

Management of Mood Changes Related to Treatment-Induced Menopause

Ms. R has been a patient in an ambulatory clinic since her diagnosis of breast cancer 14 months ago. At the age of 42, suspicious calcifications were found on routine mammography. Ms. R was found to have multifocal, infiltrating ductal carcinoma with widespread ductal carcinoma in situ of the right breast, node negative. A modified radical mastectomy with immediate reconstruction was followed by six cycles of cyclophosphamide, methotrexate, and fluorouracil (CMF). She began treatment with tamoxifen upon completing her chemotherapy protocol.

Ms. R's diagnosis was preceded by a recent divorce that left her a single mother of three young children. Immediately prior to her diagnosis, she had returned to work part-time and just started to date. Ms. R told her nurse many times over the past 12 months how emotionally challenging and draining the past two years had been; however, her attitude always was strong and positive. During a follow-up appointment, Ms. R expressed overwhelming fatigue and irritability. She stated that the past six months had been extremely challenging both physically and emotionally. She said, "I don't feel like myself anymore."

In addition to fatigue and irritability, Ms. R complained of mood swings, hot flashes with night sweats, and sleep disturbances. She expressed particular frustration with the hot flashes she experienced throughout the past six months. She felt that they had not decreased in intensity or duration; the hot flashes occurred several times a day and caused her to wake several times a night in a complete sweat. On further assessment, Ms. R denied a clinical history of anxiety or depression but stated that she now felt increasingly sad and overwhelmed. Members of her immediate family, including her mother, had a history of untreated depression and anxiety. This concerned Ms. R, and she feared that she was being swept into a "dark tunnel."

Ms. R's medication profile included daily tamoxifen, multivitamins, and ibuprofen as needed. On this clinic visit, Ms. R's physical examination was unremarkable with no evidence of disease recurrence. She became amenorrheic after her second cycle of CMF. Although she felt that she had been forewarned about treatment-induced menopause, she stated that the symptoms now seemed an unfair consequence. She had found that using

Replens® (LDS Consumer Products, Cedar Rapids, IA) managed the vaginal dryness she experienced but the hot flashes seemed intolerable since beginning tamoxifen treatment. As she is fair skinned with red hair, Ms. R joked about feeling like she was "on fire" more often than not. She described the hot flashes as a burning sensation that came over her body in waves and left her feeling "shaky and sweaty." The hot flashes were most disturbing at night and frequently woke her up; she often saturated her clothes and bed linens with perspiration.

Ms. R expressed that her lack of sleep contributed to her irritability with her family. She had bouts of crying, and most mornings described "dragging myself out of bed to try and face another day." Ms. R was openly tearful when confiding her feelings of overwhelming sadness and despair. Wringing her hands, she appeared anxious and distressed.

Nancy Jo Bush, RN, MN, MA, AOCN®
Lecturer/Assistant Clinical Professor
Graduate School of Nursing
University of California, Los Angeles

Clinical Problem Solving

In addition to Nancy Jo Bush, responding to this clinical challenge are Paula Anastasia, RN, MN, OCN®, a clinical nurse specialist in gynecologic oncology at Cedars-Sinai Medical Center in Los Angeles, CA, and Traci Young, RN, MSN, OCN®, an oncology nurse practitioner, and Linda Bosserman, MD, a medical director, both at Wilshire Oncology Medical Group, Inc., in Pomona and Rancho Cucamonga, CA.

Multiple variables, both emotional and physical, appear to influence Ms. R's mood state. What assessment criteria should be focused on?

N. Bush: Taking a detailed history, carrying out a review of systems, and completing a thorough physical examination are critical in making an accurate diagnosis and individualizing Ms. R's treatment plan. Ruling out disease recurrence is important, as well as identifying the physical symptoms that negatively affect Ms. R's quality of life. The healthcare team must include Ms. R's history of cancer and cancer treatment(s), current

medications (both prescribed and over the counter), and her history of presenting symptom(s), including precipitating factors, onset, and duration (St. Marie, 2000). In this case, differential diagnosis also should include mood disturbance versus clinical depression exacerbated by the metabolic and endocrine changes caused by treatment-induced menopause. A careful personal and family history of depression and psychiatric illness should be investigated concurrently with the patient's associated symptoms related to her mood (e.g., sadness, teariness, insomnia, change in appetite and activity level, suicidal tendencies) (St. Marie).

What is the recommended screening for cancer-related depression?

N. Bush: Researchers have recommended that patients with cancer should be screened for episodes of persistent sadness every two weeks. These serial assessments should continue not only during the first month of treatment but, ideally, throughout follow-up to evaluate confounding effects of cancer and its treatment (Lovejoy, Tabor, Matteis, & Lillis, 2000). As in the case of Ms. R, the hormonal and physical symptoms brought on by treatment-induced menopause clearly have confounded her previous stress and the personal loss that she was experiencing even prior to her cancer diagnosis. At the time of her diagnosis, Ms. R recently was divorced and challenged with reorganizing her emotional and financial life. Her social support system had changed dramatically, and she was attempting to begin a new, intimate relationship. The physical and emotional impact of her diagnosis, mastectomy, and chemotherapy treatments were life-changing and became overwhelming because of an accumulation of stressors combined with a depleted level of personal and psychosocial resources. When the continuum of cancer extends over long periods of time and the side effects of

The solutions offered to the clinical problems posed in this column are the opinions of the authors and do not represent the opinions or recommendations of the Oncology Nursing Society, the Oncology Nursing Forum, or the editorial staff.

Digital Object Identifier: 10.1188/02.ONF.1269-1272