Poster 64: Primary HPV Screening Outcomes in a Large Safety-Net Health System

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Topic
Quality of Life/Palliative Care

Objectives
Depression and anxiety are common among patients receiving chemotherapy and have been suggested to impact chemotherapy tolerance and toxicity. We evaluated whether psychiatric history and treatment were associated with the incidence or timing of chemotherapy-related toxicities in patients with ovarian cancer.

Methods
We performed a retrospective study of patients with ovarian cancer treated with first-line platinum–taxane–based chemotherapy at a single academic center (2022–2023). Demographic information, psychiatric history, baseline psychiatric medication or psychotherapy (defining mental health treatment), and treatment data were abstracted from the electronic health record. Toxicities (any grade, grade ≥3, and specific type) were recorded by cycle. Primary outcome was time to first chemotherapy-related toxicity up to 30 days after the last cycle. Secondary outcomes included time to toxicity types, healthcare utilization, and progression-free survival. Cox proportional hazards models and logistic regression models were adjusted for age, stage, planned treatment, and comorbidities.

Results
A total of 152 patients met inclusion criteria. Forty-seven (31%) patients had a documented mental health disorder, of which 29 (62%) of these patients received treatment with medication or psychotherapy. Baseline demographic and clinical characteristics, including age, race, stage, and comorbidities, were similar among patients with and without a documented mental health condition (all p>0.1). The majority of patients had at least one documented toxicity during their treatment; 20% of patients experienced a grade ≥3 toxicity with no difference by psychiatric history (21% vs 19%, p=0.7). Psychiatric history was not associated with need for dose reduction or treatment delay (Table 1). Median time to first toxicity varied by type; nausea/vomiting (24 days, IQR 21–46), peripheral neuropathy (42 days, IQR 21–71), fatigue (43 days, IQR 21–108), and myelosuppression (49 days, IQR 24–90). In multivariable Cox models, psychiatric history was not associated with time to first toxicity (untreated HR 1.43, 95% CI 0.84–2.45, p=0.19; treated HR 1.39, 95% CI 0.88–2.19, p=0.16). Interestingly, patients with untreated psychiatric conditions had earlier onset of myelosuppression (HR 2.16, 95% CI 1.01–4.62, p=0.046),whereas this was not the case for patients receiving treatment for their mental health disorder (HR 1.08, 95% CI 0.51–2.33, p=0.84). Untreated mental health conditions were associated with increased healthcare utilization, with higher odds of unplanned inpatient admission (OR 4.16, 95% CI 1.33–13.2, p=0.014), whereas treated mental health conditions were not (OR 1.14, 95% CI 0.33–3.49, p=0.87). There was no association between mental health disorders and PFS.

Conclusions
Although mental health history was not associated with overall toxicity timing or oncologic outcomes, untreated mental health conditions were associated with earlier myelosuppression and increased inpatient utilization. These findings suggest that patients with untreated underlying mental heath disorders may be at higher risk for clinically significant toxicity. Integration of mental health assessment and management into oncologic care may improve treatment tolerance and reduce healthcare utilization.

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Abstract Table or Graph

Outcome	No history of mental health disorder	Untreated mental health disorder (HR/OR, 95% CI)	p-value	Treated mental health disorder (HR/OR, 95% CI)	p-value
Time to first toxicity (overall)	Ref	1.43 (0.84–2.45)	0.19	1.39 (0.88–2.19)	0.16
Peripheral neuropathy	Ref	1.01 (0.51–1.99)	0.97	0.85 (0.46–1.55)	0.59
Nausea / vomiting	Ref	1.32 (0.70–2.51)	0.39	1.29 (0.73–2.28)	0.39
Fatigue	Ref	1.04 (0.51–2.13)	0.91	1.64 (0.93–2.89)	0.09
Myelosuppression	Ref	2.16 (1.01–4.62)	0.046	1.08 (0.51–2.33)	0.84
Dose reduction	Ref	0.67 (0.15–2.29)	0.56	0.97 (0.32–2.68)	0.96
Treatment delay	Ref	1.54 (0.32–5.73)	0.55	1.34 (0.34–4.52)	0.65
Inpatient admission	Ref	4.16 (1.33–13.2)	0.014	1.14 (0.33–3.49)	0.82
Progression-free survival	Ref	1.16 (0.51–2.63)	0.73	0.76 (0.35–1.65)	0.49

Table 1: Adjusted Cox Regression and Logistic Regression Analyses of outcomes in patients with or without a history of mental health disorder