Recognising and managing mental health conditions in those affected by a brain tumour

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Talk outline

- Background
- Depression and anxiety
- Delirium and cognition
- Personality change
- “Positive framing”

Brain tumours increase the risk of mental ill-health

Frequency >population norms

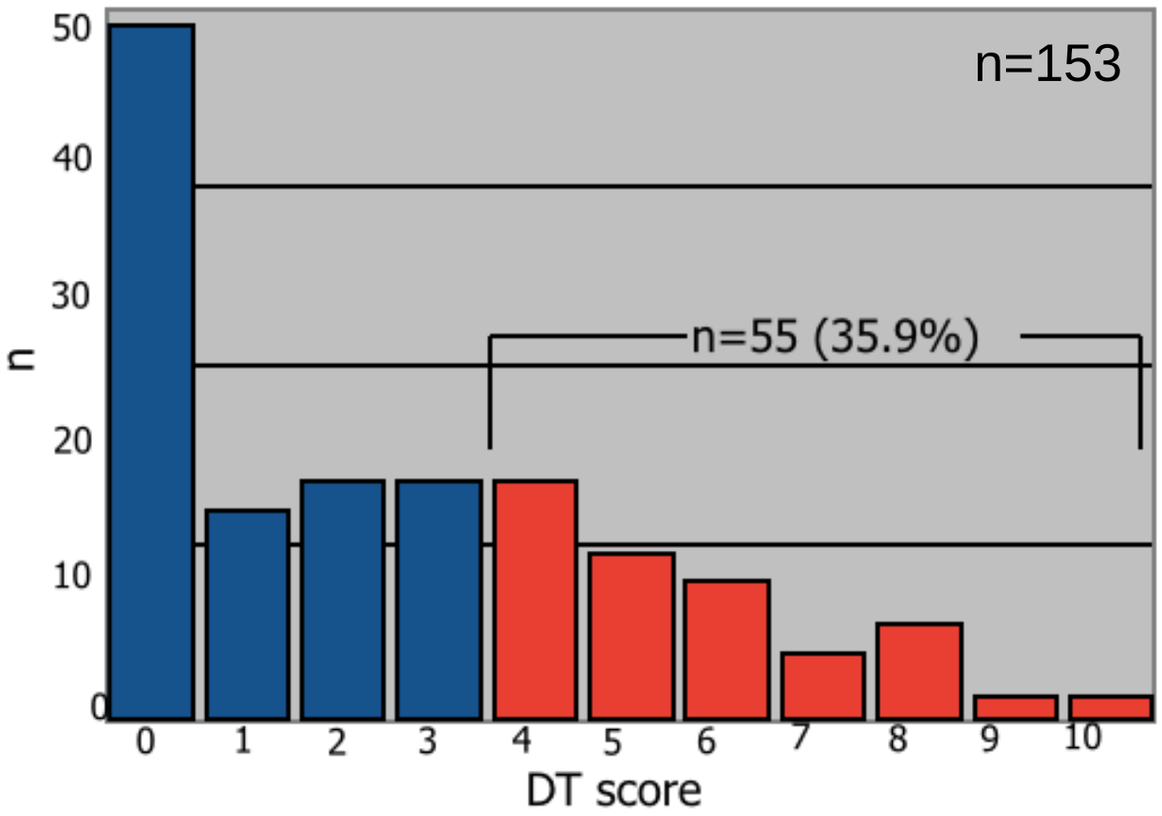
Frequency >some other cancers (but not all)

Highest risk for psychiatric contact pre-cancer diagnosis

3rd highest risk of suicide post-cancer diagnosis

Refs #1-4

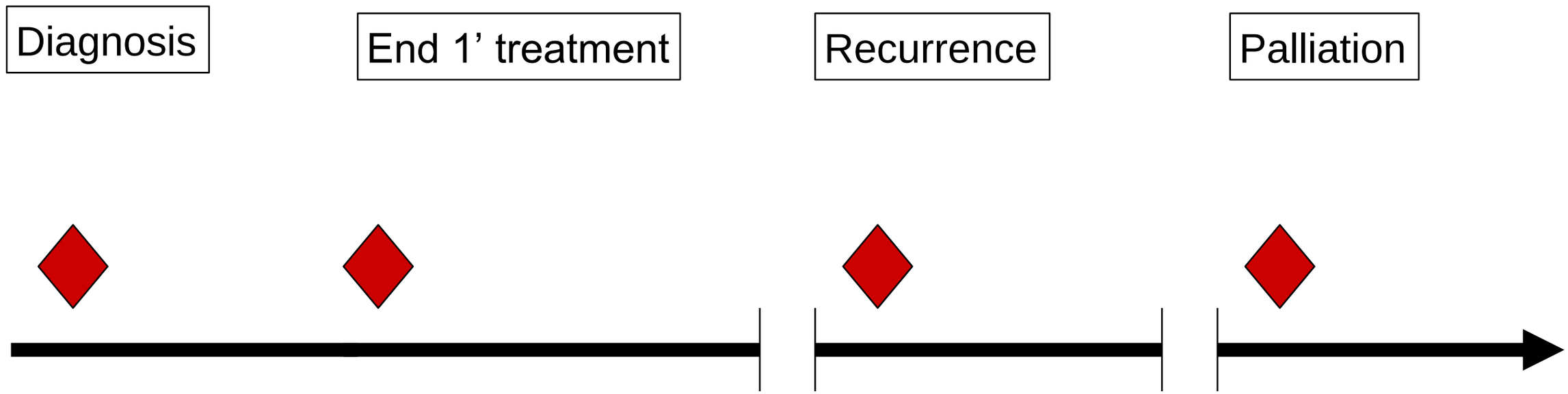
Distress is common and persistent following brain tumour diagnosis



Poor function
Younger age
Epilepsy
Depression

Ref #5

Distress may peak at several points after diagnosis



Ref #6

Distress is multifactorial

"I feel like I'm a burden. I'm no longer the capable man I once was."

64 year-old man with a high grade tumour

"I feel frightened by how I behave sometimes. It's like it isn't really me."

45 year-old woman with a low grade tumour

"Seizures have made me lose all my confidence. They make me scared to be alone and I have huge anxiety problems."

55 year-old man with a high grade tumour

"I split from my partner of five years following diagnosis. It put so much strain on our relationship and we were unable to deal with it."

39 year-old woman with a low grade tumour

The BRAIN TUMOUR CHARITY

Ref #7

Patients have multiple concerns and unanswered questions

BRAIN TUMOUR CLINIC "PATIENT CONCERNS INVENTORY"

1 Please tick any issues that have been a concern for you recently.

PRACTICAL

- ☐ Child care
- ☐ Financial benefits
- ☐ Holidays
- ☐ Housing
- ☐ Insurance
- ☐ Recreation
- ☐ Transport or driving

FAMILY

- ☐ Dealing with children
- ☐ Dealing with partner
- ☐ Ensuring support for family

EMOTIONAL

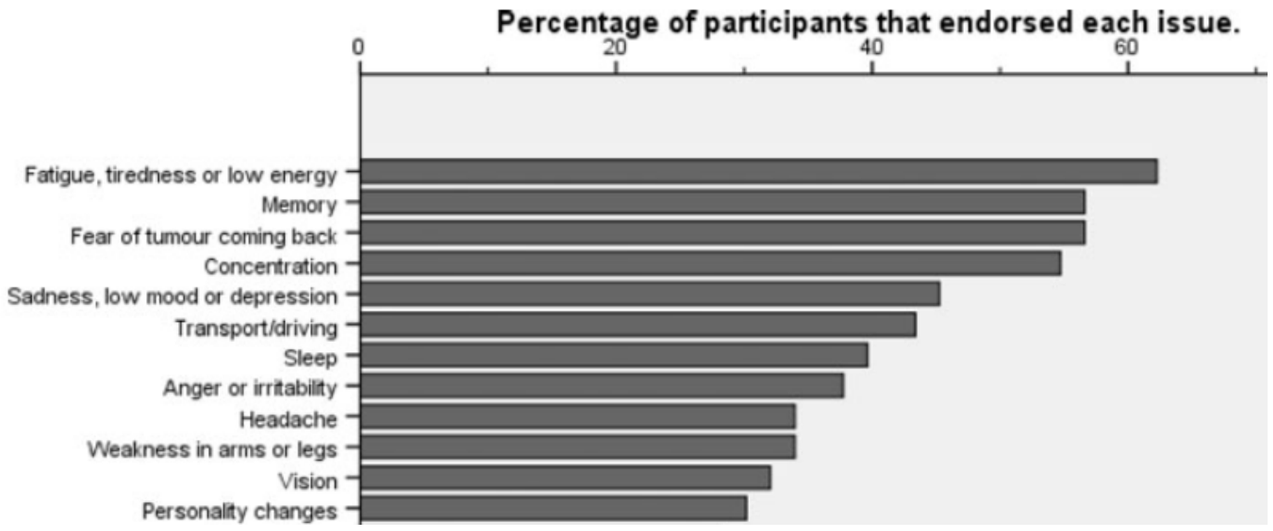
- ☐ Anger or irritability
- ☐ Fear of tumour coming back
- ☐ Other fear, anxiety or worry
- ☐ Personality changes
- ☐ Sadness, low mood or depression

SPIRITUAL

- ☐ Difficulty relating to God
- ☐ Loss of faith
- ☐ Loss of meaning to life

PHYSICAL

- ☐ Appearance
- ☐ Appetite or eating
- ☐ Bathing or dressing
- ☐ Breathing
- ☐ Changes in urination
- ☐ Concentration
- ☐ Constipation
- ☐ Co-ordination
- ☐ Diarrhoea
- ☐ Epilepsy, or seizures
- ☐ Fatigue, tiredness or low energy
- ☐ Feeling swollen
- ☐ Fever
- ☐ Headache
- ☐ Indigestion
- ☐ Memory
- ☐ Metallic taste in mouth
- ☐ Mobility/getting around
- ☐ Mouth sores
- ☐ Nausea or vomiting
- ☐ Nose dry/congested
- ☐ Pain (apart from headache)
- ☐ Sex or intimacy
- ☐ Skin dry, or itchy
- ☐ Sleep
- ☐ Speech
- ☐ Tingling in hands or feet
- ☐ Vision
- ☐ Weakness in arms or legs
- ☐ Weight change



<u>Theme of patients' questions</u>

Symptoms or social issues
73/105 (69.5%)

MRI / recurrence / prognosis / surgery
20/105 (19.0%)

Ref #8

Background

Depression and anxiety

Delirium and cognition

Personality change

“Positive framing”

Clinical depression is a huge hidden morbidity

6-month prevalence 21% in UK = over 2000 depressed new patients per year

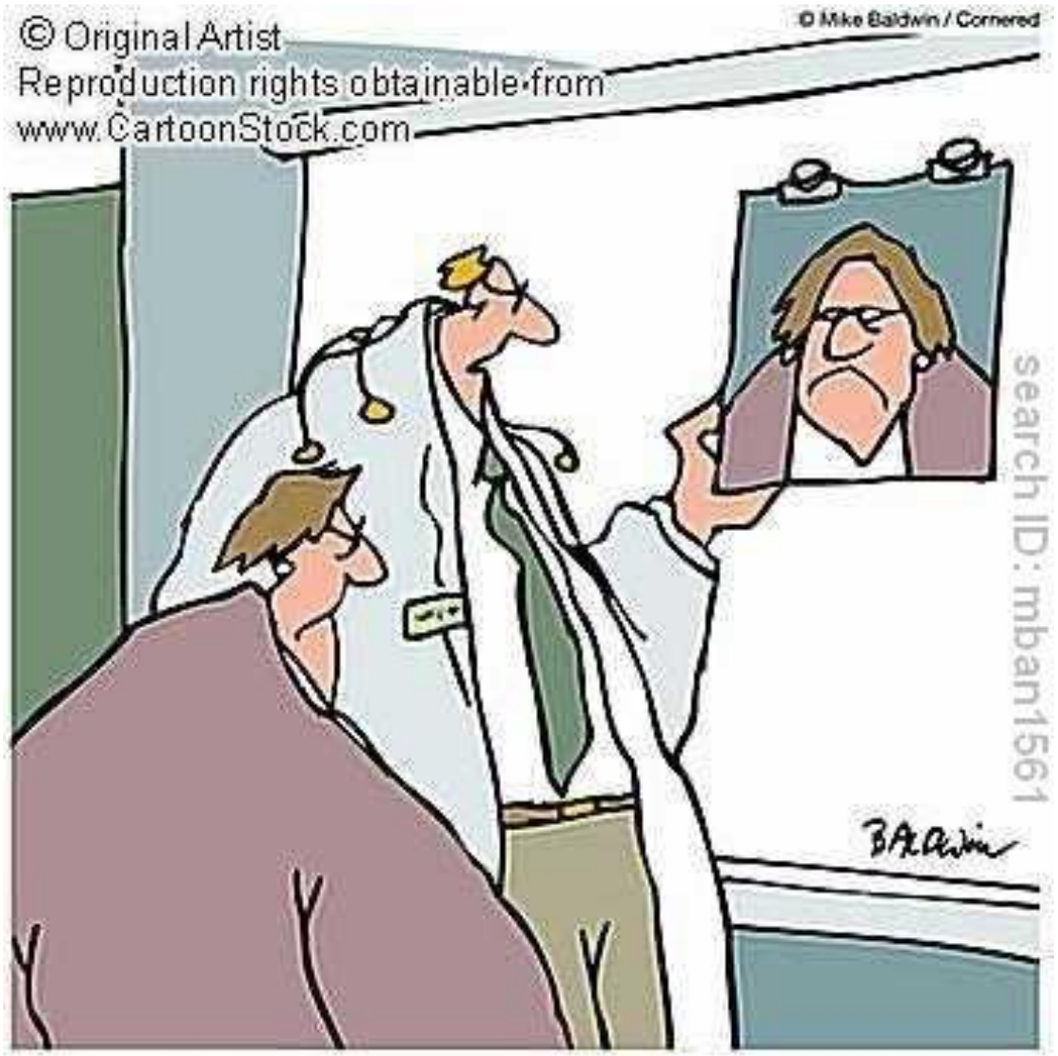
Persists for >3 months in most cases

Well-known adverse modulator of QoL

Poor function
Previous depression
Steroids
Cognitive impairment

Refs #9-10

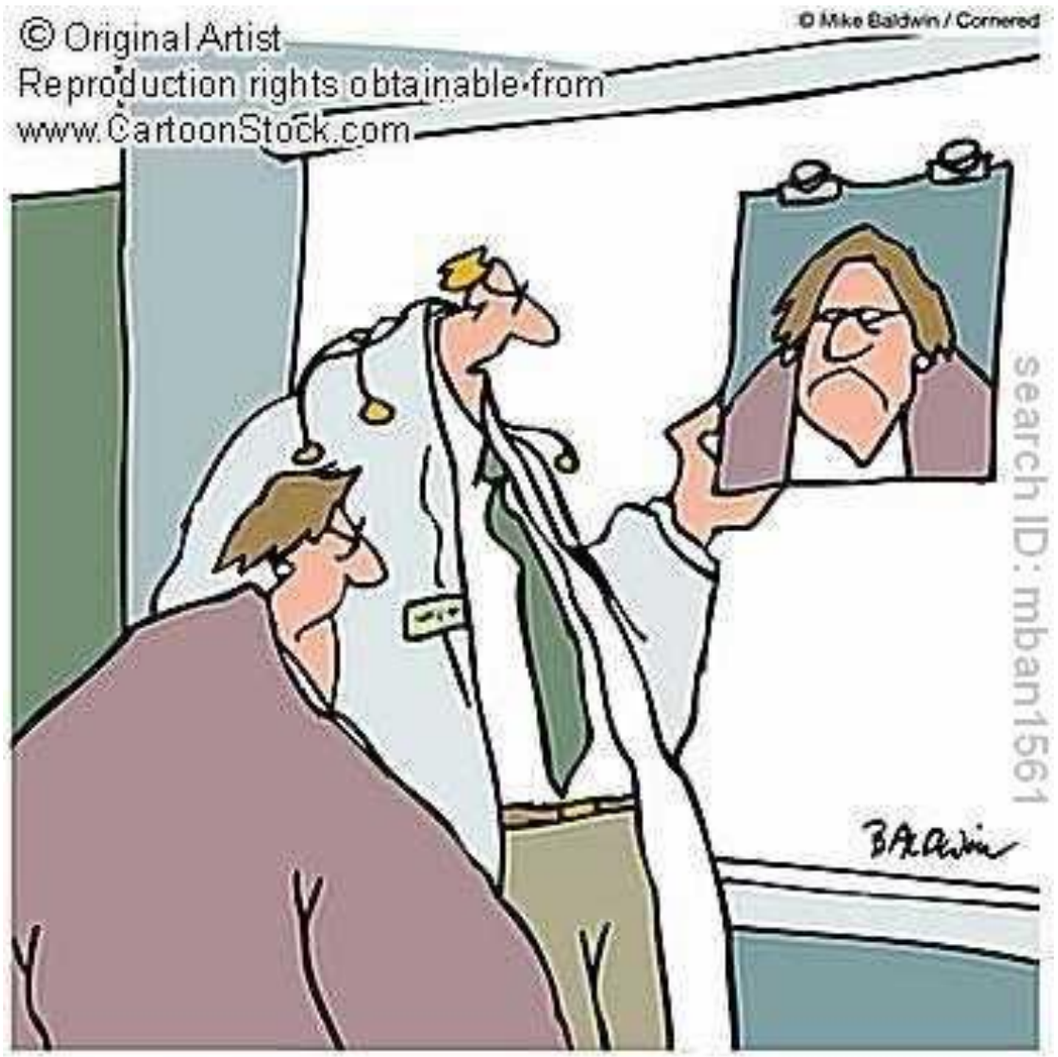
Depression is a syndrome - diagnosis requires multiple symptoms



"Looks like it could be depression."

"I'd be depressed if
I had a brain tumour!"

Depression is a syndrome - diagnosis requires multiple symptoms



"Looks like it could be depression."

Depressed mood
Loss of interest
Appetite changes
Sleep changes
Fatigue
Concentration problems
Guilt
Physical/mental slowing
Suicidal thoughts

What we call ‘depression’ is really a heterogeneous syndrome

‘Heatmap’ of symptoms present (green) or absent in individuals with depression

Diagnosing depression is a matter of clinical judgement

- Wait at least one month from diagnosis
- Focus on *severity* and *persistence* of symptoms
- Grief comes in waves; depression is pervasive
- Some degree of loss of interest and guilt is normal
- Suicidal thoughts are rare - always take seriously
- **Get a collateral history**

Screening

- HADS
- PHQ-9
- DASS-21

Adjustment disorder
Delirium / cognitive impairment
Organic personality change
Anaemia, thyroid, pituitary,…

The best way to treat depressed patients with a brain tumour is not known

NO RCT-proven effective treatments in clinically depressed brain tumour patients

Methylphenidate
Oxcarbazapine
Gingko biloba
Donepezil

Massage therapy
Acceptance therapy
Telephone based support

Some low quality evidence

Internet-based guided self-help: negative RCT (but underpowered)
Tailored, multicomponent psychosocial intervention: some RCT evidence for reducing depressive symptoms measured by rating scale

Antidepressants
Talking therapy
Exercise?

Refs #11-12

Background

Depression and anxiety

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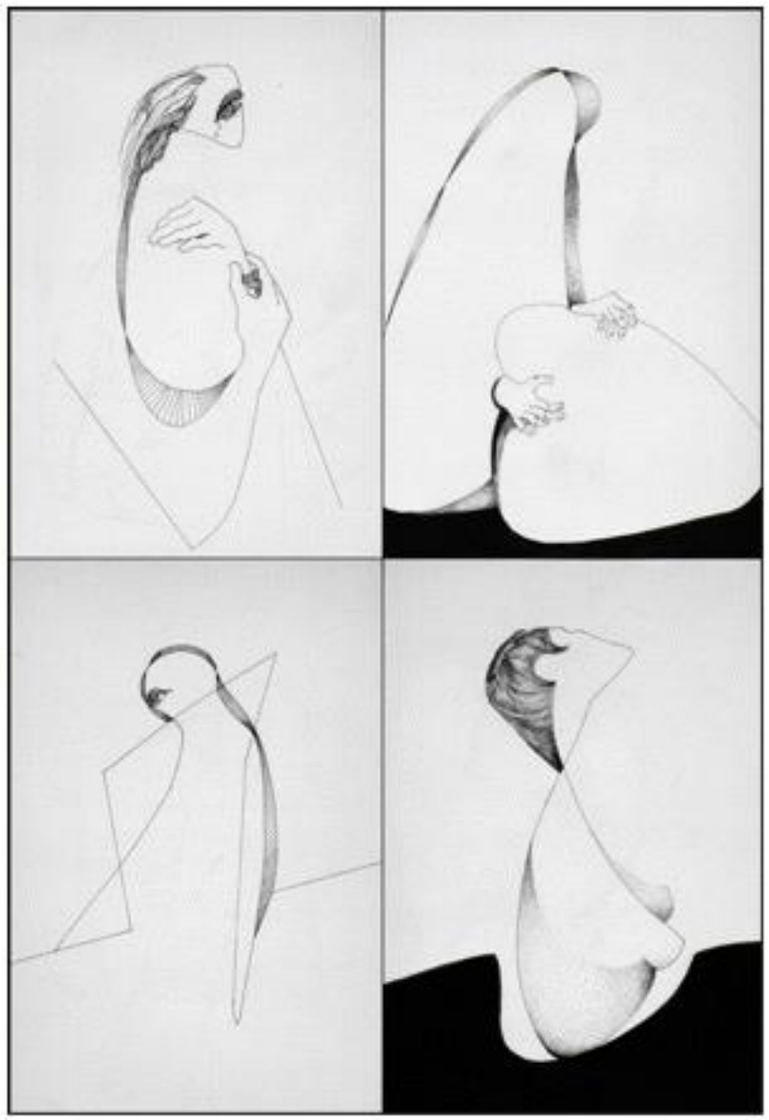
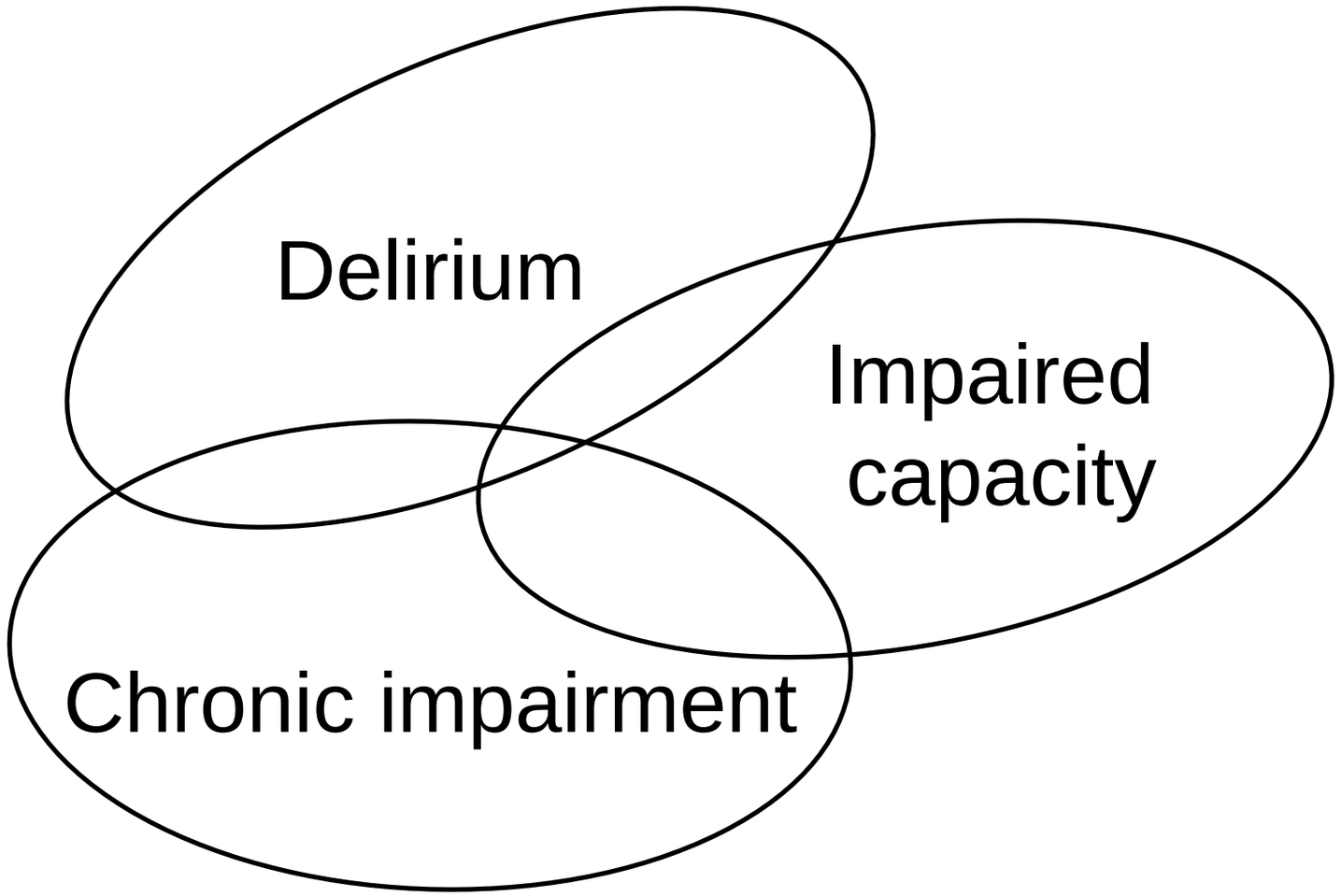
Personality change

“Positive framing”

Cognitive impairment is common and takes different forms





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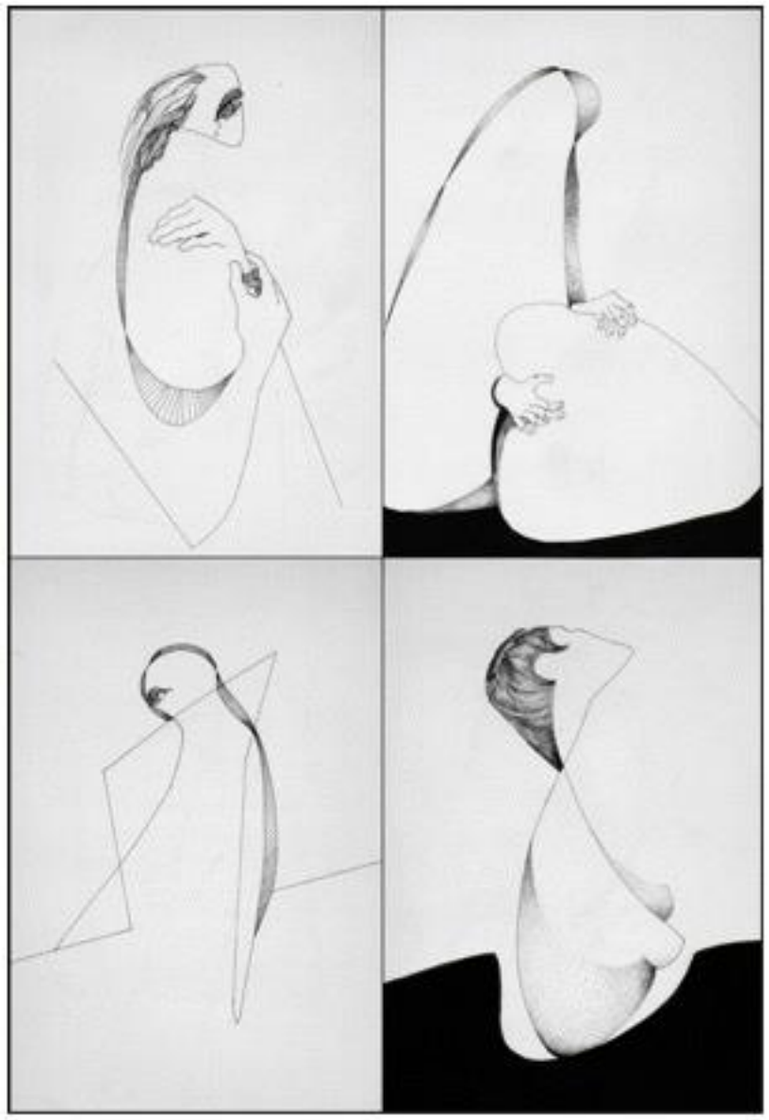


Delirium

Sudden onset fluctuating confusion

Screen using 4AT

Delirium

Soon after diagnosis

End of life phase

post-op
steroids
infection
radiotherapy

steroids
infection
opiates
disease progression
catheterisation

Older age
Cognitive impairment
Infection
Medications
Immobility
Catheter

Treat the cause

Supportive treatment of delirium

Non-pharmacological supportive measures

Side-room
Well-lit
Clock / calendar
Sensory aids
Rationalise medication
Well-known staff / carers
Familiar objects from home

Medication (where necessary to maintain safety)

Low-dose regular antipsychotic (e.g. haloperidol 1mg, or olanzapine 2.5mg)
Avoid benzodiazepines
Stop opiate and anticholinergic meds

Background

Depression and anxiety

Delirium and cognition

Personality change

“Positive framing”

Personality change is a challenging complication for families

“How can we understand each other’s point of view?

…

Why do the problems cause strain on partnerships?

…

Why do we hurt the people closest to us?

…

Why can’t we ask them to help?

…

Do I say too much or not enough?”

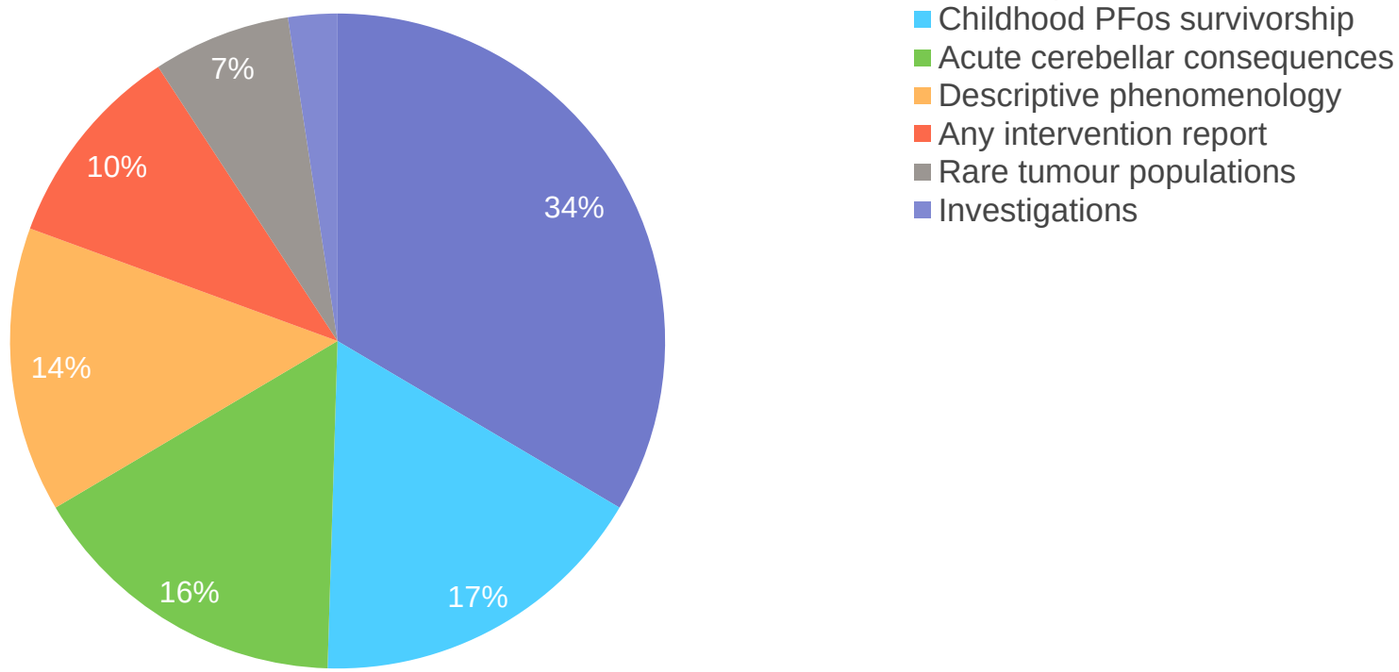
For answers… come to BNOS

British Neuro-Oncology Society

Personality change is frequent and cross-cuts histological diagnoses

First author	Year	In a nutshell
Herrlinger	1999	Up to 73% with personality change at presentation with PCNSL
Allam	2000	16% reported behavioural changes at presentation with oligodendroglioma
Davies	2005	Personality change independently predicted lower QoL for carers of patients with HGG
Wilne	2007	Marked irritability in 24% of children aged <4yrs presenting with BT
Tiemensma	2010	More apathy and irritability than controls 13 years after treatment for NFPMA
Gofton	2012	61.9% with cognitive / personality changes in palliative care primary / metastatic BT
Sterckx	2013	Several qualitative studies highlight personality change as of significant impact
Collins	2014	Significant cognitive /behavioural change at presentation = OR 3.1 (1.9-4.5) for death without being discharged from hospital

There is little evidence to guide management in adults



Behavioural programs to address personality change are being studied

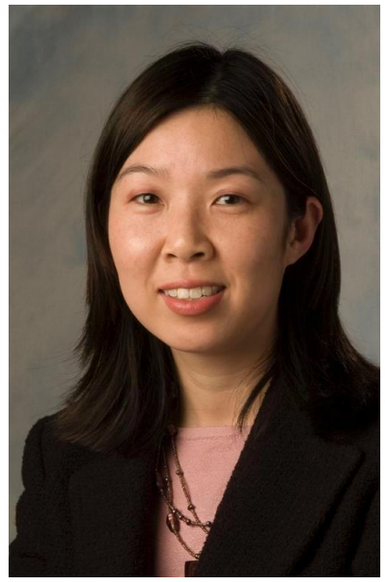
Tamara Ownsworth

MSoBT program

- Individually tailored
- Psychoeducation
- Cognitive rehabilitation
- Psychotherapy
- Couple and family support

Ownsworth (2014 - the only RCT)

Siew Koh



Behavioural consultancy

- Home-based psychoeducation
- Communications skills
- Relaxation techniques

Carer training workshop

Whiting (2012)

Refs #12-13

Could we adopt treatments used by other patient groups?

Functional Analysis in dementia

- Antecedent - Behaviour - Consequence (ABC)
- Probably effective as part of a multicomponent intervention

Drug treatment of agitation and aggression in ABI

- Best evidence is for beta blockers (propranolol)
- Antipsychotics etc - last resort; a few case reports for Risperidone in BT

Cognitive reframing for carers in dementia

- Targets distressing cognitions about patient behaviours / carer role
- Significantly reduced anxiety (SMD -0.21) and depression (SMD -0.66)

Background

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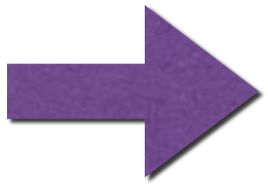

“Positive framing”

The World Health Organisation defines mental health in a positive way

"A state of *well-being*
in which every individual *realises their potential*,
can cope with the normal stresses of life,
can work productively and fruitfully,
and is able to *make a contribution* to her or his community."

Do we take a positive approach to mental health in brain tumours?

Examples

Do we help patients realise their potential after treatment?
To cope adaptively with the daily stress of having cancer?
To work (or function) productively?
To make a contribution to their community?

- Neurorehabilitation? (see Ref #15)
- Screening for mental distress?
- Carer support?
- Research funding?

Obstacles

Summary

- Having a brain tumour increases the risk of mental ill-health from diagnosis to palliation.
- Clinical depression should be diagnosed by clinical interview. Antidepressants are empirical first-line treatment.
- Delirium presents with acute onset and fluctuating confusion. Treatment consists of reversing likely underlying causes.
- Personality change may be amenable to behavioural management strategies.
- A positive goal of achieving “mental health” may trump one of treating “mental disorder”.

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Thankyou

Useful links

Screening for depression or anxiety: http://www.bgs.org.uk/pdfs/assessment/hads_mood.pdf
Screening for delirium: http://www.the4at.com (free download)
MSoBT manual: http://www.assbi.com.au/making%20sense.html ($100)

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