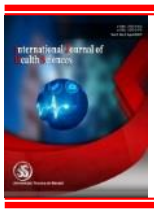

International Journal of Health Sciences

Available online at www.sciencescholar.us
Vol. 9 No. 1, April 2025, pages: 223-229
E-ISSN: 2550-696X
https://doi.org/10.53730/ijhs.v9n1.15564

Psychiatric intervention and quality of life in patient with cancer-related pain in stage IIIB cervical cancer: Case report

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Manuscript submitted: 27 November 2024, Manuscript revised: 18 January 2025, Accepted for publication: 09 February 2025

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Keywords

cancer pain;
cervical cancer;
quality of life;

Abstract

Cancer patients often experience psychological stress, which can lead to depression, especially when they use unhealthy coping strategies. The stress from a cancer diagnosis, treatment challenges, physical symptoms like pain and bleeding, and lack of family support increase the risk of depression, lowering the patient's quality of life. A 56-year-old woman came to Ngoerah Hospital Denpasar with lower abdominal pain and vaginal bleeding. Her condition worsened after hospitalization, particularly when her husband decided to terminate her treatment. She developed symptoms of depression and was referred to a psychiatrist. She received both medication and therapies like supportive psychotherapy, cognitive behavioral therapy (CBT), and counseling for her husband through a couple-based intervention. A cancer diagnosis often causes psychological stress, which can be managed with healthy coping mechanisms. However, unhealthy coping can lead to depression. Family support is crucial in protecting against this. Psychological screening and treatments, such as SSRI, can help improve a patient's quality of life. Patients with advanced cervical cancer are at high risk of depression due to physical symptoms like pain. Proper screening and treatment are necessary to improve their quality of life.

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1 Introduction

Cervical cancer is one of the gynecological malignancies and is the leading cause of death in women in developing countries. This malignancy occurs in the cervix and is caused by *Human Papillomavirus* (HPV). Cervical cancer is rarely detected in its early stages and is often overlooked because it does not cause noticeable symptoms, such as pain. Other symptoms such as spotting are only reported sporadically (National Comprehensive Cancer Network, 2024).

HPV infection is known to be persistent and long-lasting. Risk factors for cervical cancer, aside from HPV, include low socioeconomic status, smoking, marriage before the age of 18, early age at first intercourse, multiple sexual partners, and having multiple pregnancies. Cervical cancer therapy consists of a combination of modalities such as surgery, chemotherapy, and radiotherapy. Globally, cervical cancer is the fourth most common cause of death in women (National Comprehensive Cancer Network, 2024).

Patients with cervical cancer experience high levels of psychological stress, especially after being diagnosed and when first starting therapy, which adds to the burden on patients. Pain during intercourse, painful urination, pelvic cramps, and bleeding can interfere with the patient's well-being and daily activities. Treatment for cervical cancer patients causes physical impacts, such as fatigue, skin discoloration, weight loss, and severe sexual dysfunction (Suwendar, 2019).

As a result of these symptoms, patients with cervical cancer suffer from feelings of fear, helplessness, and low self-esteem, and are more prone to anxiety and depression. Depression is one of the most common mental disorders experienced by cancer patients and can affect treatment, compliance, and prognosis. Clinical manifestations in the patient's physical and psychological state cause a decrease in the patient's quality of life. Adequate symptom management will reduce suffering and directly improve quality of life (American Psychiatric Association, 2022; Rodriguez et al., 2019).

This case report presents a case of a moderate depressive episode with somatic symptoms in a 56-year-old woman with stage IIIB cervical cancer and chronic hepatitis B with lower abdominal pain as the main complaint.

2 Research Methods

This is qualitative research, a case study of a woman, 56 years old, Javanese, Indonesian citizen, Muslim, married, high school graduate, and housewife, who came to Ngoerah Hospital due to vaginal bleeding and lower abdominal pain. Vaginal bleeding had been ongoing since the day before hospitalization. The bleeding was so severe that the patient had to change tampons repeatedly, and tampons were ineffective in stopping it.

Lower abdominal pain had been experienced a week before and worsened two days before being hospitalized. The pain did not improve with rest or analgetics. The pain was accompanied by bloating which made it difficult for the patient to breathe. The patient's husband said that she often cried because the complaints did not improve even though she had been given therapy so the patient was then consulted to the psychiatric department for evaluation.

The patient complained of feeling sad because the complaints of bleeding and pain had returned. The patient had undergone chemotherapy and radiotherapy two years previously. After completing therapy, the patient and her husband returned to their home in Java. The patient underwent routine monthly check-ups and was scheduled to transition to check-ups every three months, but the bleeding reappeared. The patient felt hopeless, had difficulty sleeping, and had decreased appetite. The patient cried multiple times during the examination, with her facial expressions alternating between sadness and pain. She also experienced disappointment as her husband decided to discontinue chemotherapy and radiotherapy. Despite feeling hopeless, she remained determined to continue with the treatments.

Changes in the patient's behavior began two weeks before hospitalization. She initially appeared gloomy and frequently cried, especially when experiencing pain. After being admitted, her sadness lessened but resurfaced when her husband decided to discontinue her treatment. Despite this, she still expressed a desire to recover. Upon learning of her husband's decision, she became even more distressed, crying every night, having trouble sleeping, losing her appetite, and growing increasingly weak. The husband cited the patient's declining physical condition, despite ongoing treatment, as the reason for stopping therapy.

The patient was diagnosed with stage IIIB cervical cancer in 2022 and had undergone chemotherapy and radiotherapy, namely post ER 33 times, post paxus carboplatin VI series chemotherapy in December 2022, and post repeated paxus carboplatin III series chemotherapy. The patient also has a history of chronic hepatitis B with reactive HbsAg results in July 2022. The patient received tenofovir tablet therapy but never had a follow-up. The patient has been taking tenofovir again since May 2024. The patient's pregnancy history is four times, namely in 1995 and 1997 from her first marriage and then in 2005 and 2007 from her second marriage. The patient has never been treated by a psychiatrist before.

The patient's general status is blood pressure 93/67 mmHg, pulse 100 beats per minute, respiratory rate 20 breaths per minute, temperature 36.5 degrees Celsius, and oxygen saturation 98% room air. The pain scale is assessed using a visual analog scale (VAS) of 8 out of 10. On examination of the internal status, anemic conjunctiva was found and on gynecological status no bleeding was found, a tampon was installed. A complete blood count was found thrombocytopenia. Clinical chemistry examination showed hypokalemia and hypoalbuminemia. On abdominal USG examination, a residual malignant mass was found in the cervix to the corpus and fundus of the uterus and infiltrated the anterior wall of the rectum and ureter, causing hydronephrosis. From the psychiatric status, the general impression of the appearance was according to the illness, the facial expression was sad, visual and verbal contact was sufficient. The patient's mood was sad and the effect was inadequate (Costanza et al., 2007). The thinking process is logical thinking and realistic, coherent, and she was preoccupied with abdominal pain. In perception, there were no hallucinations or illusions. Instinctual drives showed mixed-type insomnia, there was hypobulia, and no raptus was found. The patient was calm. The Beck Depression Inventory psychometric results were 36 (severe depression).

The patient was diagnosed with a moderate depressive episode with somatic symptoms and was prescribed pharmacotherapy, including sertraline tablets (12.5 mg) once daily at night and lorazepam tablets (0.5 mg) once daily at night, both taken orally. In addition to medication, the patient receives supportive psychotherapy and cognitive-behavioral therapy (CBT). Psychoeducation is also provided to the patient's family, with a particular focus on the husband as the primary caregiver. This education covers the patient's physical and mental condition throughout treatment. The patient is actively involved in treatment decisions, as this participation is linked to improved quality of life by enhancing both physical and mental well-being.

3 Results and Discussions

Psychological stress resulting from a cancer diagnosis can be managed effectively when patients have strong coping mechanisms. Conversely, maladaptive coping strategies can lead to depression. Additionally, social factors, particularly family support, serve as protective factors against the development of depression. Hospitalized and outpatient cancer patients are encouraged to undergo screening using the Beck Depression Inventory-II (BDI-II) psychometric test. Early screening allows for timely intervention before symptoms worsen (Smith, 2015; Suwendar, 2019).

The quality of life of cervical cancer patients decreases due to symptoms that interfere with basic daily activities accompanied by feelings of helplessness and hopelessness. Depression causes a significant decrease in the quality of life in cancer patients by worsening physical symptoms and increasing the negative impact on patients and families during the disease. For example, during cancer treatment, patients with higher levels of fatigue, depression, and sleep disturbances before chemotherapy experience worsening symptoms during treatment then have a negative impact on their quality of life (Mvunta et al., 2022; Smith, 2015).

Depression in cancer patients prolongs hospital stays and increases resource utilization, leading to higher healthcare costs. Additionally, cancer patients with depression face a greater risk of suicide compared to the general population. Quality of life screening using the World Health Organization Quality of Life (WHO-QOL)

assessment provides valuable insights into the well-being of cancer patients and serves as a reference for improving their overall quality of life (Tax et al., 2017).

There is a requirement to treat depression in cancer patients effectively to improve quality and survival. Several studies have stated that treatment and improvement of depression in cancer patients in the first year significantly extends the median survival time by 28.5 months compared to patients who experience worsening depressive symptoms. Both psychosocial interventions and pharmacotherapy are effective in treating depression in cancer, but the optimal combination and administration of treatment are unknown, and further research is needed. Management of depression is likely to be different for each patient (Nayak et al., 2017; Tax et al., 2017).

The two primary classes of medication used to treat depression in cancer patients are tricyclic antidepressants (TCAs) and selective serotonin reuptake inhibitors (SSRIs). While the precise mechanism of action of antidepressants in cancer remains unclear, they are believed to induce adaptive changes in the brain that gradually enhance serotonin neurotransmission. This increase in serotonin levels contributes to improved mood (Smith, 2015).

SSRIs should be considered with caution in patients receiving chemotherapy or radiotherapy, as SSRIs can often worsen vomiting and nausea, while the anticholinergic effects of TCAs can worsen chemotherapy-related delirium. The use of conventional antidepressants in patients with terminal cancer may be unwise due to the delayed onset of action of these drugs. An observational study supports this idea, concluding that currently prescribed antidepressants have little effect on improving depression in depressed terminal cancer patients, as measured by depression scores. In one trial, methylphenidate provided moderate to marked improvement in depressive symptoms in 73% of depressed oncology patients within two days; therefore, it may be an effective alternative to conventional antidepressants (Rodriguez et al., 2019; Smith, 2015).

Positive patient-physician relationships and communication significantly reduce stress levels in patients. In addition, patients may benefit from a variety of approaches, including relaxation strategies, psychoeducation, cognitive behavioral therapy (CBT), problem-solving therapy, and acceptance and commitment therapy (ACT). Relaxation strategies, including meditation and progressive muscle relaxation, allow patients to relieve mental and physical tension, thereby reducing stress and have been shown to improve depression and quality of life in cancer patients. Psychoeducation can be used to build knowledge and strategies for coping with cancer and reduce uncertainty and anxiety (Peiretti et al., 2012). CBT identifies and equips patients with skills to overcome maladaptive thought patterns and promote emotional adjustment. Both psychoeducation and CBT are effective in improving depressive symptoms and quality of life. Problem-solving therapy (PST) focuses on generating, implementing, and evaluating solutions to manageable problems affecting the patient, including relationship and financial problems. PST may improve psychological outcomes and quality of life in patients with depression. ACT teaches patients how to tolerate difficult thoughts and develop psychological flexibility. ACT is equivalent to CBT in terms of its effects on mood and quality of life (Badr, 2017; Poço Gonçalves et al., 2021).

In a recent observational study on cancer, Badr et al. examined how emotional disclosure and treatment focus delivered through couple talk affected the psychological and marital adjustment of 125 head and neck cancer patients and their partners. This therapy was referred to as a couple-based intervention. Patients and partners reported a more positive mood after the discussions when they talked more about cancer and less distress over time (Zaza & Baine, 2002). The findings suggest that the way couples discuss cancer, conceptualizing it as a shared or individual problem, has implications for both partners' adjustment. Interventions that replace the general prescription for open talking with directed questions that encourage reflection on each partner's strengths, communication patterns, and resources may help strengthen the impact of couple-based interventions on patient and partner quality of life (Badr, 2017; Mvunta et al., 2022).

4 Conclusion

Patients with cervical cancer often experience significant psychological stress, especially after diagnosis and during treatment. Depression arises from the interaction of various factors and affects the patient's quality of life. Adequate treatment of physical and psychological symptoms is essential to improve the patient's quality of life. Treatment of depression in patients with cervical cancer requires a comprehensive approach, including

the use of pharmacotherapy such as SSRIs and TCAs, as well as psychosocial interventions such as cognitive behavioral therapy (CBT), psychoeducation, and couple-based intervention. The combination of these modalities is effective in reducing depressive symptoms and improving the patient's quality of life.

The importance of psychological screening, family support, and good communication between the patient and the healthcare provider cannot be overstated. Early intervention and appropriate treatment of depression can prolong survival time and improve overall treatment outcomes. Overall, holistic treatment that includes physical, psychological, and social aspects is needed to help cervical cancer patients overcome the challenges they face and improve their quality of life.

Acknowledgments
We are grateful to two anonymous reviewers for their valuable comments on the earlier version of this paper.

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