

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 one staff psychiatrist, 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 2005, total of 456 referrals (9% up 2004) were made for the psychiatric consultation. Consultation data included 7 cancer patients' family members and 6 oncology staff members. Among cancer patients, 75% were inpatients; the most common psychiatric diagnosis was adjustment disorders (41%) followed by delirium (17%) and major depression (11%). The most common cancer site was lung, and the next was head and neck. Sixty percent of the referred patients had recurrent or metastatic cancer. The most common reason for psychiatric consultation was anxiety/fear (35%), followed by depression (26%) and patient request (19%). Of all the referrals, More than 60% 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, Shizuoka Cancer Center Hospital, Chugoku Cancer Center Hospital, Shikoku Cancer Center Hospital, Kyushu Cancer Center Hospital, and Nagoya City University Graduate School of Medical Sciences that was started in 2001 on every Thursday evening. Since October 2005, we started Supportive Care Team consisted by psycho-oncologist, palliative care doctor, palliative care nurse, social worker, psychologist, pharmacist, and nutritionist. Team conference was held on every

Wednesday evening.

A research conference is held every Wednesday morning for discussing on planning protocols and a journal club is held every Tuesday evening for important papers with all the members of our division, Psycho-Oncology Division in National Cancer Center Research Institute East and Psychiatry Division of NCCCH.

Research activities

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.

New developments in 2005

1. Development of an Impact Thermometer for use in combination with the Distress Thermometer as a brief screening tool for adjustment disorders and/or major depression in cancer patients

Screening cancer patients for adjustment disorders and major depression is important, because both are prevalent and often underrecognized. The purpose of this study was to validate the Distress and Impact Thermometer, a 2-item questionnaire, which we newly developed as a brief screening tool for detection of adjustment disorders and/or major depression. Two hundred ninety-five cancer patients completed the Distress and Impact Thermometer and the Hospital Anxiety and Depression Scale (HADS), and were examined by psychiatrists based on DSM-IV criteria. Using cutoff points for detection of adjustment disorders and major depression of "3/4" on "distress" score and "2/3" on "impact," the sensitivity and specificity were 0.82 and 0.82, respectively. Screening performance of the Distress and Impact Thermometer was comparable to that of the Hospital Anxiety and Depression Scale. Its brevity and good performance suggest that the Distress and Impact Thermometer is an effective tool for routine screening in clinical oncology settings.

2. Usefulness of the nurse-assisted screening and psychiatric referral program.

Major depression and adjustment disorders are common psychiatric disorders in patients with cancer, but they are often overlooked in clinical oncology settings. The nurse-assisted screening and psychiatric referral

program (NASPRP) has been introduced in clinical practice to facilitate psychiatric treatment for major depression and adjustment disorders. This study assessed the usefulness of the NASPRP and compared it with usual practice. The program consists of two stages. In the first stage, consecutive patients newly admitted to the Oncology/Hematology Unit are administered the Distress and Impact Thermometer (DIT) by nurses as a brief screening tool for major depression and adjustment disorders. In the second stage, the nurses recommend psychiatric referral to patients with scores above the cutoff point. Patients' records were reviewed for a 3-month period before the start of the program and during the 3-month period after the start of the program. These records were then compared. Of 157 patients newly admitted during the program period, 86.0% (135/157) completed the DIT and results were positive in 49.6% (67/135), but only 28.2% (19/67) accepted psychiatric referral. Ultimately, 11.5% (18/157) of patients newly admitted were diagnosed with major depression or adjustment disorders and treated by psychiatric service, a significantly higher proportion than during the preceding 3-month period, before the program was begun (2.5%; $P = 0.001$). The NASPRP enabled identification of major depression and adjustment disorders in patients with cancer and introduced them to psychiatric treatment. Nevertheless, there is room for improvement in the program.

3. Occurrence of fatigue and associated factors in disease-free breast cancer patients without depression

Studies on fatigue in disease-free breast cancer patients have consistently found a significant association between fatigue and depression; and some characteristics of this fatigue may be confused with and/or concealed by those of depression. To clarify the characteristics of fatigue in disease-free breast cancer patients, we examined the frequency of fatigue and associated factors in disease-free breast cancer patients without major depression. Seventy-nine ambulatory breast cancer patients without major depression who had been disease-free for more than 3 years since their surgery completed the Cancer Fatigue Scale (CFS), a multidimensional scale assessing cancer-related fatigue. Participants also completed the Short-form Eysenck Personality Questionnaire-Revised (EPQR) for assessing their personalities. Sociodemographic, physical, and treatment-related factors were also obtained by interview. We found that 36.7% of the patients exhibited fatigue and that fatigue was significantly associated with neuroticism. These results suggest that a considerable number of disease-free breast cancer patients without major depression experience fatigue and that careful attention to those exhibiting high neuroticism may be of benefit in ameliorating their fatigue.

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Table. Psychiatric consultation data (N=498, January - December, 2005)

No.	(%)
Age (Mean(SD, yr	60 ± 13 (median; 61, Range; 21-92 yr.)
Gender (male/female)	292 (58.6) / 206 (41.4)
Inpatient/Outpatient	375 (75.3) / 123 (24.7)
Cancer site	
Lung	119 (23.9)
Head and nec	109 (21.9)
Esophagus	51 (10.2)
Breast	44 (8.8)
Colon	39 (7.8)
Stage	Recurrent or metastatic 299 (60.0)
PS	0/1,2/3,4 123 (24.7) / 214 (43.0) / 156 (31.4)
Pain	Presence 293 (62.2)
Disclosure of cancer diagnosis	
Disclosed	483 (97.0)
Reason for the consultation (multiple choice)	
Anxiety/fear	172(34.5)
Depression	128 (25.7)
Patient request	95 (19.1)
Psychiatric evaluation	80 (16.1)
Organic brain syndrome	66 (13.3)
Psychiatric diagnosis	
Adjustment disorders	202 (40.6)
mixed emotion	111 (22.3)
anxious mood	64 (12.9)
depressive mood	14 (2.8)
Delirium	85(17.1)
Major depression	57 (11.4)
Others	95 (19.1)
No diagnosis	59 (11.8)