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Clinical Updates: Literature Abstracts

MEASURES

Development of a Brief Assessment Scale for Caregivers of the Medically Ill

Glajchen, M., Kornblith, A., Homel, P. Fraidin, L., Mauskop, A., and Portenoy, R.

Journal of Pain and Symptom Management, *29* (2005), 245–254

Studies have documented high degrees of burden and negative outcomes for caregivers. The present study sought to develop a brief instrument for caregiver burden. An item pool was administered to 102 caregivers of patients with chronic illnesses (cancer, 55%; neurological, 15%; psychiatric 12%), along with measures of caregiver burden and quality of life. Item reduction was accomplished through content review and factor analysis. This yielded a 14-item Brief Assessment Scale for Caregivers (BASC) and an eight-item subscale measuring negative personal impact (NPI). Cronbach's alpha was 0.70 for the BASC and 0.80 for the NPI. Construct validity was confirmed by appropriate patterns of intercorrelation with other measures of caregiver burden. Higher burden was found for caregivers expected to have higher levels of distress (adult children caring for parents, $P < 0.005$; female caregivers, $P = 0.035$). These results support the validity of the BASC as a brief instrument for caregiver burden.

Fast, Systematic, and Continuous Delirium Assessment in Hospitalized Patients: The Nursing Delirium Screening Scale

Gaudreau, J., Gagnon, P., Harel, F., Tremblay. A., and Roy, M.

Journal of Pain and Symptom Management, *29* (2005), 368–375

Because no rigorously validated, simple yet accurate continuous delirium assessment instrument exists, we developed the Nursing Delirium Screening Scale (Nu-DESC). The Nu-DESC is an observational five-item scale that can be completed quickly. To test the validity of the Nu-DESC, 146 consecutive hospitalized patients from a prospective cohort study were continuously assessed for delirium symptoms by bedside nurses using the Nu-DESC. Psychometric properties of Nu-DESC screening were established using 59 blinded Confusion Assessment Method (CAM) ratings made by research nurses and psychiatrists. DSM-IV criteria and the Memorial Delirium Assessment Scale (MDAS) were rated along with CAM assessments. Analysis of these data showed that the Nu-DESC is psychometrically valid and has a sensitivity and specificity of 85.7% and 86.8%, respectively. These values are comparable to those of the MDAS, a longer instrument. Nu-DESC and DSM-IV sensitivities were similar. The Nu-DESC appears to be well-suited for widespread clinical use in busy oncology inpatient settings and shows promise as a research instrument.

SYMPTOM CONTROL

Predictors and Outcomes of Delirium

Minden, S., Carbone, L., Barsky, A., Borus, J., Fife, A., Fricchione, G., and Orav, J.

General Hospital Psychiatry, *27* (2005), 209–214

Our objective was to determine factors associated with the occurrence of delirium among patients undergoing surgical repair of abdominal aortic aneurysm (AAA). The sample included all consenting patients who underwent AAA repair during a 12-month period. Before surgery, daily while in hospital, and at 1 and 6 months after surgery, we assessed patients' mood, mental status and functional status. We compared delirious and non-delirious patients for severity of preoperative depressive symptoms, length of hospital stay and mortality. The effects of delirium on postoperative functional status were assessed in conjunction with postoperative depressive symptoms using regression models. The sample of 35 patients was primarily male and elderly; one-quarter had three or more medical conditions; and eight (23%) developed delirium after surgery. Postoperative delirium was significantly associated with preoperative depressive symptoms, alcohol use and cognitive impairment as well as with longer lengths of stay and poorer functional status at 1 and 6 months after surgery. Identification and treatment of

patients with depressive symptoms, alcohol use, and cognitive impairment prior to AAA surgery could reduce the incidence of postoperative delirium and the prolonged hospital stays and impaired functional status associated with it. Surgeons should consider using simple screening instruments before surgery to identify patients at risk and referring them for psychiatric evaluation and treatment. They should also consider including psychiatrists early in the care of high-risk patients to improve detection of and early intervention for delirium.

Insomnia in HIV Infection: A Systematic Review of Prevalence, Correlates, and Management.

Reid, S. and Dwyer, J.

Psychosomatic Medicine, *67* (2005), 260–269

Insomnia in people with HIV and AIDS has been widely but inconsistently reported. We present the results of a systematic review of the subject. MEDLINE, EMBASE, PSYCHLIT, and CINAHL databases were searched, and inclusion criteria were applied. The study results were then collated and described. Twenty-nine studies were identified, and there was wide variation in both method and quality. Insomnia was reported frequently and at all stages of HIV infection. Early reports of sleep-specific electroencephalographic changes were not confirmed. The role of immune dysregulation, virus progression, and adverse drug effects in contributing to insomnia is unclear. The presence of cognitive impairment, an AIDS-defining illness, and treatment with efavirenz were found to be significant risk factors, but the most notable association was with psychologic morbidity. There was limited evidence for the effect of specific treatments for insomnia in HIV infection. This review found that psychologic morbidity was a major determinant of insomnia in HIV infection. Further study would be of value in clarifying the role of other factors, as well as measuring the impact of insomnia on functioning and quality of life in this population.

Inflammatory Markers and Sleep Disturbance in Major Depression

Motivala, S., Sarfatti, A., Olmos, L., and Irwin, M.

Psychosomatic Medicine, *67* (2005), 187–194

This study was conducted to determine whether immune activation occurs in major depression, and to evaluate the associations between disordered sleep and markers of inflammation in patients with major depressive disorder. All-night polysomnography was obtained in patients with acute Diagnostic and Statistical Manual of Mental Disorders, 4th edition major depressive disorder ($n = 22$) and age-, gender-, and body weight-matched comparison controls ($n = 18$). After the onset of sleep, nocturnal serum levels of interleukin-6 (IL-6), soluble intercellular adhesion molecule (sICAM), monocyte chemotactic protein (MCP-1), and IL-6 soluble receptor (IL-6sR) were sampled. As compared with matched controls, depressed patients showed significant ($p < .05$) nocturnal elevations of circulating levels of IL-6 and sICAM. Both sleep latency and rapid eye movement (REM) density had moderate correlations with IL-6 and sICAM (r's $\geqq 0.30$). Backward regression analyses indicated that sleep latency ([beta] = 0.34, $p < .05$) and REM density ([beta] = 0.27, $p = .09$) were better predictors of IL-6 than depressive status. Similarly, sleep latency ([beta] = 0.27, $p = .06$) and REM density ([beta] = 0.32, $p = .02$) were also better predictors of sICAM. These findings support the hypothesis that sleep disturbance is associated with elevated levels of the inflammatory markers IL-6 and sICAM. This relationship was not accounted for by other confounding factors such as age and body weight. These findings suggest that the elevations in inflammatory markers found in depressive subjects may be partially the result of disturbances of sleep initiation found in this population.

The Placebo Response in the Treatment of Chronic Fatigue Syndrome: A Systematic Review and Meta-Analysis

Cho, H.J., Hotopf, M., and Wessely, S.

Psychosomatic Medicine, *67* (2005), 301–313

The placebo response is conventionally asserted to be high in chronic fatigue syndrome (CFS) because of the latter's subjective nature and obscure pathogenesis, but no systematic review of placebo responses has been undertaken. We report such a study. Patient expectation is known to be important in the placebo response. It is also known that CFS patients attending specialist clinics often have strong physical attributions regarding causation and hence skepticism about psychological or psychiatric interventions. If so, the placebo response in CFS may be influenced by the type of intervention according to its perceived rationale. We aimed to estimate the summary placebo response in clinical trials of CFS and to determine whether intervention type influences the placebo response in CFS. We searched Medline, Embase, Cochrane Library, PsychInfo, and the references of the identified articles, and contacted experts for controlled trials (randomized or

nonrandomized) of any intervention on CFS patients reporting the placebo response as a clinical improvement in physical or general outcomes. Data were extracted from the articles and validity assessment conducted by one reviewer and checked by a second. Meta-analysis and metaregression were performed. The pooled placebo response was 19.6% (95% confidence interval, 15.4–23.7), lower than predicted and lower than in some other medical conditions. The meta-regression revealed that intervention type significantly contributed to the heterogeneity of placebo response ($p = .03$). In contrast with the conventional wisdom, the placebo response in CFS is low. Psychological-psychiatric interventions were shown to have a lower placebo response, perhaps linked to patient expectations.

A Double-Blind, Placebo-Controlled Trial of Sibutramine for Olanzapine-Associated Weight Gain

Henderson, D., Copeland, P., Daley, T., Borba, C., Cather, C., Nguyen, D., Louie, P., Evins, A., Freudenreich, O., Hayden, D., and Goff, D.

The American Journal of Psychiatry, *162* (2005), 954–962

Weight gain is commonly observed with olanzapine treatment and can increase the risk for obesity, cardiovascular disease, hypertension, and diabetes mellitus. This study examined the effectiveness of sibutramine, an approved weight loss agent, in overweight and obese subjects taking olanzapine for schizophrenia or schizoaffective disorder. Each subject had a DSM-IV diagnosis of schizophrenia or schizoaffective disorder, had been taking a stable dose of olanzapine for at least 4 months, and had a body mass index of ≥ 30 kg/m^2 or ≥ 27 kg/m^2 plus at least one cardiovascular risk factor. In a 12-week double-blind, randomized, placebo-controlled study, 37 subjects received placebo or sibutramine (up to 15 mg/day). For the first 8 weeks all subjects participated in weekly group sessions focused on nutrition and behavioral modification. The sibutramine and placebo groups had no significant baseline differences on age, gender, education, ethnicity, diagnosis, weight, body mass index, and blood pressure. At week 12 the sibutramine group had significantly greater losses than the placebo group in weight (mean = 8.3 lb, SD = 2.4, versus mean = 1.8 lb, SD = 1.6), waist circumference, body mass index, and hemoglobin A_{1c}. There were no significant differences on most side effects, although the sibutramine group exhibited a mean increase in systolic blood pressure of 2.1 mm Hg (SD = 8.5), and anticholinergic side effects and sleep disturbances were at least twice as common in the sibutramine group. Sibutramine was an effective and well-tolerated adjunct to behavior modification for weight loss in patients with schizophrenia and schizoaffective disorder being treated with olanzapine.

Partner-Guided Cancer Pain Management at the End of Life: A Preliminary Study

Keefe, F., Ahles, T., Sutton, L., Dalton, J., Baucon, D., Pope, M., Knowles, V., McKinstry, E., Furstenberg, C., Syrjala, K., Waters, S., McKee, D., McBride, C., Rumble, M., and Scipio, C.

Journal of Pain and Symptom Management, *29* (2005), 263–272

This preliminary study tested the efficacy of a partner-guided cancer pain management protocol for patients who are at the end of life. Seventy-eight advanced cancer patients meeting criteria for hospice eligibility and their partners were randomly assigned to a partner-guided pain management training intervention, or usual care control condition. The partner-guided pain management training protocol was a three-session intervention conducted in patients' homes that integrated educational information about cancer pain with systematic training of patients and partners in cognitive and behavioral pain coping skills. Data analyses revealed that the partner-guided pain management protocol produced significant increases in partners' ratings of their self-efficacy for helping the patient control pain and self-efficacy for controlling other symptoms. Partners receiving this training also showed a trend to report improvements in their levels of caregiver strain. Overall, the results of this preliminary study suggest that a partner-guided pain management protocol may have benefits in the context of cancer pain at the end of life. Given the significance of pain at the end of life, future research in this area appears warranted.

Pain and Its Relation to Depressive Symptoms in Frail Older People Living in the Community: An Observational Study

Landi, F., Onder, G., Cesari, M., Russo, A., Barillaro, C., and Bernabei, R.

Journal of Pain and Symptom Management, *29* (2005), 255–262

The association of pain and depression represents an important health problem that is correlated with high rates of disability, morbidity, greater consumption of health care resources, and socioeconomic difficulties. Understanding the interaction between

pain and depression is an important issue in light of the fact that physicians frequently fail to accurately assess and diagnose pain symptoms, and that elderly patients suffering from pain are particularly likely to receive inaccurate treatments. The aim of the present study was to describe the prevalence of pain and to investigate the association between pain and depressive symptoms in a representative sample of frail elderly people living in the community (n = 5,372). The results show that more than 15% and 40% of elderly patients experienced pain less than daily and daily, respectively. The average score on the depression scale was significantly lower in patients without pain (2.5 ± 2.5) than patients with less than daily and daily pain (3.2 ± 2.5 and 3.6 ± 2.5, respectively) ($P < 0.001$). Without substantial differences between men and women, the rate of each depressive symptom was significantly and progressively higher among patients suffering less than daily and daily pain compared to those without pain. In conclusion, this study provides evidence from a large sample of frail elderly people that individuals suffering pain present an elevated risk to experience depressive symptoms. Treatment models that put together the assessment and the treatment of both pain and depression are indispensable for better outcomes.

Measurement of QTc in Patients Receiving Chronic Methadone Therapy

Cruciani, R., Sekine, R., Homel, P., Lussier, D., Yap, Y., Suzuki, Y., Schweitzer, P., Yancovits, S., Lapin, J., Shaiova, L., Sheu, R., and Portenoy, R.

Journal of Pain and Symptom Management, *29* (2005), 385–391

Recent reports suggest that methadone may prolong the QTc interval and cause torsades de pointes. This study was conducted to evaluate the prevalence of QTc prolongation during oral methadone therapy and identify factors associated with prolongation. Patients receiving oral methadone as treatment for chronic pain or addiction were eligible for the study. One hundred four patients who were receiving ≥ 20 mg methadone per day for ≥ 2 weeks underwent electrocardiograms to measure QTc interval duration. Sixty-three (61%) patients were male and 63 (61%) were receiving methadone maintenance for opioid addiction. The mean (± SD) age was 45.3 ± 9.4 years. The median (range) methadone dose was 110 mg/day (20–1200 mg/day); median (range) number of months on methadone was 12.5 months (1–444 months). The median (range) QTc interval was 428 msec (396–494 msec). Thirty-three percent had QTc prolongation (males 40%, females 20%; $P = 0.03$). No patient had a QTc longer than 500 msec. Significant dose response was observed in males on methadone <12 months (rho = 0.60, $P = 0.02$). Our study suggests that methadone may prolong the QTc interval in specific subpopulations but poses little risk of serious prolongation.

Acupuncture for Patients with Migraine a Randomized Controlled Trial

Linde, K., Streng, A., Jürgens, S., Hoppe, A., Brinkhaus, B., Witt, C., Wagenpfeil, S., Pfaffenrath, P., Hammes, M., Weidenhammer, W., Willich, S., and Melchart, D.

JAMA, *293* (2005) 2118–2125

Acupuncture is widely used to prevent migraine attacks, but the available evidence of its benefit is scarce. To investigate the effectiveness of acupuncture compared with sham acupuncture and with no acupuncture in patients with migraine. Three-group, randomized, controlled trial (April 2002–January 2003) involving 302 patients (88% women), mean (SD) age of 43 (11) years, with migraine headaches, based on International Headache Society criteria. Patients were treated at 18 outpatient centers in Germany. Acupuncture, sham acupuncture, or waiting list control. Acupuncture and sham acupuncture were administered by specialized physicians and consisted of 12 sessions per patient over 8 weeks. Patients completed headache diaries from 4 weeks before to 12 weeks after randomization and from week 21 to 24 after randomization.

Difference in headache days of moderate or severe intensity between the 4 weeks before and weeks 9 to 12 after randomization. Between baseline and weeks 9 to 12, the mean (SD) number of days with headache of moderate or severe intensity decreased by 2.2 (2.7) days from a baseline of 5.2 (2.5) days in the acupuncture group compared with a decrease to 2.2 (2.7) days from a baseline of 5.0 (2.4) days in the sham acupuncture group, and by 0.8 (2.0) days from a baseline if 5.4 (3.0) days in the waiting list group. No difference was detected between the acupuncture and the sham acupuncture groups (0.0 days, 95% confidence interval, −0.7 to 0.7 days; $P = .96$) while there was a difference between the acupuncture group compared with the waiting list group (1.4 days; 95% confidence interval; 0.8–2.1 days; $P < .001$). The proportion of responders (reduction in headache days by at least 50%) was 51% in the acupuncture group, 53% in the sham acupuncture group, and 15% in the waiting list group.

Acupuncture was no more effective than sham acupuncture in reducing migraine headaches al-

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though both interventions were more effective than a waiting list control.

Acustimulation Wrist Bands Are Not Effective for the Control of Chemotherapy-Induced Nausea in Women with Breast Cancer

Roscoe, J., Matteson, S., Morrow, G., Hickok, J., Bushunow, P., Griggs, J., Qazi, R., Smith, B., Kramer, Z., and Smith, J.

Journal of Pain and Symptom Management, *29* (2005), 376–384

This experiment examined the efficacy of an acustimulation wrist band for the relief of chemotherapy-induced nausea using a randomized three-arm clinical trial (active acustimulation, sham acustimulation, and no acustimulation) in 96 women with breast cancer who experienced nausea at their first chemotherapy treatment. Five outcomes related to wrist band efficacy (acute nausea, delayed nausea, vomiting, QOL, and total amount of antiemetic medication used) were examined. The five outcomes were examined separately using analysis of covariance controlling for age and severity of past nausea. There were no significant differences in any of these study measures among the three treatment conditions ($P > 0.1$ for all). Study results do not support the hypothesis that acustimulation bands are efficacious as an adjunct to pharmacological antiemetics for control of chemotherapy-related nausea in female breast cancer patients.

Cannabis Use in HIV for Pain and Other Medical Symptoms

Woolridge, E., Barton, S., Samuel, J., Osorio, J., Dougherty, A., and Holdcroft, A.

Journal of Pain and Symptom Management, *29* (2005), 358–367

Despite the major benefits of antiretroviral therapy on survival during HIV infection, there is an increasing need to manage symptoms and side effects during long-term drug therapy. Cannabis has been reported anecdotally as being beneficial for a number of common symptoms and complications in HIV infections, for example, poor appetite and neuropathy. This study aimed to investigate symptom management with cannabis. Following Ethics Committee approval, HIV-positive individuals attending a large clinic were recruited into an anonymous cross-sectional questionnaire study. Up to one-third (27%, 143/523) reported using cannabis for treating symptoms. Patients reported improved appetite (97%), muscle pain (94%), nausea (93%), anxiety (93%), nerve pain (90%), depression (86%), and paresthesia (85%). Many cannabis users (47%) reported associated memory deterioration. Symptom control using cannabis is widespread in HIV outpatients. A large number of patients reported that cannabis improved symptom control.

QUALITY OF PALLIATIVE CARE

Fear of Death and Good Death Among the Young and Elderly with Terminal Cancers in Taiwan

Tsai, J.S., Wu, C.H., Chiu, T.Y., Hu, W.Y., and Chen, C.Y.

Journal of Pain and Symptom Management, *29* (2005), 344–351

Fear of death is a common characteristic among palliative care patients. We might think that the elderly display a higher degree of acceptance of the inevitability and less fear in the face of death. This study was aimed at investigating the relationship between the death fear level and the good-death scale in two age groups. The study was conducted in 224 patients with terminal cancers admitted to the Palliative Care Unit in National Taiwan University Hospital during the period of January 1 through October 31, 2001. The mean age was 62.13 ± 15.47 years. The duration of admission in the elderly group was shorter than that of the younger group ($P < 0.05$). The severity of death fear decreased gradually in both groups after being admitted to the hospice ($P < 0.05$). However, the elderly (≥ 65 years of age) displayed higher levels of death fear than the younger group at two days before death ($P < 0.05$). A significant negative correlation was observed between the degree of death fear and the total good death score in both groups at two days before death ($P < 0.05$). The comprehensive care in the palliative care unit might relate to the relief of the death fear of terminal cancer patients. There is a need for psychological and spiritual care in elderly patients.

Depression, Correlates of Depression, and Receipt of Depression Care among Low-Income Women with Breast or Gynecologic Cancer

Ell, K., Sanchez, K., Vourlekis, B., Lee, P.Y., Dwight-Johnson, M., Lagomasino, I., Muderspach, L., and Russell, C.

Journal of Clinical Oncology, *23* (2005) 3052–3060

The purpose of this paper is to assess the prevalence of depression among low-income, ethnic minority women with breast or gynecologic cancer,

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receipt of antidepressant medications or counseling services, and correlates of depression.

Study patients were 472 women receiving cancer care in an urban public medical center. Women had a primary diagnosis of breast (stage 0 to III) or gynecologic cancer (International Federation of Gynecology and Obstetrics stage 0 to IIIB). A diagnostic depression screen and baseline questionnaire were administered before or during active treatment or during active follow-up. Self-report data were collected on receipt of depression treatment, use of supportive counseling, pain and receipt of pain medication, functional status and well-being, and perceived barriers to cancer care. Twenty-four percent of women reported moderate to severe levels of depressive disorder (30% of breast cancer patients and 17% of gynecologic cancer patients). Only 12% of women meeting criteria for major depression reported currently receiving medications for depression, and only 5% of women reported seeing a counselor or participating in a cancer support group. Neither cancer stage nor treatment status was correlated with depression. Primary diagnosis of breast cancer, younger age, greater functional impairment, poorer social and family well-being, anxiety, comorbid arthritis, and fears about treatment side effects were correlated with depression.

Findings indicate that depressive disorder among ethnic minority, low-income women with breast or gynecologic cancer is prevalent and is correlated with pain, anxiety, and health-related quality of life. Because these women are unlikely to receive depression treatment or supportive counseling, there is a need for routine screening, evaluation, and treatment in this population.

Side Effects and Cancer-Related Stress Determine Quality of Life in Long-Term Survivors of Testicular Cancer

Mykletun, A., Dahl, A., Haaland, C., Bremnes, R., Dahl, O., Klepp, O., Wist, E., and Fosså, S.

Journal of Clinical Oncology, *23* (2005), 3061–3068

The prevalence of long-term survivors after treatment for testicular cancer (TC) is increasing, and most studies display normal or only slightly reduced quality of life (QOL) in TC survivors (TCSs). Impaired QOL is claimed to be associated with treatment modality and its side effects, although most studies in this field can be criticized for various methodologic shortcomings. We wanted to examine variation in long-term QOL in TCSs in relation to TC treatment modality, side effects, and TC-related stress in a large population. QOL, side effects, and TC-related stress were self-rated by a questionnaire at a mean of 11 years of follow-up in 1,409 TCSs treated from 1980 to 1994. Norm data was obtained from 2,678 males who were representative of the general population. QOL was measured with the Short Form-36 (SF-36), and TC-related stress was measured with the Impact of Event Scale. There were no clinically relevant differences in QOL between TCSs and age-adjusted norm data, although there was a slightly lowered SF-36 Physical Component Summary Score in TCSs. Variation of QOL in TCSs was related to self-reported side effects and TC-related stress but not to TC treatment modality. A significant association was found between side effects and TC-related stress. TCSs do not suffer long term from reduced QOL, and only minor differences in QOL were found between different treatment modalities. TCSs who report more side effects or TC-related stress have increased risk for reduced QOL, but these associations are not explained by TC treatment modalities. Further QOL research in this area should explore vulnerability factors for side effects and TC-related stress.

Couples Who Get Closer After Breast Cancer: Frequency and Predictors in a Prospective Investigation

Dorval, M., Guay, S., Mondor, M., Mâsse, B., Falardeau, M., Robidoux, A., Deschênes, L., and Maunsell, E.

Journal of Clinical Oncology, *23* (2005), 3588–3596

Although some couples report an improved relationship since coping with breast cancer together, little quantitative information exists about this phenomenon. We assessed extent to which both couple members report that breast cancer brought them closer and characteristics that predicted this. This prospective study was based on all women with newly diagnosed nonmetastatic disease first treated during recruitment in four Quebec hospitals, in addition to their spouses. Participation was 87% among eligible patients and 91% among spouses of participating patients. Both couple partners were interviewed individually about quality of life at 2 weeks and 3 and 12 months after treatment start. At 12 months, each was asked whether the disease had brought them closer, distanced them, or had no effect. Overall, 42% of the 282 couples said breast cancer brought them closer, 6% had one or other partner reporting feeling distanced, and less than 1% of couples had both partners reporting feeling

distanced. Characteristics assessed explained 31% of variance in the proportion of couples getting closer ($P < .0001$). After taking into account partners' prediagnosis characteristics and the woman's treatment, the spouse reporting the patient as confidant ($P = .003$), getting advice from her in the first 2 weeks about coping with breast cancer ($P = .03$), accompanying her to surgery ($P = .057$), the patient's reporting more affection from her spouse at 3 months since diagnosis ($P = .003$) predicted both partners saying the disease brought them closer. Breast cancer can be a growth experience for couples under certain conditions. This information may help reassure patients and their spouses confronting this disease.

Somatoform Disorders: Time for a New Approach in DSM-V

Mayou, R., Kirmayer, L., Simon, G., Kroenke, K., and Sharpe, M.

American Journal of Psychiatry, *162* (2005), 847–855

DSM-III introduced somatoform disorders as a speculative diagnostic category for somatic symptoms "not explained by a general medical condition." Although retained and enlarged in DSM-IV, somatoform disorders have been the subject of continuing criticism by both professionals and patients. The extended period of preparation for DSM-V offers an important opportunity to reconsider the category of somatoform disorders. Exploration of the diverse aims of a diagnostic classification indicates that the authors must not only address the conceptual and practical problems associated with this category but also reconcile it with the parallel medical descriptive classification of functional symptoms and syndromes. The existing somatoform disorders categories require modification. The authors favor the radical option of the abolition of the categories. Diagnoses currently within somatoform disorders could be redistributed into other groupings, and the disorders currently defined solely by somatic symptoms could be placed on axis III as "functional somatic symptoms and syndromes." Greater use could be made of "psychological factors affecting medical condition" on axis I. The authors suggest supplementing the diagnosis of functional somatic symptoms with a multiaxial formulation. The authors promote a classification of somatic symptoms in DSM-V that is compatible with that used in general medicine and offers new opportunities both for research into the etiology and treatment of symptoms and for the greater integration of psychiatry into general medical practice.

PSYCHOSOCIAL INTERVENTION

Impact on Delirium Detection of Using a Sensitive Instrument Integrated into Clinical Practice

Gaudreau, J.D., Gagnon, P., Harel, F., and Roy, M.A.

General Hospital Psychiatry, *27* (2005), 194–199

Early symptoms of delirium often go unnoticed. The Nursing Delirium Screening Scale (Nu-DESC) is a recently developed short, accurate and sensitive 24-h screening instrument. The Nu-DESC is more sensitive than the instrument from which it was derived, the Confusion Rating Scale (CRS). This study examined the impact on delirium detection of using the Nu-DESC over the CRS in 134 consecutive oncology patients. Expected false-negative rate (FNR) reductions at different delirium prevalence rates when using the Nu-DESC compared to the CRS and the number needed to screen (NNS) by the Nu-DESC were calculated. Kaplan–Meier survival analyses were used to study Nu-DESC–CRS divergences in delirium status and length of delirium-free survival. Ninety-nine patients were negative for delirium according to both tests. Of the remaining 35 patients, 16 had identical Nu-DESC–CRS delirium status and delirium-free survival, whereas 19 were detected later by the CRS (mean, 4.8 days). Among the 19 patients, 6 were still CRS negative upon hospital discharge. Integrating a continuous and sensitive delirium assessment instrument into usual care can facilitate its recognition, since more cases of delirium are diagnosed and patients are detected earlier.

Physical Exercise in Cancer Patients During and After Medical Treatment: A Systematic Review of Randomized and Controlled Clinical Trials

Knols, R., Aaronson, N., Uebelhart, D., Fransen, J., and Aufdemkampe, G.

Journal of Clinical Oncology, *23* (2005), 3830–3842

Our purpose was to systematically review the methodologic quality of, and summarize the evidence from trials examining the effectiveness of physical exercise in improving the level of physical functioning and psychological well-being of cancer patients during and after medical treatment. Thirty-four randomized clinical trials (RCTs) and controlled clinical trials were identified, reviewed for substantive results, and assessed for methodologic quality. Four of 34 trials met all (seven of seven) method-

ologic criteria on the Delphi criteria list. Failure to conceal the sequencing of treatment allocation before patient recruitment, failure to blind the outcome assessor, and failure to employ an intention-to-treat analysis strategy were the most prevalent methodologic shortcomings. Various exercise modalities have been applied, differing in content, frequency, intensity, and duration. Positive results have been observed for a diverse set of outcomes, including physiologic measures, objective performance indicators, self-reported functioning and symptoms, psychological well-being, and overall health-related quality of life.

The trials reviewed were of moderate methodologic quality. Together they suggest that cancer patients may benefit from physical exercise both during and after treatment. However, the specific beneficial effects of physical exercise may vary as a function of the stage of disease, the nature of the medical treatment, and the current lifestyle of the patient. Future RCTs should use larger samples, use appropriate comparison groups to rule out the possibility of an attention-placebo effect, use a comparable set of outcome measures, pay greater attention to issues of motivation and adherence of patients participating in exercise programs, and examine the effect of exercise on cancer survival.

Home-Based Physical Activity Intervention for Breast Cancer Patients

Pinto, B., Frierson, G., Rabin, C., Trunzo, J., and Marcus, B.

Journal of Clinical Oncology, *23* (2005), 3577–3587

The efficacy of a home-based physical activity (PA) intervention for early-stage breast cancer patients was evaluated in a randomized controlled trial. Eighty-six sedentary women (mean age, 53.14 years; standard deviation, 9.70 years) who had completed treatment for stage 0 to II breast cancer were randomly assigned to a PA or contact control group. Participants in the PA group received 12 weeks of PA counseling (based on the Transtheoretical Model) delivered via telephone, as well as weekly exercise tip sheets. Assessments were conducted at baseline, after treatment (12 weeks), and 6 and 9 month after baseline follow-ups. The post-treatment outcomes are reported here. Analyses showed that, after treatment, the PA group reported significantly more total minutes of PA, more minutes of moderate-intensity PA, and higher energy expenditure per week than controls. The PA group also out-performed controls on a field test of fitness. Changes in PA were not reflected in objective activity monitoring. The PA group was more likely than controls to progress in motivational readiness for PA and to meet PA guidelines. No significant group differences were found in body mass index and percent body fat. Post-treatment group comparisons revealed significant improvements in vigor and a reduction in fatigue in the PA group. There was a positive trend in intervention effects on overall mood and body esteem.

The intervention successfully increased PA and improved fitness and specific aspects of psychological well-being among early-stage breast cancer patients. The success of a home-based PA intervention has important implications for promoting recovery in this population.

Physical Activity and Survival After Breast Cancer Diagnosis

Holmes, M., Chen, W., Feskanich, D., Kroenke, C., and Colditz, G.

JAMA, *293* (2005) 2479–2486

Physical activity has been shown to decrease the incidence of breast cancer, but the effect on recurrence or survival after a breast cancer diagnosis is not known. Our objective was to determine whether physical activity among women with breast cancer decreases their risk of death from breast cancer compared with more sedentary women. Prospective observational study based on responses from 2987 female registered nurses in the Nurses' Health Study who were diagnosed with stage I, II, or III breast cancer between 1984 and 1998 and who were followed up until death or June 2002, whichever came first. Breast cancer mortality risk according to physical activity category (<3, 3–8.9, 9–14.9, 15–23.9, or ≥24 metabolic equivalent task [MET] hours per week). Compared with women who engaged in less than 3 MET-hours per week of physical activity, the adjusted relative risk (RR) of death from breast cancer was 0.80 (95% confidence interval [CI], 0.60–1.06) for 3 to 8.9 MET-hours per week; 0.50 (95% CI, 0.31–0.82) for 9 to 14.9 MET-hours per week; 0.56 (95% CI, 0.38–0.84) for 15 to 23.9 MET-hours per week; and 0.60 (95% CI, 0.40–0.89) for 24 or more MET-hours per week (*P* for trend = .004). Three MET-hours is equivalent to walking at average pace of 2 to 2.9 mph for 1 hour. The benefit of physical activity was particularly apparent among women with hormone-responsive tumors. The RR of breast cancer death for women with hormone-responsive tumors who engaged in 9 or more MET-hours per week of activity compared with women with hormone-responsive tumors who engaged in less than 9 MET-hours per week was 0.50 (95% CI, 0.34–0.74). Compared with women

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who engaged in less than 3 MET-hours per week of activity, the absolute unadjusted mortality risk reduction was 6% at 10 years for women who engaged in 9 or more MET-hours per week. Physical activity after a breast cancer diagnosis may reduce the risk of death from this disease. The greatest benefit occurred in women who performed the equivalent of walking 3 to 5 hours per week at an average pace, with little evidence of a correlation between increased benefit and greater energy expenditure. Women with breast cancer who follow US physical activity recommendations may improve their survival.

Phase III, Randomized, Double-Blind Study of Epoetin Alfa Compared With Placebo in Anemic Patients Receiving Chemotherapy

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Our aim was to determine whether weekly epoetin alfa could improve hemoglobin (HgB) levels, reduce RBC transfusions, and improve quality of life (QOL) in patients with advanced cancer and with anemia after receiving myelosuppressive chemotherapy. This double-blind, placebo-controlled study randomly assigned patients to placebo or epoetin alfa (Ortho Biotech, Bridgewater, NJ) 40,000 U subcutaneous weekly for 16 weeks. QOL, HgB, and RBC transfusions were measured pretreatment and monthly. The study accrued 344 patients; 330 were assessable for efficacy and 305 were assessable for QOL. Placebo-treated patients had a mean increase in HgB of 0.9 g/dL (range, −3.8 to +5.3) compared with 2.8 g/dL (range, −2.2 to +7.5) for epoetin-treated patients ($P < .0001$). During the study, 31.7% of placebo-treated patients achieved a ≥2 g/dL HgB increase compared with 72.7% of epoetin-treated patients ($P < .0001$). The incidence of RBC transfusion for placebo and epoetin treatment arms was 39.6% and 25.3% ($P = .005$), respectively. The placebo group received 256 units of RBCs compared with 127 units in the epoetin group ($P < .0001$). The incidence of toxicity in the groups was similar. Changes in the average QOL scores from baseline to the end of the study were similar in the two groups (P = not significant). The HgB responders (irrespective of treatment arm) had a mean change in Functional Assessment of Cancer Therapy (FACT) fatigue score from a baseline of +5.1 compared with −2.1 for the nonresponders ($P = .006$). Epoetin alfa significantly improved HgB and reduced transfusions in this patient population. These results support the use of weekly epoetin alfa as an ameliorative agent for cancer-related anemia.

Weekly Epoetin Alfa Maintains Hemoglobin, Improves Quality of Life, and Reduces Transfusion in Breast Cancer Patients Receiving Chemotherapy

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Epoetin alfa administered at 40,000 U once weekly (qw) to anemic cancer patients receiving chemotherapy increases hemoglobin levels, improves quality of life (QOL), and reduces transfusions. The benefit of epoetin alfa in maintaining hemoglobin levels in cancer patients with hemoglobin less than 12 g/dL has not been evaluated. Breast cancer patients ($N = 354$) receiving chemotherapy were randomly assigned in 1:1 ratio to epoetin alfa (40,000 U qw) or standard of care (SOC). QOL was assessed at baseline and week 12. Hemoglobin responses, transfusion requirements, and prognostic factors for responses were measured. At week 12, Functional Assessment of Cancer Therapy–Anemia (FACT–An; mean, 2.16 ± 12.84 for epoetin alfa v −4.43 ± 13.42 for SOC) and FACT–An fatigue (mean, 1.85 ± 10.52 for epoetin alfa v −3.55 ± 11.14 for SOC) change scores were significantly higher in the epoetin alfa group ($P < .0001$). Hemoglobin responses defined as mean hemoglobin ≥12 g/dL or a ≥2 g/dL increase compared with baseline were significantly higher in the epoetin alfa group versus SOC: 52.0% v 5.1% and 65.7% v 6.3%, respectively ($P < .0001$ for both comparisons). Percentage transfused was significantly lower in the epoetin alfa group compared with SOC (8.6% v 22.9%). More than 90% of patients did not require a dose increase and 28.7% had a dose reduction. Epoetin alfa administered at 40,000 U qw is effective in improving QOL, maintaining hemoglobin level, and reducing transfusion requirements in breast cancer patients. The high effectiveness observed could be attributed in part to early treatment with epoetin alfa.