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Preferences of Patients With Myeloproliferative Neoplasms for Accepting Anxiety or Depression Treatment

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Background: *Patients with chronic hematologic malignancies such as myeloproliferative neoplasms suffer from significant physical and psychological symptom burden. This study examined their willingness to accept an antidepressant and their preferences for which provider (mental health professional or hematologist/oncologist) prescribes an antidepressant for the management of anxiety and depression.* **Methods:** *Anxiety and depression treatment preferences were measured with 3 questions assessing: (1) willingness to accept an antidepressant, (2) willingness to have their hematologist/oncologist prescribe the antidepressant, and (3) preference for treatment by a psychiatrist or mental health professional. Additionally, the Distress Thermometer and Problem List, Hospital Anxiety and Depression Scale, Risky Families Questionnaire, and demographic information were assessed to assess levels of distress, anxiety, and depression.* **Results:** *Of the 117 participants, 69 (63.0%) were willing to accept an antidepressant in general and 61 (58.1%) were willing to accept an antidepressant from their hematologist/oncologist ($p < 0.000$). Although 41 (39.0%) preferred to be treated by a mental health provider, this preference was not significantly associated with their respective preference for accepting an antidepressant ($p = 0.057$). Participants already taking antidepressants and those with elevated chronic stress levels were more willing to receive an antidepressant from their hematologist/oncologist ($p = 0.035$, $p = 0.03$, respectively). Treatment preferences did not vary based on myeloproliferative neoplasm type, length of time with myeloproliferative neoplasm, race/ethnicity, marital or working status, or by meeting distress/anxiety/depression criteria. A significant minority ($n = 28$, 26.7%) would not accept any treatment.* **Conclusion:** *Most patients with myeloproliferative neoplasm accepted an antidepressant and readily accepted the prescription from their hematologist/oncologist. The hematologists/oncologist's psychopharmacologic knowledge and their willingness to prescribe antidepressants should be assessed.*

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Key words: antidepressants; cancer; depression; anxiety; psycho-oncology.

INTRODUCTION

Symptom burden in patients with Philadelphia chromosome (*BCR-ABL*)-negative myeloproliferative neoplasms (MPNs) is considerable and endures over many years and usually for the duration of illness.[1,2] The most common physical symptoms include the following: fatigue, pruritus, night sweats, bone pain,

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fevers, weight loss, and splenic pain. Worsening cytopenias and splenomegaly are associated with heavier symptom burden and an inability to perform activities of daily living.[1] The MPNs can be divided into 2 groups; those that have the Philadelphia chromosome or *BCR-ABL* gene rearrangement (i.e., most chronic myelogenous leukemia) and those MPNs that lack the Philadelphia chromosome represented by a heterogeneous group of 3 primary hematologic malignancies—essential thrombocythemia, polycythemia vera, and primary myelofibrosis.[1,3]

In general, symptom burden in patients with cancer tends to correlate with distress, anxiety, and depression.[4,5] The prevalence of depression and anxiety among those with MPNs are likely equivalent to that seen in other malignancies, but this has not been well studied. In addition, patient preferences for the treatment of either depression or anxiety in the MPN treatment setting have not been studied previously.

Historically, psychological symptoms have been underrecognized and undertreated.[6] Approximately 20 years ago, the National Comprehensive Cancer Network promulgated a standard of clinical care for the management of depression that today remains a category 1 recommendation but is not yet a consistent standard of care.[7] Additionally, the American Society of Clinical Oncology published clinical practice guidelines for the management of anxiety and depression[8] in patients with cancer, highlighting the need for paying attention to this issue among patients with cancer. Although these guidelines, and others, have been published, they are not routinely followed nor adequately implemented into routine oncology practice. Consequently, depression in patients with cancer remains inadequately addressed or treated.[9] Screening for depression or anxiety or for both alone is not sufficient to change the outcomes of depression and anxiety in patients with cancer.[10,11]

Understanding patient's preferences for the treatment of depression and anxiety is crucial, especially in the medical setting, and has been shown to improve adherence and other treatment outcomes.[12] The effective use of antidepressants for the treatment of depression requires an adequate assessment of depression, appropriate patient education about adherence and side effects to the medication, assessments for medication effectiveness and side effects, and titration of the dose.[13] This requires close doctor-patient interaction that often happens routinely during active anticancer treatments. Although oncologists lack formalized training in this area, a referral to a mental health provider can be met with resistance or be seen by patients as disruptive for this aspect of care.[14] In addition, some patients may resist referral to a psychiatrist because of the stigma or expense, and prefer instead to follow-up with their hematologist/oncologist.[15]

The use of patient-guided treatment preferences for the treatment of depression and anxiety are known to improve adherence and treatment outcomes in primary care settings,[16,17] but these preferences are not known in patients with Philadelphia chromosome–negative MPNs and other hematologic malignancies. This study addressed the patients' perspective and their willingness to accept an antidepressant, to accept an antidepressant from their hematologist/oncologist, and their preference to be cared for by a psychiatrist or mental health provider for treatment of anxiety or depression. Early recognition and management of distress, anxiety, and depression would limit the delay in obtaining appropriate treatment, especially at difficult time points in the cancer trajectory (e.g., at diagnosis/recurrence/progression/unremitting physical symptoms).[18,19] The understanding of patient preference should facilitate the early recognition and treatment of distress, anxiety, and depression in patients with MPNs.

METHODS AND MATERIALS

The Mount Sinai Hospital Institutional Review Board approved this study in July 2014. Surveys were collected from participants from May 2015 to October 2015.

Participants

Men and women with documented MPNs were screened based on inclusion criteria consisting of a confirmed tissue diagnosis of an MPN as identified by the treating physician. Patients selected their disease designation as essential thrombocythemia, polycythemia vera, myelofibrosis, or other. Exclusion criteria consisted of another cancer diagnosis as identified by the patient as not having an MPN. Recruitment occurred over 4 months in a dedicated MPN clinic. New and established patients were recruited to participate in the study.