Patients with head and neck cancer (HNC) are at high risk for developing depressive symptoms and a major depressive disorder as comorbidities. Depression can affect quality of life (QOL), with data indicating an associated increased risk of recurrence and mortality for patients with HNC. The purpose of this article is to urge oncology nurses to consider depression as an important comorbidity in the care plan for patients with HNC. Resources allocated for depression prevention and screening can decrease symptoms, the incidence of suicidal ideation, and healthcare-associated costs while improving QOL and mortality.

AT A GLANCE

- The incidence of depression and associated outcomes is highest in patients with HNC.
- Depression risk consideration includes identification as a comorbidity in HNC care plans.
- Oncology nursing considerations involve standardized methods for depression prevention and screening in patients with HNC.

KEYWORDS
head and neck cancer; depression; comorbidity; quality of life

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Head and Neck Cancer

Identifying depression as a comorbidity among patients

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The National Institute of Mental Health ([NIMH], 2018) reported that 16.2 million adults in the United States were diagnosed with major depressive disorder (MDD) from 2016–2018. The prevalence of depression in patients with head and neck cancer (HNC) ranges from 19%–57% and has vastly increased, with a 25% incidence occurring prior to any cancer treatment or surgical intervention (Rieke et al., 2017). Depression incidence has increased for all types of HNC diagnoses before and after treatment (Rieke et al., 2017). The HNC population has the highest incidence of suicide in all oncology populations, with a three times greater risk for developing suicidal ideation than the general public (Lydiatt, Bessette, Schmid, Sayles, & Burke, 2013). Cancers of the tongue and larynx account for the highest rate of suicide in all cancer populations, with 19% of HNC cases requiring hospitalization for suicide risk (Kam et al., 2015).

Patients with HNC are at a higher risk for developing clinical depression, which can lead to MDD and require early identification by oncology nurses and providers (Kam et al., 2015). Depression is a significant predictor of five-year survival and recurrence in patients with HNC (MD Anderson, 2015). Undetected and untreated depression in patients with cancer can increase cost of care by involving additional services by providers, hospitals, and healthcare organizations (Pan & Sambamoorthi, 2015). The incidence and subsequent complications seen with the occurrence of depressive symptoms in the HNC population support the need for standardized methods in screening for, diagnosing, and treating MDD.

The high incidence of MDD and suicide rates among patients with HNC may be related to the location of cancers in the hypopharyngeal, laryngeal, and oral cavity regions, which are associated with a patient's ability to speak and swallow (Kim et al., 2016). Loss of speaking and swallowing functions can dramatically decrease a patient's quality of life (QOL) (Kim et al., 2016). Other HNC-related factors, such as tube-feeding dependency, inability to speak, neck disfiguration, noisy breathing, increased mucus production, and dietary modifications, can lead to anger, low self-esteem, and social isolation (Kam et al., 2015). Symptoms related to HNC treatment with surgery, chemotherapy, and/or radiation therapy include increased pain, fatigue, insomnia, and worsened dysphagia; poor wound healing, decreased weight, and anorexia all can lead to depression and MDD (Haisfield-Wolfe, McGuire, Soeken, Geiger-Brown, & De Forge, 2009). Adverse HNC-related symptoms and factors contribute to a vicious cycle of depression and MDD with potential for suicidal ideation (Kam et al., 2015).

Earlier identification of depression is important because 40%–57% of patients with HNC will develop MDD at the time of diagnosis or during treatment (Barber et al., 2016; Lydiatt et al., 2013). Research has shown that 25% of patients with HNC develop depression prior to treatment (Verdonck-de Leeuw, Cuijpers, &