

SUICIDE AND EPIDEMIOLOGY AND RISK FACTORS IN ONCOLOGICAL DISEASES

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Abstract. *The messages of the days allocated according to the calendar are combined with an interdisciplinary and interdepartmental approach, methodological foundations of the organization and practice of psychiatry, suicide and Psycho – Oncology in the cross-fields of Psychiatry, Psychology and sociology. The field of synthetic knowledge includes biopsychosocial aspects of carcinogenesis, manifestations, course and outcomes of cancer, "normal" emotional reactions and behavior, mental disorders of cancer patients at all stages of disease and treatment, diverse and elastic needs of the patient and his environment, burden of family and professionals, protective (sanogenic) factors [2, 3].*

Keywords: *suicide, epidemiology, risk factor, mental disorders, cancer.*

Introduction. Retrospective population studies based on national registers covering millions of people with catamnesis over several decades have identified a standardized mortality ratio (SMR) in race, gender, age, diagnosis based on cancer suicide. The risk of cancer, suicide of men and women is 2-4 times higher than in the total population of Europe, Australia, Japan and the United States [1-6]. SMR 1-11 (in pancreatic cancer) means that cancer suicide rates (US) are 100-110% higher than in a comparable population. Early diagnosis, the success of treatment, and a decrease in the rate of cancer suicide associated with citizen awareness of cancer are encouraging. Palliative care (Hospis, home care) reduces suicide rates, increases the quality of life of cancer patients. Biopsychosocial risk factors for cancer suicide behaviors are partially consistent and correlated [7-13].

They are similar and different from suicide in physical and physical patients with other diseases. Many-serve as risk and depression factors in cancer. General (sociodemographic, psychiatric) factors [11-14]. Race (white), age (≥ 65 years-the risk increases with age), gender (male). History of psychiatry: depression, surfactant abuse; impulsive behavior (borderline personality disorder); the history of suicidal behavior in the family, attempts to commit suicide in the past (the most important prognostic factor of suicide). Social (functional) factors: recent (actual) loss: death of a loved one (including from cancer), helplessness, low social support, loneliness [15-20]. Unemployment (unemployment, disability), role, domestic, everyday dysfunction. Clinical factors: depression (not necessarily expressed by syndrome) and/or anxiety with feelings of helplessness (depression) frustration, frustration, burden on yourself and those around you. Abuse of surfactants [21-25]. Psychosocial anxiety. Existential "barrier". Fear of the future. Refusal of treatment, violation of the treatment regimen. Lack of vigilance of uneducated employees, family. Distrust. Access to suicide AIDS (drugs, catheter, duct tube). (Special) factors associated with cancer. Diagnosis recently (up to a year). The location of the tumor (especially in harmful smokers and potatoes) [26-31]. Advanced (metastatic) stages; poor prognosis (small

chance of 5 years of survival). Side effects of chemo-radiotherapy on the subjective painful effect (inhibition, hormonal disorders, postoperative defects). Physical symptoms: chronic pain, fatigue, fatigue. Deficiency symptoms: restriction of mobility, life management. Unwanted actions of therapy [32-37].

Confusion with impulsive behavior. Media (reproducing low-quality reports of suicidal behavior of people with cancer). False concepts (myths) about the nature, possibilities, treatment alternatives (risk-benefit balance) and consequences of cancer [38-42].

The purpose of the study. Show reserves to study the prevalence and Risk Factors of suicide behavior in cancer, improve statistics and identify risk factors for suicide behavior.

Materials and methods. Literary Review, original studies.

Results and their discussion. "Sample portrait" of cancer patients at high risk of suicide: recent (<1 year old) with lung (or pancreatic, head and neck, prostate) tumors in advanced stages with metastases, but late diagnosed single impulsive elderly pensioner (≥ 65 years old), potator and / or harmful smoker suicide attempt, refusal of treatment with a history of depressive conditions. In this regard, the issue of early diagnosis of cancer and adherence to treatment is relevant, and avoiding it is associated not only with the internal appearance of the disease, but also with the balance of benefits (control of signs and course of the disease) / harm (unwanted actions). The study of mortality risk factors for non-cancer cancers improves early interventions and high quality of life. Research limitations. Cancer registers do not contain data on Cancer Risk Factors and suicidal behavior: heredity, medical and psychiatric comorbidity, surfactant abuse (tobacco smoking and alcoholism), suicide history, microsocioal conflicts. The actual rate of suicide for cancer patients, like the general population, does not want to report suicide at different levels, starting with the level of family and lower police, as in Durkheim a century ago. Suicide was covered by death from the underlying disease, not recognized in death reports, administrative databases. Most likely, death from a fall, overdose of drugs (sleeping pills, drugs), especially diagnosis and exacerbation of the flow – a hidden suicide Depot. Medical and psychiatric morbidity is associated with the search for help, and the actual population of cancer patients exceeds that recorded in the register. As a result, the proportion of confirmed suicides for cancer in the Russian Federation is $< 1/3$. Only suicidal behavior is taken into account, which led to serious medical consequences (hospitalization), became the subject of forensic examination, resonated thanks to the media.

Typically, retrospective cohort studies combine heterogeneous samples of oncological patients (diversity of types and stages of tumors, terms of treatment, criteria and methods, evaluation periods, screening), the most severe ones ("clinical illusion" is possible). In the death composition of the population of Russia, malignant neoplasms occupy the third place after diseases of the circulatory system (15%) (55%); suicide is the most common cause of death (15%) from external causes of Russians and the sixth (1,5%) in the ranking of causes of death in the Russian Federation (in the USA – tenth). Every day > 800 cancer (1/10 of those registered) die and 100 Russians die from suicide. The proportion of cancer among suicides at the Federal level is unknown. Part of the suicide is carried out by individuals whose cancer diagnosis is not confirmed, possibly accompanied by pre-cancer manifest depression or an unrecognized process. The average 5-year life expectancy of cancer patients in the Russian Federation is 50%, compared with 65% in the world 10 years ago and 80% in the United States. The high rate of annual mortality is explained by a delayed diagnosis: in 45% of cancers, in 3-4 stages.

The messages of the days allocated according to the calendar are combined with an interdisciplinary and interdepartmental approach, methodological foundations of the organization and practice of psychiatry, suicide and Psycho – Oncology in the cross-fields of Psychiatry,

Psychology and sociology. The field of synthetic knowledge includes biopsychosocial aspects of carcinogenesis, manifestations, course and results of cancer, "normal" emotional reactions and behavior, mental disorders of cancer patients (ob) at all stages of disease and treatment, diverse and elastic needs of the patient and his environment, burden of family and professionals, protective (sanogen) factors. An integral element of the suicide prevention program is to highlight the target group of individuals at high risk of suicide movement (SP). Chronic diseases of the body and their consequences are typical causes and causes of suicidal behavior, but suicide is a tragic end to life, regardless of the state of health of the victim.

Body disease is a risk factor for suicide behaviors documented by state registers in both depression and Alcohol Abuse Control, but the risk of mental illness and suicide behavior is higher in combined physical disorders. Cancer is the only chronic somatic disease (not arterial hypertension, coronary artery disease, or diabetes mellitus) associated with an increased risk of suicide in men and women after controlling the effects of mental illness and medical comorbidity. Epidemiology of suicide behavior for cancer patients. Retrospective (typically) population studies based on national registries covering millions of people with catamnesis have been standardized over several decades on cancer suicide mortality rate (standard mortality rate or SMR) race, gender, age, diagnosis. The risk of suicide is 2-4 times higher than that of cancer patients, men and women, the general population of Europe (England, Denmark, Italy, Norway, Switzerland, Sweden, Scotland, Finland, Estonia), Australia, Japan, the United States. The suicide rate (US) of SMR 1-11 (pancreatic cancer) is 100-1100% higher than the comparable population for cancer patients. Thus, the suicide rate in a malignant tumor, regardless of location, is twice that of the US population, with a suicide rate for cancers in Taiwan 7 times higher than in other countries, which raises the question of the importance of taking into account the frequency of cancer types, the manifestation of ethnocultural depression. At the same time, suicide in western Europe and the United States determines 0,2-0,5 percent of cancer deaths. The proportion of cancers (diagnosis not always lifetime) among Permian suicides was 6% (6% male and 8% female). The gradual decline of suicide rates in Norway in 1960-1999 corresponded to the general population trend.

In 1985-1999, the suicide rate of cancer patients in Catholic Italy declined with the suicide rate of the population traditionally with strong family ties. Early diagnosis, success of treatment, decreased suicide rates for cancers associated with citizen awareness of cancer are encouraging. In the 350,000 cancer groups, suicide rates dropped after screening for Prostate Specific Antigen (1993-2004), which remained high in metastases. Palliative care (Hospis, home care) reduces suicide rates, increasing the quality of life (CF) for cancers. However, after controlling for intervening factors, the decline in suicide rates is negligible for those with cancer in South East England. In 2001-2006, when suicide rates were low, the proportion of cancer in the suicide Massif increased from 1% to 2,5%; in the capital of the Republic (with the best status of suicide behavior?) From 3 to 5,5%.

Biopsychosocial risk factors for cancer suicide behaviors are partially congruent and cumulative. They are similar to and differ from suicidal factors in physical and physical patients with other diseases.

Socio-demographic characteristics. Race, sex, age. the suicide rate of people with cancer is higher in white men. They do not tolerate pain and functional limitations. The risk of children's suicide behaviors has not been recorded, but at the age of 20-39, cancer is the second cause of suicide in addition to depression: in 60% of 15-30 – year-old cancers (Sweden), the risk of suicide behaviors increases. the rate of suicide increases with the age of diagnosis – in adulthood (55-65 years old), with the highest ≥ 80 , which is not always clear. The average age of Russians, men and women with cancer, at approximately equal incidence is 64 years, while suicide victims, men and

women, are 42 and 44 years old, respectively, but the suicide rate of the elderly is several times higher than the average.

The suicide rate of elderly people with cancer (the bulk of subpopulation) is higher in controlling the risk of mental illness and death within a year than their peers with other body diseases. With the aging of the population, an increase in the share of ob and suicide can be expected.

Conclusions. Many cancer patients never commit suicide in the "understandable" state of the motive in the most severe and desperate conditions, but the risk of suicide increases in all stages of illness and treatment (the "important" points of maximum risk are highlighted), including long-term remissions. Some groups of cancer are characterized by a high level of suicide behavior and serve primarily as the goal of therapeutic and preventive (anti-crisis) measures. The degree of suicidal behavior of cancer sufferers is an indirect indicator of the quality of daily assistance (timely diagnosis and diagnosis algorithm, informed consent to "friendly" combined treatment: safe, well tolerated and effective, which allows timely control of somatic and mental symptoms that cause the greatest sadness). Dynamics of suicidal behavior of people with cancer (compliance with population trend), local and gender differences, psychiatric severity in different types, stages and treatment conditions of Cancer, Epidemiology of suicidal behavior and equivalents of self-destructive behavior, general and special suicidal and protective (antisuicidal) factors. The burden of suicidal behavior should be objectified in a broad perspective (family, medical costs associated with suicide attempts).

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