

Original Research Article

Evaluation of current physical symptoms and psychological sufferings of patients during attending department of palliative medicine in a tertiary care hospital

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ABSTRACT

Background: Empirical evidence indicates that anxiety and depression in cancer patients are often overlooked, leading to insufficient assistance for their psychosocial needs. Distinguishing between clinical anxiety and depression and the typical emotional distress post-cancer diagnosis can be challenging but holds significant implications for coping strategies and outcomes. The aim of this study was to assess current physical symptoms and psychological sufferings of patients' during attending in a Palliative care department of a tertiary care hospital.

Methods: This cross-sectional study was conducted among 191 patients with cancer attending the department of palliative medicine, Bangabandhu Sheikh Mujib Medical University, Dhaka, Bangladesh from November 2021 and March 2022. Data was collected by face-to-face interview using a structured questionnaire. Depression and anxiety were evaluated using a modified version of the primary care evaluation of mental disorders guide.

Results: 47 participants (20.7% prevalence of depressive disorders and 13.9% prevalence of anxiety disorders) met the diagnostic criteria for at least one anxiety or depressive disorder, according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. The 95% confidence interval for these results was between 20.2 and 29.0.

Conclusions: In summary, depression and anxiety disorders are prevalent among patients in palliative care, significantly reducing the quality of life for those facing cancer-related mortality.

Keywords: Physical symptoms, Psychological sufferings, Palliative medicine

INTRODUCTION

Palliative care has emerged as a specialty service as a result of significant symptom burden and sufferings

among patients living with advanced cancer in their end of life. Palliative care, as defined by the National comprehensive cancer network (NCCN) Guidelines, is an interdisciplinary comprehensive approach to symptom

management that aims to maximize quality of life by providing patients and their families with physical, psychological, social, and spiritual care.¹ The elements of physical, psychological, existential, and spiritual well-being make up quality of life.² The cooperation of the interdisciplinary team (IDT), a fundamental element of palliative care, is one of the main reasons palliative care is so successful in addressing multidimensional aspects of sufferings and pain.³ Hospice care for patients with advanced cancer, the IDT approach has been linked to favourable outcomes such as better symptom control, fewer days of inpatient admission, and lower overall hospital costs.^{4,5} Furthermore, IDT's have been linked to a higher likelihood of patients receiving care that aligns with their values and their family's values, as well as a preferred setting for death.⁵

Mental health issues are common among cancer patients, and many of them stand alone as clinically significant problems. Based on various factors such as the patient populations studied, the diagnostic criteria used, and the assessment method (e.g., structured interviews versus self-reports), prevalence rates have been found to vary greatly; however, recent reviews indicate that the median prevalence of major depression among patients with advanced disease is approximately 15% across studies.^{6,7} Furthermore, a large number of other patients exhibit milder forms of depression, like dysthymia or minor depression, which are also linked to a great deal of distress.⁸⁻¹⁰ Although less research has been done on anxiety disorders than depression, it is still believed that a fair number of cancer patients suffer from them.¹⁰⁻¹² These mental health conditions are associated with notable reductions in quality of life when it comes to primary care.¹³

An increasing amount of research has linked psychological distress indicators, such as anxiety and depression diagnoses, to problems that affect cancer patients, including pain weakness or exhaustion, and low functional status.^{8-10,14,15} Patients with advanced disease receiving palliative care were included in some of these studies. However, as Hotopf et al point out, the research on mental disorders in palliative care has been hampered by small sample sizes, a dearth of standardized diagnostic interviews, and a lack of attention to the issue of diagnoses co-occurring.¹ It has been proposed that these disorders may make it more difficult to manage the physical symptoms of advanced disease and may also have an impact on the social or existential well-being of the patients during this crucial stage of their lives. For these reasons, it is imperative that this issue be resolved. Semi-structured diagnostic interviews were conducted among cancer patients receiving palliative care at Bangabandhu Sheikh Mujib medical university (BSMMU) by us. Apart from evaluating depression and anxiety disorders, the interviews also covered a variety of typical physical symptoms, social worries, and existential questions. Therefore, the current study set out to find out how common depression and anxiety disorders are

prevalent among BSMMU patients, how often they co-occur, how well these disorders are understood and treated, how their clinical and demographic characteristics relate to each other, and how these disorders relate to other aspects of health-related quality of life.

Aim and objectives

The aim of this study was to assess current physical symptoms and psychological sufferings of patients during attending in a palliative care department of a tertiary care hospital.

METHODS

In a Bangladeshi tertiary care hospital, a cross-sectional descriptive study was carried out with the purpose of researching and treating cancer. For our study, we enrolled patients over the age of eighteen who had received a cancer diagnosis but had not yet begun treatment. Prior to the interview, the participants gave their written consent. This cross-sectional study was conducted among 191 patients with cancer attending the Department of Palliative Medicine, Bangabandhu Sheikh Mujib Medical University, Dhaka, Bangladesh from November 2021 and March 2022. The study included two groups of participants older than 18 years: patients with a diagnosis of advanced-stage cancer; patients with diabetes living with SHS (e.g., severe pain, severe diabetes complication with disability in daily living activities). The study excluded patients who were too sick to participate or who could not understand the questionnaire. A structured, self-prepared questionnaire was given to study participants in order to obtain their clinical and socio-demographic information. After three months, all of the individuals who were recruited were re-interviewed to gather information about their treatment regimen and any complications that may have arisen. Statistical analyses had been carried out using SPSS 28.0 for Windows software. Data had been expressed as either mean or as a percentage of the total number of patients who provided a response. Descriptive analysis had been used to describe the population by age, sex, educational status, occupational status, marital status and monthly income and would have been presented as frequency and percentage. All of the means had been calculated at 95% confidence interval and $p < 0.05$ would have been considered as the level of statistical significance.

Features of the demographics

We recorded age, sex, marital status, and social network size (total number of close children, relatives, and friends). Additionally, we collected data on religious denomination and measured religiosity through organizational (service attendance), non-organizational (private prayer), and subjective aspects (self-perception).^{16,17}

Status both clinically and functionally

Primary malignancy details and prescribed medications were extracted from medical records. The palliative performance scale (PPS), an extension of the Karnofsky performance status scale, assessed participants' functional status. Ratings, on a scale of 0 to 100, factored in ambulation, task performance, self-care, nutrition, and consciousness, determined by the interviewer with clinical staff input if needed.^{18,19}

Methodical symptom and concern interview

Sixteen physical symptoms, social concerns, and existential issues were assessed using semi-structured interviews, guided by a quality-of-life model for those nearing the end of life. Two additional items focused on overall suffering and the desire for death. The structured interview of symptoms and concerns (SISC) in palliative care employed a single-item screening format, with global ratings on a seven-point scale (0 to 6) and a threshold of 1/4 3 indicating 'moderate' distress. In a reliability assessment of 80 audiotaped interviews, 17 items showed substantial to perfect integrated agreement (kappas 0.68 to 1.00), except for one item assessing spiritual crisis, which had poor agreement due to low frequency.

Evaluation of anxiety and depression disorders

Depression and anxiety disorders were evaluated using a modified version of the primary care evaluation of mental disorders (PRIME-MD) clinician evaluation guide. The PRIME-MD, a quick screening method aligning with DSM-IV criteria, demonstrated 88% accuracy in initial research and has been validated in oncology and palliative care settings. Our modification included detailed assessment of core symptoms using semi-structured interview questions formatted similarly to other Structured Interview of Symptoms and Concerns items. Integrated reliability for diagnostic judgments ranged from moderate to almost perfect (kappas 0.47-0.93). Severity thresholds for major or minor depression were linked explicitly to DSM-IV criteria, and diagnoses were reported in a non-hierarchical format for comorbid conditions. Remaining symptoms, including panic disorder screening, were assessed using the yes-no checklist format of the original PRIME-MD. We did not exclude physical symptoms, addressing concerns about over estimation with evidence suggesting greater accuracy when applying strict severity thresholds. The requirement for mental disorders to cause further impairment was suspended, instead emphasizing participant-identified problems with anxiety or depression.

Examining data with statistics

SPSS 28 was used to analyze the data. We detailed the prevalence of specific depressive and anxiety disorders,

comparing participants meeting or not meeting DSM-IV criteria. Statistical methods included t-tests for continuous variables, Fisher's exact tests for categorical data, and Kaplan-Meier analysis for survival duration. Significance criterion: $p < 0.05$. Some SISC items had skewed scores; we categorized them into 0-2 (no to mild) and 3-6 (moderate to extreme). These scores, reflecting significant distress, were pivotal in gauging absolute prevalence of crucial symptoms. Analyzed via logistic regression, adjusting for age and sex. Exploratory analyses within the disorder-diagnosed subgroup delved into comorbidity, comparing those with both depression and anxiety disorders to those diagnosed with depression alone.

RESULTS

In Table 1, participants diagnosed with a mental disorder were younger and had smaller social networks than others. They also reported less frequent attendance at organized religious services, but their levels of religiosity in other dimensions were similar. No significant differences were observed in other demographic characteristics between the groups, although those with a disorder were somewhat more likely to be female ($p=0.082$). In a sub analysis focusing on depressed participants, women were significantly more likely to be depressed than men (25.0%, 95% CI 19.3-31.4 vs. 15.4%, 95% CI 10.3-21.7), $\chi^2(1)=5.29$, $p=0.021$, OR=1.83, 95% CI=1.09-3.08. Patients diagnosed with a depressive or anxiety disorder had lower scores in PPS, but there was no association between these disorders and the time to death, with a logrank p value of 0.776.

The prevalence of different anxiety and depressive disorders is shown in Table 2 Major depression was the most common condition, affecting 25 individuals (13.1%) out of the 46 participants (24.4%) who met the diagnostic criteria for at least one disorder. Twenty individuals met the criteria for two or more diagnoses, demonstrating the widespread presence of comorbidity between disorders. For example, 32 (66%) of the 27 (13.9%) people who were diagnosed with anxiety disorders also met the criteria for depression, and 22 (45%) of them met the criteria for a second anxiety disorder.

The Table 3 presents the correlation between anxiety and depression disorders and other particular symptoms and issues. Overall, compared to individuals without a disorder (M 1/4; 2.68, 2.28), participants with a diagnosis reported more symptoms at the moderate-to-extreme level (M 1/4; 5.48, 3.06, $t=379$ 1/4; 8.13, $p < 0.001$). Indeed, on 14 out of the 18 distinct items that the SISC covered, they were more likely to report experiencing significant difficulty.

The only exceptions were the existential recognition of a spiritual crisis, the physical symptom of dyspnea, and the social concerns of a noticeable communication issue with a family member and financial hardship.

Table 1: Participants clinical and demographic features whether or not they were diagnosed with anxiety or depression.

Characteristic	With a disorder (n=47)	Without a disorder (n=144)	T or χ^2 value	df	P value
Age, mean (SD) years	61.5 (12.3)	67.4 (12.7)	3.19	379	0.002
Sex, N (%)					
Men	17 (36.6)	68 (46.9)	3.03	1	0.082
Women	30 (63.4)	76 (53.1)			
Religion, N (%)					
Muslim	33 (70.9)	110 (76.0)	2.29	3	0.515
Hindu	6 (11.8)	12 (8.0)			
Christian	1 (8.6)	2 (8.0)			
Other	1 (5.8)	1 (16.0)			
Religiosity, mean (SD)					
Organizational	2.4 (1.5)	3.6 (1.6)	2.73	379	0.007
Non-organizational	3.3 (1.6)	4.3 (1.5)	0.35	377	0.726
Subjective	2.7 (0.9)	2.8 (1.0)	1.35	379	0.179
Marital status, N (%)					
Married	38 (82.2)	135 (93.7)	0.33	1	0.567
Other	8 (17.8)	9 (6.3)			
Social network size, mean (SD)	11.6 (7.7)	14.2 (9.2)	2.69	377	0.008
Education, N (%)					
Less than high school	15 (32.3)	53 (26.5)	0.70	2	0.706
High school graduate	10 (21.5)	31 (21.9)			
More than high school	22 (46.2)	60 (41.7)			
Language, N (%)					
Bangla	45 (86.8)	141 (97.6)	0.18	2	0.916
Other	2 (3.2)	3 (2.4)			
Setting, N (%)					
Palliative care unit	25 (52.7)	74 (51.4)	1.21	2	0.546
Hospital inpatient	11 (23.7)	29 (19.8)			
Outpatient, home care	11 (23.7)	41 (28.8)			
Palliative performance scale, mean (SD)	52.6 (12.3)	53.6 (13.4)	2.39	378	0.017
Survival duration, median (IQR)	65.2 (114.1)	62.1 (116.5)	0.32	1	0.574
Medications, N (%)					
Opioids	36 (76.3)	112 (77.7)	0.07	1	0.786
Antidepressants	18 (39.8)	25 (17.1)	20.69	1	<0.001
Benzodiazepines	31 (66.7)	57 (39.4)	21.06	1	<0.001
Neuroleptics	13 (28.0)	23 (15.0)	7.96	1	0.005

Significantly, compared to 16.0% (95% CI=11.9-20.7) of participants without a disorder, 55.9% (95% CI=45.2-66.2) of participants with a disorder described their overall global experience as one of moderate-to-extreme “suffering” (p<0.001). Additionally, they reported a persistent desire to die at a higher rate (p<0.001).

Anxiety and depression disorder treatment

The place of care was similar between groups, but differences existed in prescribed medications. Participants with mental disorders were more likely to receive antidepressants, benzodiazepines, and neuroleptics. About 40% were on antidepressants (95% CI/4, 29.8e50.5), and approximately two-thirds had

benzodiazepine prescriptions (95% CI/4 56.1e76.1). Common antidepressants included selective serotonin reuptake inhibitors (14.0%, 95% CI/4, 7.7e22.7) and tricyclic antidepressants (12.9%, 95% CI/4, 6.9e21.5). Venlafaxine and stimulants were also noted. Among those without a disorder, 17.1% were on antidepressants (95% CI/4, 12.9e21.9), and nearly 40% had benzodiazepine prescriptions (95% CI/4, 33.7e45.3).

Significance of comorbidities

To explore comorbidity between depression and anxiety disorders, we compared patients with depression only (n=44) to those with both depression and anxiety (n=35).

Table 2: Depression and anxiety disorder prevalence (n=191).

Diagnosis	N	%	95% CI
Major depression	25	13.1	9.9-16.9
Major depression in partial remission	9	4.7	2.8-7.4
Minor depression	4	2.1	0.9-4.1
Dysthymia	9	4.5	2.6-7.1
Any depressive disorder	39	20.7	16.8-25.2
Panic disorder	11	5.5	3.4-8.3
Generalized anxiety disorder	11	5.8	3.7-8.6
Anxiety disorder not otherwise specified	9	4.7	2.8-7.4
Anxiety disorder secondary to a general medical condition	3	1.8	0.7-3.8
Any anxiety disorder	27	13.9	10.6-17.8
Any disorder	46	24.4	20.2-29.0
More than one disorder	20	10.2	7.4-13.7

Table 3: Symptoms and concerns mentioned by individuals with or without anxiety disorder or depression.

Symptoms or concern	With a disorder (n=47)	Without a disorder (n=144)	P value	Odds Ratio	95% CI
Social concerns					
Social isolation	13 (26.9)	10 (6.9)	<0.001	5.49	2.81-10.75
Communication problem	2 (4.3)	2 (1.4)	0.145	2.90	0.69-12.15
Burden to others	18 (37.6)	32 (21.9)	0.009	1.99	1.19-3.31
Financial problem	7 (14.0)	11 (7.3)	0.185	1.68	0.78-3.60
Physical symptoms					
General malaise	28 (61.3)	53 (36.5)	<0.001	2.70	1.65-4.44
Pain	23 (49.5)	41 (28.8)	0.001	2.26	1.37-3.72
Drowsiness	23 (49.5)	39 (26.7)	<0.001	2.46	1.51-4.02
Nausea	14 (30.1)	19 (12.8)	0.002	2.55	1.43-4.55
Weakness	34 (72.0)	79 (54.9)	0.003	2.17	1.29-3.64
Breathlessness	13 (28.0)	37 (25.3)	0.526	1.19	0.70-2.03
Existential issues					
Loss of resilience	12 (25.0)	6 (4.2)	<0.001	7.66	3.57-16.46
Loss of dignity	7 (15.1)	6 (4.2)	0.002	3.69	1.61-8.46
Loss of control	9 (19.4)	4 (2.8)	<0.001	8.44	3.47-20.55
Spiritual crisis	3 (6.5)	3 (1.7)	0.071	3.10	0.91-10.58
Difficulty accepting	8 (16.1)	9 (6.3)	0.023	2.39	1.13-5.07
Dissatisfaction with life	6 (11.8)	5 (3.1)	0.005	3.78	1.49-9.61
Desire for death	12 (26.4)	11 (7.7)	<0.001	4.70	2.42-9.10
Suffering	26 (55.9)	23 (16.0)	<0.001	6.59	3.88-11.17

Those with comorbidity had higher education levels (62.9% vs. 36.4%, $p=0.019$, $OR=2.96$). The comorbidity group reported more symptoms at a moderate-to-extreme level on the SISC ($M=6.89$ vs. $M=4.36$, $p<0.001$). Specific problems included higher prevalence of general malaise (71.4% vs. 47.7%, $p=0.041$, $OR=2.74$), loss of resilience (38.2% vs. 15.9%, $p=0.036$, $OR=3.27$), and loss of control (34.3% vs. 9.1%, $p=0.010$, $OR=5.22$). They were more likely to report suffering (82.9% vs. 31.8%, $p<0.001$, $OR=10.35$) and express a desire for death (45.5% vs. 20.5%, $p=0.026$, $OR=3.24$). Those with both depression and anxiety had higher benzodiazepine prescriptions than depression-only patients (74.3% vs. 52.3%, $p=0.045$, $OR=2.64$). Antidepressant utilization rates were similar between the groups (40.9% vs. 40.0%, $p=0.935$, $OR=0.96$).

DISCUSSION

Only palliative care patients who were medically capable of enduring a prolonged interview and were cognitively clear were contacted for our study. It's possible that the prevalence rates are lower than what would be discovered in a consecutive series of patients if cognitive impairment and debilitating illness are linked to anxiety and depression disorders. Furthermore, it should be mentioned that the diagnostic interview was a modified version of a protocol designed for primary care rather than palliative care, with the goal of quickly screening for mental disorders. It must be acknowledged that, despite its use in oncology settings in earlier studies, there is a dearth of solid evidence to support its use with patients who have advanced illness, especially when it comes to

our modified format. However, the observed prevalence figures fall within the broad range that other researchers have reported indicating that a wider range of results may be possible.^{6,7}

The majority of patients receiving palliative care do not fit the official diagnostic criteria for clinical depression or anxiety, despite the fact that these disorders are common but not universal. The most extensively researched individual disorder, major depression, has a current prevalence of 13.1%, which is undoubtedly higher than the 1.8-4.9% found in epidemiologic studies of general community residents, but it might not be higher than primary care rates.²⁰⁻²² In fact, the study participants' demographic traits linked to their anxiety and depression disorders seem to be pretty much the same as what is seen in other contexts. For instance, epidemiologic studies of the general population, primary care, and certain cancer patient studies have all found that younger adults are more at risk than the elderly.^{10,23-25} Numerous other populations have also shown a correlation between organizational religiosity and low levels of depressive symptoms, as well as an association with larger social networks.²⁶⁻²⁹ Furthermore, women experience depressive disorders at rates significantly higher than those of men, a finding that is consistent with epidemiologic studies conducted on community and primary care samples.³⁰⁻³² The current results are consistent with this larger body of literature, even though gender differences are less common in studies involving cancer patients.⁷ It appears that even in the setting of palliative care, younger women and those with less access to substantial social support are most at risk for depression.

Psychological disorders in advanced disease patients may complicate the treatment of physical symptoms, as indicated by previous research.²⁰ Recent studies, however, have not consistently linked depression to various problems, with some reporting no significant trends in physical concerns for depressed and non-depressed patients and others finding no differences in pain and disability measures between groups.^{25,26} Our results strongly support an association between anxiety/depressive disorders and physical symptoms, with these patients more likely to report moderate-to-extreme pain, weakness, drowsiness, and illness.

Despite lower performance status, survival durations were not affected, suggesting psychological factors contribute to disability beyond the medical condition. Furthermore, the impact of these disorders on social and existential concerns may outweigh their effect on physical symptoms, emphasizing the importance of addressing psychological well-being in end-of-life care. This is significant given evidence that existential issues play a crucial role in determining the quality of life for individuals nearing the end of life.³³ It's important to recognize that our study did not attempt to diagnose adjustment disorders, which are not covered by the PRIME-MD, when analyzing observed prevalence rates.

When it comes to patients with advanced illnesses, adjustment disorders are controversial because they require subjective clinical judgment on whether the emotional response is greater than a normal reaction.³⁴ This is in contrast to many other DSM-IV diagnoses, which have explicit definitions.³⁵ A careless application could make it difficult to distinguish between normal grieving expressions and mental illnesses.⁷ Nevertheless, when included in diagnostic interviews, cancer studies frequently report 25-50% of patients with adjustment disorders.¹⁰ Therefore, people who fit the criteria for adjustment disorder in other studies are probably among the participants without a PRIME-MD diagnosis.

It is commonly known that anxiety and depression can coexist, and that when both are present, patients' symptoms worsen.³⁶⁻³⁹ In the context of palliative care, our study examines comorbidity. The findings indicate that individuals who satisfy the criteria for both anxiety and depression face more substantial challenges than those who only have depression. Interestingly, moderate-to-extreme global suffering was reported by 82.9% of participants who had both conditions. This group closely resembles the palliative care profile of "total pain", given their elevated symptom reports and distressed mental state.²⁰ Our study affirms the association between mental suffering (depression and anxiety) and enhanced quality of life, overall functionality (Physical Function, Roller Performance, Emotional Function, Cognitive Function, and Social Function), and symptoms in advanced cancer patients receiving palliative care.

Despite the cross-sectional design limiting the assessment of temporal relationships among mood, quality of life, and symptoms (fatigue, loss of appetite, nausea/vomiting), our findings emphasize the crucial role of control and relief for optimal quality of life. Despite limitations, the study underscores the necessity for psychological support, suggesting the monitoring of all advanced cancer patients for psychological suffering and associated factors to identify those needing additional evaluation and treatment.

Despite global guidelines for symptom management, shortcomings persist.⁴⁰ Supporting this, a Chinese study revealed that 61% of advanced cancer patients with symptoms received no treatment, with only 10.93% undergoing non-pharmacological intervention, 1.77% receiving opioid pain treatment, and 1.99% being prescribed psychotropic medicines for mental suffering.⁴⁰ Notably, physical symptoms significantly affect patients' quality of life, extend hospitalization, and predict mortality.⁴⁰

Limitations

This was a single centre study with a limited purposive sample size over a short period of time. So, the findings of this study may not reflect the whole scenario of the country.

CONCLUSION

One of the main psychological problems that cancer patients face is anxiety and depression. Every cancer patient should have regular psychological distress screenings and evaluations. Improving quality of life may be aided by early intervention and identification of anxiety and depression by mental health specialists experienced in caring for cancer patients.

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