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Review

Psychosocial and legal aspects of oncological treatment in patients with cognitive impairment

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ABSTRACT

With society getting older and affected by many diseases, more and more people suffer from severe cognitive disorders. As practice shows, the legal situations of such people is often problematic. This is due to a number of factors, such as short time since the deterioration of patient's condition, initial symptoms ignored, social prejudice towards the idea of incapacitation or taking decisions for a patient, complicated procedures and, sometimes, insufficient knowledge of legal regulations. Cognitive disorders also occur in patients treated for cancer. To be effective, oncological treatment needs to be started as early as possible. This, however, does not meet the criteria of sudden threat to life. The present article relates to both the psychosocial and legal aspects of care of people suffering from intense disorders of memory, attention, problem solving, executive functions, and other. Surely, physicians know how to handle patients with the above dysfunctions. However, legal procedures aimed to protect patients' rights are often unclear and time consuming. In practice, this often amounts to a dilemma whether to treat or follow the applicable law. Certainly, solutions in this regard should be clearer and better adapted to the needs arising from specific treatment needs of particular groups of patients.

Cognitive impairment is a group of symptoms that often occur in patients treated for oncological diseases. Among these, are those who, due to cancer, experience sudden symptoms of brain damage, and those treated for cancers of different locations who have a history of brain damage or any sort of neurodegenerative disease. Such disorders may develop for months or even years, with effects covering virtually all functions. Cognitive dysfunctions also apply to patients treated psychiatrically, e.g. for affective disorders. Moreover, they may occur temporarily as symptoms of other somatic diseases or as a side effect of surgery, radiation therapy, chemotherapy or drugs applied in those therapies.[1–3] In many cases, they present as mild cognitive impairment, but sometimes make it very difficult to make a contact or exchange information with patients and prevent them from functioning by their own, including taking important decisions, such as those to start or continue treatment.[4]

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1. Psychosocial and medical aspects of oncological treatment of patients with cognitive impairment

Diagnosing cognitive dysfunctions in patients is of utmost importance, particularly when they are subjected to a long-term and traumatic treatment, as oncological treatment surely is. It is significant for medical reasons, as an important symptom that helps determine optimal treatment modality, to assess possibilities of cooperating with the patient, but also in view of the need to respect the existing legal regulations. A detailed interview concerning patient's life so far might prove very helpful here. Information is gathered mostly from patients themselves so as to obtain a preliminary picture of their difficulties in cognition, memory, thinking and speech, and then, in the second instance, from their caretakers. An essential role in the process is played by psychiatric consultation supported by a neuropsychological evaluation of cognitive function using test methods to deliver more detailed information in this regard. The most commonly used methods include: Wechsler Adult Intelligence Scale (WAIS-R(PL)) and Wechsler Intelligence Scale for Children (WISC-R(PL)), Right Hemisphere Language Battery (RHLB-PL), Boston Diagnostic Aphasia Examination (BDAE), a set of tests for patients brain damage, Bright Vision Therapeutic Riding (BVTR), Rey-Osterrieth Complex Figure, Auditory Verbal Lerning Test, Mini-Mental State Examination (MMSE), Clock Drawing Test (CDT), Verbal Fluency Test, Trail Making Test (TMT).[5,6]

The psychopathological conditions which are typical for cognitive impairment and which are most commonly diagnosed in cancer patients include: impairment of consciousness, dementia, depression and focal brain damage.

Cognitive disorders are general dysfunctions of the central nervous system which often occur suddenly and are potentially transient and reversible in nature. The literature divides conditions of impaired consciousness into quantitative and qualitative ones. The quantitative disorders include: clouding of consciousness, where a verbal contact with the patient is possible but limited to answers to simple questions due to a reduced thinking performance and coherence and uncertain orientation to time and place; or somnolence, semicoma and coma where the patient does not respond to any verbal or physical stimuli, their reflexes gradually disappearing. The qualitative category comprises: delirium, which may be the most common symptom of cognitive function deterioration in patients with somatic diseases; oneiroid syndrome which presents with hallucination and complex and severe memory disorders; obnubilation characterised by a total disorientation and disorders of perception, problem solving and psychomotor activity (slow-down or acceleration); as well as mental confusion with distinct and intense disturbance of auto and allopsychical orientation, train of thought, memory and verbal contact, and motor restlessness. Mental confusion mostly arises from patient's poor somatic condition.[7–9] As mentioned before, the most commonly occurring type of consciousness disorder in somatic patients, including those treated for cancer, is delirium. The definition contained in *the International Classification of Diseases (ICD-10)*, identifies such symptoms as disturbances of consciousness manifested by various sorts of difficulties in recognising the environment; limited ability to focus, maintain and re-direct attention; and disorders of cognitive processes which present primarily with difficulties in a direct and short-term memory, with relatively well-preserved long-term memory. Usually, confusion of time, place and/or person is also observed. Those symptoms are accompanied by psychomotor disorders, such as reduced or intensified activity, extended or intensified reaction of surprise, rapid or slowed speech. Frequently observed are also disturbances in the sleep-wake cycle and a varied intensity of the symptoms during the day, e.g. stronger disorders in the evening or at night and a much better performance at daytime.[10] Sometimes, changes occur and disappear within minutes. It is important to identify the background of the symptoms, as they can go in pair with life-threatening disease processes, such as stroke, increase of intracranial pressure, encephalitis and other.[7] As much as impaired consciousness is symptomatic of many diseases, the determination of its etiological background may prove difficult. Also in oncological patients treated with surgery, radio- and/or chemotherapy or other modalities, the identification of the reasons for rapidly growing symptoms is a problematic task, as they may be associated with many factors, directly preceding the disorders of conscience. These include: physical immobility, catheterisation, malnutrition, dehydration, a number of drugs and risk factors of a chronic nature, e.g. side effects of treatment, somatic diseases, conditions associated with acute pain, and many more.[7] It needs also to be borne in mind that disorders of conscientiousness are common symptoms in a variety of old-age diseases, and elderly people, as mentioned before, represent a large proportion of cancer patients. Therefore, distinguishing disorders of consciousness from cognitive impairment resulting from dementia may be a challenge, particularly at the first or single contact with the patient. The main distinguishing trait is the duration of the symptoms.[9]

In dementia alike the main symptoms are memory disorders, applying particularly to the direct, short-term and operating memory, attention and learning processes. However, the course and dynamics of the changes are different. The onset of dementive disorders is hard to discern, as this type of dysfunction advances very slowly as a long-term process contrary to impairments of consciousness which usually turn up suddenly and persist for some ten to twenty days.[9] Dementia usually affects thinking-reduced level of generalisation (disturbance in abstract thinking) and difficulty in executive functions, such as motivation, planning, coordination and control of actions and emotions. With symptoms highly intensified, the patient might find it difficult to answer questions concerning time and place or related to themselves or people from their close circle. Dementive disorders occur for instance in Alzheimer's disease, cardiovascular diseases and other diseases affecting the cerebral circulation, Lewy bodies dementia, or due to frontotemporal degeneration. They may also result from focal injuries and other focal damage or the activity of toxic agents. In contrast to disorders of consciousness, dementia is irreversible and deepening in time, although the course of the disease may vary depending on the cause: primary degenerative processes will differ from dementia induced by a vascular process, toxic agent or injury (spurting progression, often marked with a sudden onset).[8–10]