International Journal of Surgery (2006) 4, 37–44

INTERNATIONAL JOURNAL OF SURGERY

www.int-journal-surgery.com

REVIEW

Psychological responses and support needs of patients following head and neck cancer

Gerry M. Humphris*, **Gozde Ozakinci**

Bute Medical School, University of St Andrews, Queen's Terrace, St Andrews KY16 9TS, UK

KEYWORDS
Head and neck cancer;
Quality of life;
Psychology;
Patient information needs

Abstract The patient with head and neck (H&N) cancer is prone to psychological distress immediately following diagnosis and during the treatment phase. Lowered mood is typical and tends to extend beyond the treatment phase. There is little evidence for a specific treatment method predicting a characteristic psychological response. Rather, patients' reactions vary widely according to fears of recurrence, health beliefs, personality, coping and available support. Patient reports of quality of life show a return to pre-treatment status after a year but are determined to some degree by initial depression levels and dispositional factors such as optimism. Information provided to patients (e.g. leaflets, booklets of written guidance) by specialist treatment centres about the disease and its management require sustained effort in their design and distribution. Our understanding of patient responses to this disease has improved and has assisted in the development of psychological interventions. Controlled trials will provide important evidence of the components, effects and sustainability of these experimental programmes, and improve overall care plans for this often neglected patient group.

Introduction

The treatment of patients diagnosed with head and neck (H&N) cancer presents challenges to the surgical team. Successful outcome is assessed by traditional survival rates and by additional factors notably morbidity, functional status and quality of life (QoL). The assessment of QoL is salient when the differences in survival rates between different treatment regimens are marginal. The decision on the method to select may then be indicated by patient preference or known QoL improvements. Recently, the literature on outcomes has extended to related issues including: psychological status and a discussion of what patients experience during the recovery and rehabilitation phase. This article presents a brief review of current knowledge in this expanding field for clinicians performing highly individualised treatments. The aim of this brief review is to highlight the

* Corresponding author. Tel.: +44 1334 463565; fax: +44 1334 463482.
E-mail address: gmh4@st-andrews.ac.uk (G.M. Humphris).

1743-9191/$ - see front matter © 2006 Surgical Associates Ltd. Published by Elsevier Ltd. All rights reserved.
doi:10.1016/j.ijsu.2005.12.004

important factors that will assist in helping to select the most beneficial treatment pathway for the patient with H&N cancer.

Head and neck cancer is the sixth most common cancer worldwide.[1,2] Ninety per cent of these cancers are squamous cell carcinomas. Men are more likely than women to succumb to the disease by a ratio of 3:1. The disparity between the sexes is becoming less pronounced in the U.K. Mortality rates are high at 54% overall.[3,4] Also, recurrence rates are high in the first year following diagnosis of the primary tumour, compared to many other cancers.

Detection and treatment

Primary care doctors detect most tumours on complaint of soreness in the mouth or throat by their patients. However, on enquiry GMPs preferred that this task associated with any oral symptoms should be the major remit of the dentist.[5] A number of psychological factors explain the delay of patients with advanced H&N cancer seeking medical care. Patients who delay more than 3 months tend to be less optimistic, less committed or involved in health activities (termed 'health hardy'), cope less actively and seek less support, compared to those who seek medical attention within 3 months.[6] The management of H&N cancer relies strongly on surgery or radiotherapy, or their combination (see Fig. 1).[7] Surgical intervention aims to completely remove the primary cancer and any involved lymph nodes. Preservation of function is a secondary aim and finally the maintenance of aesthetics. Many H&N cancer patients are treated with high-dose radiotherapy, which as a consequence also irradiates associated sensitive tissues such as mucous membranes, nerves and circulatory structures.[8] Increasing intensity of treatment has produced significant improvements to outcome but has raised side effects.[8] Delay (greater than 6 weeks) in starting radiotherapy following surgery has been shown to be detrimental to 5-year local

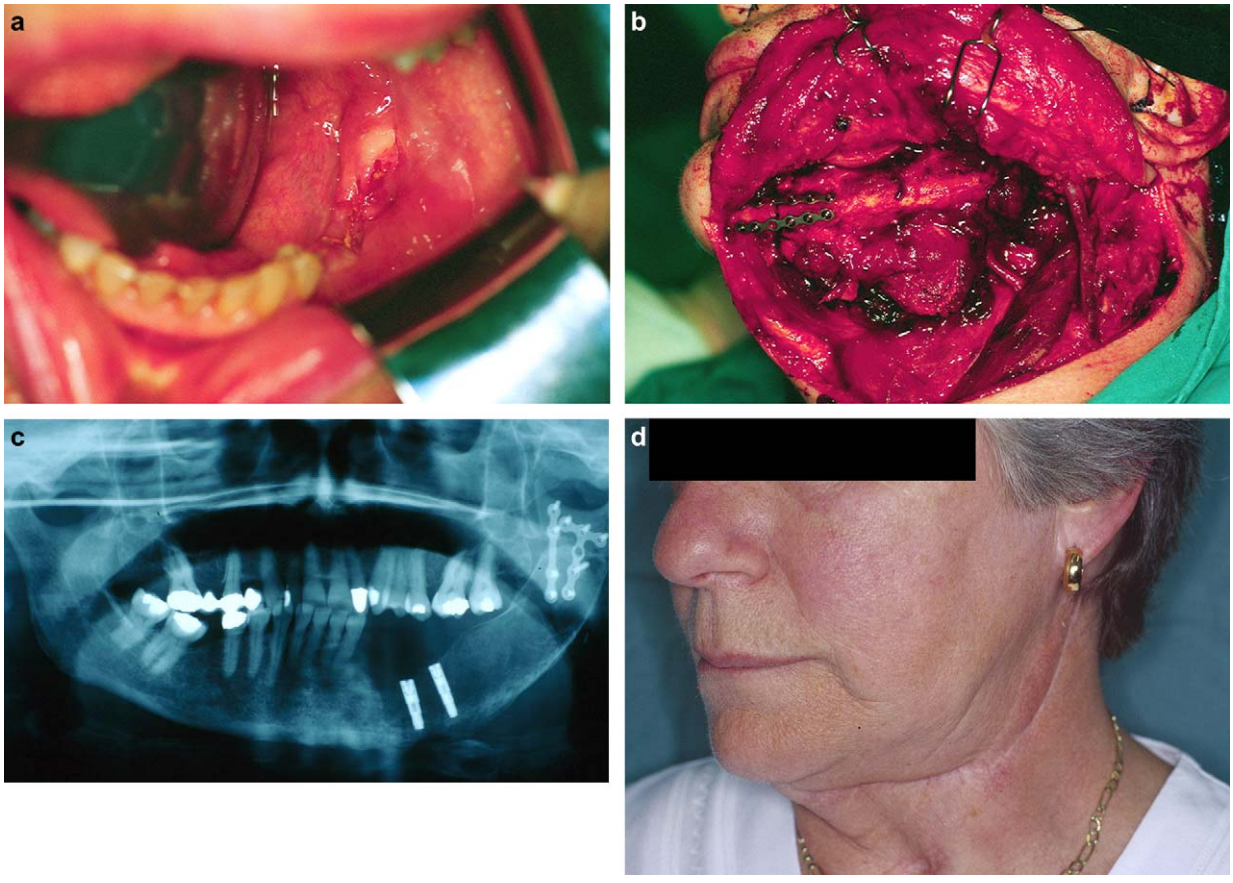

Figure 1 (a) Squamous cell carcinoma of the left posterior mandible. (b) Mandibular resection with reconstruction. (c) Postoperative panoral radiograph showing placement of plants and implants. (d) Six months post surgery, showing good aesthetic results.