5	12.6+3.7
P	0.7	0.1	0.04	0.04
Treatment				
Adjuvant	9.2+2.7	9.9+2.7	8+5.6	8.8+4.5
Metastatic	10.2+4	9.8+3.9	8.9+4.9	9.1+4.8
P	0.2	0.7	0.6	0.8
Steroids				
Receiving	9.5+3.5	9.9+3.6	7.9+4.3	8+4.4
Not receiving	11.7+2.9	9.6+2.4	11+6	11.6+4.6
P	0.1	0.8	0.05	0.02

Results of simple linear regression showed that depression score significantly increases in patients being treated from a malignancy independent of age, sex, and marital status or even having a CNS condition or previous irradiation (B=1.12±0.5, p=0.03). The situation differs in anxiety where female gender was the only independent factor for increasing anxiety score regardless malignancy, age, marriage or CNS condition (B=1.5±0.5, p=0.004).

DISCUSSION

Interest in psychosocial care can be viewed as part of a broader trend within oncology of evaluating care in terms of its impact on quality of life as well as quantity of life. Consequently routine screening of cancer patients for psychosocial distress had been recommended by a number of professional and governmental organizations and it is considered by the Canadian authorities as the sixth vital sign. The importance of routine screening for heightened distress stems from the fact that its association with a number of negative outcomes including poorer adherence to treatment recommendations, worse satisfaction with

care, worse quality of life, and poorer survival. Second, heightened distress is treatable by pharmacologic and non-pharmacologic interventions. Third, heightened distress is common. Prevalence estimates derived from large-scale studies typically exceed 30%. Fourth, and perhaps most important, evidence indicates that heightened distress often goes unrecognized by oncology professionals Jacobsen, (2007).

In this study, 37.9% and 38.7% of the patient group showed moderate and high score for depression and anxiety respectively with a significantly higher mean depression score compared with controls. Females, non responding patients and those on steroids had particularly higher score. These findings are in agreement with other investigators Mehnert and Koch, (2008) reported on 1083 breast cancer patients after a variable period following diagnosis. Thirty-eight percent of patients had moderate to high anxiety, and 22% had moderate to high depression using HADS. The overall psychological co-morbidity was 43% and 26% for a possible and probable psychiatric disorder. The risk remained high during subsequent years although less than the first year. Findings are on line with those reported by Mahmoud, et al. (2007) who found 80% of Egyptian cancer patients to be suffering psychological distress including anxiety, fear, pain, depression, sadness, and fatigue, and with results of Amer and Quttb, (2007) who found the prevalence of depression among Egyptian thyroid cancer patients to be 64% and support those reported by Amin, (1994), who found significant differences between terminally ill cancer patients and controls as regards scores of Hamiton Depression, and Anxiety scales and contradicts those reported by El-Battrawi, (1989), who found no differences between cancer patients and control as regards depression and anxiety. On the other way around Omar, et al. (1998) found depression among elderly Egyptian patients to be significantly related to major health problems including cancer. Recently, Dalton, et al. (2009) reported a nationwide population based study of cancer patients in Denmark from 1973-2003. The relative risk for depression in the first year after diagnosis ranged from 1.1 in women with colorectal cancer to 3 in patients with brain cancer. The risk remained high during subsequent years although less than the first year. El Rufaie and Absood, (1995), validated the Arabic version of HADS against psychiatrist's clinical evaluation. Subjects were screened and interviewed by single psychiatrist. Their study indicated that the HAD depression subscale is more consistent and more predictive than the anxiety subscale, further consolidating our results.

Further studies, studying either one or more than malignant disease category, using screening instruments showed prevalence rate of up to 50% for anxiety, depression and adjustment disorders respectively. Using clinical interviews to measure prevalence returned a frequency of mental disorders that is lower (30, 15% respectively). In few of these studies the frequency is determined to be slightly higher than the general population while in others it seems to be significantly higher with the consistent of much higher rates reaching 80% with worsening of the general condition (Massie and Holland, 1987; Zabora, et al. 2001; Uchitomi, et al. 2003; Kissane, et al. 2004; Okamura, et al. 2005; Grabsch, et al. 2006; Lueboonthavatchai, 2007).

Moreover in our study, higher scores were obtained in females, and those who are not responding to treatment. The higher scores obtained in females were also reported by Amin, (1994). Regression analysis showed that female gender is an independent factor for development of anxiety while having a malignancy by itself is an independent factor for depression. This is in concordance with the previous studies which also reported younger age as a predictor for psychological distress although this was not shown in ours.

Although comprehensive assessment using structured interviews is the gold standard for diagnosis of mental disorders, screening methods which are not time consuming are advocated by many to assess cancer patients for psychosocial distress. Mitchell, (2007) evaluated the ultra short methods for detection of distress in cancer patients in a way similar to meta-analysis. He concluded that the principal strength of these methods is their accuracy in ruling out the presence of heightened distress relative to longer methods; and the principal weakness is their generally poor accuracy in confirming the presence of heightened distress. In his analysis, the implementation of ultra short screening measures is likely to result in many patients who are not distressed receiving inappropriate referrals with consequent needless use of generally scarce resources available for psychosocial care. The mislabeling of some patients as distressed might also have the unintended consequence of causing distress where it was not present previously. Conversely, the generally good accuracy of ultra short methods in ruling out heightened distress can be viewed as a major asset that outweighs the previously identified liability.

Of the two types of errors, incorrectly identifying a patient as not distressed is likely to have more severe consequences for an individual's quality of life and quality of care than incorrectly identifying him or her as distressed.

In conclusion, patients with cancer had significantly higher mental distress compared with normal people. Detection and management of distress is still lagging behind and oncologists are blamed for part of it. Greater adoption of routine screening for distress might be facilitated by demonstration of stronger evidence that it results in better outcomes. Randomized controlled trials are needed to prove that care delivered with routine

screening followed by referral of distressed individuals to appropriate professionals yields better control of disease than care delivered without. Furthermore, implementation of these methods as to be self reported by the patient or to be done by social workers or nursing while in the waiting areas or through computer terminals for certain population might help in their easy adoption.

REFERENCES

Amer, D. and Quttb, M. 2007. Mar 7-9; Depression in Egyptian thyroid cancer patients with hypothyroidism: A preliminary study. Ain Shams International Congress in Psychiatry: Towards Global Patient's Care, Cairo, Egypt.

Amin, M. E. 1994. Psychiatric aspect of terminally ill patients. M.Sc. diss., Faculty of Medicine, Cairo University.

Berard, R. M., Boermeester, F., and Viljoen, G. 1998. Depressive disorders in an out-patient oncology setting: Prevalence, assessment and management. Psycho-Oncology 7(2):112-120.

Bjelland, I., Dahl, A. A., Haug, T. T., and Neckelmann, D. 2002. The validity of the Hospital Anxiety and Depression Scale. An updated literature review. Journal of Psychosomatic Research 52(2):69-77.

Capuron, L., Ravaud, A., and Dantzer, R. 2000. Early depressive symptoms in cancer patients receiving interleukin 2 and/or interferon alfa-2b therapy. Journal of Clinical Oncology: Official Journal of the American Society of Clinical Oncology 18(10):2143-2151.

Dalton, S. O., Laursen, T. M., Ross, L., et al. 2009. Risk for hospitalization with depression after a cancer diagnosis: A nationwide, population-based study of cancer patients in Denmark from 1973 to 2003. Journal of Clinical Oncology: Official Journal of the American Society of Clinical Oncology 27(9):1440-1445.

De Haes, J. C., Van Knippenberg, F. C., and Neijt, J. P. 1990. Measuring psychological and physical distress in cancer patients: Structure and application of the Rotterdam Symptom Checklist. British Journal of Cancer 62(6):1034-1038.

El-Battrawi, M. A. 1989. Psychological variables and personality characteristics in cancer patients. Ph.D. diss.

El Rufaie, O. E., and Absood, G. H. 1995. Retesting the validity of the Arabic version of the Hospital Anxiety and Depression (HAD) scale in primary health care. Social Psychiatry and Psychiatric Epidemiology 30(1):26-31.

Grabsch, B., Clarke, D. M., Love, A., et al. 2006. Psychological morbidity and quality of life in women with advanced breast cancer: A cross-sectional survey. Palliat.Support.Care. 4(1):47-56.

Herrmann, C. 1997. International experiences with the Hospital Anxiety and Depression Scale--a review of validation data and clinical results. Journal of Psychosomatic Research 42(1):17-41.

Institute of Medicine. 2007. Cancer care for the whole patient: Meeting psychosocial health needs. Washington, DC: The National Academies Press.

Jacobsen, P. B. 2007. Screening for psychological distress in cancer patients: Challenges and opportunities. Journal of Clinical Oncology: Official Journal of the American Society of Clinical Oncology 25(29):4526-4527.

Jacobsen, P. B., and Jim, H. S. 2008. Psychosocial interventions for anxiety and depression in adult cancer patients: Achievements and challenges. CA: A Cancer Journal for Clinicians 58(4):214-230.

Kissane, D. W., Grabsch, B., Love, A., et al. 2004. Psychiatric disorder in women with early stage and advanced breast cancer: A comparative analysis. The Australian and New Zealand Journal of Psychiatry 38(5):320-326.

Lueboonthavatchai, P. 2007. Prevalence and psychosocial factors of anxiety and depression in breast cancer patients. Journal of the Medical Association of Thailand = Chotmaihet Thangphaet 90(10):2164-2174.

Lynch, M. E. 1995. The assessment and prevalence of affective disorders in advanced cancer. Journal of Palliative Care 11(1): 10-18.

Mahmoud, A., Zaki, N., Huwaidi,D., El-Battrawi, A. and Refaat,G. 2007. Mar 7-9; Distress among cancer inpatients at Institute of Oncology, Ain Shams University Hospitals. Ain Shams International Congress in Psychiatry: Towards Global Patient's Care, Cairo, Egypt.

Massie, M. J., and Holland, J. C. 1987. Consultation and liaison issues in cancer care. Psychiatric Medicine 5(4):343-359.

Mehnert, A., and Koch, U. 2008. Psychological comorbidity and health-related quality of life and its association with awareness, utilization and need for psychosocial support in a cancer register-based sample of long-term breast cancer survivors. Journal of Psychosomatic Research 64(4):383-391.

Mitchell, A. J. 2007. Pooled results from 38 analyses of the accuracy of distress thermometer and other ultra-short methods of detecting cancer-related mood disorders. Journal of Clinical Oncology: Official Journal of the American Society of Clinical Oncology 25(29): 4670-4681.

Newport, D. J., and Nemeroff, C. B. 1998. Assessment and treatment of depression in the cancer patient. Journal of Psychosomatic Research 45(3):215-237.

Okamura, M., Yamawaki, S., Akechi, T., et al. 2005. Psychiatric disorders following first breast cancer recurrence: Prevalence, associated factors and relationship to quality of life. Japanese Journal of Clinical Oncology 35(6):302-309.

Omar, A. N., Haroun, A., and Nagy, N. E. 1998. Prevalence of depressive symptoms in physically-ill elderly inpatients. Current Psychiatry 5(2):145-155.

Peter, C. T. 2004. Assessment of depression in cancer patients. Journal of the National Cancer Institute Monographs(32):80-92.

Stark, D. P., and House, A. 2000. Anxiety in cancer patients. British Journal of Cancer 83(10):1261-1267.

Uchitomi, Y., Mikami, I., Nagai, K., et al. 2003. Depression and psychological distress in patients during the year after curative resection of non-small-cell lung cancer. Journal of Clinical Oncology: Official Journal of the American Society of Clinical Oncology 21(1): 69-77.

Zabora, J., BrintzenhofeSzoc, K., Curbow, B., et al. 2001. The prevalence of psychological distress by cancer site. Psycho-Oncology 10(1):19-28.

Zigmond, A. S., and Snaith, R. P. 1983. The hospital anxiety and depression scale. Acta Psychiatrica Scandinavica 67(6):361-370.

Egyptian Journal of Psychiatry
June 2009; Vol. 29, No. 2

الملخص العربى

الكرب النفسي فى مرضى السرطان المصريين

حسين جاد الله[١]، سلوى محمد فوزى[٢]، محمد السيد[٣]، نيللى على الدين[٤] ووائل محمود سامى[٥]
[١]استاذ مساعد باطنة الأورام (المعهد القومى للأورام-جامعة القاهرة)،
[٢]استاذ مساعد الطب النفسى (كلية الطب-جامعة القاهرة)،
[٣]استاذ مساعد قسم العلاج الإشعاعى (المعهد القومى للأورام-جامعة القاهرة)،
[٤]استاذ ورئيس وحدة الإحصاء ووبائيات السرطان (المعهد القومى للأورام-جامعة القاهرة)،
[٥]استشارى مساعد جراحة الأورام (المعهد القومى للأورام-جامعة القاهرة)

مقدمة:

قد يحدث كرب اجتماعي نفسي بدراجات متفاوتة الشدة أثناء المراحل المختلفة للأمراض الخبيثة. المصادر المحتملة متغيره وتتضمن خسارة السلامة الجسدية، فقدان التحكم وخوف المعاودة أو الموت، قرارات علاجية صعبة.

هدف هذه الدراسة:

أن تقيم الكرب النفسي بين مرضى الأمراض الخبيثة المصرية باستخدام مقياس إكتئاب وقلق المستشفى. مع ربط النتائج بخصائص المرضى

عينة الدراسة و أدواتها:

كان عدد المرضى 160 مريض بالأمراض الخبيثة المختلفة (صلبة وناشئة في الدم) وكانت العينة الضابطة تتكون من 93 شخص (بدون أمراض سرطانية أو أمراض سرطانية في احد أهل البيت) قد تم استعمال نسخة المقياس المترجمة المصدقة.

النتائج:

كان متوسط مقدار الإكتئاب أعلى في مرضى كلا من الأمراض السرطانية الصلبة أو الناشئة في الدم مقارنة بالعينة الضابطة. (p=0.009) كانت النتائج عالية أو متوسطة في 43 مريض (<37.5%) مقارنة بعدد 21 (22.5%) من العينة الضابطة لم يكن هناك فرق إحصائي ذو دلالة بالنسبة لمتوسط مقياس القلق. كان متوسط مقياس الإكتئاب والقلق أعلى في الإنـاث مقارنة بالذكور لم يكن هناك ارتباط ذو دلالة بين علامات السن، الحالة الاجتماعية، التاريخ العائلي للأمراض السرطانية، نوع العلاج ومعدل الاستجابة لكن كانت العلامات أعلى في ذوى المرض التقدمي مقارنة بالآخرين. كانت النتائج أعلى بالنسبة لهؤلاء المرضى الذين استعملوا الستروبدز كجزء من العلاج مقارنة بهؤلاء الذين لم يستعملوها. لم تظهر اختلافات واضحة بالنسبة لكلا المقياسين بين الأورام الصلبة وذات المنشأ الدموي، كانت العلامات أعلى لكلا من القلق والإكتئاب في مرضى الأمراض السرطانية ذات المنشأ الدموي الذين عولجوا الستروبدز والمرضى الغير المستجابين.