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Clinical Case
Optional Treatments and Quality of Life
Commentaries by Mary Jane Massie, MD, and Johannes Meran, MD, MA

Dr Brooks completed a routine breast exam on Ms Civali and found a suspicious mass. After running necessary tests, Dr Brooks discovered that Renee Civali has early stage breast cancer. Ms Civali is a 40-year-old, petite woman who is single and works as a successful car salesperson. Ms Civali has been seeing Dr Brooks for the past 5 years, and chart notes indicate that Ms Civali has been occasionally emotionally unstable and has made most decisions based on what others tell her to do.

Following the diagnosis of breast cancer, Dr Brooks explained to Ms Civali that she had 2 main treatment options: a total mastectomy or breast-conserving surgery, both options followed by chemotherapy and radiation. Dr Brooks told Ms Civali that both treatment plans would most likely rid her body of the cancer, but each would carry a specific consequence. Ms Civali, admittedly overwhelmed and unsure of what decision to make, asked Dr Brooks to make a therapeutic decision on her behalf. Dr Brooks ultimately suggested the breast conserving surgery and justified the decision by reasoning that this was a less intrusive method with lower chances for a loss of body image, self-esteem, and other psychological issues that often affect younger women with this type cancer. Dr Brooks believed that, if followed by chemotherapy and radiation, the less radical surgery would achieve the same medical results as the more radical total mastectomy.

Several months after the surgery, chemotherapy, and radiation treatments—all of which appear to have been successful—Dr Brooks raises the possibility of Ms Civali's beginning an orally administered hormone-based therapy, telling Ms Civali that this could help reduce the risk of the cancer's recurring. Dr Brooks however, admits to Ms Civali that research suggests that many women may not actually need the hormonal treatment in order to remain in remission because their initial surgery coupled with the follow-up therapies were sufficient. Dr Brooks explains the various side effects of a hormone-based regimen and states that some women find that the potential benefit is not worth the distressing side effects when there are no signs of aggressive disease. After listening to this proposal, Ms Civali discloses her feelings of depression about the status of her disease and questions whether or not the partial mastectomy was most effective in eliminating her cancer. Ms Civali also acknowledges significant frustration with her current medical situation, saying she feels worn down by the constant trips to the hospital and other reminders of her recent medical history and wishes that she could return to the life she led prior to the discovery of her cancer. After hearing Dr Brooks discuss the next possible round of treatment and expressing her concerns—both physical and psychological—Ms Civali reports that she is

unwilling to make an independent decision with regard to the hormone treatment and asks Dr Brooks for her recommendation.

Commentary 1
by Mary Jane Massie, MD

This case demonstrates some of the problems that many young women with breast cancer experience. The problems Ms C is having are common reasons for referring a patient with cancer to a psychiatrist.

Only 5 percent of breast cancer occurs in women under the age of 40. Although Ms C was unlucky to have breast cancer at such a young age, her cancer was caught at an early stage, and she was fortunate to have treatment choices. Dr Brooks had a 5-year relationship with Ms C prior to her cancer diagnosis, is aware of this patient's emotional instability and indecisiveness, and is well positioned to help Ms C continue with her cancer treatment.

Although we don't have precise knowledge about the estrogen and progesterone hormonal receptivity of the tumor, since antiestrogens are being recommended, we can assume that Dr Brooks has evidence that this regimen can provide a relatively significant benefit to Ms C. Chemotherapy and antiestrogen therapies are frequently described to patients as an "insurance policy" and given that Ms C is a "successful car salesperson" she probably advises her clients about their need for insurance to protect their investment when they purchase a valuable machine, Dr Brooks may have used this analogy when describing the role of antiestrogens to Ms C. Although Dr Brooks knows that the most difficult part of Ms C's treatment is behind her, Ms C is feeling overwhelmed and uncertain as to whether she can go on. It's unclear whether she understands that antiestrogen treatment is merely the ingestion of a pill daily, albeit for 5 or more years.

Ms C also appears to be questioning the previous treatment decision and asks Dr Brooks for another "recommendation." The best advice, I believe, that Dr Brooks can give is that Ms C consult with a mental health professional (a psychiatrist or psychologist) who specializes in working with women with breast cancer. These professionals, known as psycho-oncologists, commonly consult with women who have just completed surgery, irradiation, and chemotherapy. Many women like Ms C describe feeling depressed, emotionally "worn out," and unable to move forward with their life after 6 to 9 months of cancer treatment. Dr Brooks will explain that the referral to the psychiatrist is not being made because she thinks Ms C is "crazy," but because she appreciates how long and difficult the treatment has been for Ms C and how arduous breast cancer treatment is for all women. Dr Brooks knows that starting an antiestrogen immediately is not vital for Ms C's health, and allowing Ms C time to discuss the treatment with another professional may make her more comfortable with her final decision. The psychiatrist also has ample time to: better understand the range of problems that Ms C is struggling with, provide support, treat depression, and, ultimately, help Ms C think through her decision to take or not take an antiestrogen.

When Ms C meets with the psychiatrist, he or she will want to know her family history of breast cancer. Is part of her depression related to the personal tragedy associated with loosing 1 or several family members to breast cancer or other cancers? Is part of the reason she feels depressed or emotionally depleted because she has undergone treatment alone, without enough people available to provide support and practical assistance? Did she continue to work during chemotherapy without telling her employer or business colleagues about her breast cancer because she wished to maintain her privacy?

Dr Brooks has noted previous emotional instability and a pattern of "making decisions based on what others tell her to do." Many patients ask their doctors to recommend the best treatment and then defer to their physician's clinical judgment. To better understand Ms C's current psychological state, the psychiatrist will ask her about her personal history of depression, anxiety, insomnia, substance use, and her current emotional symptoms. The psychiatrist will also ask how she has made other important decisions in the past. As a successful salesperson, Ms C knows how to "close" or "complete a deal" and must have experience observing others make significant decisions when there is an element of uncertainty. The psychiatrist will probably tell Ms C that Dr Brooks has really only asked her to start this final phase of breast cancer treatment because, to the best of our current knowledge, doing so will "complete the deal," offering her the best chance of a "cure." The psychiatrist will acknowledge that considering an antiestrogen is difficult when one is overwhelmed, exhausted, depleted, and has decreased ability to concentrate after chemotherapy and then will explain that there are people and strategies available for Mrs C to use so the decision-making process does not feel so overwhelming.

Ms C is 40, single, presumably without children, and was likely premenopausal prior to chemotherapy. If chemotherapy has made her prematurely menopausal, some of her current emotional distress and depression may be related to fluctuating or reduced estrogen levels and insomnia resulting from vasomotor instability. Part of her concern about antiestrogen use may be her knowledge that some women describe having insomnia, weight gain, and depressed mood when taking antiestrogens, and she may view this as intolerable or worse than her current symptoms.

Maybe Ms C hopes to become pregnant and sees taking 5 years of antiestrogens as dashing an important dream. The psychiatrist will explore her previous plans, thoughts, and hopes about child bearing or child rearing and her current hopes and fears in the aftermath of chemotherapy.

Symptom management to improve Ms C's quality of life will be an important first step before any final decision regarding antiestrogens is made. If her anxiety is severe, the psychiatrist will prescribe a benzodiazepine to manage daytime anxiety and a hypnotic for insomnia. Reducing anxiety to acceptable levels permits many patients to think more clearly and better participate in the decision making process.

Additionally, if Ms C is depressed or has disabling menopausal symptoms, the psychiatrist may prescribe an antidepressant such as fluoxetine, sertraline, paroxetine,

or venlafaxine to treat the depressed mood and to reduce the frequency and intensity of hot flashes and night sweats that she may be experiencing.

Although pharmacologic therapy is likely to benefit Ms C significantly, psychotherapy, which has many components including support, will give her a private space in an unhurried setting to voice her frustration, sadness, disappointment, and mourning for the "loss of good health" at a young age. During or after breast cancer treatment younger women commonly want to discuss fears of death, body image concerns, sense of themselves as women, desirability as sexual partners, future sexual relationships, fertility, career, and relationship issues.

In individual psychotherapy, Ms C can discuss her most intimate fears and concerns and how those fears affect her decision making about further treatment. In addition to talking "one-on-one" with a trained professional, many women appreciate the opportunity to participate in support groups for women who are undergoing breast cancer treatment. In a group setting, Ms C is likely to hear other women describe their cancer treatment experiences and say that antiestrogens are, in fact, very tolerable and viewed as an important component of breast cancer treatment to ensure that the cancer "will never come back." Both her psychiatrist and support group members will ask her to think through how she would feel about not trying an antiestrogen if her cancer returned; many women report they would be very disappointed if they had not accepted all anticancer treatment available to them and their cancer recurred. Women who attend breast cancer groups benefit from seeing that they are not alone and that others have and are successfully completing cancer treatment.

In summary, an antidepressant combined with support and encouragement delivered in both individual and group therapy settings are likely to help Ms C feel more in control and better able to think through the pros and cons of future decisions. Dr Brooks will point out that only rarely does a woman become so uncomfortable on antiestrogens that she chooses to discontinue them. Both Dr Brooks and the psychiatrist can reassure Ms C that there is good evidence that young women who have been treated for breast cancer achieve good physical and emotional recovery and ultimately have psychological, social, and sexual health equal to that of their peers.

References

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Commentary 2
by Johannes Gobertus Meran, MD

The case of Ms Civali evokes questions that physicians need to reflect on when dealing with early stage breast cancer and its potential psychosocial implications.

Initially, the physician has to give priority to providing sound medical advice and counseling. This clinical step should always be based on a risk-benefit assessment, which requires a complete and detailed medical characterisation of the respective cancer: one would like to know, for example, the localisation, histology, TNM staging, grading, hormone-receptor status (ER, PR), and additional risk factors, at least the HER2/neu overexpression. Primary treatment of localized breast cancer, which is what Ms Civali has, consists, in most cases, of breast-conserving surgery, followed by radiation and systemic adjuvant therapy according to the particular risks of the cancer. In this case these prognostic and predictive factors are unknown, but it may be assumed that Dr Brooks' decision to perform a breast-conserving surgery followed by chemotherapy and radiation was the most appropriate first step of Ms Civali's cancer treatment.

Now the next treatment questions are: why was hormone treatment not suggested earlier, and should the physician recommend Ms Civali start the hormone treatment several months after completing chemotherapy and radiation? With respect to medical facts, Dr Brooks' proposal of a hormone therapy allows us to conclude that the carcinoma cells are receptor-positive. The benefit of hormone therapy is about 5–10 percent reduction in the 10 year mortality rate. Although Tamoxifen—the most popular hormone treatment drug—is associated with an increased risk of venous thromboembolism and endometrial cancer, the statistical gain is widely believed to greatly outweigh the medical risks. Thus, based on statistical and diagnostic trends, Dr Brooks is justified in recommending the hormone treatment. Recent data suggest using Anastrozole instead of Tamoxifen as the preferred treatment, because it significantly prolonges disease-free survival and has fewer side-effects [1].

A physician's advice should not be based solely on general statistical outcomes, but should always include a personalized risk-benefit assessment that takes into account the unique circumstances of the individual patient. Clear and sensitive communication about the anticipated long-term outcomes and acute effects must be discussed openly and within the context of the patient's life. In this case, Ms Civali feels unable to make an independent, personal decision and asks Dr Brooks for a recommendation. This situation is an analogue to the earlier instance in which Ms CiIvali asked Dr Brooks to decide whether or not she should have breast surgery. When considering her unwillingness to actively participate in the decision making process, it is important to recognize that Ms Civali's attitude indicates early symptoms of clinical depression. These symptoms require specific medical treatment and psychological support.

So how should Dr. Brooks advise Ms Civali about the adjuvant therapy? Adjuvant therapies are often thought to present considerable restrictions on patients' quality of

life. Thus, 2 criteria of medical decision making compete with each other: general statistical benefit has to be weighed against possible changes in individual quality of life. The basis for assessing the patient's quality of life is the patient's subjective evaluation of her own condition. These subjective perceptions cannot be derived authentically from the outside. They depend on personal values and moral principles that reflect the very individual experiences and understandings each person has had in her or his life. If, for example, a patient who has a chronic disease and has received extensive medical treatments views taking drugs and making regular visits to the hospital as a significant burden, this presents a serious and important decision making consideration for the consulting physician. Sometimes fatigue, frustration with the medical situation, and the need for prolonged inpatient hospital care, may justify a decision to forgo specific forms of treatment. Here, Ms Civali is obviously frustrated with her current situation. She feels worn down by the constant trips to the hospital and wishes to return to the life she led before her cancer was detected. So should Dr Brooks *not* recommend hormone therapy to Ms Civali in light of her individual psychosocial situation and the fact that there are currently no signs of cancer in her body?

This scenario also has to take into account the possibility that Ms Civali may just be temporarily overwhelmed by emotions related to her medical condition and treatment. These reactions may pass after a short time when the patient has gained some rational, reflective distance on her situation. Therefore it seems to be important to rule out true depression as well as a temporary emotional state that may unduly influence her quality-of-life assessment. In such fragile situations it is not only the right of the patient to waive the active role in decision making, it may even be wise to do so by asking the physician for advice, as Ms Civali has done—especially when the physician appears to have led the decision-making process very responsibly. Although time is scarce in everyday clinical life, good quality care and empathy require the doctor to find out about patients' preferences and wishes and to disclose potential agonizing symptoms and side effects of treatment options. As physicians, we need this kind of normative and psychosocial cooperation from the patient in order to reach a patient-centered treatment decision.

The alternatives to adjuvant hormone treatment should also be openly discussed with the patient. In the case of Ms Civiali one of the alternatives is no further treatment at all. But would the denial of hormone treatment allow her to live a "normal life" again, ie, the life she led prior to the discovery of her cancer? Although Ms Civali hopes so, cancer patients usually do not forget the disease and their changed status of life simply by avoiding the hospital. The anxiety of cancer recurrences or possibly undetected metastases remains. Some periodical follow-up is usually requested by the patients to confirm the remission of the cancer. Hence, the hope of Ms Civali to escape her disease merely by rejecting a hormone treatment seems to be illusionary. Nevertheless, if her fatigue of treatment is so strong that she wants to avoid any more external medical reminders of her disease, Dr Brooks should accept these feelings while assuring her that she is welcomed whenever she feels the need to communicate with or be seen by a doctor.

If I were in Dr Brooks' place, I would try to make Ms Civali aware of her particular risk-benefit ratio, including the statistical advantages of adjuvant therapy. Assuming a hormone-receptor-positive tumour and considering the given psychosocial facts, the justification for a hormone treatment seems preponderant. Anastrozole (or Tamoxifen) is usually well-tolerated, and its benefits will almost certainly outweigh its potential side effects (eg, hot flashes and vaginal discharge). These side effects are rather mild given that the patient has already tolerated the much harsher side effects of chemotherapy. If the assumption that the benefits will outweigh the individual side effects turns out to be wrong in Ms Civali's case, it is still possible to either modify or discontinue the treatment after evaluating the regimen together with the patient.

In conclusion, I would recommend the hormone treatment to Ms Civali, but acknowledge her concerns by accompanying the treatment with psychological support, specifically a program to enhance self-esteem and to provide all possible help for reintegration in her life and work. As argued above, communication between patient and physician remains the most important guide to achieving shared decision making which depends heavily on excellent medical information and the personal risk-benefit assessment. The latter is usually best expressed by the patient, who is the only one in a position to make the individual risk-benefit assessment since this has to be done according to her very own way of living, her experiences, and her preferences.

Reference

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