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# Clinical Update: Literature Abstracts

## MEASURES

### The Cancer Care Monitor: Psychometric Content Evaluation and Pilot Testing of a Computer Administered System for Symptom Screening and Quality of Life in Adult Cancer Patients

Fortner, B., Okon, T., Schwartzberg, L., Tauer, K., and Houts, A.C.

*Journal of Pain Symptom Management*, *26* (2003), 1077–1092

Technology is making the routine screening of symptoms and the measurement of quality of life (QoL) more feasible at the point of care. However, most existing symptom screening scales and QoL measures were not developed for clinical use and were not formatted and validated for administration through computerized mediums. The Cancer Care Monitor (CCM) is a symptom-based scale developed for administration on pen-based computers. This study is an initial evaluation of the reliability and validity of the CCM. Three samples of adult outpatients provided ratings on 38 physical, psychological, and functional oriented items of the CCM that comprise six symptom scales and one global QoL index. All additive scales are converted to normalized *T* scores. Reliability was examined through internal consistency and confirmatory factor analysis. Convergent and divergent validity were examined by comparing CCM scores to established measures of corresponding constructs and physician judgments. Alternative forms reliability was established by comparing paper-and-pencil administration with computer administration. Internal consistency reliability and factor analyses confirmed the structure of the CCM as comprising six primary symptom scales and one global QoL index. Internal consistency reliabilities ranged from 0.80 to 0.89. The pattern of correlations between CCM scales and established measures supported the convergent and divergent validity of the CCM scales. Alternate forms reliability based on paper and computer forms of the CCM scales was high. Patients indicated a preference for the computer-administered version. Results suggest that CCM items can be scored as a reliable and valid measure of constructs related to physical, psychological, and functional status, and global health-related QoL in adult cancer patients. Future studies should replicate and further evaluate the properties of the CCM, especially in relation to clinical utility.

### Further Validation of the Multidimensional Fatigue Symptom Inventory–Short Form

Stein, K.D., Jacobsen, P.B., Blanchard, C.M., and Thors, C.

*Journal of Pain Symptom Management*, *27* (2004), 14–23

A growing body of evidence is documenting the multidimensional nature of cancer-related fatigue. Although several multidimensional measures of fatigue have been developed, further validation of these scales is needed. To this end, the current study sought to evaluate the factorial and construct validity of the 30-item Multidimensional Fatigue Symptom Inventory–Short Form (MFSI-SF). A heterogeneous sample of 304 cancer patients (mean age 55 years) completed the MFSI-SF, along with several other measures of psychosocial functioning including the MOS-SF-36 and Fatigue Symptom Inventory, following the fourth cycle of chemotherapy treatment. The results of a confirmatory factor analysis indicated the five-factor model provided a good fit to the data as evidenced by commonly used goodness-of-fit indices (CFI 0.90 and IFI 0.90). Additional evidence for the validity of the MFSI-SF was provided via correlations with other relevant instruments (range −0.21 to 0.82). In sum, the current study provides support for the MFSI-SF as a valuable tool for the multidimensional assessment of cancer-related fatigue.

### The Symptom Monitor. A Diary for Monitoring Physical Symptoms for Cancer Patients in Palliative Care: Feasibility, Reliability and Compliance

Hoekstra, J., Bindels, P.J., van Duijn, N.P., and Schade, E.

*Journal of Pain Symptom Management*, *27* (2004), 24–35

The aim of this study was to evaluate the feasibility, reliability, and compliance of a new instrument, a diary to monitor physical symptoms for patients with cancer in the palliative phase of their illness. The development of the diary took place in three phases: two pilot studies and one intervention study. In Pilot I, reliability was tested within 13 pairs of patients and their proxy in a patient–proxy comparison. Pilot II was performed to test the feasibility of the instrument among 47 frail elderly. In the intervention study among patients with cancer in the palliative phase, the feasibility as well as the compliance have been tested. The phases have been completed with good results: reliability (ICC) of prevalent symptoms was above 0.75, good feasibility and good compliance. The Symptom Monitor can be used by patients and doctors as an instrument to monitor physical symptoms. The effectiveness of the use of this diary for improvement in treatment of symptoms in the palliative phase of cancer is being tested in a randomized clinical trial.

### Psychometric Evaluation of the Pittsburgh Sleep Quality Index in Cancer Patients

Beck, S.L., Schwartz, A.L., Towsley, G., Dudley, W., and Barsevick, A.

*Journal of Pain Symptom Management*, *27* (2004), 140–148

This report summarizes findings related to the psychometric properties (internal consistency and construct validity) of the Pittsburgh Sleep Quality Index (PSQI) and discusses issues related to its use based on data from two clinical studies with diverse samples of cancer patients. Subjects completed a questionnaire that included the PSQI, the Schwartz Cancer Fatigue Scale, and specific demographic, disease, and treatment variables. There were complete data on 170 (of 214) cases in Study 1 and 249 (of 259) cases in Study 2. The Cronbach's alpha for the Global Sleep Quality scale was 0.81 in Study 1 and 0.77 in Study 2. A comparison of Global Sleep Quality in two contrasting groups with low and high fatigue yielded statistically significant differences in both samples. Psychometric evaluation supports its internal consistency reliability and construct validity. However, the scoring is rather cumbersome and raises questions regarding level of measurement and appropriate analysis techniques.

## COMMUNICATION

### Measuring Quality of Life in Routine Oncology Practice Improves Communication and Patient Well-Being: A Randomized Controlled Trial

Velikova, G., Booth, L., Smith, A.B., Brown, P.M., Lynch, P., Brown, J.M., and Selby, P.J.

*Journal of Clinical Oncology*, *22* (2004), 714–724

The purpose of this study was to examine the effects, on process of care and patient well-being, of the regular collection and use of health-related quality-of-life (HRQL) data in oncology practice. In a prospective study with repeated measures involving 28 oncologists, 286 cancer patients were randomly assigned to either the intervention group (regular completion of European Organization for Research and Treatment of Cancer–Core Quality of Life Questionnaire version 3.0 and Hospital Anxiety and Depression Scale on touch-screen computers in clinic and feedback of results to physicians), attention-control group (completion of questionnaires, but no feedback), or control group (no HRQL measurement in clinic before encounters). Primary outcomes were patient HRQL over time, measured by the Functional Assessment of Cancer Therapy–General questionnaire, physician–patient communication, and clinical management, measured by content analysis of tape-recorded encounters. Analysis employed mixed-effects modeling and multiple regression. Patients in the intervention and attention-control groups had better HRQL than the control group ($P = 0.006$ and $P = 0.01$, respectively), but the intervention and attention-control groups were not significantly different ($P = 0.80$). A positive effect on emotional well-being was associated with feedback of data ($P = 0.008$), but not with instrument completion ($P = 0.12$). A larger proportion of intervention patients showed clinically meaningful improvement in HRQL. More frequent discussion of chronic nonspecific symptoms ($P = 0.03$) was found in the intervention group, without prolonging encounters. There was no detectable effect on patient management ($P = 0.60$). In the intervention patients, HRQL improvement was as-

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sociated with explicit use of HRQL data ($P = 0.016$), discussion of pain, and role function ($P = 0.046$). Routine assessment of cancer patients' HRQL had an impact on physician–patient communication and resulted in benefits for some patients, who had better HRQL and emotional functioning.

## SYMPTOM CONTROL

### Symptom Burden in the Last Week of Life

Klinkenberg, M., Willems, D.L., van der Wal, G., and Deeg, D.J.

*Journal of Pain Symptom Management*, *27* (2004), 5–13

To investigate symptom burden in the last week of life, we conducted after-death interviews with close relatives of deceased older persons from a population-based sample of older people in The Netherlands ($n = 270$). Results show that fatigue, pain, and shortness of breath were common (83%, 48%, and 50%, respectively). Other symptoms were confusion (36%), anxiety (31%), depression (28%), and nausea and/or vomiting (25%). Cancer patients and patients with chronic obstructive pulmonary disease were clearly at a disadvantage with respect to pain and shortness of breath, respectively. Furthermore, cognitive decline turned out to be predictive of specific symptom burden. Persons with cognitive decline in the last three months had a higher symptom burden and different symptoms compared to patients with no cognitive decline. It is suggested that older persons with cognitive decline require specific attention.

### Fatigue after Treatment for Malignant and Benign Bone and Soft Tissue Tumors

Servaes, P., Verhagen, S., Schreuder, H.W., Veth, R.P., and Bleijenberg, G.

*Journal of Pain and Symptom Management*, *26* (2003), 1113–1122

Fatigue has been mentioned as an important complaint in several groups of disease-free patients after curative treatment for cancer. However, it has never been investigated in a sample of patients who have been treated for a bone or soft tissue tumor in the past. In the current study, these patients participated. Measurement included posted questionnaires at baseline and at follow-up (2 years later). Baseline results indicated that fatigue is a severe problem for 28% of the investigated patients. Percentages were equal for patients who were treated for malignant or benign tumors. Fatigue complaints seem to be most severe for patients who finished treatment relatively recently, and for patients who had to undergo more than one operation. In addition, fatigue was associated with several psychological and physical variables. At follow-up, the majority of all patients who were severely fatigued at baseline continued to be severely fatigued. Severe fatigue at follow-up was predicted by oncological complications after initial treatment, less optimism, and more somatization. It can be concluded that fatigue is an important problem for more than a quarter of a sample of patients who have been treated for a malignant or benign bone or soft tissue tumor in the past.

### Patient-Controlled Methylphenidate for the Management of Fatigue in Patients with Advanced Cancer: A Preliminary Report

Bruera, E., Driver, L., Barnes, E.A., Willey, J., Shen, L., Palmer, J.L., and Escalante, C.

*Journal of Clinical Oncology*, *21* (2003), 4439–4443

The purpose of this study was to assess the effects of patient-controlled methylphenidate for cancer-related fatigue. In this prospective open study, 31 patients with advanced cancer and fatigue who scored ≥4 on a scale of 0 to 10 received methylphenidate 5 mg by mouth every 2 hours as needed for 7 days (maximum, 20 mg/d). Multiple symptoms were assessed daily; the primary end point, fatigue, was measured using the 0 to 10 scale, and the Functional Assessment for Chronic Illness Therapy–Fatigue (FACIT-F) was performed at baseline, day 7, and day 28. The following mean (± standard deviation) scores for 30 assessable patients improved significantly between baseline and day 7: fatigue (0 to 10 scale), 7.2 ± 1.6 vs. 3.0 ± 1.9 ($P < 0.001$); overall well-being (0 to 10 scale), 4.5 ± 2.2 vs. 2.8 ± 2.1 ($P < 0.001$); fatigue (FACIT-F) subscore, 17.5 ± 11.3 vs. 34.7 ± 10.0 ($P < 0.001$); functional well-being, 14.4 ± 5.9 vs. 18.3 ± 6.6 ($P < 0.001$); and physical well-being, 13.5 ± 6.4 vs. 21.4 ± 5.0 ($P < 0.001$). Anxiety, appetite, pain, nausea, depression, and drowsiness all improved significantly ($P < 0.05$). All patients took afternoon or evening doses, and 28 patients (93%) took three or more doses daily. All patients chose to continue taking methylphenidate after 7 days of treatment. No serious side effects were reported. These preliminary results suggest that patient-controlled methylphenidate administration rapidly improved fatigue and other symptoms. Randomized controlled trials are justified.

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### Pain Characteristics and Treatment Outcome for Advanced Cancer Patients during the First Week of Specialized Palliative Care

Stromgren, A.S., Groenvold, M., Petersen, M.A., Goldschmidt, D., Pedersen, L., Spile, M., Irming-Pedersen, G., and Sjogren, P.

*Journal of Pain and Symptom Management*, *27* (2004), 104–113

To examine pain in cancer patients referred for specialized palliative care, we described pain characteristics and medication on admission, examined changes in pain during the first week, and searched for predictors of initial pain intensity and treatment outcome. On arrival in the department (T0) and after 1 week (T1), pain was evaluated with the Edmonton Symptom Assessment System (ESAS) and EORTC QLQ-C30. Analgesics were recorded. We investigated the associations between initial pain scores as well as differences from T0 to T1, and clinical and sociodemographic parameters, initial medication, and medical interventions. Of 267 eligible patients, initial pain scores were obtained from 175. Initial pain scores were high, although 81% of patients received opioid treatment at T0. Bone metastases, neuropathic pain, mixed pain pathophysiology, and breakthrough pain were associated with higher initial pain scores. Pain scores decreased during the first week. No single parameter convincingly predicted a better or worse outcome of pain treatment.

### Celiac Plexus Block for Pancreatic Cancer Pain: Factors Influencing Pain, Symptoms and Quality of Life

Mercadante, S., Catala, E., Arcuri, E., and Casuccio, A.

*Journal of Pain and Symptom Management*, *26* (2003), 1140–1147

Neurolytic celiac plexus block (NCPB) is claimed to be an effective method of pain control for pancreatic cancer pain. However, the factors that may influence long-term analgesia, adverse effects, and quality of life after performing NCPB have never been determined. In a prospective multicenter study, 22 patients who underwent NCPB were followed until death. Numerous parameters other than pain and symptom intensity were evaluated, including age, gender, initial site of cancer, sites of pain, possible peritoneal involvement, technique, and oncologic interventions. Indices were calculated to determine the opioid consumption ratio (EAS) and the trend of opioid escalation (OEI). NCPB was effective in reducing opioid consumption and gastrointestinal adverse effects for at least 4 weeks. In the last 4 weeks prior to death, there was the typical trend of increasing symptom intensity common to the terminal cancer population. None of the factors studied influenced the analgesic effectiveness of NPCB. NPCB, performed by skilled clinicians, regardless of the technique chosen, is a safe and useful means that should be considered as an adjuvant to common analgesic regimens at any stage, as it may allow the reduction of the visceral component of pancreatic pain that may prevail in certain phases of the illness. The analgesic and symptomatic effect of NCPB is presumably advantageous for about 4 weeks. A possible factor interfering with long-term outcome includes the capacity of cancer to involve the celiac axis, which can distort the anatomy and prevent neurolytic spread or modify the pain mechanisms. Outcomes are strongly based on individual variation.

### Efficacy of Postoperative Epidural Analgesia: A Meta-Analysis

Block, B.M., Liu, S.S., Rowlingson, A.J., Cowan, A.R., Cowan, J.A., Jr., and Wu, C.L.

*JAMA*, *290* (2003), 2455–2463

Whether epidural analgesia is a better method than parenteral opioids for postoperative pain control remains controversial. The authors systematically reviewed the efficacy of postoperative epidural analgesia versus parenteral opioids, the primary alternative technique. Studies were identified primarily by searching the National Library of Medicine's PubMed database (1966 to April 25, 2002) and other sources for studies related to postoperative epidural analgesia. Inclusion criteria were a comparison of epidural therapy versus parenteral opioids for postoperative analgesia, measurement of pain using a visual analog scale (VAS) or numeric rating scale, randomization of patients to either therapy, and adult patients (≥18 years). A total of 1404 abstracts were identified, 100 of which met all inclusion criteria. Each article was reviewed and data extracted from tables, text, or extrapolated from figures as needed. Weighted mean pain scores, weighted mean differences in pain score, and weighted incidences of complications were determined by using a fixed-effect model. Epidural analgesia provided better postoperative analgesia compared with parenteral opioids (mean [*SE*], 19.40 mm [0.17] vs. 29.40 mm [0.20] on the VAS;

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$P < 0.001$). When analyzed by postoperative day, epidural analgesia was better than parenteral opioids on each postoperative day ($P < 0.001$ for each day after surgery). For all types of surgery and pain assessments, all forms of epidural analgesia provided significantly better postoperative analgesia compared with parenteral opioid analgesia ($P < 0.001$ for all), with the exception of thoracic epidural analgesia versus opioids for rest pain after thoracic surgery (weighted mean difference, 0.6 mm; 95% confidence interval, −0.3 to 1.5 mm; $P = 0.12$). The complication rates were lower than expected for nausea or vomiting and pruritus but comparable with existing data for lower extremity motor block. Epidural analgesia, regardless of analgesic agent, location of catheter placement, and type and time of pain assessment, provided better postoperative analgesia compared with parenteral opioids.

### Evaluation of Efficacy of the Perioperative Administration of Venlafaxine XR in the Prevention of Postmastectomy Pain Syndrome

Reuben, S.S., Makari-Judson, G., and Lurie, S.D.

*Pain Symptom Management*, *27* (2004), 133–139

Postmastectomy pain syndrome (PMPS) is a neuropathic pain syndrome that may develop following breast surgery. Venlafaxine has been shown to be efficacious in the management of PMPS. The preemptive administration of venlafaxine has been shown to be efficacious in reducing the incidence of neuropathic pain in the rat model. We examined the efficacy of administering either venlafaxine or placebo for 2 weeks starting the night before surgery to 100 patients scheduled for either partial or radical mastectomy with axillary dissection. Patients were administered PCA morphine for the first 24 h following surgery and then acetaminophen/oxycodone tablets. Pain scores were recorded at rest and movement on day 1, at 1 month, and at 6 months after surgery. At 6 months postoperatively, the presence of pain in the chest, arm, and axilla, edema, decreased sensation in the operative area, and phantom breast pain were recorded. There was no difference in postoperative opioid use. Pain scores with movement were lower in the venlafaxine group at 6 months. Pain scores at all other time intervals were similar. There was a significant decrease in the incidence of chest wall pain (55% vs. 19%, $P = 0.0002$), arm pain (45% vs. 17%, $P = 0.003$), and axilla pain (51% vs. 19%, $P = 0.0009$) between the control group and the venlafaxine group, respectively. No significant differences were noted between the two groups with regard to edema, phantom pain, or sensory changes. We conclude that the perioperative administration of venlafaxine beginning the night prior to surgery significantly reduces the incidence of PMPS following breast cancer surgery.

## PSYCHOSOCIAL INTERVENTION

### Effect of a Cognitive Behavioral Intervention on Reducing Symptom Severity during Chemotherapy

Given, C., Given, B., Rahbar, M., Jeon, S., McCorkle, R., Cimprich, B., Galecki, A., Kozachik, S., Brady, A., Fisher-Malloy, M.J., Courtney, K., and Bowie, E.

*Journal of Clinical Oncology*, *22* (2004), 507–516

The purpose of this study was to describe a randomized trial of a cognitive behavioral intervention on reducing symptom severity among patients diagnosed with solid tumors and undergoing a first course of chemotherapy and to determine whether the intervention had an additive or interactive effect on symptom severity in the presence of supportive care medications. Patients ($N = 237$) were accrued from comprehensive and community cancer centers, interviewed, and randomly assigned to either the experimental intervention ($n = 118$) or conventional care ($n = 119$). A symptom severity index, based on summed severity scores across 15 symptoms, was the primary outcome. Each patient's site of cancer, stage at diagnosis, chemotherapy protocols, and use of supportive medications were learned from medical records. Groups were equivalent at baseline, and attrition by characteristics by group was not different. The proportion of patients not receiving chemotherapy at 10 and 20 weeks did not differ by group. At the 10- and 20-week observations, there was a significant interaction between the experimental group and baseline symptom severity. Patients in the experimental group who entered the trial with higher symptom severity reported significantly lower severity at 10 and 20 weeks. Controlling for chemotherapy treatment status at follow-up and supportive care medications did not alter the effect of the experimental intervention. Compared with conventional care alone, the experimental intervention was effective among patients who entered the trial with higher levels of symptom severity. Age, sex, site or stage of cancer, and supportive medications did not modify the effect of this cognitive behavioral intervention on symptom severity.

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### Memantine Treatment in Patients with Moderate to Severe Alzheimer Disease Already Receiving Donepezil: A Randomized Controlled Trial

Tariot, P.N., Farlow, M.R., Grossberg, G.T., Graham, S.M., McDonald, S., Gergel, I., Memantine Study Group

*JAMA*, *291* (2004), 317–324

Memantine is a low- to moderate-affinity, uncompetitive N-methyl-D-aspartate receptor antagonist. Controlled trials have demonstrated the safety and efficacy of memantine monotherapy for patients with moderate to severe Alzheimer disease (AD) but no controlled trials of memantine in patients receiving a cholinesterase inhibitor have been performed. The objective of the study was to compare the efficacy and safety of memantine versus placebo in patients with moderate to severe AD already receiving stable treatment with donepezil. A randomized, double-blind, placebo-controlled clinical trial of 404 patients with moderate to severe AD and Mini-Mental State Examination scores of 5 to 14, who received stable doses of donepezil, was conducted at 37 U.S. sites between June 11, 2001, and June 3, 2002. A total of 322 patients (80%) completed the trial. Participants were randomized to receive memantine (starting dose 5 mg/d, increased to 20 mg/d, $n = 203$) or placebo ($n = 201$) for 24 weeks. MAIN OUTCOME MEASURES: Change from baseline on the Severe Impairment Battery (SIB), a measure of cognition, and on a modified 19-item AD Cooperative Study–Activities of Daily Living Inventory (ADCS-ADL19). Secondary outcomes included a Clinician's Interview-Based Impression of Change Plus Caregiver Input (CIBIC-Plus), the Neuropsychiatric Inventory, and the Behavioral Rating Scale for Geriatric Patients (BGP Care Dependency Subscale). The change in total mean (SE) scores favored memantine versus placebo treatment for SIB (possible score range, 0–100), 0.9 (0.67) versus −2.5 (0.69), respectively ($P < 0.001$); ADCS-ADL19 (possible score range, 0–54), −2.0 (0.50) versus −3.4 (0.51), respectively ($P = 0.03$); and the CIBIC-Plus (possible score range, 1–7), 4.41 (0.074) versus 4.66 (0.075), respectively ($P = 0.03$). All other secondary measures showed significant benefits of memantine treatment. Treatment discontinuations because of adverse events for memantine versus placebo were 15 (7.4%) versus 25 (12.4%), respectively. In patients with moderate to severe AD receiving stable doses of donepezil, memantine resulted in significantly better outcomes than placebo on measures of cognition, activities of daily living, global outcome, and behavior and was well tolerated. These results, together with previous studies, suggest that memantine represents a new approach for the treatment of patients with moderate to severe AD.

### Exercise Plus Behavioral Management in Patients with Alzheimer Disease: A Randomized Controlled Trial

Teri, L., Gibbons, L.E., McCurry, S.M., Logsdon, R.G., Buchner, D.M., Barlow, W.E., Kukull, W.A., LaCroix, A.Z., McCormick, W., and Larson, E.B.

*JAMA*, *290* (2003), 2015–2022

Exercise training for patients with Alzheimer disease combined with teaching caregivers how to manage behavioral problems may help decrease the frailty and behavioral impairment that are often prevalent in patients with Alzheimer disease. The objective of this study was to determine whether a home-based exercise program combined with caregiver training in behavioral management techniques would reduce functional dependence and delay institutionalization among patients with Alzheimer disease. A randomized controlled trial of 153 community-dwelling patients meeting National Institute of Neurological and Communicative Diseases and Stroke/Alzheimer Disease and Related Disorders Association criteria for Alzheimer disease was conducted between June 1994 and April 1999. Patient–caregiver dyads were randomly assigned to the combined exercise and caregiver training program, Reducing Disability in Alzheimer Disease (RDAD), or to routine medical care (RMC). The RDAD program was conducted in the patients' home over 3 months. The main outcome measures included: Physical health and function (36-item Short-Form Health Survey's [SF-36] physical functioning and physical role functioning subscales and Sickness Impact Profile's Mobility subscale), and affective status (Hamilton Depression Rating Scale and Cornell Depression Scale for Depression in Dementia). At 3 months, in comparison with the routine care patients, more patients in the RDAD group exercised at least 60 min/week (odds ratio [OR], 2.82; 95% confidence interval [CI], 1.25–6.39; $P = 0.01$) and had fewer days of restricted activity (OR, 3.10; 95% CI, 1.08–8.95; $P < 0.001$). Patients in the RDAD group also had improved scores for physical role functioning compared with worse scores for patients in the RMC group (mean difference, 19.29; 95% CI, 8.75–29.83; $P < 0.001$). Patients in the RDAD group had improved Cornell Depression Scale for Depression in Dementia scores whereas the patients in the RMC group had worse scores (mean difference, −1.03; 95% CI, −0.17 to −1.91; $P =$

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0.02). At 2 years, the RDAD patients continued to have better physical role functioning scores than the RMC patients (mean difference, 10.89; 95% CI, 3.62–18.16; $P = 0.003$) and showed a trend (19% vs. 50%) for less institutionalization due to behavioral disturbance. For patients with higher depression scores at baseline, those in the RDAD group improved significantly more at 3 months on the Hamilton Depression Rating Scale (mean difference, 2.21; 95% CI, 0.22–4.20; $P = 0.04$) and maintained that improvement at 24 months (mean difference, 2.14; 95% CI, 0.14–4.17; $P = 0.04$). Exercise training combined with teaching caregivers behavioral management techniques improved physical health and depression in patients with Alzheimer disease.

### The Influence of HIV-Related Support Groups on Survival in Women Who Lived with HIV. A Pilot Study

Summers, J., Robinson, R., Capps, L., Zisook, S., Atkinson, J.H., McCutchan, E., McCutchan, J.A., Deutsch, R., Patterson, T., and Grant, I.

*Psychosomatics*, *41* (2000), 262–268

To determine the effect of support groups on survival, the authors retrospectively studied 21 HIV-seropositive women who died during the course of participation in a natural history study of HIV. Groups were composed of women who self-selected HIV support groups before death ($n = 11$) and a comparison group ($n = 10$). Survival analysis found group participation to be associated with increased longevity (73 months vs. 45 months; $P = 0.011$). Proportional-hazards regression demonstrated that HIV-related support groups and smaller family size significantly influenced survival ($P = 0.0002$). Factors related to group participation and ways in which support groups might promote longevity are discussed.

### Changes in Psychological Distress of Women with Breast Cancer in Long-Term Remission and Their Husbands

Baider, L., Andritsch, E., Goldzweig, G., Uziely, B., Ever-Hadani, P., Hofman, G., Krenn, G., and Samonigg, H.

*Psychosomatics*, *45* (2004), 58–68

The purpose of this randomized, prospective study was to identify factors influencing the psychological distress of breast cancer patients and their husbands during remission. Background variables and distress levels of 172 couples in two locations (Graz, Austria, and Jerusalem, Israel) were assessed by using three standardized instruments in two interviews conducted 6–8 months apart. In both geographic-cultural groups, women whose partners refused to participate in the interview reported significantly less perceived family support. The global severity index (measuring total psychological distress) reflected minor changes in psychological distress of both patients and their husbands over time.

### Reducing Suicidal Ideation and Depressive Symptoms in Depressed Older Primary Care Patients: A Randomized Controlled Trial

Bruce, M.L., Ten Have, T.R., Reynolds, C.F., 3rd, Katz, I.I., Schulberg, H.C., Mulsant, B.H., Brown, G.K., McAvay, G.J., Pearson, J.L., and Alexopoulos, G.S.

*JAMA*, *291* (2004), 1081–1091

Suicide rates are highest in late life; the majority of older adults who die by suicide have seen a primary care physician in preceding months. Depression is the strongest risk factor for late-life suicide and for suicide's precursor, suicidal ideation. The objective of this study was to determine the effect of a primary care intervention on suicidal ideation and depression in older patients. A randomized controlled trial known as PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial) with patient recruitment from 20 primary care practices in the New York City, Philadelphia, and Pittsburgh regions, was conducted between May 1999 through August 2001. Two-stage, age-stratified (60–74, ≥75 years) depression screening of randomly sampled patients was used. Enrollment included patients who screened positive and a random sample of screened negative patients. This analysis included patients with a depression diagnosis ($N = 598$). The intervention was comprised of the use of treatment guidelines tailored for the elderly with care management compared with usual care. Main outcome measures included assessment of suicidal ideation and depression severity at baseline, 4 months, 8 months, and 12 months. Rates of suicidal ideation declined faster ($P = 0.01$) in intervention patients compared with usual care patients; at 4 months, in the intervention group, raw rates of suicidal ideation declined 12.9% points (29.4%–16.5%) compared with 3.0% points (20.1%–17.1% in usual care [$P = 0.01$]). Among patients reporting suicidal ideation, resolution of ideation was faster among intervention patients ($P = 0.03$); differences peaked at 8 months (70.7% vs. 43.9% resolution; $P = 0.005$). Intervention patients had a more favorable course of depression in both degree and speed

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of symptom reduction; group difference peaked at 4 months. The effects on depression were not significant among patients with minor depression unless suicidal ideation was present. Evidence of the intervention's effectiveness in community-based primary care with a heterogeneous sample of depressed patients introduces new challenges related to its sustainability and dissemination. The intervention's effectiveness in reducing suicidal ideation, regardless of depression severity, reinforces its role as a prevention strategy to reduce risk factors for suicide in late life.

### Effect of Improving Depression Care on Pain and Functional Outcomes among Older Adults with Arthritis: A Randomized Controlled Trial

Lin, E.H., Katon, W., Von Korff, M., Tang, L., Williams, J.W., Jr., Kroenke, K., Hunkeler, E., Harpole, L., Hegel, M., Arean, P., Hoffing, M., Della Penna, R., Langston, C., Unutzer, J., IMPACT Investigators

*JAMA*, *290* (2003), 2428–2429

Depression and arthritis are disabling and common health problems in late life. Depression is also a risk factor for poor health outcomes among arthritis patients. The objective of this study was to determine whether enhancing care for depression improves pain and functional outcomes in older adults with depression and arthritis. The study design included a preplanned subgroup analysis of Improving Mood-Promoting Access to Collaborative Treatment (IMPACT). A randomized controlled trial of 1801 depressed older adults (≥60 years), was performed at 18 primary care clinics from eight health care organizations in five states across the United States from July 1999 to August 2001. A total of 1001 (56%) reported coexisting arthritis at baseline. The intervention took the form of antidepressant medications and/or six to eight sessions of psychotherapy (Problem-Solving Treatment in Primary Care). The main outcome measures included depression, pain intensity (scale of 0 to 10), interference with daily activities due to arthritis (scale of 0 to 10), general health status, and overall quality-of-life outcomes assessed at baseline, 3, 6, and 12 months. In addition to reduction in depressive symptoms, the intervention group compared with the usual care group at 12 months had lower mean [*SE*] scores for pain intensity (5.62 [0.16] vs. 6.15 [0.16]; between-group difference, −0.53; 95% confidence interval [CI], −0.92 to −0.14; $P = 0.009$), interference with daily activities due to arthritis (4.40 [0.18] vs. 4.99 [0.17]; between-group difference, −0.59; 95% CI, −1.00 to −0.19; $P = 0.004$), and interference with daily activities due to pain (2.92 [0.07] vs. 3.17 [0.07]; between-group difference, −0.26; 95% CI, −0.41 to −0.10; $P = 0.002$). Overall health and quality of life were also enhanced among intervention patients relative to control patients at 12 months. In a large and diverse population of older adults with arthritis (mostly osteoarthritis) and comorbid depression, benefits of improved depression care extended beyond reduced depressive symptoms and included decreased pain as well as improved functional status and quality of life.

### Cognitive Behavior Therapy for Hypochondriasis: A Randomized Controlled Trial

Barsky, A.J. and Ahern, D.K.

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Hypochondriasis is a chronic, distressing, and disabling condition that is prevalent in ambulatory medical practice. Until recently, no specific treatment has been clearly demonstrated to be effective. The objective of this study was to assess the efficacy of a cognitive behavior therapy (CBT) for hypochondriasis. A randomized, usual care control group design was conducted between September 1997 and November 2001. The individual primary care physician was the unit of randomization, and all patients clustered within each physician's practice were assigned to the experimental treatment (individual CBT and a consultation letter to the primary care physician) or to the control condition. Subjects were assessed immediately before and 6 and 12 months after the completion of treatment. Participants were 80 patients from primary care practices and 107 volunteers responding to public announcements, all of whom exceeded a predetermined cutoff score on a hypochondriasis self-report questionnaire on two successive occasions. A scripted, six-session, individual CBT intervention was compared with medical care as usual. The CBT was accompanied by a consultation letter sent to the patient's primary care physician. The main outcome measures included hypochondriacal beliefs, fears, attitudes, and somatic symptoms and role function and impairment. A total of 102 individuals were assigned to CBT and 85 were assigned to medical care as usual. The sociodemographic and clinical characteristics of the two groups were similar at baseline. Using an intent-to-treat analytic strategy, a consistent pattern of statistically and clinically significant treatment effects was found at both 6- and 12-month follow-up, adjusting for baseline covariates that included educational level, generalized psychiatric distress, and participant status (patient vs. volunteer). At 12-month follow-up, CBT

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patients had significantly lower levels of hypochondriacal symptoms, beliefs, and attitudes ($P < 0.001$) and health-related anxiety ($P = 0.009$). They also had significantly less impairment of social role functioning ($P = 0.05$) and intermediate activities of daily living ($P < 0.001$). Hypochondriacal somatic symptoms were not improved significantly by treatment. This brief, individual CBT intervention, developed specifically to alter hypochondriacal thinking and restructure hypochondriacal beliefs, appears to have significant beneficial long-term effects on the symptoms of hypochondriasis.

## QUALITY OF PALLIATIVE CARE

### American Cancer Society Award Lecture. Psychological Care of Patients: Psycho-Oncology's Contribution

Holland, J.C.

*Journal of Clinical Oncology*, *21* 253s–265s

The centuries-old stigma attached to cancer precluded patients' being told their diagnoses, and thus, delayed any exploration of how they dealt with their illness. This situation changed in the United States in the 1970s when patients began to be told their cancer diagnosis, permitting the first formal study of the psychological impact of cancer. However, a second and equally long-held stigma attached to mental illness has been another barrier and this has kept patients from being willing to acknowledge their psychological problems and to seek counseling. This "double stigma" has slowed the development of psycho-oncology. However, we began to see rapid changes occurring in the last quarter of the 20th century. Valid assessment instruments were developed that were used in well-designed studies. Data from these studies and clinical observations led to increased recognition that psychosocial services are needed by many patients and provide significant assistance in coping with illness. Psycho-oncology has two dimensions: first, the study of the psychological reaction of patients at all stages of the disease, as well as of the family and oncology staff; second, exploring the psychological, social, and behavioral factors that impact on cancer risk and survival. Psycho-oncology now has a recognized role within the oncologic community through clinical care, research, and training as it relates to prevention of cancer through lifestyle changes, evaluation of quality of life, symptom control, palliative care, and survivorship. Presently, there are sufficient research studies from which standards of care have been established. Both evidence and consensus-based clinical practice guidelines have been promulgated. It now possible to monitor the quality of existing psychosocial services by using these benchmarks of quality that have evolved in recent years.

### The Attitudes of Cancer Patients and Their Families toward the Disclosure of Terminal Illness

Yun, Y.H., Lee, C.G., Kim, S.Y., Lee, S.W., Heo, D.S., Kim, J.S., Lee, K.S., Hong, Y.S., Lee, J.S., and You, C.H.

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To ascertain the attitude of cancer patients and their families toward disclosure of terminal illness to the patient. We constructed a questionnaire that included demographic and clinical information and delivered it to 758 consecutive individuals (433 cancer patients and 325 families that have a relative with cancer) at seven university hospitals and one national cancer center in Korea. A total of 380 cancer patients and one member from each of 281 families that have a relative with cancer completed the questionnaire. Cancer patients were more likely than family members to believe that patients should be informed of the terminal illness (96.1% vs. 76.9%; $P < 0.001$). Fifty percent of the family members and 78.3% of the patients thought that the doctor in charge should be the one who informs the patient. Additionally, 71.7% of the patients and 43.6% of the family members thought that patients should be informed immediately after the diagnosis. Stepwise multiple logistic regression indicated that the patient group was more likely than the family group to want the patient to be informed of the terminal illness (odds ratio [OR], 9.76; 95% CI, 4.31–22.14), by the doctor (OR, 4.00; 95% CI, 2.61–6.11), and immediately after the diagnosis (OR, 3.64; 95% CI, 2.45–5.41). Our findings indicated that most cancer patients want to be informed if their illness is terminal, and physicians should realize that the patient and the family unit may differ in their attitude toward such a disclosure. Our results also reflect the importance of how information is given to the patient.

### Effects of Religiosity on Patients' Perceptions of Do-Not-Resuscitate Status

Sullivan, M.A., Muskin, P.R., Feldman, S.J., and Haase, E.

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Forty-eight oncology inpatients participated in a survey designed to characterize their understand-

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ing of and beliefs about do-not-resuscitate (DNR) decisions and to identify dimensions of religiosity associated with moral beliefs about DNR decisions. Seventy-five percent of the patients believed they understood the meaning of "DNR," but only 32% were able to provide an accurate definition. Seventeen percent believed that DNR decisions are morally wrong, and 23% believed that they are equivalent to suicide. Those who lacked an accurate understanding of DNR status were significantly more likely to perceive them as morally wrong. Gender, but not religious denomination, was significantly related to patients' attitudes about the morality of DNR decisions. The belief that DNR decisions are morally wrong was predicted by certain religious practices, including near-daily meditation, near-daily thinking about God, and the current practice of meditation, and by endorsement of the statement, "My faith sometimes restricts my action."

**Desire for Death and Requests to Hasten Death of Japanese Terminally Ill Cancer Patients Receiving Specialized Inpatient Palliative Care**

Morita, T., Sakaguchi, Y., Hirai, K., Tsuneto, S., and Shima, Y.

*Journal of Pain and Symptom Management*, *27* (2004), 44–52

A desire for death and requests to hasten death are major topics in recent medical literature. The aim of this study was to clarify the bereaved family-reported incidence and reasons for desiring death and requests to hasten death during the whole course of terminally ill cancer patients receiving specialized palliative care in Japan. A nationwide questionnaire survey of 500 primary caregivers yielded a total of 290 responses (effective response rate, 62%). Sixty-two (21%) families reported that the patients had expressed a desire to die, and 29 (10%) families reported that the patients had requested that death be hastened. The major reasons for desiring death and requests to hasten death were burden on others, dependency, meaninglessness, unable to pursue pleasurable activities, general malaise, pain, dyspnea, concerns about future distress, and wish to control the time of death. No intolerable physical symptoms were reported in 32% and 28% of the patients who desired death and those who requested to hasten death, respectively. Concerns about future distress and wishes to control the time of death were significantly more likely to be listed as major reasons for desiring death in patients who requested that death be hastened than those who did not. A desire for death and requests to hasten death are not uncommon in terminally ill cancer patients receiving specialized inpatient palliative care in Japan. More intensive strategies for general malaise, pain, and dyspnea near the end of life and for feelings of being a burden, meaninglessness, and concerns about future distress would alleviate the serious suffering of patients with a desire for death. However, some patients with a strong wish to control the time of death might not receive benefit from conventional palliative.

**Psychiatric Evaluation of Death-Hastening Requests. Lessons from Dialysis Discontinuation**

Cohen, L.M., Steinberg, M.D., Hails, K.C., Dobscha, S.K., and Fischel, S.V.

*Psychosomatics*, *41* (2000), 195–203

The authors aim to facilitate the psychiatric evaluation of death-hastening decisions, such as cessation of life-support treatment or physician-assisted suicide, by deriving principles for evaluating patients from a literature review and a recently completed prospective study on dialysis discontinuation conducted by consultation psychiatrists. Factors are delineated and suggestions are provided for the evaluation of requests to accelerate dying. Included are the authors' method for determining major depression in the context of terminal illness and their "vector analysis" in assessing patient requests to stop dialysis. As our society heatedly examines the care provided to the terminally ill, psychiatry also needs to reconsider whether actions that foreshorten life can be normative and permissible. Familiarity with competency, psychiatric diagnosis, and ease in communication and negotiation between patient, family, and staff are resources that psychiatrists can bring to these complicated assessments. Challenging areas include diagnosing depression, establishing the adequacy of palliative care, and appreciating issues related to personality features, family dynamics, and ethnic differences.