



FEATURES OF PSYCHOPATHOLOGICAL DISORDERS IN A MALIGNANT TUMOR OF THE ABDOMINAL CAVITY

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ABSTRACT

In Russia, gastric cancer consistently ranks 2nd in the structure of cancer incidence after lung cancer in men and breast cancer in women. The intensive rate of gastric cancer incidence in 2001 in Russia was 2001 \pm 32.7 cases per 100 thousand of the population in 2001, the death rate from gastric neoplasms in Russia in 2001. 2001 \pm . Cleft 29.7 per 100 thousand of the population. [4] Психопатологические проблемы на различных этапах лечения и адаптации к болезни [2,4]. Однако, психиатрическая помощь онкологическим больным не очень хорошо развита и знания о психическом состоянии больных ограничены. Некоторые исследования были проведены для изучения психического здоровья и качества жизни у пациентов с дуоденальным раком [3,6]. Тревога и депрессия являются распространенными психологическими симптомами у онкологических больных [11, 12]. Шкала тревожности и депрессии в больнице (HADS), разработанная Сигмондом и Снайтом [8], является одним из наиболее часто используемых инструментов для измерения тревожности и депрессии у онкологических больных, включая дуоденальный рак. Она была применена к широкому кругу заболеваний [10], и многочисленные исследования были проведены для проверки психометрических свойств шкалы [11]. Многочисленные исследования были проведены для изучения влияния социально-демографических и клинических переменных на тревожность и депрессию [4,8].

Purpose of the study. To study the features of psychopathological disorders in malignant tumour of the abdominal cavity.

Material and methods of research. This study was conducted at the specialized Republican Cancer Research and Practice Center of the Bukhara branch. During the period from January 2011 to January 2012, 44 cancer patients who were treated in this hospital were eligible to participate in this study. 1 года по 44 онкологических больных, проходящих

Participants were invited to participate in the study if they had a malignant tumor of any location and stage of the disease, and they were at least 18 years old. Tumor formations and stage of the disease did not serve as exclusion criteria. Patients were informed about the study objectives and asked to participate and give informed consent. Medical data was taken from medical records stored at the hospital. The control group consisted of the second stage of cancer patients of duodenum 12. The sample consisted of 12 men with an average age of 57.3 years. The average age of this group was 44.6 years. All patients gave informed consent.

Results and their discussion. HADS consists of 14 items, seven of which indicate anxiety, and the remaining seven indicate depression. The response format offers four possible responses, which are evaluated with values ranging from 0 to 3. This results in scale values from 0 to 21 for each scale. The authors of the original test identified three ranges for both scales: 0-7 (non-cases), 8-10 (doubtful cases), and 11-21 (cases). It is possible to calculate the overall HADS score by simply summing up the elements of anxiety and depression [9]. In addition to HADS, two additional questionnaires were used. The European Organization for Research and Treatment of Cancer Quality of Life questionnaire consists of 30 items that relate to five functional scales (physical, role, emotional, social, and cognitive functioning), four symptom scales (fatigue, pain, and nausea/vomiting), a two-point global health scale, and six one-point scales (shortness of breath, loss of sleep), insomnia, constipation, diarrhea, and financial difficulties). Higher functioning scores represent better HRQL functioning, while higher symptom scores represent more severe symptoms. A multi-dimensional fatigue inventory was used to measure fatigue, and it evaluates five aspects of fatigue: general fatigue, physical fatigue, decreased activity, decreased motivation, and mental fatigue. Each subscale consists of four points scored with values from 1 to 5. Higher scores reflect a higher level of fatigue. We also calculated the total score of 1 for all 20 points. Of the eligible patients, 44 (95.9%) gave informed consent and completed questionnaires. The most common types of cancer were colon cancer (19.2%) and peri-colon cancer (16.8%). The distribution of the tumor stage was as follows: stage 1 (21.2%), stage 2 (23.8%), stage 3 (21.9%), and stage 4 (34.7%). Comparison of the mean values of stage 1 patients shows that 2,3,4 stage 12 duodenal tumor patients had a higher level of psychological stress than stage 1 duodenal tumor patients. This difference was especially high on the depression scale. All but one of the 14 points showed higher averages. One item (A3: feeling afraid) showed the opposite trend. The largest difference between stage 1 and stage 2 cancer patients was found for depressive item D14, where an effect of size greater than 1 was observed. The distribution of three categories (absence, doubtful, severe cases of anxiety and depression) in the two samples is presented in Table 1. Categorical distribution of anxiety and depression

stage	Anxiety	Depression	n	%	n	%	n	%	n	%
No cases	2	20.4	5	33.0	3	27.2	2	10.4	4	18.1
Questionable cases	4	18.7	41	22.9	3	26.3	4	18.1	28	30.9
Severe cases	2	20.4	5	33.0	3	27.2	2	10.4	21	44.0
	20.0	10	13.5							

Latent variables of anxiety and depression were correlated with $r = 0.88$, while the correlation of average scores of anxiety and depression was $r = 0.75$. All downloads were in the range from 0.55 to 0.76, the lowest download was found for the product D14 (book/TV) with a coefficient of 0.55. The influence of socio-demographic and clinical variables on anxiety and depression in cancer patients was shown. Neither age nor gender was significantly associated with anxiety and depression. Patients with low levels of education were more depressed than

their more educated counterparts. There was an almost linear increase in anxiety and depression with the tumor stage. Patients who received surgery or chemotherapy were less anxious and less depressed than patients who did not receive cancer treatment.

Conclusions. Comparison between stage 1 and 2 duodenal cancer patients showed that stage 2 and stage 3 patients were more anxious ($d = 0.28$) and more severely depressed ($d = 0.94$) than stage 1 patients. Nevertheless, the high level of mental stress of cancer patients suggests that there are unrecognized and unmet needs for psychosocial care. Anxiety and depression were associated with the stage of the tumor. Patients with stage 3 cancer had the highest rates of depression. Although the association between tumor stage and depression is easy to understand, it is interesting to note that patients who received medication (surgery or chemotherapy) were significantly less anxious and less depressed than patients who did not receive such treatment. One possible reason is that cancer treatment is primarily focused on patients with a lower stage of the tumor, while patients with stage 3 cancer often do not receive such treatment. Another possible reason may be that the very fact of receiving medical care and treatment (regardless of the medical impact of such treatment) has a greater beneficial effect on the mental state of patients.

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