

Psychological Distress and Suicide Correlated with Long-Life Expectancy in Advanced Cancer Patients

Danila Comandini¹, Fabio Catalano^{1*}, Erika Romano², Malvina Cremante¹, Maria Laura Iaia¹, and Sara Elena Rebuzzi^{3*}

¹Medical Oncology Unit 1, IRCCS Ospedale Policlinico San Martino, Genova, Italy

²Clinical psychology and psychotherapy unit, IRCCS Ospedale Policlinico San Martino, Genova, Italy

³Department of Internal Medicine and Medical Specialties (Di.M.I.), University of Genova, Genova, Italy

⁴Medical Oncology Unit, Ospedale San Paolo, Savona, Italy

Correspondence should be addressed to Sara Elena Rebuzzi, Ospedale San Polo, Via Genova 30, 17100, Savona, Italy; Department of Internal Medicine and Medical Specialties (Di.M.I.), University of Genova, Viale Benedetto XV 6, 16132, Genova, Italy

Received: February 21, 2022; Accepted: March 04, 2022; Published: March 11, 2022

ABSTRACT

OBJECTIVE

Advances in systemic therapy together with better diagnostic and surgical techniques have contributing to survival improvement of many tumor types. Patients with cancer have an increased risk of suicide and the psychological impact of cancer is due the diagnosis itself, side effects of the therapy and cancer-related symptoms.

METHOD

The purpose of this study is to present the clinical case of an advanced gastrointestinal stromal tumor patient who committed suicide after 6 years of treatment.

RESULT

A 49-years-old male with a history positive only for an anxiety-depressive disorder was diagnosed with a locally advanced gastrointestinal stromal tumor. After 6 months of neoadjuvant imatinib, with stable disease, the patients decided to undergo surgery, with the subsequent resumption of adjuvant imatinib. Once the patient experienced disease progression, he preferred a surgical approach, even though he was aware that surgery was not the standard treatment and that a second-line systemic therapy was recommended. When the start of a second line therapy was the only possible treatment option, the patient has resigned himself to the idea that he would never be able to heal from cancer. After few months of second-line therapy he died of suicide.

Citation: Danila Comandini, Psychological Distress and Suicide Correlated with Long-Life Expectancy in Advanced Cancer Patients. Cancer Med J 5(S5): 34-38.

SIGNIFICANCE OF RESULTS

This case report shows that suicidality in cancer patients is a continuum spectrum from wanting to live, through the decreasing will to live, the readiness to die and then actively ending one's life. Multidisciplinary teams should focus their attention not only on the disease itself but also on the cancer-related long-term psychological distress. Therefore, patient palliative care on psychological aspects should be improved strengthening psycho-social interventions during the entire cancer treatment history, not only at the end of life.

KEYWORDS

Advanced cancer; Suicide risk; Life expectancy; Psychological distress; Palliative care

INTRODUCTION

Gastrointestinal stromal tumors (GIST) are rare tumors with a long-life expectancy and a median overall survival of about 5 years in advanced disease [1]. Advancing in systemic therapy and better diagnostic and surgical techniques have contributed to survival improvement [2]. This is a new scenario to face with, since before the introduction of new efficient therapies, oncological patients had a short life expectancy [1]. Similarly, to other chronic diseases, cancer disease is associated with higher rates of suicidal ideas and attempts [3]. In this context, oncologists should focus their attention not only on the disease itself but also on the impact of the disease on health-related quality of life and the long-term psychological distress.

Here we report the clinical case of an advanced GIST patient who committed suicide after 6 years of treatment, focusing our attention on the management of the patient's wishes and expectations and on the correlation between cancer and suicide.

CASE PRESENTATION

In February 2012, a 49-years-old Caucasian male presented at our attention for abdominal and back pain. The patient's history was positive only for an anxiety-depressive disorder. A total body (TB) computed tomography (CT) scan showed a large mass (35 cm), whose biopsy revealed

a histological diagnosis of GIST harbouring c-KIT exon 9 mutation.

In the same month, a neoadjuvant therapy with Imatinib was started. After 6 months of therapy, the TB CT scan showed no significant changes in tumor size. Despite stable disease being considered a positive prognostic factor, the patient demanded surgery, which was performed in September 2012 after a multidisciplinary consultation. One month after surgery (October 2012), post-operative Imatinib was resumed but after 6 months a TB CT scan revealed a single lesion peritoneal progression.

In consideration of the brief progression-free survival (6 months), we proposed to start Sunitinib, but the patient preferred not to start a second-line therapy, requesting a surgical resection again. Although it was not considered a standard approach, in May 2014 the patient underwent to radical surgical resection confirming the diagnosis of GIST's relapse.

One month after surgery (June 2014), Imatinib was started again. Follow up was negative until December 2015 when CT scan showed local abdominal disease progression. In one year, three surgery resections were performed for abdominal tumor relapses as the patient considered the surgical approach as the only acceptable treatment.

After several abdominal relapses and our strong advice to start a second line therapy, the patient has resigned himself to the idea that he would never be able to heal from cancer. With a mood no longer of anxiety but resignation he began second-line therapy with Sunitinib in October 2017. After 7 months of treatment, in the last clinical visit in May 2018, the patient did not show any symptoms and signs of anxiety or depression. Nonetheless, only one week later, he died of suicide at home by shooting himself in the face.

PSYCHOLOGICAL FEATURES

During the management of the disease over the years, the patient has always shown to be collaborative with the care team establishing a friendly and grateful relationship. Nonetheless, he has always shown anxiety about his disease, asking many questions about possible therapeutic options if the ongoing treatment would have been failed. Every time a disease relapse occurred, despite the fact that patient was adequately informed on the systemic therapeutic options and that surgery was not a resolving approach, the patient pushed to undergo surgery as he considered it the only way to survive. In the last year, his behaviour changed reducing questions and his friendly relationship with oncologists approaching life with a demoralization.

The characteristics and the course of the patient's disease played an important role. The patient was aware of having a rare tumour but had high expectations on surgical approach, despite he was informed that surgery that surgery wouldn't have been led to recovery and it was not free from complications and hospitalizations. Despite being adequately informed on the therapeutic options available, the patient experienced the end of the surgical options as a defeat and the transition to a terminal stage of the disease and so to the end of life.

Moreover, other life events occurred in the last year. He had been struck by the death of the widowed father with

whom he lived and by the death of another patient who suffered from the same disease, with whom he had established a strong bond along the years. The death of the elderly father aggravated the psychological condition and social isolation in which the patient already lived. Over the years he had reduced his interest in social interactions as he was not married and with very few friends. Furthermore, the death of his friend with the same disease, had probably caused pervasive and distressing identification.

Consequently, the demoralization, never shown until then, appeared as a new element at the non-verbal level linked to a decisive and sudden change of the way of dealing with the disease. The oncologists, who had known the patient for years, saw indeed a clear sign of psychological vulnerability and offered the possibility of a consultation which the patient refused.

The difficulties that emerged in the adjustment process, in addition to all the aforementioned stressful events, compromised in our patient the possibility of maintaining the will to live. The ease of finding the weapon autonomously and easily, since he was a hunter, provided our patient with the possibility to reach a final solution to commit suicide. The explosive anguish of the suicidal drive did not affect the care towards his own dogs. The last thought of care in his last days was to entrust them to some dear friends.

DISCUSSION

Despite important diagnostic and therapeutic advances, cancer remain the disease that most cause deep fear in the general population. Cancer patients have an increased risk of suicide, two-fold higher than the general population [3,4]. The prolongation of life expectancy of cancer patients exposes them to a long-term psychological distress due to the diagnosis itself, the treatment side effects and cancer-related symptoms, such as pain, physical impairment, and loss of autonomy [5]. Patient's

characteristics correlated with a higher suicide risk are age (more 40 years - 50 years), gender (more males), religiosity, family environment, previous life experiences and a history of psychiatric disorders [5,6]. More than 80% of suicide victims have contact with their physician during the year before their death and about 65% of them within the last month [7].

Granek et al. consider suicidality in cancer patients as a fluid concept rather than a discrete category of suicidal intentions as the classical psychiatric definition [8]. Suicidality is shown as a broad spectrum as a continuum of wanting to live, passing through the decreasing will to live until the readiness to die and actively ending one's life [8]. In this process they identify four phases [8]. In the first phase patients have a strong will to live, are under active treatments, seek overtreatment and alternative treatments. The second phase is characterized by a decreasing will to live in which patients continued to be treated but show non-verbal signs of mental and physical distress such as sadness, apathy, and overall impaired functioning. In the third phase patients express their readiness to die to their families and caregivers and actively chose to stop treatments to maintain control over their bodies and lives. The last phase is characterized by an active will to die taking active steps to end their own lives.

The understanding, assessment, and recognition of suicide risk in cancer patients are limited. In another study, Granek et al. examined how oncology personnel identify suicide risk in their cancer patients and the barriers they face in this

task [9]. The indicators of suicide risk include verbal indicators (explicit talk of suicide, decreased future plans), explicit actions (stopping or rejecting treatment), exhibiting mental distress (signs of depression), disease and patient's characteristics (diseases with poor prognosis, disease relapse, terminal status) [9].

The barriers in the identification of the suicide risk are related to patient's factors and healthcare personnel ones. Patient-related factors include the absence of patients' warnings or signs of suicide and the share of their emotional state in the healthcare setting. On the other side, healthcare personnel factors include the lack of knowledge about identifying suicide risk the absence of time due to stressful jobs, the fear of consequences of asking about suicide and on what to do when a suicidal intent was identified [9].

CONCLUSION

Nowadays, there are no proven ways to identify cancer patients with a high risk of suicide. There is, therefore, the need to improve the patient palliative care highlighting the psychological aspects (psychosocial distress, non-verbal signs of suicide risk, unmet health needs) and strengthening psycho-social interventions during the entire cancer treatment history, not only at the end of life. Multidisciplinary teams should include psychologists to build new strategies not only to improve patients' quality of life but also to train healthcare personnel and care givers on how to deal with the patient's psychological distress and how to recognize the suicide risk [10].

REFERENCES

1. Call JW, Wang Y, Montoya D, et al. (2019) Survival in advanced GIST has improved over time and correlates with increased access to post-imatinib tyrosine kinase inhibitors: Results from Life Raft Group Registry. *Clinical Sarcoma Research* 9: 4.
2. Parab TM, DeRogatis MJ, Boaz AM, et al. (2019) Gastrointestinal stromal tumors: A comprehensive review. *Journal of Gastrointestinal Oncology* 10(1): 144-154.

3. Anderson C, Park EM, Rosenstein DL, et al. (2018) Suicide rates among patients with cancers of the digestive system. *Psycho-oncology* 27(9): 2274-2280.
4. Misono S, Weiss NS, Fann JR, et al. (2008) Incidence of suicide in persons with cancer. *Journal of Clinical Oncology* 26(29): 4731-4738.
5. Spoletini I, Gianni W, Caltagirone C, et al. (2011) Suicide and cancer: Where do we go from here? *Critical Reviews in Oncology/Hematology* 78(3): 206-219.
6. Ahn E, Shin DW, Cho SI, et al. (2010) Suicide rates and risk factors among Korean cancer patients, 1993-2005. *Cancer Epidemiol Biomarkers and Prevention* 19(8): 2097-2105.
7. Andersen UA, Andersen M, Rosholm JU, et al. (2000) Contacts to the health care system prior to suicide: A comprehensive analysis using registers for general and psychiatric hospital admissions, contacts to general practitioners and practising specialists and drug prescriptions. *Acta Psychiatrica Scandinavica* 102(2): 126-134.
8. Granek L, Nakash O, Ariad S, et al. (2017) From will to live to will to die: Oncologists, nurses, and social workers identification of suicidality in cancer patients. *Supportive Care in Cancer*. 25(12): 3691-3702.
9. Granek L, Nakash O, Ben-David M, et al. (2018) Oncologists', nurses', and social workers' strategies and barriers to identifying suicide risk in cancer patients. *Psychooncology* 27(1): 148-154.
10. AIOM Guidelines on psycho-social assistance for cancer patients.