

Claustrophobia in an oncologic patient: a life-saving treatment

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Dear Editor,

Patients with head and neck cancer (HNC) are immobilized with a thermoplastic mask to ensure accurate radiotherapy (RT) delivery and avoid surrounding structures¹. The immobilization process requires fitting a mask firmly to secure the patient to the treatment couch².

Use of the mask often engenders the patients anxiety to an extent which is not only distressing for the patient but also affects the departments operations through disruption of treatment, longer waiting times for other patients and distress of staff³. At times, it may be necessary to suspend a treatment procedure after a period of time or, in some cases, this form of intervention is not successful and other strategies may be required, such as a referral to psycho-oncology to manage the level of anxiety².

Here we report a clinical case of a 62-year-old male. He was proposed for intensive RT due to an HNC. The patient was immobilized but the planned computed tomography scan (CT) was not performed due to claustrophobia. CT had to be rescheduled and Psychiatry Unit was requested to attend to the patient.

In our psychiatric consultation, the patient reported his first phobic symptoms due to fear of enclosed spaces during his first magnetic resonance imaging scan (MRI), a few months before. He felt so distressed and breathless that the MRI had to be interrupted and was only successfully performed a few hours later. On the RT treatment day, the patient tried to prepare himself by doing some preemptive breathing exercises, but by the time of the planned CT with the mask he felt so anxious that the procedure had to be suspended.

The patient denied previous phobic symptoms or other personal psychiatric history. His family record was also negative. He had also no toxophilic habits (tobacco, illicit substances or alcohol). His only medical comorbidity was Parkinson disease, which was stabilized. He has an adjusted personality, with some recognized anankastic and alexithymic traits "very organized, has everything under control, no time for emotions". He usually reacts with anxiety to the unexpected.

During our psychiatric observation, the patient presented intrusive thoughts that he would not be able to do RT treatment, with great difficulty in identifying associated cognitions. He did not present any symptoms (cognitive or other) of a depressive nature, showing a good self-concept, and describing his personal achievements with evident pride. He did not have any psychotic

symptoms. Critical judgment was maintained, as well as perception of oncologic diagnosis, its severity, and treatment alternatives.

For clinical case management, we suggested self-taught strategies (breath regulation, relaxation and meditation), cognitive-behavioural therapy, and use of medication (Alprazolam 0.25mg three times per day). We also explained the cognitive rationale of anxiety and scheduled a gradual exposure session for desensitization with the mask held. The session was done one week later, successfully.

Two weeks later, in our psychiatric consultation, the patient was very satisfied since he successfully underwent the first RT session. He described moments of cognitive and neuro-vegetative anxiety throughout the session. He managed it with previously learned cognitive and behavioural strategies (information/physiology of anxiety, distraction techniques, breathing control) and use of medication (Alprazolam 0,25mg).

Our psychiatric team followed the patient throughout the course of his RT treatment, which was concluded successfully, gradually decreasing the medication until its suspension, and discharged him from Psychiatric consultation.

Given the negative survival sequelae associated with distress in the HNC population and that mask anxiety is a well-identified contributor to distress, it is essential for patient care that cancer centres have an understanding of mask anxiety with the HNC population receiving RT⁴. A higher level of patient distress before and during RT is associated with a poorer outcome after RT⁵. One fast-acting intervention for mask anxiety is the use of medication³. Self-taught strategies such as breath regulation, meditation and visualisation are also helpful in minimizing mask anxiety during RT for HNC⁴.

There is a need to consider distress and a patient's subjective treatment expectations, since early intervention may mitigate the consequences.

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