PROSTATE CANCER

The psychological toll of prostate cancer

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Matta et al.[1] reported that men with prostate cancer treated by surgery or radiation therapy had greater odds of receiving anti-depressants compared to controls, however this was not observed for men on active surveillance. Caution in interpreting this study as supporting a psychological benefit for men on active surveillance compared to active treatment is needed given methodological limitations. Screening for distress in men with prostate cancer and referral to evidence-based intervention should be a priority for urologic oncology.

Refers to Matta, R. et al. Variation and trends in antidepressant prescribing for men undergoing treatment for nonmetastatic prostate cancer: a population-based cohort study. *Eur Urol* https://doi.org/10.1016/j.eururo.2018.08.035 (2018).

A recently published report by Matta et al.[1] exploring the use of antidepressants among men with nonmetastatic prostate cancer compared with propensity-score-matched members of the general population is timely given the increasing recognition over the past decade of the psychological toll associated with the diagnosis and treatment of this disease. Intriguingly, men with prostate cancer treated actively through surgery or radiation therapy had greater odds of receiving anti-depressants (peaking at two years) compared to controls, however this effect was not observed for men who were on active surveillance. Psychological distress prevalence estimates vary as a result of differences in sampling frames and measurement approaches, but a meta-analysis published in 2014 reported that 15–27% of men experience anxiety and 15–18% report depression before and after prostate cancer treatment[2]. Heightened psychological distress is more prevalent in men with locally advanced or metastatic prostate cancer compared to men with localized disease [3]; risk factors for higher levels of distress in men with prostate cancer include young age, comorbidities, and a high symptom burden, with the negative effects of domain-specific symptoms on quality of life and mental health increasing over time. The Matta et al.[1] study suggests that men with localized disease who are managed through active surveillance experience better psychological outcomes than those who receive surgery or radiation therapy. However, the age (median of 73 years with a range of 71-75), presence of comorbidities such as diabetes and hypertension, and receipt of adjuvant treatment in the active surveillance cohort suggest that this group also included men who were on watchful waiting and, therefore, does not reflect the contemporary practice of active surveillance. In addition, the large number of sampling exclusions (for example, only 23% of Ontario-based men on active surveillance were included in the study) raises questions about unexplained study bias. These issues, in addition to the lack of important clinical data about disease stage, grade, and PSA levels, call for caution in the interpretation of the findings[1].

The interpretation that the report by Matta et al.[1] shows a psychological benefit for men on active surveillance as opposed to active treatment is simplistic. Analysis of data on antidepressant uptake is a blunt tool for understanding the psychological impact of a prostate cancer diagnosis. Each treatment or management approach has different demand characteristics, benefits, and costs that need to be matched to men's preferences about their health. Shared decision-making that is informed not only by clinical information but also by the active incorporation of men's values and life circumstances is indicated. Men will have different risk profiles for poor or favourable outcomes on the basis of their general health, prostate cancer stage, grade of sociodemographic disadvantage, and social and support networks, as well as pre-existing physical and psychological health concerns. A

consideration of these factors by the oncology treatment team is required at all stages of the prostate cancer experience.

In contrast to the study by Matta and coworkers[1], Taylor et al.[4] — who used a different methodology to track newly diagnosed men with low-risk prostate cancer — found that, over time, men on active surveillance had a better physical quality of life with no difference in rates of depression, but higher levels of both general and prostate-cancer-specific anxiety, than men on active treatment. These findings[4] and those of previous research**. reference 4** point to the risk of men experiencing anxiety about surveillance that not only decreases their overall quality of life but also can lead to conversion to active treatment sooner than is clinically indicated.

Attention by the health care team to the effective detection and management of psychological distress after prostate cancer diagnosis is urgently needed. Men with prostate cancer have an higher risk of suicide than age-matched prostate cancer free men, with the first 6–12 months after diagnosis being a period of heightened risk[5,6]; men with locally advanced or metastatic disease and/or single marital status are at increased risk. Suicidal ideation has been reported by ~12% of men with prostate cancer and can persist for many years[7], and one-third of men report a high level of fear of cancer recurrence[8]. Thus, although many men will cope effectively with their prostate cancer experience, others will not and the outcome of this psychological distress can be catastrophic.

The greatest reductions in the psychological burden in this patient group will likely be gained through brief distress screening, which is a well-accepted, but not yet systematically and broadly implemented, standard of optimal oncology care. Distress screening has been well validated in men with prostate cancer[9]. A simple single-item scale that measures men's current levels of distress, which has been empirically validated for anxiety, depression, and cancer-specific psychological distress **reference 9**, can be easily incorporated into clinical practice and, when followed by the identification and exploration of a patients' problems, can guide referral for intervention at the required depth and with the correct focus. Importantly, effective psychosocial interventions for men with prostate cancer have been identified[10]. Multimodal psychosocial and psychosexual care for men with prostate cancer is acceptable and effective for improving decision-related distress, mental health, and domain-specific and health-related quality of life[10]. Combinations of educational, cognitive behavioural, communication, peer support, decision support and relaxation training, have been commonly applied and are effective. Face-to-face and remote technologies with therapists, nurses, or peer support interventions provide a range of mechanisms and sources of support. The key is to identify men with psychological distress early and provide psychological and survivorship care in a manner that is acceptable to them and responsive to their constructions of masculinity and health and their preferences for support.

At the very least, the study by Matta et al.[1] supports our call for action. After the diagnosis of prostate cancer, and regularly throughout treatment and surveillance, men with prostate cancer should be screened regularly for psychological distress and referred to evidence-based psychosocial intervention, when indicated[9]. A failure to act and implement high-quality psychological care for men with prostate cancer across urology and oncology care settings is not an option.

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Acknowledgments

Competing interests

The author declares no competing interests.

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