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Krebs und Depression – eine
Übersicht

Due to advances in diagnostic and treatment, survival rates for cancer have steadily improved over the last decades (DeAngelis et al. 2014; Miller et al. 2019).

However, many cancer patients have to face their **life threatening disease** and **severe adverse effects** from

chemotherapy, radiotherapy or surgical procedures, including pain, nausea,

vomiting, loss of appetite or weight, diarrhea, decreased muscular strength,

cognitive deficits, sleeping disorders and fatigue (Dong et al. 2014; Strömgren et al. 2006).

Not surprisingly, many cancer patients report of strongly reduced quality of life and suffer from comorbid depression or anxiety (Carlson et al. 2004; Hartung et al. 2017)

Distress /Anpassung/Trauerreaktion bis hin zur klinischen Depression

For patients with cancer, it is necessary to differentiate between the more frequent **distress syndrome** (anxiety and depression in a preclinical level) and the comorbidity with **clinical depression**.

Comorbidity means incidence of two or more diseases (e. g., cancer and depression) for the same patient.

Clinical comorbidity describes the co-occurrence of clinical depression with cancer beyond the statistically expectable probability – i. e., values above the prevalence of depression in the general population which is about 4.5 % (Mental Health Report 2017) – and further describes the influence of the co-occurrence on the course of the disease (Feinstein 1967).

- For several chronic diseases (e. g., diabetes mellitus), it is well documented that the comorbidity with depression is significantly increased, with more than 10–15 % of these patients showing a depression in prevalence studies.
- The consequences are relevant: in patients with physical diseases depression is associated with higher symptom severity, reduced functioning, higher medical costs and deteriorating prognosis (Katon et al. 2007; Schüßler and Heuft 2008)

Prevalence of Depression and Cancer –

A systematic review

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- A systematic review of all published peer-review studies on all types of cancer and clinical depression between 2005 and 2019
- Z Psychosom Med Psychother 67, 1438–3608, ISSN (online): 2196–8349
- <https://doi.org/10.13109/zptm.2021.67.oa11>

The database search resulted in a total number of 1,308 studies and additional 174 studies which were added based on the reference lists of the included articles of which 692 articles were selected as potentially relevant on the basis of their titles. After reviewing the abstracts of these studies, a total of 427 articles were then assessed by a full-text review and among these, 204 articles fulfilled the inclusion criteria. Since three of the included studies consisted of mixed samples which were large enough (i. e., > 50 patients) and described in enough detail to be treated as separate cancer entity groups rather than a mixed sample. Thus, a total number of **210 samples with a total number of 281,642** patients were included in the review.

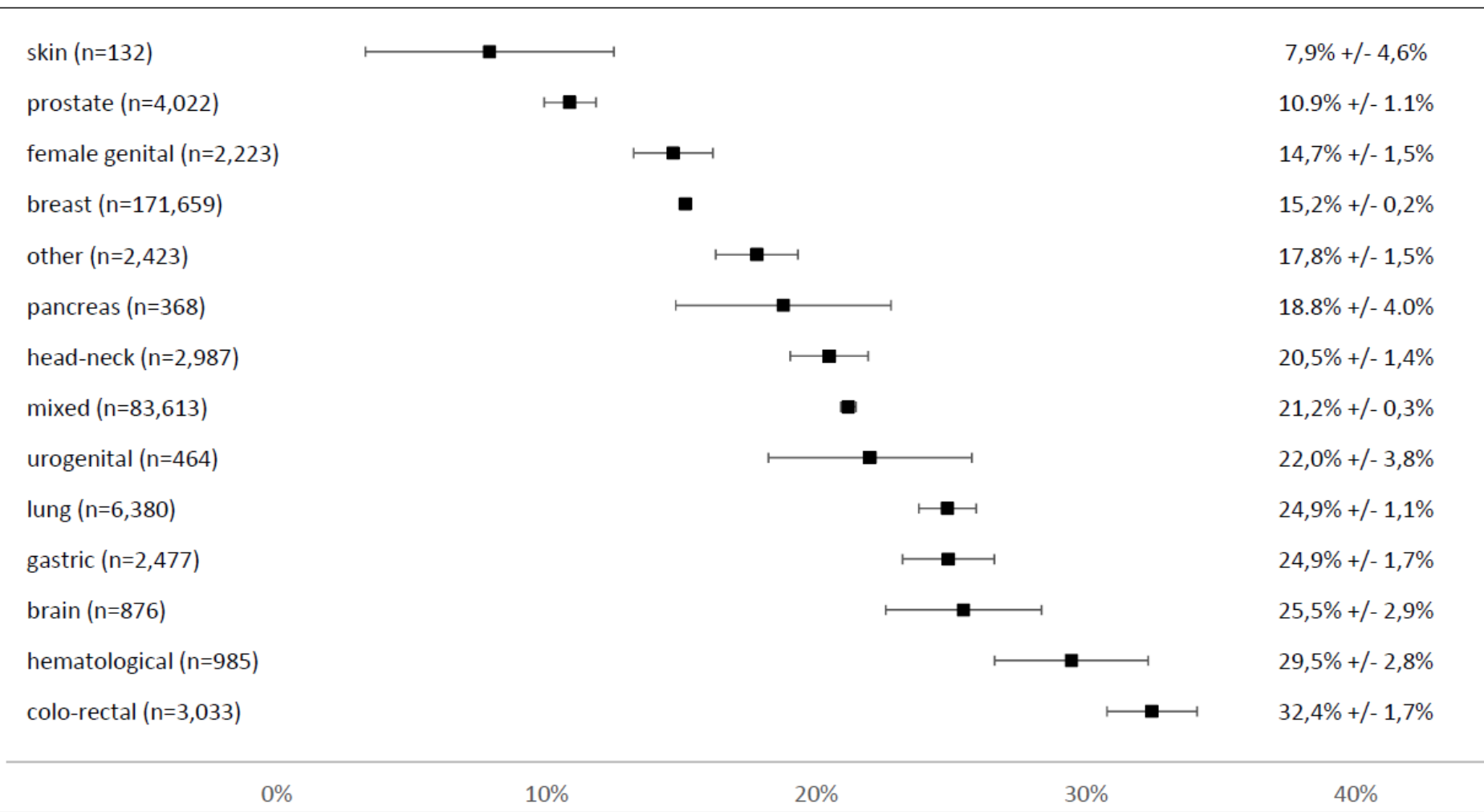


Figure 2: Prevalence rates and 95 % confidence interval per cancer entity for all included studies. Number of included patients is presented in brackets)

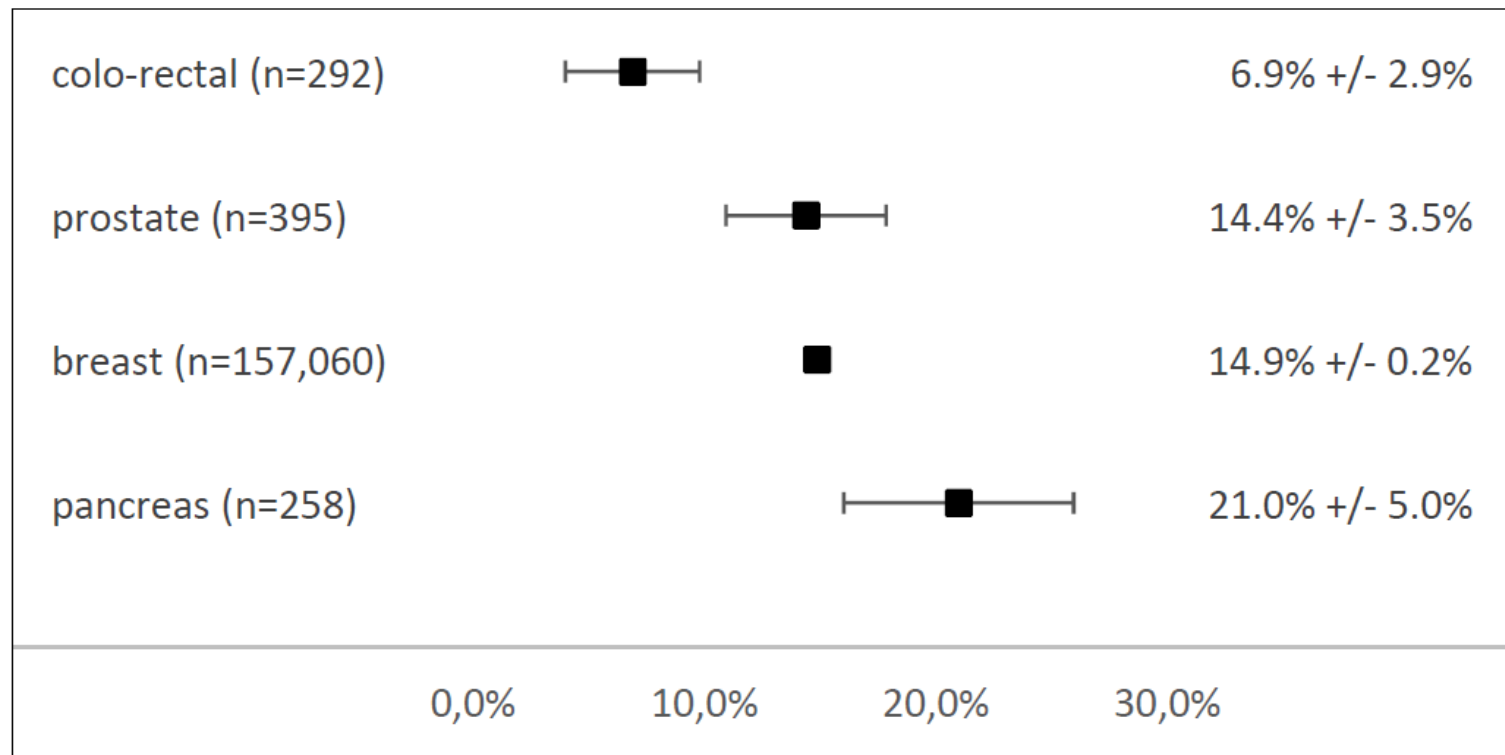


Figure 3: Prevalence rates and 95 % confidence interval per cancer entity for studies with chart-based diagnoses

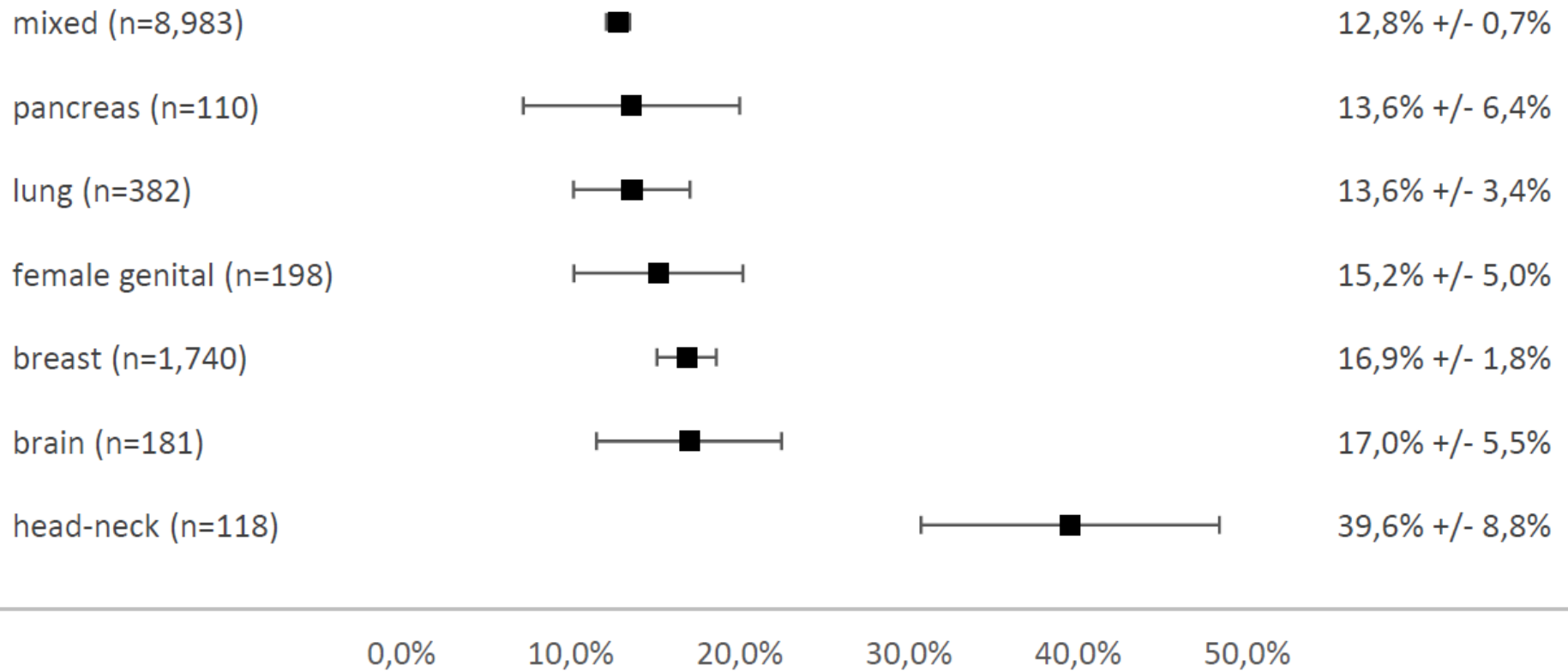


Figure 5: Prevalence rates and 95 % confidence interval per cancer entity for studies with interview-based diagnoses

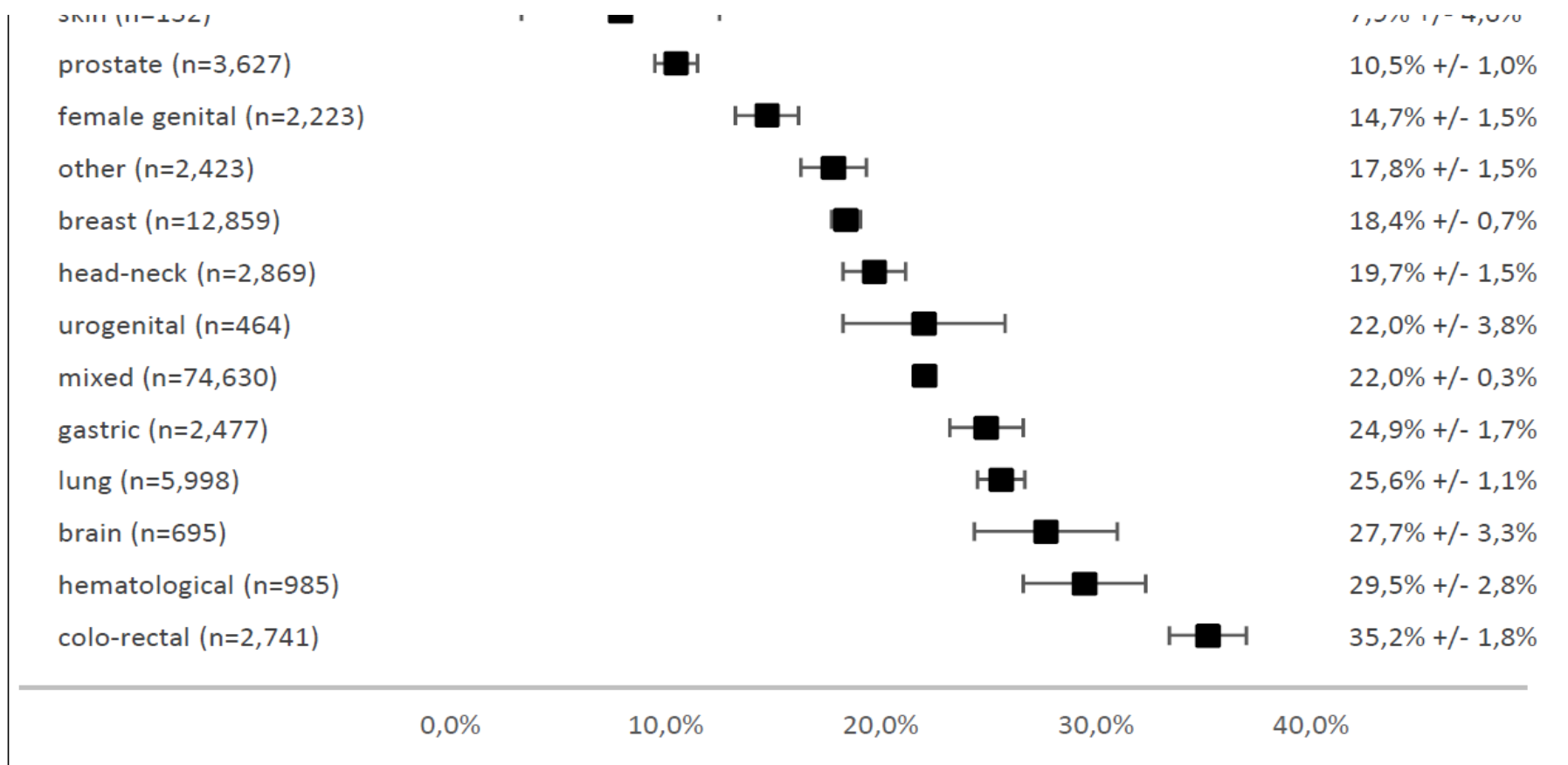


Figure 4: Prevalence rates and 95 % confidence interval per cancer entity for studies with ques-

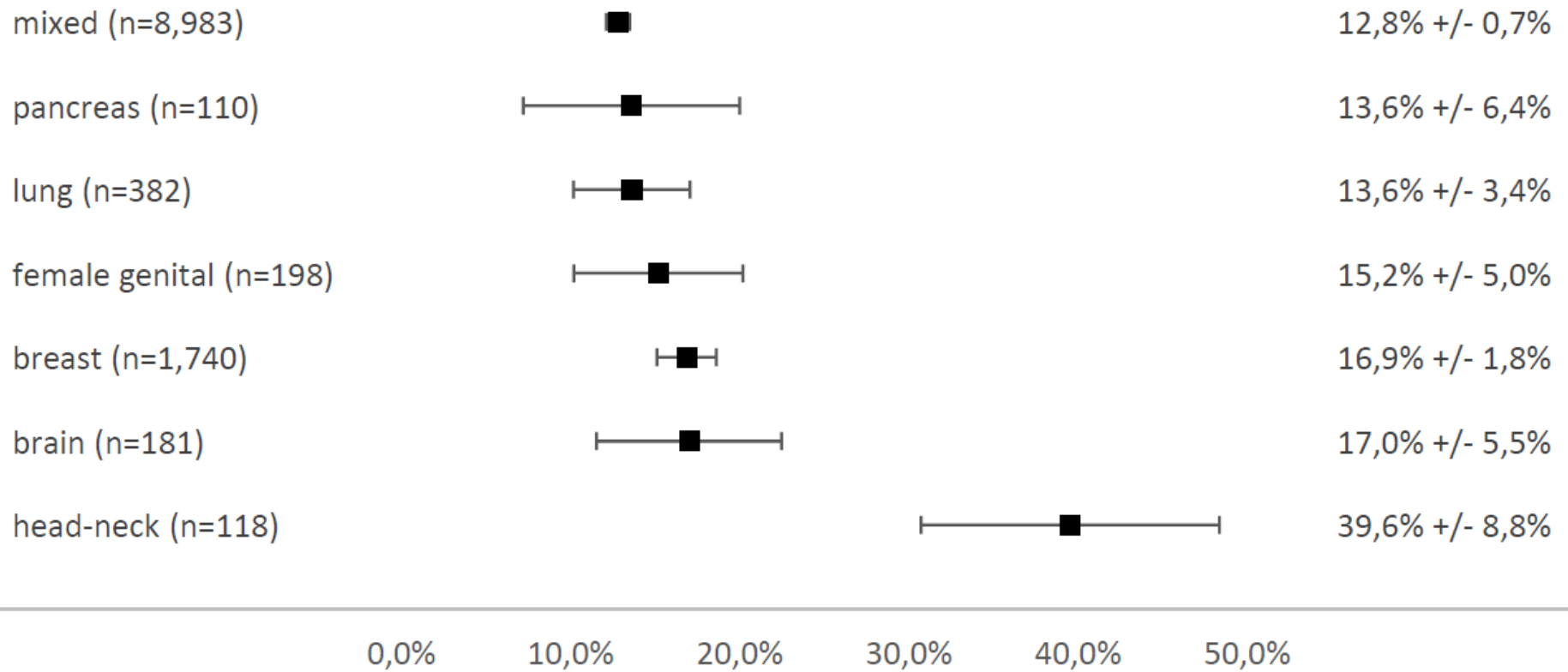


Figure 5: Prevalence rates and 95 % confidence interval per cancer entity for studies with interview-based diagnoses

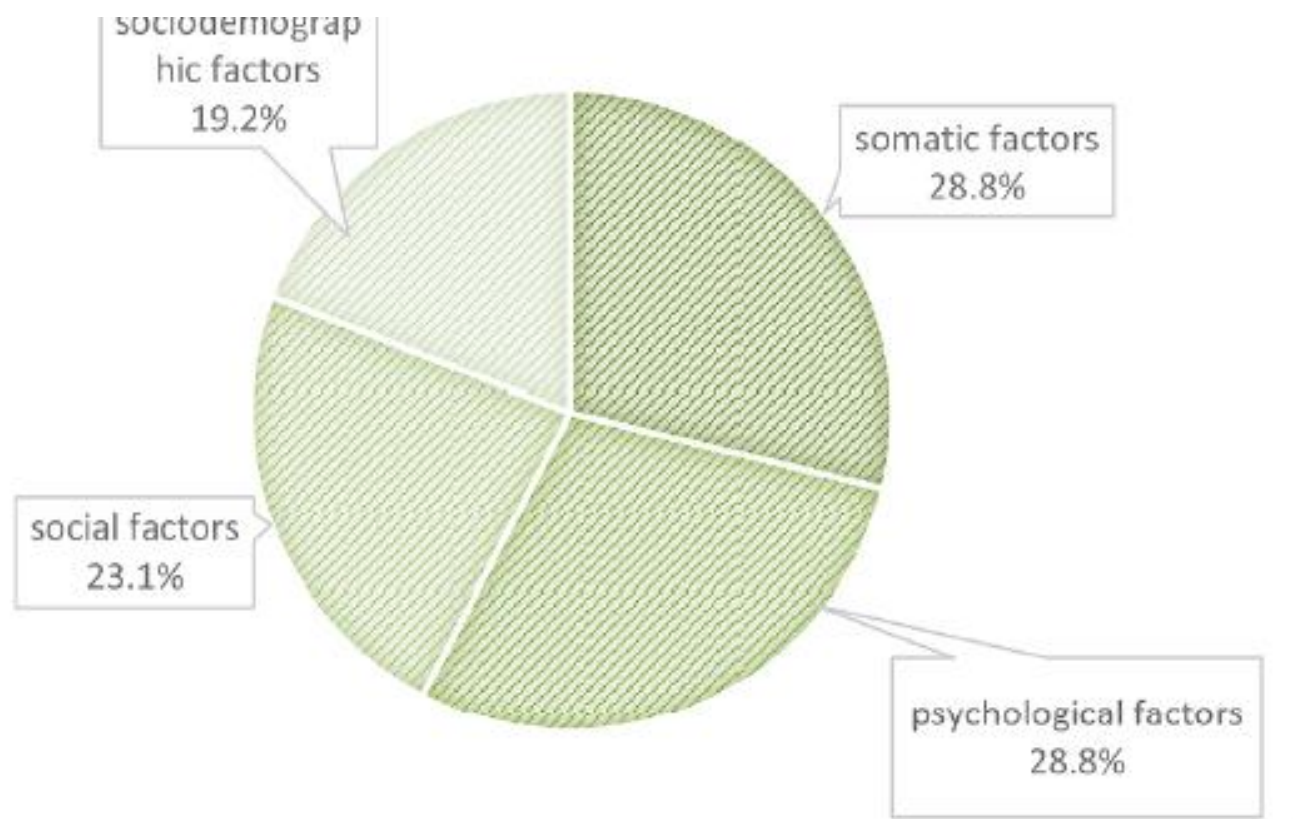


Fig. 2. Clustered percentage of assessed associated and risk factors

Factors associated with depression.

Domain	Risk factor	No. investigated	+	~	-
Sociodemographic factors	Ethnicity (Caucasian)	11 / 40	2	7	2
	Gender (female)	40 / 40	9	31	0
	Age (older)	36 / 40	8	19	7
Somatic factors	cancer treatment	23 / 40	8	15	0
	cancer type	16 / 40	3	13	0
	cancer symptoms	11 / 40	8	3	0
	cancer stage	23 / 40	4	19	0
	comorbidities	15 / 40	9	6	0
	metastases	8 / 40	4	4	0
	pain	7 / 40	4	3	0
Social factors	physical functioning	10 / 40	8	2	0
	educational level (lower)	30 / 40	6	24	0
	relationship status (single / separated / widowed)	29 / 40	12	17	0
	socioeconomic status (lower)	25 / 40	10	15	0
	level of social support	12 / 40	8	4	0
Psychological factors	previous depression	13 / 40	13	0	0
	psychological / psychiatric history	20 / 40	13	7	0
	personality factors (introverted)	10 / 40	9	0	1
	disease awareness	2 / 40	1	0	1
	health behavior (worse)	9 / 40	3	6	0
	coping behavior (passive)	5 / 40	4	1	0

+ positive association; ~ no association; - negative association; reference value for risk factor in parentheses.

Elements of effective history taking

Element	Patient outcomes affected
<p>Physician Asks many questions about the patient's understanding of the problem, concerns and expectations, and about his or her perception of the impact of the problem</p>	<p>Patient anxiety and symptom resolution</p>
<p>on function</p>	
<p>Asks the patient about his or her feelings</p>	<p>Psychologic distress</p>
<p>Shows support and empathy</p>	<p>Psychologic distress and symptom resolution</p>
<p>Patient Expresses himself or herself fully, especially with regard to conveying feelings, opinions and information</p>	<p>Role limitation and physical limitation; health status, functional status and blood pressure</p>
<p>Perceives that a full discussion of the problem has taken place</p>	<p>Symptom resolution</p>

GESUNDHEIT – KRANKHEIT

Folgerungen der WHO

1. Förderung und Erhaltung von Gesundheit,
2. Verhütung und Behandlung von Krankheiten,
3. Bestimmung von Risikoverhaltensweisen,
4. Diagnose und Ursachenbestimmung von gesundheitlichen Störungen,
5. Rehabilitation und
6. Verbesserung des Systems gesundheitlicher Versorgung.

The Influence of Doctor-Patient Communication on Health Outcomes: A Systematic Review

David Riedl¹, Gerhard Schüßler¹

Zusammenfassung

Der Einfluss der Arzt-Patient-Beziehung auf den Gesundheitszustand: eine systematische Übersicht

Hintergrund: Für den Einfluss der Arzt-Patient-Beziehung sowie -kommunikation auf den Gesundheitszustand ist eine weitere empirische Fundierung notwendig. Anhand der Unterscheidung zentraler Bereiche (bspw. Beziehungsqualität, Informationsvermittlung, Patientenedukation) können spezifische Ergebnisse beschrieben werden. Um die empirische Basis dieser Annahmen zu überprüfen haben wir einen systematischen Review durchgeführt.

Methoden: In einem systematischen Review der Publikationen in Medline, Embase, Cochrane, PsychLit und Psycindex zwischen 2000 und 2015 wurden RCTs, kontrollierte und unkontrollierte peer-reviewte Studien mit erwachsenen klinischen Stichproben identifiziert und analysiert. Studien mit psychiatrischen Stichproben, psychologischen oder psychotherapeutischen Interventionen wurden ausgeschlossen.

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Ergebnisse: Siebzehn RCTs, siebzehn kontrollierte Studien sowie acht qualitative Studien erfüllten alle Einschlusskriterien. Die generelle Studienqualität der RCTs und kontrollierten Studien war zufriedenstellend. 60% der Studien konnten einen positiven Effekt der Arzt-Patient-Beziehung auf den Gesundheitszustand zeigen. Die Rolle von Informationsermittlung sowie -vermittlung (Patientenedukation) wurde am häufigsten untersucht, wobei ein eindeutiger positiver Effekt gefunden wurde. Auch die Kommunikationsfähigkeit führte zu verbesserten Ergebnissen sowie zur verbesserten Unterstützung behandlungsbezogener Verhaltensweisen und Emotionen. Zwei Studien, in denen eine ökonomische Evaluation mit eingeschlossen wurde, zeigten verringerte Kosten für das Gesundheitssystem.

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Study	Quality Score	Disease	Duration	Number of Participants	Main communication function	Main outcome
Zhang et al. 2009	20	advanced cancer patients	–	603 patients	– relationship building (EOL)	– EOL leads to significantly lower healthcare costs (950 \$) in the last week of life – higher costs were associated with lower quality of death
Bhattacharyya et al. 2010	12	diabetes	3 months	106 patients	– information provision	– information and education lead to lower non-compliance (–15%) and better health status (HbA1C)
Dibbelt et al. 2010	13	mixed orthopaedic/internal disorders	6 months	470 patients 61 physicians	– information provision – relationship building	– higher quality of interaction associated with better treatment outcome (e.g., depression, anxiety) – physicians showed good capabilities to establish emotional relationships – but lacked the ability to effectively inform and motivate patients
Parchman et al. 2010	18	diabetes	12 months	141 patients 5 GPs	– relationship building – enabling treatment-related behavior	– PDM α more patient activation – more patient activation α better medication adherence – higher adherence α better health status (HbA1C, LDL, RR)
Hojat et al. 2011	15	diabetes	–	891 patients 29 GPs	– relationship building – enabling treatment-related behavior	– higher empathy associated with better health status (A1c and LDL-C) – physicians empathy significantly predicts clinical outcome
Alexander et al. 2012	13	chronic diseases	–	8140 patients	– relationship building – enabling treatment-related behavior	– better interpersonal exchange, better communication leads to patients activation

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Zusammenfassung: Im vorliegenden systematischen Review wurden überzeugende Effekte für unterschiedliche Bereiche der Arzt-Patient-Beziehung sowie Aspekte der Kommunikation auf verschiedene objektive und subjektive Gesundheitsparameter gefunden.

Z Psychosom Med Psychother 63/2017, 131-150

- Die Pandemie hat die Arzt-Patient-Beziehung vor neue Herausforderungen gestellt:
- Aufklärung und Information beim Impfarzt ?
- Shared-decision-making oder Paternalismus ?
- Verlust von bereits Erreichtem