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Clinical Update: Literature Abstracts

MEASURES

What Is the Risk of Distress in Palliative Care Survey Research?

Takesaka, J., Crowley, R., and Casarett, D.

Journal of Pain and Symptom Management, *28* (2004), 593–598

To determine whether caregivers believe that interviews about end-of-life care are distressing and to identify patient and respondent characteristics associated with an increased risk of distress, distress was assessed in four studies that used family interviews. The setting was four Medicare-certified hospice organizations, the University of Pennsylvania Memory Disorders Clinic, and two nursing homes, and participants included 296 family members of seriously ill or recently deceased patients. For three of the studies, respondents described their distress on a 5-point scale. Distress was reported as either present or absent in the fourth study. Sixty-four respondents (22%) reported experiencing distress. Intensity of distress was higher for younger respondents (Spearman rho -0.16; $P = 0.013$), younger patients (Spearman rho -0.28; $P < 0.001$), and family members of patients with cancer (mean 0.55 vs. 0.24; Rank sum test $P < 0.001$). In a multivariable model, after adjusting for study population, younger patient age and cancer diagnosis were independently associated with the severity of distress. Sensitive questions about death and dying are unlikely to cause distress for family members. Although the likelihood of distress is low overall, investigators recruiting from these populations may improve the research by incorporating methods to assess and manage distress.

Diagnostic Accuracy of the Palliative Prognostic Score in Hospitalized Patients with Advanced Cancer

Glare, P.A., Eychmueller, S., and McMahon, P.

Journal of Clinical Oncology, *22* (2004), 4823–4828

The investigators evaluated the predictive accuracy of the Palliative Prognostic (PaP) score in patients with advanced cancer under the care of an oncologist. The PaP score was calculated in 100 consecutive patients with advanced cancer hospitalized under the care of a medical or radiation oncologist at a university teaching hospital in Australia. The attending oncologist predicted the survival duration for the purpose of the scoring. The positive predictive value of the PaP score was evaluated. Survival analysis was performed to compare the survival of the three prognostic groups. Assessable survival data were available for 98 patients. The overall median survival was 12 weeks (interquartile range, 7 to 25 weeks). The PaP score divided the heterogeneous patient sample into three isoprognostic groups related to the chance of surviving 1 month, with 64 patients in group A (>70% chance), 32 patients in group B (30% to 70% chance), and four patients in group C (<30% chance). The estimated median survival of the three groups was 17 weeks (95% CI, 12 to 26 weeks), 7 weeks (95% CI, 4 to 12 weeks), and less than 1 week (95% CI, <1 to 3 weeks), respectively. These survival differences were highly significant (log-rank test of trend, $\chi^2_1 = 25.65$; $P < 0.0001$). The 1-month survival of the groups was 97%, 59%, and 25%, respectively.

When oncologists' survival estimates are used, the PaP score is able to identify accurately three isoprognostic patient groups, irrespective of the cancer type. The PaP score may help reduce the uncertainty of formulating a prognosis in patients with advanced cancer.

Agreement among Family Members in Their Assessment of the Quality of Dying and Death

Mularski, R., Curtis, J.R., Osborne, M., Engelberg, R.A., and Ganzini, L.

Journal of Pain and Symptom Management, *28* (2004), 306–315

Improving end-of-life care requires accurate indicators of the quality of dying. The purpose of this study was to measure the agreement among family members who rate a loved one's dying experience. We administered the Quality of Dying and Death instrument to 94 family members of 38 patients who died in the intensive care unit. We measured a quality of dying score of 60 out of 100 points and

found moderate agreement among family members as measured by an intraclass correlation coefficient (ICC) of 0.44. Variability on individual items ranged from an ICC of 0.15 to 1.0. Families demonstrated more agreement on frequencies of events (ICC 0.54) than on determinations of quality (ICC 0.32). These findings reveal important variability among family raters and suggest that until the variability is understood, multiple raters may generate more comprehensive end-of-life data and may more accurately reflect the quality of dying and death.

Screening for Depression in the Medically Ill: A Comparison of Self-Report Measures, Clinician Judgment, and DSM-IV Diagnoses

Wilhelm, K., Kotze, B., Waterhouse, M., Hadzi-Pavlovic, D., and Parker, G.

Psychosomatics, *45* (2004), 461–469

The performance of the self-report 10-item Depression in the Medically Ill scale was observed in 210 patients as part of clinical assessment by consultation-liaison psychiatry clinicians. Both the Depression in the Medically Ill scale and the Beck Depression Inventory for Primary Care were completed by the patient, and the clinicians made their judgment of the presence and severity of "clinical depression" and DSM-IV affective disorder diagnoses. Both the Depression in the Medically Ill scale and the Beck Depression Inventory for Primary Care detected 85% of patients with DSM-IV major depressive episode. The Depression in the Medically Ill scale was slightly superior to the Beck Depression Inventory for Primary Care in its relationship to clinicians' judgments of clinical depression caseness.

Diagnostic Criteria for Psychosomatic Research and Psychosocial Variables in Breast Cancer Patients

Grassi, L., Rossi, E., Sabato, S., Cruciani, S., and Zambelli, M.

Psychosomatics, *45* (2004), 483–491

The aim of the study was to examine the relationship of the Diagnostic Criteria for Psychosomatic Research (DCPR) with psychosocial variables and quality of life among cancer patients. Of 105 women with breast cancer who participated in the study, 40 (38.1%) had symptoms meeting the criteria for at least one DCPR syndrome, and 30 (28.6%) had more than one DCPR syndrome. Health anxiety, demoralization, and alexithymia were the most frequent DCPR syndromes. Patients who were diagnosed with DCPR syndromes reported higher levels of cancer-related worries and poorer quality of life than those without a DCPR diagnosis. Analysis of the single DCPR clusters and coping with cancer indicated that health anxiety was related to higher scores on the Mini-Mental Adjustment to Cancer (Mini-MAC) anxious preoccupation subscale, DCPR demoralization was related to higher scores on the Mini-MAC hopelessness subscale, and DCPR alexithymia was related to higher scores on the Mini-MAC avoidance subscale. The study indicates the usefulness of the application of the DCPR in breast cancer, although further research is needed to improve the feasibility and internal validity of DCPR constructs.

The Parents' Postoperative Pain Measure: Replication and Extension to 2–6-Year-Old Children

Chambers, C.T., Finley, G.A., McGrath, P.J., and Walsh, T.M.

Pain, *105* (2003), 437–443

Pain assessment is a difficult task for parents at home following children's surgery. The purpose of the present study was to confirm the psychometric properties of a behavioral measure of postoperative pain developed to assist parents with pain assessment in children aged 7–12 years following day surgery. The study also examined the reliability and validity of the measure with children aged 2–6 years. Participants were 51 parents of children aged 7–12 years and 107 parents of children aged 2–6 years. For the 2 days following surgery, parents completed a pain diary that included global ratings of their children's pain and the 15-item Parents' Postoperative Pain Measure (PPPM). The older children provided self-reports of their pain intensity. The PPPM items showed good internal consistency on the two postoperative days for both samples (αs = 0.81–0.88) and scores on the PPPM were highly correlated with children's (for the older children) and parents' (for the young children) global ratings of pain (rs = 0.53–0.72). As global pain ratings decreased from days 1 to 2, as did scores on the PPPM. Scores on the PPPM were successful in discriminating between children who had undergone low/moderate and high pain surgeries. The results of this study provide evidence of the reliability and validity of the PPPM as a measure of postoperative pain among children aged 2 through 12 years.

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Psychometric Update of the Functional Interference Estimate: A Brief Measure of Pain Functional Interference

Ferguson, R.J., Seville, J., Cole, B., Hanscom, B., Wasson, J.H., Johnson, D.J., and Ahles, T.

Journal of Pain and Symptom Management, *28* (2004), 389–395

The Functional Interference Estimate (FIE) is a brief, 5-item self-report measure that assesses the degree to which pain interferes with daily functioning. Although the FIE has demonstrated reliability and validity with a small normative sample, not much is known about its reliability and validity with a broad sample of individuals with pain. The current study presents FIE score means, variability estimates, and reliability and validity data based on a large sample (n = 1,337) of primary care patients who report problematic pain. The FIE has excellent internal consistency and appears to have strong convergent validity with other well-established measures of function (e.g., SF-36 and Dartmouth COOP Charts). Because of its brevity and flexibility, the FIE may be a useful self-report measure of pain functional interference in clinical research on pain.

Towards a New Clinical Tool for Needs Assessment in the Palliative Care of Cancer Patients: The PNPC Instrument

Osse, B.H.P., Vernooij, M.J.F.J., Schadé, E., and Grol, R.P.T.M.

Journal of Pain and Symptom Management, *28* (2004), 329–341

This study describes a new clinical tool for needs assessment in palliative care: the Problems and Needs in Palliative Care questionnaire (PNPC). It was developed to support the provision of care tailored to the specific demands of patients, which only can be provided when their needs are clearly identified. To test validity and reliability, 64 patients with metastatic cancer living at home completed the PNPC. Of 140 initial items, 2 were deleted because of low response. No important topics were missing. Dimensions were proposed to organize the problems and needs in a logical and practical array for use in individual patients, and to enable statistical analysis of patient-groups. Reliability analysis supported the proposed dimensions, with Cronbach's alpha coefficient >0.70 for dimensions with ≥ 5 items, and alpha >0.65 for the 3- and 4-item dimensions. However, the dimensions "physical symptoms" and "social issues" lacked coherency with some low item-total correlations. The PNPC demonstrated convergent validity with the European Organization for Research and Treatment of Cancer (EORTC) and COOP-WONCA quality-of-life measures. These data are a first step in validating the PNPC, although the "social issues" dimension needs reconsideration. Further studies are needed to evaluate clinical use.

A Prospective Study to Compare Three Depression Screening Tools in Patients Who Are Terminally Ill

Lloyd-Williams, M., Dennis, M., and Taylor, F.

General Hospital Psychiatry, *26* (2004), 384–389

Depression is a significant symptom for approximately one in four palliative care patients. This study investigates the performance of three screening tools. Patients were asked to verbally rate their mood on a scale of 0–10; to respond "yes" or "no" to the question "Are you depressed?" and to complete the Edinburgh depression scale. They were also interviewed using a semistructured clinical interview according to DSM-IV criteria. Complete data were available for 74 patients. For the single question, a "yes" answer had a sensitivity of 55% and specificity of 74%. The Edinburgh depression scale at a cutoff point of ≥ 13 had a sensitivity of 70% and specificity of 80%. The verbal mood item with a cutoff point of ≥ 3 had a sensitivity of 80% and specificity of 43%. The Edinburgh depression scale proved to be the most reliable instrument for detecting clinical depression in palliative care patients.

SYMPTOM CONTROL

Prostate Cancer in African Americans: Relationship of Patient and Partner Self-Efficacy to Quality of Life

Campbell, L.C., Keefe, F.J., McKee, D.C., Edwards, C.L., Herman, S.H., Johnson, L.E., Colvin, O.M., McBride, C.M., and Donattuci, C.F.

Journal of Pain and Symptom Management, *28* (2004), 433–444

This study examined the relationship between patient and partner ratings of self-efficacy for symptom control and quality of life (QOL) among 40 African American prostate cancer survivors and their intimate partners. Data analyses revealed that cancer survivors who had rated their self-efficacy for symptom control higher reported better QOL related to urinary, bowel, and hormonal symptoms and better general health QOL (i.e., better

physical functioning and better mental health). Data analyses also revealed that partners who rated their self-efficacy for helping the patient manage symptoms as higher reported better QOL (i.e., less negative mood and less caregiver strain). Finally, exploratory analyses indicated that higher self-efficacy in patients was associated with less anxiety and caregiver strain in partners, and higher self-efficacy in partners was associated with better adjustment to bowel and hormonal symptoms and better mental health in patients. The clinical implications of these findings are discussed and future directions for research on self-efficacy in African American prostate cancer survivors are identified.

Acceptable, Manageable, and Tolerable Days: Patient Daily Goals for Medication Management of Persistent Pain

Zelman, D.C., Smith, M.Y., Hoffman, D., Edwards, L., Reed, P., Levine, E., Siefeldin, R., and Dukes, E.

Journal of Pain and Symptom Management, *28* (2004), 474–487

Although the construct of "a symptom-free day" has been widely applied in asthma and gastric reflux disease, there is no analogous concept in the field of pain management. This study represents the initial development of a "day of acceptable or manageable pain control," a construct that reflects patients' daily strategic use of pain medication in order to allow the accomplishment of desired activities while minimizing side effects. Focus group methodology was used to extract patient-generated themes of "an acceptable day of pain control." Fifty-three outpatients with persistent moderate to severe average pain intensity due to osteoarthritis (n = 18), metastatic cancer (n = 15), and low back pain (n = 20) participated. Participants preferred the term "manageable" or "tolerable" to "acceptable." Thematic analysis revealed components of a manageable/tolerable day of pain control as including (1) taking the edge off the pain, (2) performing valued activities, (3) relief from dysphoria and irritability, (4) reduced medication side effects, and (5) feeling well enough to socialize. Additional cancer-specific themes included relief from fatigue and ability to have a positive day when one's future days were perceived as being limited. The set of themes is presented and their relevance for developing a measure of "a manageable day of pain control" discussed. Study findings identify a novel construct that can inform development of an outcome for evaluating the effectiveness of different pharmacotherapies for pain management.

Opioid Switching from Transdermal Fentanyl to Oral Methadone in Patients with Cancer Pain

Benítez-Rosario, M.A., Feria, M., Salinas-Martín, A., Martínez-Castillo, L.P., and Martín-Ortega, J.J.

Cancer, *101* (2004), 2866–2873

Patients with cancer often are rotated from other opioids to methadone to improve the balance between analgesia and side effects. To the authors' knowledge, no clear guidelines currently exist for the safe and effective rotation from transdermal fentanyl to methadone. The authors evaluated a protocol for switching opioid from transdermal fentanyl to oral methadone in 17 patients with cancer. Reasons for switching were uncontrolled pain (41.1% of patients) and neurotoxic side effects (58.9% of patients). Methadone was initiated 8–24 h after fentanyl withdrawal, depending on the patient's previous opioid doses (from $<$100 g per hour to $>$300 g per hour). The starting methadone dose was calculated according to a 2-step conversion between transdermal fentanyl:oral morphine (1:100 ratio) and oral morphine:oral methadone (5:1 ratio or 10:1 ratio). The correlation between previous fentanyl dose and the final methadone dose or the fentanyl:methadone dose ratio was assessed by means of Pearson and Spearman correlation coefficients (r), respectively. A Friedman test was used to compare pain intensity before and after the switch and the use of daily rescue doses. Opioid rotation was fully or partially effective in 80% and 20%, respectively, of patients with somatic pain. Neuropathic pain was not affected by opioid switching. Delirium and myoclonus were reverted in 80% and 100% of patients, respectively, after opioid switching. A positive linear correlation was obtained between the fentanyl and methadone doses (Pearson r, 0.851). Previous fentanyl doses were not correlated with the final fentanyl:methadone dose ratios (Spearman r, -0.327). The protocol studied provided a safe approach for switching from transdermal fentanyl to oral methadone, improving the balance between analgesia and side effects in patients with cancer.

Perceptions of Analgesic Use and Side Effects: What the Public Values in Pain Management

Palos, G.R., Mendoza, T.R., Cantor, S.B., Aday, L.A., and Cleeland, C.S.

Journal of Pain and Symptom Management, *28* (2004), 460–473

In this population-based telephone survey, we evaluated the attitudes of 302 adults toward analgesic

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use and related side effects. Over half (68%) reported prior experience with two or more side effects. Vomiting (34%), confusion (32%), and nausea (17%) were ranked as the worst side effects. Exploratory cluster analysis grouped responses to six questions about willingness to use analgesics into two categories. Participants in Cluster I (n = 106), "Conservatives," were less willing to take analgesics for pain as compared to those in Cluster II (n = 153), "Liberals." Univariate analysis found that Hispanics, women, those less affluent or educated, and those with prior side-effect experience were more likely to be Conservative. Experience with side effects (OR = 1.3) and being female (OR = 2.1) were the strongest predictors of conservative cluster membership. To achieve better pain outcomes, clinicians and patients must identify factors that contribute to conservative decision making about analgesic use and side effect management.

Efficacy of Two Cannabis Based Medicinal Extracts for Relief of Central Neuropathic Pain from Brachial Plexus Avulsion: Results of a Randomised Controlled Trial

Berman, J.S., Symonds, C., and Birch, R.

Pain, *112* (2004), 299–306

The objective was to investigate the effectiveness of cannabis-based medicines for treatment of chronic pain associated with brachial plexus root avulsion. This condition is an excellent human model of central neuropathic pain as it represents an unusually homogenous group in terms of anatomical location of injury, pain descriptions, and patient demographics. Forty-eight patients with at least one avulsed root and baseline pain score of 4 or more on an 11-point ordinate scale participated in a randomized, double-blind, placebo-controlled, three period crossover study. All patients had intractable symptoms regardless of current analgesic therapy. Patients entered a baseline period of 2 weeks, followed by three, 2-week treatment periods, during each of which they received one of three oromucosal spray preparations. These were placebo and two whole plant extracts of *Cannabis sativa L.*: GW-1000-02 (Sativex®), containing Δ^9tetrahydrocannabinol (THC):cannabidiol (CBD) in an approximate 1:1 ratio and GW-2000–02, containing primarily THC. The primary outcome measure was the mean pain severity score during the last 7 days of treatment. Secondary outcome measures included pain related quality-of-life assessments. The primary outcome measure failed to fall by the two points defined in our hypothesis. However, both this measure and measures of sleep showed statistically significant improvements. The study medications were generally well tolerated with the majority of adverse events, including intoxication type reactions, being mild to moderate in severity and resolving spontaneously. Studies of longer duration in neuropathic pain are required to confirm a clinically relevant, improvement in the treatment of this condition.

A Population-Based Evaluation of an Intervention to Improve Advanced Stage Cancer Pain Management

Hoffmann, W., Munzinger, H., Horstkotte, E., and Greiser, E.

Journal of Pain and Symptom Management, *28* (2004), 342–350

The purpose of this study was to evaluate the effect of a community-oriented intervention in one part of the Free Town of Bremen, northern Germany (population 541,000) on the prescription prevalence of World Health Organization (WHO) class III opioids for cancer patients in their final year of life. A community-oriented, multimodal intervention included information, teaching, and training modules tailored to physicians, pharmacists, nursing staff, patients and their relatives, and the public. Prescription prevalences were calculated for the intervention region (Bremen-Nord) and a control region (Bremen-Mitte) before and after the intervention. Specifically, a population-based, controlled, quantitative assessment of opioid prescriptions for patients with cancer during their final year of life was undertaken for two time periods, prior to 1992–1993 and after 1995–1996, respectively. Prescription ascertainment was based on duplicates kept in the pharmacies. Patients comprised two anonymized complete 4-month samples who died in 1993 and 1996, respectively, with cancer as the primary or a contributory cause of death on their death certificates. A total of 1282 prescriptions were abstracted from duplicates in 109 of 119 pharmacies in Bremen-Mitte and all 31 pharmacies in Bremen-Nord (overall pharmacy participation proportion 93%) and individually matched to 856 patients with cancer in their final year of life. In 1993, 16.3% of all terminal cancer patients in Bremen-Mitte and 19.1% in Bremen-Nord had received at least one prescription for a WHO class III opioid. Corresponding numbers after the intervention were 20% and 21%, respectively. The total amount of class III opioids, however, increased 20% in Bremen-Mitte and 210% in Bremen-Nord after the intervention. In 1996, the spectrum of prescribed opioids had changed markedly toward the WHO recommendations. The proportion of prescribing physicians

remained constant. These data suggest that a community-oriented intervention in one part of Bremen had a limited impact on cancer pain therapy on the population level. A measurable change of prescription practice seemed to be restricted to the minority of physicians who had prior experience with prescribing WHO class III opioids.

Pain in Community-Dwelling Persons with Dementia: Frequency, Intensity, and Congruence between Patient and Caregiver Report

Shega, J.W., Hougham, G.W., Stocking, C.B., Cox-Hayley, D., and Sachs, G.A.

Journal of Pain and Symptom Management, *28* (2004), 585–592

To better understand the pain experience of persons with dementia and to describe what factors are related to congruence of pain reports within patient–caregiver dyads, a cohort study enrolled patient–caregiver dyads at a primary care geriatrics clinic. Thirty-two percent of persons with dementia self-report pain "right now." Of these, 65% report slight/mild pain, 27% moderate pain, and 8% severe pain or greater. Fifty-two percent of caregivers report their care recipients with dementia are in some pain "right now." Of these, 52% report slight/mild pain, 30% moderate, and 18% severe pain or greater. Fifty-nine percent of dyads agree on the presence or absence of patient pain. In multivariate analysis of dyadic congruence of pain reports by patient and caregiver factors, only patient factors predicted congruence. The dds of congruence of pain reports increase 3.7 (1.2–12.3) if the patient is male and decrease 0.938 (0.93–0.99) as the patient becomes more agitated. These findings suggest that community-dwelling persons with dementia report less pain than those in the nursing home and caregivers do a fair job of predicting patient pain.

Course of Fatigue in Women Receiving Chemotherapy and/or Radiotherapy for Early Stage Breast Cancer

Donovan, K.A., Jacobsen, P.B., Andrykowski, M.A., Winters, E.M., Balducci, L., Malik, U., Kenady, D., and McGrath, P.

Journal of Pain and Symptom Management, *28* (2004), 373–380

Although much has been learned about the complication of fatigue during breast cancer treatment, the possibility that there are differences across treatment modalities in breast cancer patients' experience of fatigue has not yet been established. In this study, fatigue was assessed in 134 women receiving chemotherapy and radiotherapy or radiotherapy only for early stage breast cancer. Comparisons of fatigue during initial treatment indicated that women who received chemotherapy reported greater fatigue severity and disruptiveness than women receiving radiotherapy. Women not pretreated with chemotherapy experienced increased fatigue over the course of radiotherapy. Results confirmed predictions that fatigue in women with early stage breast cancer differs as a function of the type of treatment and sequencing of treatment. Findings indicating increases in fatigue during radiotherapy only among women not pretreated with chemotherapy suggest a response shift, or a change in internal standards, in women's perceptions of fatigue as a function of prior chemotherapy treatment.

Family Experience with Palliative Sedation Therapy for Terminally Ill Cancer Patients

Morita, T., Ikenaga, M., Adachi, I., Narabayashi, I., Kizawa, Y., Honke, Y., Kohara, H., Mukaiyama, T., Akechi, T., Uchitomi, Y., and the Japan Pain, Rehabilitation, Palliative Medicine, and Psycho-Oncology (J-PRPP) Study Group

Journal of Pain and Symptom Management, *28* (2004), 557–565

Symptomatic sedation is often required in terminally ill cancer patients, and could cause significant distress to their families. The aims of this study were to clarify the family experience during palliative sedation therapy, including their satisfaction and distress levels, and the determinants of family dissatisfaction and high-level distress. A multicenter questionnaire survey assessed 280 bereaved families of cancer patients who received sedation in seven palliative care units in Japan. A total of 185 responses were analyzed (response rate, 73%). The families reported that 69% of the patients were considerably or very distressed before sedation. Fifty-five percent of the patients expressed an explicit wish for sedation, and 89% of families were clearly informed. Overall, 78% of the families were satisfied with the treatment, whereas 25% expressed a high level of emotional distress. The independent determinants of low levels of family satisfaction were poor symptom palliation after sedation, insufficient information-giving, concerns that sedation might shorten the patient's life, and

feelings that there might be other ways to achieve symptom relief. The independent determinants of high levels of family distress were poor symptom palliation after sedation, feeling the burden of responsibility for the decision, feeling unprepared for changes in the patient's condition, feeling that the physicians and nurses were not sufficiently compassionate, and shorter interval to patient death. Palliative sedation therapy was principally performed to relieve severe suffering based on family and patient consent. Although the majority of families were comfortable with this practice, clinicians should minimize family distress by regular monitoring of patient distress and timely modification of sedation protocols, providing sufficient information, sharing the responsibility of the decision, facilitating grief, and providing emotional support.

Dexamethasone in Addition to Metoclopramide for Chronic Nausea in Patients with Advanced Cancer: A Randomized Controlled Trial

Bruera, E., Moyano, J.R., Sala, R., Rico, M.A., Bosnjak, S., Bertolino, M., Willey, J., Strasser, F., and Palmer, J.L.

Journal of Pain and Symptom Management, *28* (2004), 381–388

Chronic nausea occurs in most patients with advanced cancer. This study was done to assess the antiemetic effects of dexamethasone in patients with chronic nausea refractory to metoclopramide. Secondary outcomes included appetite, fatigue, and pain. Fifty-one patients who had nausea (≥3/10 on a 0–10 scale) for ≥2 weeks despite 48 h of oral metoclopramide therapy (40–60 mg/day) were enrolled. Patients received 20 mg/day dexamethasone (DM) orally (n = 25) or placebo (n = 26) for severe nausea in addition to metoclopramide (60 mg/day orally). At baseline the mean nausea intensity ratings in the DM and placebo groups were 8.0 and 7.4. At Day 8 they were 2.1 and 2.0, respectively. At Day 3 and Day 8, the mean difference in nausea intensity for the DM and placebo groups was 4.5 and 2.9 (P = 0.16) and 5.9 and 5.7 (P = 0.85), respectively. Improvement in appetite and fatigue were observed on Day 3 and Day 8 in both groups as compared with the baseline. Pain, vomiting, well-being, and quality of life remained unchanged in both groups at both times. We conclude that DM was not superior to placebo in the management of chronic nausea in our patients with advanced cancer.

Physician- and Nurse-Reported Effects of Intravenous Hydration Therapy on Symptoms of Terminally Ill Patients with Cancer

Morita, T., Shima, Y., Miyashita, M., Kimura, R., and Adachi, I.

Journal of Palliative Medicine, *7* (2004), 683–693

Purpose: To clarify physician- and nurse-reported effects of intravenous hydration therapy on symptoms of terminally ill patients with cancer.

Methods: A cross-sectional questionnaire survey of Japanese physicians and nurses. The respondents were requested to report their clinical observations about improvement or deterioration of seven symptoms of terminally ill patients with lung or gastric cancer receiving 0.5–1 L/d intravenous hydration therapy, 1.5–2 L/d intravenous hydration therapy, and reduction of intravenous hydration volume from 1.5–2 L/d to 0.5–1 L/d. The responses from a total of 413 oncologists, 88 palliative care physicians, 2735 oncology nurses, and 593 palliative care nurses were analyzed (response rates, 53% in physicians and 83% in nurses). Fewer than 30% of the respondents in all specialties reported that they often or very often observed improvement of dehydration symptoms with 0.5–1 L/d or 1.5–2 L/d intravenous hydration therapy. Deterioration of fluid retention symptoms was reported by 5.8%–13% of the oncologists and 20%–50% of the other specialists with 0.5–1 L/d intravenous hydration therapy for patients with lung cancer, and by 9.3%–24% of the oncologists and 16%–68% of the other specialties with 1.5–2.0 L/d hydration for patients with gastric cancer. By reducing intravenous hydration volume, 20%–70% of the palliative care physicians and nurses reported that they often or very often observed improvement of fluid retention symptoms, whereas less than 7.0% of all specialists reported that they often or very often observed deterioration of dehydration symptoms.

Conclusions: The physicians and nurses in both oncology and palliative care settings frequently observed deterioration of fluid retention symptoms with limited benefits in alleviating dehydration symptoms by intravenous hydration therapy for terminally ill patients with cancer. It is suggested that routine use of artificial hydration therapy should not be recommended, and individualized treatment policy based on the comprehensive assessment of each patient's needs is strongly required.

QUALITY OF PALLIATIVE CARE

Hospice Use for the Patient with Advanced Alzheimer's Disease: The Role of the Geriatric Psychiatrist

Aupperle, P.M., MacPhee, E.R., Strozeski, J.E., Finn, M., and Heath, J.M.

American Journal of Hospice and Palliative Medicine, *21* (2004), 427–437

Advanced Alzheimer's disease (AD) can place an immense burden on caregivers as they struggle to provide end-of-life care for the patient. Palliative care, as delivered by hospice, provides a viable solution. Hospice maintains the patient's quality of life and helps the family during the grieving process. However, many providers are not familiar with hospice and its care for advanced AD patients. Geriatric psychiatrists can be central in implementing hospice, and they can remain an important part of the care once it is in place. A principal clinical challenge is establishing the 6-month prognosis for such patients, which is a prerequisite for initiating hospice admission.

Frequency and Perceived Competence in Providing Palliative Care to Terminally Ill Patients: A Survey of Primary Care Physicians

Farber, N.J., Urban, S.Y., Collier, V.U., Metzger, M., Weiner, J., and Boyer, E.G.

Journal of Pain and Symptom Management, *28* (2004), 364–372

We surveyed primary care physicians about their involvement and perceived skills in palliative care. A survey instrument asked how frequently internal medicine and family practice physicians performed 10 palliative care items. Subjects rated their skills in each area. A majority of physicians always or frequently performed all 10 palliative care items, but fewer than 50% of respondents adequately attended to the spiritual needs and economic problems of patients. Interest in palliative care was associated with an increased frequency in performing palliative care items ($P = 0.036$), and training in palliative care was associated with better perceived performance ($P = 0.05$). Only 36% of respondents had received training in palliative care. Internists and family practitioners provide palliative care to patients, but feel their skills are lacking in certain areas. Training may improve care to patients at the end of life.

Considerations of Healthcare Professionals in Medical Decision-Making about Treatment for Clinical End-Stage Cancer Patients

van Leeuwen, A.F., Voogt, E., Visser, A., van der Rijt, C.C.D., and van der Heide, A.

Journal of Pain and Symptom Management, *28* (2004), 351–355

To determine which considerations health care professionals use in decision making about treatment for inpatients with end-stage cancer, we observed 110 discussions at multidisciplinary meetings at two oncology departments. The discussions concerned 74 patients. Thirty-three of the 110 discussions concerned potentially life-prolonging or life-shortening treatments. The most important decision-making considerations were chance of improvement, patient's treatment wishes, amount of suffering, and the chance of therapy being successful. Discussions resulted in 6 decisions that might shorten life, 10 decisions that might prolong life, and 23 postponements of decisions because of lack of information. These observations confirm that medical interventions with a possible life-prolonging or life-shortening effect are a frequently discussed issue in medical decision making for end-stage cancer patients in The Netherlands. Before making a decision, health care professionals gather extensive information about what gain is to be expected from an intervention. When health care professionals establish that a decision would be medically appropriate, the patient's wish will often be an important consideration.

Measuring Hospice Care: The National Hospice and Palliative Care Organization National Hospice Data Set

Connor, S.R., Tecca, M., LundPerson, J., and Teno, J.

Journal of Pain and Symptom Management, *28* (2004), 316–328

Hospice has seen rapid growth in recent years, but there is a lack of consistency among hospices when it comes to compliance with standards of care. Consequently, hospices vary in performance and in services they provide. With state hospice organizations, the NHPCO developed a National Data Set (NDS) intended to understand demographics, practices, and outcomes; illustrate industry effectiveness; facilitate communication of industry legislative needs; and to support agency performance and im-

provement. Our paper describes development of the NDS and data that are being collected, and summarizes key findings from the 2000, 2001, and 2002 NDS. The data collection process, which began in 1999, has evolved substantially over a 4-year period to the point that we believe the 2002 NDS represents a well-designed core that will receive only minor modifications annually. This database will be invaluable for comparative audit, clinical practice, and managing services because only that which is measured can be improved.

Assessment of the Education for Physicians on End-of-Life Care (EPEC™) Project

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Palliative medicine is assuming an increasingly important role in patient care. Yet, most physicians did not learn this during their formal training. The Education for Physicians in End-of-life Care (EPEC) Project aims to increase physician knowledge in palliative care by disseminating the *EPEC Curriculum* through a train-the-trainer approach. An assessment of its use to help the project reach its targets was performed. An independent evaluation pursued a two-step qualitative and quantitative approach to assess the ways that the curriculum is used by EPEC Trainers. The main findings are (1) The *EPEC Curriculum* is well regarded by a quota sample of 200 physicians who were trained to use the *curriculum* between January 1999 and March 2000. When asked, "How would you rate the effect of EPEC training on your knowledge of end-of-life care?" 62% (123/200) selected "greatly improved it." When asked, "What was the effect of the EPEC conference on your ability to teach end-of-life care?" 72% (144/200) selected "greatly improved it." (2) Dissemination has been effective. Ninety-two percent (184/200) use the curriculum for teaching. Of these, 83% (153/184) presented the material in 30–60-min sessions as part of regularly scheduled conferences. We estimate that these 184 EPEC Trainers have presented 1 or more of the 16 *EPEC Curriculum* modules to approximately 120,000 professionals. There is evidence that physicians selected to be EPEC Trainers judge the *EPEC Curriculum* to be high in quality, respected, and, most importantly, usable. They use the *EPEC Curriculum* as part of a train-the-trainer dissemination strategy. The interpretation of this enthusiastic assessment is tempered by the study's limitations, including respondent bias and possible acquiescence. Nevertheless, it appears that the *EPEC Curriculum* has set a standard of knowledge in the field and is an example of disseminating new information to physicians in practice. We conclude that the *EPEC Curriculum* is an effective vehicle to transmit palliative care information to physicians in practice.

PSYCHOSOCIAL INTERVENTIONS

Treating Tobacco Dependence: State of the Science and New Directions

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Despite almost two decades of intensive tobacco control efforts, nearly one quarter of Americans continue to smoke. The two United States Food and Drug Administration–approved medications used to treat tobacco dependence, bupropion and nicotine replacement therapy, are effective for only a fraction of smokers. Investigations of medications approved for affective disorders and other forms of substance abuse, such as fluoxetine and naltrexone, have yielded mixed results as tobacco dependence treatments. A particular challenge in tobacco dependence treatment is the development of effective approaches for smokers with unique needs, such as cancer patients and pregnant women. Despite new developments in these areas, significant gaps in knowledge and practice remain. Basic research in the neurobiologic and genetic basis of nicotine dependence offers promise for the development of novel and more effective treatment approaches. For example, emerging research in pharmacogenetics explores how genetic variation in drug-metabolizing enzymes and drug targets modifies response to pharmacotherapy. These discoveries could someday help practitioners to individualize the type, dosage, and duration of tobacco dependence treatment based on genotype, and maximize the efficacy.

Suicide Risk in Cancer Patients from 1960 to 1999

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Suicide risk is reportedly higher for cancer patients than for the general population, but estimates vary and analyses of trends are few. The aim of the present study was to determine whether cancer

patients had a higher suicide risk between 1960 and 1999. A cohort comprising patients from the Cancer Registry of Norway 1960 to 1997 was linked to suicide diagnosis in the Register of Deaths at Statistics Norway and observed during 1960 to 1999. The cohort consisted of all cancer patients registered in the Cancer Registry of Norway 1960 to 1997 (N = 490,245 patients with 520,823 cancer diagnoses). Suicide was defined according to death certificates based on the International Classification of Diseases (versions 7, 8, 9, and 10). During the period, 589 cancer patients (407 males and 182 females) committed suicide. The relative risk was elevated for males and females, with standardized mortality ratios (SMRs) of 1.55 (95% CI, 1.41 to 1.71) and 1.35 (95% CI, 1.17 to 1.56), respectively. Risk was highest in the first months after diagnosis. For both sexes, there was a significant decrease in the relative suicide risk over decades. The risk was markedly increased among male patients with cancer of respiratory organs (SMR, 4.08; 95% CI, 2.96 to 5.47). Otherwise, the SMRs varied from 0.76 to 3.67 across cancer types. Cancer may be a risk factor for suicide, particularly shortly after diagnosis. However, the relative risk gradually decreased during the period 1960 to 1999.

Breast Cancer Treatment in Older Women: Does Getting What You Want Improve Your Long-Term Body Image and Mental Health?

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Little is known about the impact of surgical treatment on body image and health outcomes in older breast cancer patients. The purpose of this article is to evaluate whether concordance between treatment received and treatment preferences predicts posttreatment body image and whether body image, in turn, affects mental health in older women with breast cancer 2 years after treatment. A longitudinal cohort of 563 women who were 67 years old or older and who had stages I and II breast cancer were surveyed by telephone at 3, 12, and 24 months after surgery. All women were clinically eligible for breast conservation. Body image was measured using questions adapted from the Cancer Rehabilitation Evaluation System–Short Form, and mental health was evaluated using a Medical Outcomes Study subscale. Body image was an important factor in treatment decisions for 31% of women. Women who received breast conservation had better body image 2 years after treatment than women who had mastectomies ($P < 0.0001$). Women who preferred breast conservation but received mastectomy had the poorest body image. Using generalized estimating equations, we found that body image, in turn, predicted 2-year mental health.

Body image is important for many older women, and receiving treatment consistent with preferences about appearance was important in long-term mental health outcomes. Health professionals should elicit preferences about appearance from women and provide treatment choices in accordance with these preferences. Enhancing shared decision making has the potential to improve mental health in older breast cancer survivors.

EXISTENTIAL AND SPIRITUAL ISSUES

Belief in an Afterlife, Spiritual Well-Being and End-of-Life Despair in Patients with Advanced Cancer

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General Hospital Psychiatry, *26* (2004), 484–486

Despite the plethora of research linking spirituality, religiosity, and psychological well-being among people living with medical illnesses, the role of afterlife beliefs on psychological functioning has been virtually ignored. The present investigation assessed afterlife beliefs, spiritual well-being, and psychological functioning at the end of life among 276 terminally ill cancer patients. Results indicated that belief in an afterlife was associated with lower levels of end-of-life despair (desire for death, hopelessness, and suicidal ideation) but was not associated with levels of depression or anxiety. Further analyses indicated that when spirituality levels were controlled for, the effect of afterlife beliefs disappeared. The authors concluded that spirituality has a much more powerful effect on psychological functioning than beliefs held about an afterlife. Treatment implications are discussed.

Identifying Barriers to Psychosocial Spiritual Care at the End of Life: A Physician Group Study

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American Journal of Hospice and Palliative Medicine, *21* (2004), 419–426

Objective: The recent literature addresses the need to improve care for dying patients. The purpose of

this study was to identify barriers to the psychosocial spiritual care of these patients by their physicians. Psychosocial spiritual care is defined as aspects of care concerning patient emotional state, social support and relationships, and spiritual well-being. The study was an exploratory means for generating hypotheses and identifying directions for interventions, research, and training in care for the dying.

Design and participants: The study used a qualitative group discussion format. Seventeen physicians at a university-based health sciences center representing 10 areas of medical specialty—including internal medicine, oncology, pediatrics, and geriatrics—met in two groups for 20 75-min discussion sessions over the course of 1 year. Discussions were recorded, analyzed, and categorized.

Results: Barriers to psychosocial spiritual care were grouped into three domains and seven themes. The cultural domain included the themes of training, selection, medical practice environment, and debt/delay. Participants believed that medical selection and training combine to marginalize psychosocial spiritual approaches to patient care, whereas the practice environment and debt/delay augment emotional isolation and dampen idealism. The organizational domain included the themes of dissatisfaction and time/busyness. Physicians indicated that the current reimbursement climate and time pressures contribute to dissatisfaction and the tendency to avoid patient psychosocial spiritual issues. The clinical domain included the theme of communication. Physicians were concerned about their ability to communicate nonmedical issues effectively and manage the patient's reactions and needs in the psychosocial spiritual arena.

Conclusions: This study suggests that research and educational approaches to improving the psychosocial spiritual care of the dying by physicians should address barriers at the cultural, organizational, and clinical levels. Suggestions for interventions at various levels are offered.

Palliative Sedation to Relieve Psycho-Existential Suffering of Terminally Ill Cancer Patients

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To clarify the prevalence and the characteristics of patients who received palliative sedation therapy for psycho-existential suffering, a questionnaire was sent to 105 responsible physicians at all certified palliative care units in Japan. The participants were requested to report the number of patients who received continuous deep sedation for refractory psycho-existential suffering during the past year, and to provide details of the two most recent patients. A total of 81 physicians returned questionnaires (response rate, 80%). Twenty-nine physicians (36%) reported clinical experience in continuous deep sedation for psycho-existential suffering. The overall prevalence of continuous deep sedation was calculated as 1.0% (90 cases/8,661 total patient deaths), and a total of 46 patient histories were collected. Performance status just before sedation was 3 or 4 in 96%, and predicted survival was 3 weeks or less in 94%. The suffering requiring sedation was feeling of meaninglessness/worthlessness (61%), burden on others/dependency/inability to take care of oneself (48%), death anxiety/fear/panic (33%), wish to control the time of death by oneself (24%), and isolation/lack of social support (22%). Before sedation, intermittent sedation and specialized psychiatric, psychological, and/or religious care had been performed in 94% and 59%, respectively; 89% of 26 depressed patients had received antidepressant medications. All competent patients ($n = 37$) expressed explicit requests for sedation, and family consent was obtained in all cases where family members were available ($n = 45$). Palliative sedation for psycho-existential suffering was performed in exceptional cases in specialized palliative care units in Japan. The patient condition was generally very poor, and the suffering was refractory to intermittent sedation and specialized psychiatric, psychological, and/or religious care. Sedation was performed on the basis of patient and family consent. These findings suggest that palliative sedation for psycho-existential suffering could be ethically permissible in exceptional cases if the proportionality and autonomy principle is applied. More discussion about the role of palliative sedation therapy for refractory psycho-existential suffering in end-of-life care is urgently necessary.

Religious Affiliation and Suicide Attempt

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American Journal of Psychiatry, *161* (2004), 2303–2308

Few studies have investigated the association between religion and suicide either in terms of Durkheim's social integration hypothesis or the hypothesis of the regulative benefits of religion. The relationship between religion and suicide attempts

has received even less attention. Depressed inpatients (N = 371) who reported belonging to one specific religion or described themselves as having no religious affiliation were compared in terms of their demographic and clinical characteristics. Religiously unaffiliated subjects had significantly more lifetime suicide attempts and more first-degree relatives who committed suicide than subjects who endorsed a religious affiliation. Unaffiliated subjects were younger, less often married, less often had children, and had less contact with family members. Furthermore, subjects with no religious affiliation perceived fewer reasons for living, particularly fewer moral objections to suicide. In terms of clinical characteristics, religiously unaffiliated subjects had more lifetime impulsivity, aggression, and past substance use disorder. No differences in the level of subjective and objective depression, hopelessness, or stressful life events were found. Religious affiliation is associated with less suicidal behavior in depressed inpatients. After other factors were controlled, it was found that greater moral objections to suicide and lower aggression level in religiously affiliated subjects may function as protective factors against suicide attempts. Further study about the influence of religious affiliation on aggressive behavior and how moral objections can reduce the probability of acting on suicidal thoughts may offer new therapeutic strategies in suicide prevention.

COMMUNICATION

Talking with Terminally Ill Patients and Their Caregivers about Death, Dying, and Bereavement; Is It Stressful? Is It Helpful?

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Archives of Internal Medicine, *164* (2004), 1999–2004

Discussing end-of-life issues with terminally ill patients is often considered distressing and harmful. This study was conducted to assess whether interviewing terminally ill patients and their caregivers about death, dying, and bereavement is stressful and/or helpful. Patients from six sites in the United States who were estimated to have 6 months or less to live were interviewed in person and reinterviewed 2 to 6 months later. Their caregivers were interviewed separately. At the end of the interviews, patients and caregivers were asked how stressful and how helpful the interview had been. Of 1131 eligible patients, 988 (87.4%) were interviewed, and of 915 eligible caregivers, 893 (97.6%) were interviewed. At the end of the first interview, 1.9% of the patients reported having experienced a great deal of stress, 7.1% some stress, and 88.7% little or no stress from the interview. Among the caregivers, 1.5% reported a great deal of stress, 8.4% some stress, and 89.7% little or no stress. Slightly more stress was reported to have been caused by the reinterview. Overall, 16.9% of the patients reported the initial interview as very helpful, 29.6% as somewhat helpful, and 49.6% as offering little or no help. Among the caregivers, 19.1% reported the initial interview as very helpful, 34.3% as somewhat helpful, and 44.9% as offering little or no help. The reported helpfulness of the second interview was slightly less. Patients experiencing pain (odds ratio [OR], 1.26; 95% confidence interval [CI], 1.02–1.56), more personal meaning in dying (OR, 3.05; 95% CI, 2.02–4.59), and less ease with talking about the end of life (OR, 1.32; 95% CI, 1.09–1.60) were significantly more likely to report stress. Patients who were from an ethnic minority (OR, 1.85; 95% CI, 1.31–2.63), anxious about the end of their life (OR, 1.39; 95% CI 1.16–1.67), more spiritual (OR, 1.30; 95% CI, 1.06–1.61), and serene (OR, 1.25; 95% CI, 1.08–1.45) were significantly more likely to report the interview helpful. There was no relationship between stress and helpfulness. Terminally ill patients and their caregivers can discuss death, dying, and bereavement in a structured interview with minimal stress and report that the interview was helpful. Institutional review boards should not preemptively restrict surveys with terminally ill patients without reliable evidence that they will be stressful or otherwise harmful.

Cancer Patient and Caregiver Experiences: Communication and Pain Management Issues

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This study examined facilitators and barriers to effective patient and caregiver communication with providers with emphasis on communication related to cancer pain management. Focus groups and personal interviews were conducted with cancer patients and family caregivers of patients. Communication experiences of subjects as well as suggestions for ways to improve the communication process were elicited. Twenty-two cancer patients and 16 family caregivers participated in the study. Seven themes emerged suggesting improvements that are

needed in the communication process. These include (1) improving the process of information exchange, (2) increasing active participation of patient and caregiver in the care process, (3) improving provider relationship-building skills, (4) overcoming time barriers, (5) addressing fears regarding use of pain management medications, (6) fostering appropriate involvement of family and caregivers in the communication process, and (7) improving coordination of care among providers. Specific suggestions and their practice implications for health care providers are highlighted.

Cancer Consultation Preparation Package: Changing Patients but Not Physicians Is Not Enough

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Journal of Clinical Oncology, *22* (2004), 4401–4409

This study evaluated a cancer consultation preparation package (CCPP) designed to facilitate patient involvement in the oncology consultation. A total of 164 cancer patients (67% response rate) were randomly assigned to receive the CCPP or a control booklet at least 48 h before their first oncology appointment. The CCPP included a question prompt sheet, booklets on clinical decision making and patient rights, and an introduction to the clinic. The control booklet contained only the introduction to the clinic. Physicians were blinded to which intervention patients received. Patients completed questionnaires immediately after the consultation and 1 month later. Consultations were audiotaped, transcribed verbatim, and coded. All but one patient read the information. Before the consultation, intervention patients were significantly more anxious than were controls (mean, 42 vs. 38; $P = 0.04$); however anxiety was equivalent at follow-up. The CCPP was reported as being significantly more useful to family members than the control booklet ($P = 0.004$). Patients receiving the intervention asked significantly more questions (11 vs. 7 questions; $P = 0.005$), tended to interrupt the physician more (1.01 vs. 0.71 interruptions; $P = 0.08$), and challenged information significantly more often (twice vs. once; $P = 0.05$). Patients receiving the CCPP were less likely to achieve their preferred decision making style (22%) than were controls (35%; $P = 0.06$). This CCPP influences patients' consultation behavior and does not increase anxiety in the long term. However, this intervention, without physician endorsement, reduced the percentage of patients whose preferred involvement in decision making was achieved.