

Psychiatry Service

Introduction

The Psychiatry Division of the National Cancer Center Hospital East was established in July 1996. This Division has been designed not only to manage and alleviate the emotional distress due to cancer among patients, their families, and oncology staff, but also to study the influence of psychosocial issues on patients' quality of life or survival.

Routine Activities

The Psychiatry Division consists of five adjunct psychiatrists, one staff clinical psychologist, and two clinical residents. The main clinical practice involves psychiatric consultation to assess and deal appropriately with the emotional distress and other psychiatric problems of cancer patients who are referred by oncologists and patients themselves. The consultation data are shown in the Table. Psychiatric diagnosis was based on the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th edition) criteria. In 2004, total of 456 referrals (4% down to 2002) were made for the psychiatric consultation. Consultation data included 12 cancer patients' family members and 2 oncology staff members. Among cancer patients, 80% were inpatients; the most common psychiatric diagnosis was adjustment disorders (32%) followed by delirium (25%) and major depression (16%). The most common cancer site was head and neck, and the next was lung. More than 60% of the referred patients had recurrent or metastatic cancer. The most common reason for psychiatric consultation was anxiety/fear (32%), followed by depression (29%) and psychiatric evaluation (23%). Of all the referrals, nearly 70% of the patients had pain.

We had a liaison round for the newly referred inpatients on every Wednesday afternoon with the staff from the Psycho-Oncology Division, National Cancer Center Research Institute East. Before the rounds, we discuss on all currently referred cases carefully. Also, we have clinical rounds for all cases on every Friday evening. We have multi-center joint clinical tele-conference with National Cancer Center Hospital, Hokkaido Cancer Center Hospital, Shizuoka Cancer Center Hospital, Chugoku Cancer Center Hospital, Shikoku Cancer Center Hospital, and Kyushu Cancer Center Hospital that was started in 2001 on every Thursday evening.

A research conference is held every Wednesday morning for discussing on planning protocols and a journal club is held every Monday evening for important papers with all the members of our division, Psycho-Oncology

Division in NCCRIE and Psychiatry Division of NCCH.

New developments in 2004

1. Major depression, adjustment disorders, and post-traumatic stress disorder in terminally ill cancer patients
Psychological distress of terminally ill cancer patients have not been studied well. This study attempted to determine the prevalence of adjustment disorders (AD), major depression (MD), and post-traumatic stress disorder (PTSD) among terminally ill cancer patients, to identify factors that contribute to them, and to determine how they change longitudinally. Consecutive terminally ill cancer patients were recruited and were assessed for psychiatric disorders by structured clinical interview twice: once at the time of their registration with a palliative care unit (baseline), and again at the time of their palliative care unit admission (follow-up). Possible contributed biomedical and psychosocial factors were evaluated. The proportions of patients diagnosed with AD, MD, and PTSD at baseline (n = 209) were 16.3%, 6.7%, and 0% respectively, whereas at follow-up (n = 85), 10.6% were diagnosed with AD and 11.8% with MD. Lower performance status, concern about being a burden to others, and lower satisfaction with social support were significantly associated with AD/MD at baseline. There were changes in the diagnosis of AD and MD in 30.6% of the patients. Only the Hospital Anxiety and Depression Scale at the baseline was significantly predictive of AD/MD at follow-up. The factors underlying psychological distress are multifactorial. Early intervention to treat subclinical anxiety and depression may prevent subsequent psychological distress.

2. Adequacy of cancer pain management in National Cancer Center Hospital East

Pain is one of the most frequent and deleterious symptoms in cancer patients. This study was carried out to investigate the adequacy of pain management at the National Cancer Center Hospital East, Japan. The data from 138 ambulatory cancer patients with pain was assessed retrospectively. The data included pain severity, which patients reported using the Japanese version of the M. D. Anderson Symptom Inventory, along with such medical information as cancer and treatment information and currently prescribed analgesics. Adequacy of pain management was assessed using the Pain Management Index, which revealed whether prescribed analgesic drugs were congruent with pain severity. Physicians undertreated

pain in 70% of patients. Patients with non-advanced cancer (local cancer or no evidence of any recurrent cancer) were more likely to receive inadequate treatment than those with advanced cancer (P<0.01) in the exploratory logistic regression analysis. Additionally, we found significant differences among physicians in ability to manage cancer pain, unrelated to a physician's years of experience as an oncologist. This study suggests that cancer pain management is insufficient at NCCHE. Remedial action should be taken, including increasing awareness of symptom management in medical staff and incorporating existing knowledge into routine clinical practice.

3. Case report of a nurse with post traumatic symptoms after patient suicide

The suicide of the patient has great impact on medical staff, and several studies addressed the serious psychological responses experienced by medical staff after patient suicide. We experienced the psychological treatment to a nurse who presented post traumatic symptoms after a suicide by a terminally ill cancer patient. The nurse and her colleague found the hanged body of the patient by electrical cord in the ward at midnight shift. Five days after, she was referred to the psychiatry division, because she continued to experience intrusive recollections of the colleague's

terrified face and the scene that she had taken the body. Her symptoms fluctuated and were severe during the first 10 days after the suicide, and they gradually improved during next 10 days. She experienced avoidance of entering private room on the ward and exaggerated startle reactions in response to loud noise. At day 87, she felt that she had been almost overcome her fear, but she still had mild avoidance of darkness. At final session on day 120, most symptoms were disappeared. This case suggests the necessity of careful assessment of psychological distress of surrounding medical staff and debriefing when patient committed suicide in medical ward.

4. Ongoing protocol study

Feasibility study on treatment algorithm for major depression among advanced cancer patients is ongoing. Studies on patients' preferences regarding communication of bad news and development of communication skill training program for Japanese oncologists are now ongoing. Longitudinal psychiatric prevalence study among pancreatic cancer patients is ongoing. In addition, feasibility study on effectiveness of nurse-assisted psychiatric liaison program on early detection of adjustment disorders and/or major depression is ongoing.

● Y. Uchitomi ●

Table. Psychiatric consultation data (N=456, January - December, 2004)

No.	(%)
Age (Mean(SD, yr)	60 12 (median; 60, Range; 22-89 yr.)
Gender (male/female)	236 (51.8) / 220 (48.2)
Inpatient/Outpatient	364 (79.8) / 92 (20.2)
Cancer site	
Head and neck	90 (19.7)
Lung	89 (19.5)
Breast	54 (11.8)
Esophagus	40 (8.8)
Malignant Lymphoma	28 (6.1)
Stage	Recurrent or metastatic
PS	0/1,2/3,4
Pain	Presence
Disclosure of cancer diagnosis	
Disclosed	440 (96.5)
Reason for the consultation (multiple choice)	
Anxiety/fear	144(31.6)
Depression	131 (28.7)
Psychiatric evaluation	104 (22.8)
Organic brain syndrom	94 (20.6)
Patient request	53 (11.6)
Psychiatric diagnosis	
Adjustment disorders	146 (32.0)
mixed emotion	84 (18.4)
anxious mood	44 (9.6)
depressive mood	17 (3.7)
Delirium	116(25.4)
Major depression	75 (16.4)
Others	76 (16.7)
No diagnosis	43 (9.4)