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Clinical Update: Literature Abstracts

MEASURES

Validation of the Palliative Performance Scale in the Acute Tertiary Care Hospital Setting

Olajide, O., Hanson, L., Usher, B.M., Qaqish, B.F., Schwartz, R., and Bernard, S.

Journal of Palliative Medicine, 10 (2007), 111–117

Physicians are often asked to prognosticate patient survival. However, prediction of survival is difficult, particularly with critically ill and dying patients within the hospitals. The Palliative Performance Scale (PPS) was designed to assess functional status and measure progressive decline in palliative care patients, yet it has not been validated within hospital health care settings. This study explores the application of the PPS for its predictive ability related to length of survival. Other variables examined were correlates of symptom distress in a tertiary academic setting. Patients were assigned a score on the PPS ranging from 0% to 100% at initial consultation. Standardized symptom assessments were carried out daily, and survival was determined by medical record review and search of the National Death Index. Of 261 patients seen since January 2002, 157 had cancer and 104 had other diagnoses. PPS scores ranged from 10% to 80% with 92% of the scores between 10% and 40%. Survival ranged from 0 to 30 months, with a median of 9 days. By 90 days, 83% of patients had died. Proportional hazards regression estimates showed that a 10% decrement in PPS score was associated with a hazard ratio of 1.65 (95% confidence interval: 1.42–1.92). Proportional odds regression models showed that a lower PPS was significantly associated with higher levels of dyspnea. The PPS correlated well with length of survival and with select symptom distress scores. We consider it to be a useful tool in predicting outcomes for palliative care patients.

Evaluation of the Functional Assessment of Cancer Therapy Cognitive Scale with Hematopoietic Stem Cell Transplant Patients

Jacobs, S.R., Jacobsen, P.B., Booth-Jones, M., Wagner, L.I., and Anasetti, C.

Journal of Pain and Symptom Management, 33 (2007), 13–23

The current study evaluated a newly developed self-report measure of cognitive complaints with cancer patients, the Functional Assessment of Cancer Therapy Cognitive Scale (FACT-Cog). Six or 12 months following hematopoietic stem cell transplantation, participants completed a psychosocial assessment that included the FACT-Cog and a neuropsychological assessment. Using a criterion of two or more times a week, an average of 12 of a total of 50 items were endorsed as complaints on the FACT-Cog. FACT-Cog total, domain, and subscale scores were significantly correlated with measures of depression, fatigue, anxiety, and physical and mental well-being. FACT-Cog scores, with the exception of one subscale, Other People Noticed Deficits, were not significantly correlated with cognitive performance. In general, the FACT-Cog and a commonly used measure of cognitive complaints (European Organization for Research and Treatment of Cancer-Quality of Life Questionnaire-C30 Cognitive Functioning Scale) demonstrated similar psychometric properties. However, the FACT-Cog assesses broader aspects of cognitive complaints, thereby providing greater information about the types of cognitive complaints patients are experiencing.

Mobilization-Observation-Behavior-Intensity-Dementia Pain Scale (MOBID): Development and Validation of a Nurse-Administered Pain Assessment Tool for Use in Dementia

Husebo, B.S., Strand, L.I., Moe-Nilssen, R., Husebo, S.B., Snow, A.L., and Ljunggren, A.E.

Journal of Pain and Symptom Management, 34 (2007), 67–80

Pain assessment in older persons with severe cognitive impairment (SCI) is a challenge due to reduced self-report capacity and lack of movement-related pain assessment instruments. The purpose of this article was to describe the development of the Mobilization-Observation-Behavior-Intensity-Dementia Pain

Scale (MOBID) and to investigate aspects of reliability and validity. MOBID is a nurse-administered instrument developed for use in patients with SCI, where presence of pain behavior indicators (pain noises, facial expression, and defense) may be observed during standardized active, guided movements, and then inferred to represent pain intensity. Initially, the MOBID contained seven items (observing at rest, mobilization of the hands, arms, legs, turn over in bed, sitting on bedside, and teeth/mouth care). This was tested in 26 nursing home patients with SCI. Their primary caregivers, five registered nurses and six licensed practical nurses (LPNs), rated the patients' pain intensity during regular morning care, and by MOBID, both at bedside and from video uptakes. Three external raters (LPNs), not knowing the patients, also completed the MOBID by rating the videos. Internal consistency of the MOBID indicated high Cronbach's alpha ($\alpha = .90$) after deleting the items for observation at rest and observation of teeth/mouth care. MOBID disclosed significantly more pain than did pain scorings during regular morning care, and video observation demonstrated higher pain intensity than bedside scoring. Intertester reliability for inferred pain intensity was high to excellent (intraclass correlation coefficient = .70–.96), but varied between poor and excellent for pain behavior indicators ($\kappa = .05–.84$). These results suggest that registration of pain behavior indicators during active, guided movements, as performed by the MOBID procedure, is useful to disclose reliable and valid pain intensity scores in patients with SCI.

Screening New Cancer Patients for Psychological Distress Using the Hospital Anxiety and Depression Scale

Sellick, S.M. and Edwardson, A.D.

Psycho-oncology, 16 (2007), 534–542

The diagnosis of a life-threatening illness creates immediate psychosocial distress for the patient and his or her family. The threat is real and the rational response is to be afraid. We need to be reaching out to patients and their families and not waiting for crises. The responsibility remains with the health care system and psychosocial health care professionals to identify those who are in most need. Psychological distress is something that can be relatively easily measured and responded to when psychosocial oncology healthcare professionals are immediately available to address those needs. This paper describes the process used to gather this information, how that information has been used by the psychosocial clinicians in the Supportive Care program, and what we have learned, in terms of a retrospective data analysis, about our patient population. At the Cancer Centre in Thunder Bay, Ontario, Canada, new cancer patients complete the HADS on the day of their first appointment. Since October 2000 we have collected baseline psychological distress data for 3035 new cancer patients who fully completed all 14 items on the HADS. Of those, 781 patients, or 25.7%, scored above cutoff points and were given a telephone call. We were able to contact 607 (or 77.7%) of these patients. Five hundred and eight (or 83.7%) of those contacted made, and subsequently attended, one or more appointments with a psychosocial counsellor.

SYMPTOM CONTROL

Depression, Anxiety and Quality of Life in a Chronic Lymphocytic Leukemia Cohort

Levin, T.T., Li, Y., Riskind, J., and Rai, K.

General Hospital Psychiatry, 29 (2007), 251–256

Although chronic lymphocytic leukemia (CLL) accounts for 25%–30% of leukemia cases, little is known about its psychosocial correlates. This study examines anxiety, depression, and quality of life (QOL) in a CLL cohort. One hundred five patients recruited from a CLL research database were classified into two groups: "watch and wait" or active treatment. The patients completed a mail-in battery of depression, anxiety, and QOL measures. There was no statistical difference between depression, anxiety, and physical/mental QOL in watch and wait versus active-treatment groups. Patients $\leq$60 years reported more depression ($p = .014$) and worse emotional ($p = .0001$) and social QOL ($p = .002$). They also had more watch and wait anxiety ($p = .052$). Social and emotional QOL were similar in both newly diagnosed patients and those diagnosed >6 years ago, although physical QOL worsens with time ($p = .05$). Depression, anxiety, and QOL are remarkably similar in watch and wait versus actively treated CLL, despite the latter group having, by definition, later stage disease. Patients £60 years are more depressed and have reduced emotional and social QOL. Younger watch and wait patients are more anxious. Patients diagnosed for more than 6 years have a worse physical QOL, but their social and emotional QOL are similar to those of newly diagnosed patients.

Mood State and Quality of Sleep in Cancer Pain Patients: A Comparison to Chronic Daily Headache

Wang, R.C., Wang, S.J., Chang, Y.C., and Lin, C.C.

Journal of Pain and Symptom Management, 33 (2007), 32–39

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Cancer pain is commonly believed to be a unique type of pain and dissimilar to noncancer pain; however, only limited research efforts have been directed at examining this belief. The aim of this study was to explore whether patients with chronic daily headache (CDH) and patients with chronic cancer pain (CCP) present with different pain, mood, and sleep quality profiles. Forty-seven patients diagnosed with CDH were matched by age and gender with 47 patients with CCP. The research instruments included the Brief Pain Inventory-Chinese version, the Profile of Mood States Short Form, and the Pittsburgh Sleep Quality Index-Taiwan Form (PSQI-T). Results revealed that there was no difference in pain intensity between the patients with CDH and those with CCP; however, the CCP group reported significantly higher mean levels of pain interference with daily life than did the CDH group. These two groups did not differ on the Total Mood Disturbance score; however, the CCP group reported significantly lower mean levels of vigor than did the CDH group. Moreover, there was no difference on the PSQI-T total score between these two groups; however, the CDH group reported higher mean scores of sleep disturbance, higher mean scores of use of sleep medications, lower mean scores of sleep efficiency, and lower mean scores of daytime dysfunction than did the CCP group. Despite some differences between these two groups, pain, mood, and sleep quality profiles in these two types of pain groups are similar.

Pain Management in the Last Six Months of Life among Women Who Died of Ovarian Cancer

Rolnick, S.J., Jackson, J., Nelson, W.W., Butani, A., Herrinton, L.J., Hornbrook, M., Neslund-Dudas, C., Bachman, D.J., and Coughlin, S.S.

Journal of Pain and Symptom Management, 33 (2007), 24–31

Previous studies indicate that the symptoms of many dying cancer patients are undertreated and many suffer unnecessary pain. We obtained data retrospectively from three large health maintenance organizations and examined the analgesic drug therapies received in the last 6 months of life by women who died of ovarian cancer between 1995 and 2000. Subjects were identified through cancer registries and administrative data. Outpatient medications used during the final 6 months of life were obtained from pharmacy databases. Pain information was obtained from medical charts. We categorized each medication based on the World Health Organization classification for pain management (mild, moderate, or intense). Of the 421 women, only 64 (15%) had no mention of pain in their charts. The use of medications typically prescribed for moderate to severe pain ("high intensity" drugs) increased as women approached death. At 5–6 months before death, 55% of women were either on no pain medication or medication generally used for mild pain; only 9% were using the highest intensity regimen. The percentage on the highest intensity regimen (drugs generally used for severe pain) increased to 22% at 3–4 months before death and 54% at 1–2 months. Older women (70 or older) were less likely to be prescribed the highest intensity medication than those under age 70 (44% vs. 70%, $p < .001$). No differences were found in the use of the high intensity drugs by race, marital status, year of diagnosis, stage of disease, or comorbidity. Our finding that only 54% of women with pain were given high intensity medication near death indicates room for improvement in the care of ovarian cancer patients at the end of life.

Differences in the Prevalence and Severity of Side Effects Based on Type of Analgesic Prescription in Patients with chronic Cancer Pain

Villars, P., Dodd, M., West, C., Koetters, T., Paul, S.M., Schumacher, K., Tripathy, D., Koo, P., and Miaskowski, C.

Journal of Pain and Symptom Management, 33 (2007), 67–77

An understanding of the relationship between the type of analgesic prescription and the prevalence and severity of side effects is crucial in making appropriate treatment decisions. The purposes of this study were to determine if there were differences in the prevalence of side effects among four different types of analgesic prescriptions (i.e., no opioid, only an as needed (PRN) opioid, only an around-the-clock (ATC) opioid, or an ATC + PRN opioid), to determine if there were differences in the severity of side effects among the four prescription groups, and to determine the relationships between the total dose of opioid analgesic medication prescribed and taken and the severity of side effects. As part of a larger study, 174 cancer patients with bone metastasis reported their analgesic use and the prevalence and severity of 11 side effects. Significant differences ($p < .05$) were found in prevalence rates for seven of the side effects among the four prescription groups. The highest prevalence rates were found in the only ATC and ATC + PRN groups. Significant differences were found in the severity scores for five of the side effects, with the highest severity scores reported by patients in the only ATC and ATC + PRN groups. Significant positive correlations were found between the severity of six of the side effects and

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the total dose of opioid prescribed and taken. Risk factors for analgesic-induced side effects are ATC and ATC + PRN prescription types and higher doses of opioid analgesics.

Improving Treatment of Depression among Low-Income Patients with Cancer: The Design of the ADAPt-C Study

Ell, K., Quon, B., Quinn, D.I., Dwight-Johnson, M., Wells, A., Lee, P.J., and Xie, B.

General Hospital Psychiatry, 29 (2007), 223–231

This article describes the randomized clinical trial methodology for a population-based study of oncology patients receiving cancer care in a public sector medical center. The primary goal is to test the effectiveness of socioculturally tailored collaborative care intervention in improving depression and quality of life outcomes among low-income ethnic minority patients with major depression and cancer. The Patient Health Questionnaire (PHQ-9) depression scale was used to identify patients meeting criteria for major depression (one cardinal depression symptom plus a PHQ-9 score of $\geq$10). Study-eligible patients were $\geq$90 days from cancer diagnosis who were receiving acute cancer treatment or follow-up care in oncology clinics. Patients with advanced disease limiting life expectancy to $<$6 months, acutely suicidal, or on antipsychotic medication were excluded. Allowing for attrition due to death or loss to follow-up, the study was powered at the 80% level to detect a 20% difference between study arms in the proportion of patients with $\geq$50% reduction in PHQ-9 symptoms at 12 months. Of 2330 patients screened, 23.2% met criteria. An 82.4% enrollment rate resulted in 446 primarily women being recruited and randomized to intervention or usual care. The study applies methods used in primary care depression trials with adaptations for oncology care clinics and for low-income minority patients.

Sublingual Methadone for the Management of Cancer-Related Breakthrough Pain: A Pilot Study

Hagen, N.A., Fisher, K., and Stiles, C.

Journal of Palliative Medicine, 10 (2007), 331–337

Breakthrough pain is a highly prevalent and difficult to manage cancer pain problem. Current strategies are frequently ineffective, in part because of a mismatch between the sudden onset and brief duration of breakthrough pain and the slower onset and more prolonged duration of oral immediate-release opioids. Novel analgesic interventions are needed to provide a closer match between the temporal profile of the pain and the pharmacodynamics of the pain medication, and novel models of study of breakthrough pain are needed to evaluate them. This is an open-label feasibility study of a model to evaluate sublingual methadone for cancer-related breakthrough pain. The model has three phases: screening, upward titration, and optimal dose evaluation. Seven patients with breakthrough pain because of cancer entered the upward titration phase of the trial, and 61 episodes of breakthrough pain were evaluated with sublingual methadone at escalating doses ranging from 2 to 18 mg. Toxicity was generally mild and similar to patients' prior breakthrough medication. Four patients entered the optimal dose evaluation phase, and 39 discrete episodes of breakthrough pain were available for evaluation. Significant relief of pain occurred with a median onset of 5 min, and no serious adverse events were encountered. This model of assessment of breakthrough pain, whereby each episode of pain is treated as a separate data set and multiple discrete episodes of breakthrough pain are assessed every 5 min in each patient appears to be feasible within the cancer pain population. Preliminary results suggest a very rapid onset of relief of breakthrough pain with sublingual methadone when administered at the optimal dose, consistent with a highly favorable early pharmacodynamic profile of methadone administered via this route. Further study is warranted.

First Do No Harm . . . Terminal Restlessness or Drug-Induced Delirium

White, C., McCann, M.A., and Jackson, N.

Journal of Palliative Medicine, 10 (2007), 345–351

Terminal restlessness is a term frequently used to refer to a clinical spectrum of unsettled behaviors in the last few days of life. Because there are many similarities between the clinical pictures observed in terminal restlessness and delirium, we postulate that, at times, what is referred to as terminal restlessness may actually be an acute delirium sometimes caused by medication used for symptom control. It is important therefore to consider the causes for this distressing clinical entity, treat it appropriately, and ensure the treatment provided does not increase its severity. This brief review aims to consider the medications that are commonly used toward the end of life that may result in a picture of delirium (or terminal restlessness). These include opioids, antisecretory agents, anxiolytics, antidepressants, antipsychotics, antiepileptics, steroids, and nonsteroidal anti-inflammatory drugs. This review also aims to raise awareness regarding the

recognition and diagnosis of delirium and to highlight the fact that delirium may be reversible in up to half of all cases. Good management of delirium has the potential to significantly improve patient care at the end of life.

A Randomized, Double-Blind, Multi-Site, Crossover, Placebo-Controlled Equivalence Study of Morning versus Evening Once-Daily Sustained-Release Morphine Sulfate in People with Pain from Advanced Cancer

Currow, D.C., Plummer, J.L., Cooney, N.J., Gorman, D., and Glare, P.A.

Journal of Pain and Symptom Management, 34 (2007), 17–23

Diurnal variation in pain perception is recognized. The question of whether opioid prescribing should be adjusted to account for diurnal variation can be tested with the advent of once-daily sustained-release morphine. The study recruited 45 people with opioid-responsive pain on stable doses of analgesics and advanced cancer from five regional palliative care programs in Australia. Each participant took one placebo and a 24-hourly dose of sustained-release morphine daily, 12 hours apart-active dose in the morning for 1 week and in the evening for the other week. The order of the weeks was randomized in a double-blind manner. The primary outcome from the last 2 days (steady state) on both arms was averaged 4-hourly pain scores while awake on a 100-mm visual analogue scale (VAS). Secondary outcomes included VAS and categorical scales for other pain parameters, quality of sleep, nausea, vomiting, constipation, confusion, and somnolence. Twenty-six of 42 participants completed the study and provided adequate power for analysis. Mean VAS was 16 mm for morning dosing and 14 mm for evening dosing ($p = .76$, difference of adjusted means 2 mm, 95% confidence interval: −2, 6). No differences were found in pain control, pain during the day, pain disturbing sleep, or with breakthrough medication use. This study suggests that any difference between morning and evening dosing of once-daily sustained-release morphine in people with significant opioid-responsive pain and advanced cancer is small and unlikely to be clinically significant for most people.

PSYCHOSOCIAL INTERVENTION

Impact of Psychotherapeutic Support for Patients with Gastrointestinal Cancer Undergoing Surgery: 10-Year Survival Results of a Randomized Trial

Küchler, T., Bestmann, B., Rappat, S., Henne-Bruns, D., and Wood-Dauphinee, S.

Journal of Clinical Oncology, 25 (2007), 2702–2708

The impact of psychotherapeutic support on survival for patients with gastrointestinal cancer undergoing surgery was studied. A randomized controlled trial was conducted in cooperation with the Departments of General Surgery and Medical Psychology, University Hospital of Hamburg, Germany, from January 1991 to January 1993. Consenting patients ($N = 271$) with a preliminary diagnosis of cancer of the esophagus, stomach, liver/gallbladder, pancreas, or colon/rectum were stratified by sex and randomly assigned to a control group that received standard care as provided on the surgical wards or to an experimental group that received formal psychotherapeutic support in addition to routine care during the hospital stay. From June 2003 to December 2003, the 10-year follow-up was conducted. Survival status for all patients was determined from our own records and from three external sources: the Hamburg cancer registry, family doctors, and the general citizen registration offices. Kaplan–Meier survival curves demonstrated better survival for the experimental group than the control group. The unadjusted significance level for group differences was $p = .0006$ for survival to 10 years. Cox regression models that took TNM staging or the residual tumor classification and tumor site into account also found significant differences at 10 years. Secondary analyses found that differences in favor of the experimental group occurred in patients with stomach, pancreatic, primary liver, or colorectal cancer. The results of this study indicate that patients with gastrointestinal cancer who undergo surgery for stomach, pancreatic, primary liver, or colorectal cancer benefit from a formal program of psychotherapeutic support during the inpatient hospital stay in terms of long-term survival.

Effects of Citalopram and Interpersonal Psychotherapy on Depression in Patients with Coronary Artery Disease: The Canadian Cardiac Randomized Evaluation of Antidepressant and Psychotherapy Efficacy (CREATE) Trial

Lespérance, F., Frasure-Smith, N., Koszycki, D., Laliberté, M.A., van Zyl, L.T., Baker, B., Swenson, J.R., Ghatavi, K., Abramson, B.L., Dorian, P., Guertin, M.C., CREATE Investigators.

JAMA, 297 (2007), 367–379

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Few randomized controlled trials have evaluated the efficacy of treatments for major depression in patients with coronary artery disease (CAD). None have simultaneously evaluated an antidepressant and short-term psychotherapy. The aim of this study was to document the short-term efficacy of a selective serotonin reuptake inhibitor (citalopram) and interpersonal psychotherapy (IPT) in reducing depressive symptoms in patients with CAD and major depression. We used The Canadian Cardiac Randomized Evaluation of Antidepressant and Psychotherapy Efficacy, a randomized, controlled, 12-week, parallel-group, 2×2 factorial trial conducted May 1, 2002, to March 20, 2006, among 284 patients with CAD from nine Canadian academic centers. All patients met *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, criteria for diagnosis of major depression of 4 weeks' duration or longer and had baseline 24-item Hamilton Depression Rating Scale (HAM-D) scores of 20 or higher. Participants underwent two separate randomizations: (1) to receive 12 weekly sessions of IPT plus clinical management ($n = 142$) or clinical management only ($n = 142$) and (2) to receive 12 weeks of citalopram, 20 to 40 mg/day ($n = 142$) or matching placebo ($n = 142$). The primary outcome measure was change between baseline and 12 weeks on the 24-item HAM-D, administered blindly during centralized telephone interviews (tested at $\alpha = .033$); the secondary outcome measure was self-reported Beck Depression Inventory II (BDI-II) score (tested at $\alpha = .017$). Citalopram was superior to placebo in reducing 12-week HAM-D scores (mean difference, 3.3 points; 96.7% confidence interval [CI], 0.80–5.85; $p = .005$), with a small to medium effect size of 0.33. Mean HAM-D response (52.8% vs 40.1%; $p = .03$) and remission rates (35.9% vs. 22.5%; $p = .01$) and the reduction in BDI-II scores (difference, 3.6 points; 98.3% CI, 0.58–6.64; $p = .005$; effect size = 0.33) also favored citalopram. There was no evidence of a benefit of IPT over clinical management, with the mean HAM-D difference favoring clinical management (−2.26 points; 96.7% CI, −4.78 to 0.27; $p = .06$; effect size = 0.23). The difference on the BDI-II did not favor clinical management (1.13 points; 98.3% CI, −1.90 to 4.16; $p = .37$; effect size = 0.11). This trial documents the efficacy of citalopram administered in conjunction with weekly clinical management for major depression among patients with CAD and found no evidence of added value of IPT over clinical management. Based on these results and those of previous trials, citalopram or sertraline plus clinical management should be considered as a first-step treatment for patients with CAD and major depression.

Ethnicity and Preferences for Depression Treatment

Givens, J.L., Houston, T.K., Van Voorhees, B.W., Ford, D.E., and Cooper, L.A.

General Hospital Psychiatry, 29 (2007), 182–191

The objective of this work was to describe ethnic differences in attitudes toward depression, depression treatment, stigma, and preferences for depression treatment (counseling vs. medication). This study used a cross-sectional Internet survey measuring treatment preference, stigma, and attitudes toward depression. Depressive symptoms were measured with the Center for Epidemiological Studies Depression (CES-D) scale. Multivariable regression models adjusting for treatment attitudes and demographics estimated the independent effect of ethnicity on treatment preference. A total of 78,753 persons with significant depressive symptoms (CES-D > 22), including 3596 African Americans, 2794 Asians/Pacific Islanders, and 3203 Hispanics, participated. Compared to Whites, African Americans, Asians/Pacific Islanders, and Hispanics were more likely to prefer counseling to medications (odds ratio [OR] = 2.6, 95% confidence interval [95% CI] = 2.4–2.8, OR = 2.5, 95% CI = 2.2–2.7, and OR = 1.8, 95% CI = 1.7–2.0, respectively). Ethnic minorities were less likely to believe that medications were effective and that depression was biologically based, but were more likely to believe that antidepressants were addictive and that counseling and prayer were effective in treating depression. Attitudes and beliefs somewhat attenuated the association between ethnicity and treatment preference in adjusted analyses. Racial and ethnic minorities prefer counseling for depression treatment more than Whites. Beliefs about the effects of antidepressants, prayer, and counseling partially mediate preferences for depression treatment.

Looming Threat-Processing Style in a Cancer Cohort

Levin, T.T., Riskind, J.H., and Li, Y.

General Hospital Psychiatry, 29 (2007), 32–38

Looming threat-processing style, where threats are perceived to be progressing (looming) at a frightening velocity, is implicated in anxiety vulnerability. This study aims to validate a new measure of looming, the looming cancer and to explore its clinical correlates in a chronic lymphocytic leukemia (CLL) cohort. In a cross-sectional design, 105 CLL patients completed the Looming Cancer Scale, Looming

Cognitive Style Questionnaire (LCSQ), SF-36, Beck Anxiety Inventory (BAI), and Beck Depression Inventory II (BDI-II). Exploratory factor analysis reduced the 20-item Looming Cancer Scale to a 10-item version, which demonstrated good psychometric properties (Cronbach's $\alpha = .926$). Convergent validity was demonstrated by Pearson's correlation with the LCSQ (.418), BAI (.380), BDI-II (.336), and the mental component score of the SF-36 ($-.434$) (all $p < .001$). Divergent validity was demonstrated by a lack of correlation with the SF-36 physical component score and cross tabulation frequencies of high and low loomers. High versus low loomers showed significantly more anxiety (31% vs. 13%), depression (23% vs. 2%) and mixed anxiety-depression (18% vs. 2%). An area under the receiver operating characteristic curve analysis revealed high sensitivity (82%) and specificity (69%) in detecting mixed anxiety-depression using a cutoff score of $\geq 20/30$. The Looming Cancer Scale is a valid measurement of looming cognitive style and this is the first time that the looming construct has been studied in a cancer cohort. The importance of this research lies in its potential to identify populations vulnerable to developing anxiety, depression, and mixed anxiety-depression symptoms.

Impact of a Peer-Delivered Telephone Intervention for Women Experiencing a Breast Cancer Recurrence

Gotay, C.C., Moinpour, C.M., Unger, J.M., Jiang, C.S., Coleman, D., Martino, S., Parker, B.J., Bearden, J.D., Dakhil, S., Gross, H.M., Lippman, S., and Albain, K.S.

Journal of Clinical Oncology, 25 (2007), 2093–2099

A first breast cancer recurrence creates considerable distress, yet few psychosocial interventions directed at this population have been reported. The Southwest Oncology Group conducted a phase III randomized trial to evaluate the effectiveness of a brief telephone intervention. Three hundred five women experiencing a first recurrence of breast cancer were randomly assigned to standard care or intervention. The intervention consisted of four to eight telephone calls delivered over a 1-month period. The calls were conducted by trained peer counselors at a breast cancer advocacy organization, the Y-ME National Breast Cancer Organization, and followed a standard curriculum. Psychosocial distress (Cancer Rehabilitation Evaluation System-Short Form [CARES-SF]) and depressive symptoms (Center for Epidemiologic Studies Depression Scale [CES-D]) outcomes were assessed at baseline and 3 and 6 months. The 3-month assessment was the primary end point and is the focus of this article. Analysis revealed no differences in distress or depressive symptoms at 3 months between the intervention and control groups; at 3 months, 70% of control patients and 66% of intervention patients reported psychosocial distress, and 40% of control patients and 47% of intervention patients exhibited depressive symptoms. Telephone peer counseling did not lead to better psychosocial outcomes. The persistent distress in these women supports the urgent need for the development and testing of more intensive or different supportive interventions for this group of patients.

QUALITY OF PALLIATIVE CARE

Stress and Coping in Hospice Nursing Staff. The Impact of Attachment Styles

Hawkins, A.C., Howard, R.A., and Oyebode, J.R.

Psycho-oncology, 16 (2007), 563–572

Previous research suggests that the attachment style developed during childhood informs adult attachment styles, which in turn affects adult relationships and responses to stress. This study considers the sources of stress in hospice nurses and addresses the potential impact of their attachment styles on stress and coping experiences. Adult attachment style, stress, and coping were measured in 84 nurses recruited from five hospices. The results supported previous research regarding the most common sources of stress in this nursing group. The study found partial support for the hypothesis that nurses with insecure attachment styles experience more stress than securely attached nurses. Hospice nurses with a fearful or dismissing attachment style were found to be less likely to seek emotional social support as a means of coping with stress than hospice nurses with a secure or preoccupied attachment style. Supervision, support, and career-long training for nurses in hospices are recommended. Further research is needed to clarify the involvement of attachment style in hospice nurse stress and coping experiences.

Critical Events in the Dying Process: The Potential for Physical and Psychosocial Suffering

Schroepfer, T.

Journal of Palliative Medicine, 10 (2007), 136–147

Understanding what aspects of the dying process motivate terminally ill individuals to consider hastening their death can lead to improving end-of-life care. The aim of this paper is to advance knowledge regarding critical events within the dying process

that have the potential to give rise to physical and psychosocial suffering such that an elder wishes for or considers a hastened death. My method was face-to-face in-depth qualitative interviews conducted with 96 terminally ill elders, 15 of whom discussed an event in their dying process that resulted in suffering so great they wished for, or considered, a hastened death. Data were content analyzed to identify and categorize the main themes and patterns involved in these elders' experiences. The interviews were conducted on palliative care hospital units, and in outpatient clinics, free standing hospice facilities, and home hospice. Four critical events emerged: perceived insensitive and uncaring communication of a terminal diagnosis, experiencing unbearable physical pain, unacknowledged feelings regarding undergoing chemotherapy or radiation treatment, and dying in a distressing environment. Respondents discussed physical and/or psychosocial suffering that occurred at these events and the end-of-life care practices that reduced their suffering. Awareness of events common to the dying process, the potential physical and psychosocial suffering that may arise at these events, and the end-of-life care practices associated with reducing that suffering can lead to health care professionals being able to take a proactive rather than reactive approach to end-of-life care.

Age, Health, and Education Determine Supportive Care Needs of Men Younger Than 70 Years with Prostate Cancer

Smith, D.P., Supramaniam, R., King, M.T., Ward, J., Berry, M., and Armstrong, B.K.

Journal of Clinical Oncology, 25 (2007), 2560–2566

It is important to meet the supportive care needs of cancer patients to ensure their satisfaction with their care. A population-wide sample of men younger than 70 years and newly diagnosed with prostate cancer was surveyed to determine their unmet needs in five domains and the factors predicting them. Eligible men were younger than 70 years and residents in New South Wales, Australia, with newly diagnosed histopathologically confirmed prostate cancer. Sixty-seven percent of eligible men diagnosed between October 2000 and October 2001 participated. Demographic, treatment, and self-reported health data were collected. Information on cancer stage, grade, and prostate-specific antigen was obtained from medical records. Logistic regression analyses determined patient and treatment variables that predicted higher unmet needs. More than half (54%) of men with prostate cancer expressed some level of unmet psychological need, and 47% expressed unmet sexuality needs. Nearly one fourth expressed a moderate or high level of unmet need with respect to changes in sexuality. Sexuality needs were independently predicted by being younger, having had a secondary school education only, having had surgery, and being married, living as married, or divorced. Uncertainty about the future was also an important area of unmet need. Attention should be given to sexual and psychological needs in the early months after diagnosis or treatment of prostate cancer, particularly in younger men, those with less education, and those having surgery. Research into better ways of meeting these needs will enable us to meet them with as much rigor as we meet clinical treatment needs.

COMMUNICATION

The Dying Role

Emanuel, L., Bennett, K., and Richardson, V.E.

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Roles are relevant during the last stage of the life cycle, as at any other stage. Awareness and an understanding of the dying role have the capacity to guide the process. Lack thereof can impede good deaths and may have been in part responsible for the intense and often futile interventions provided to many dying patients in the past. We describe relevant aspects of role theory and recent scholarship and then examine the dying role, describing three key elements: the practical element, which involves concrete tasks of preparation; the relational element, which involves engaging with others; and the personal element, which involves tasks that foster personal growth and finishing one's life story. We also identify some barriers to and misuses of the dying role that appear to limit productive engagement with it and offer suggestions for how clinicians can assist patients with the dying role. The described elements of the dying role and appreciation of how to avoid barriers and facilitate its implementation can help patients access the unique quality of life that can occur near the end of life.

Influence of Patient and Physician Characteristics on Percutaneous Endoscopic Gastrostomy Tube Decision Making

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Data are lacking to support percutaneous endoscopic gastrostomy (PEG) tube placement in

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advanced dementia, yet it is common, especially in the southeast United States and in African Americans. In a cross-sectional survey, we examined whether physicians recommend PEG placement more for African American than Caucasian patients and identify physician characteristics related to recommendation for PEG. We randomly assigned two versions, varying only by race, of a case patient with advanced dementia to all internal and family medicine physicians in the North Carolina Medical Society. Respondents gave recommendations regarding PEG tube feeding and demographic data including their race, age, gender, and specialty. We analyzed data using logistic regression, controlling for physician characteristics that were statistically significant in χ^2 analyses. Of 2058 physicians, 53% ($n =$ 1083) responded. Of 981 responses with complete data, 18.0% recommended PEG and 80.0% recommended against PEG or made no recommendation. Recommendations for PEG did not differ significantly by race of the case patient (Caucasian = 16.4% vs. African American = 19.6%). Fewer recommendations for PEG tube placement were made by Caucasian (13.0% vs. Asian 54.3% and African American 40.0%; $p < .001$) and internal medicine and geriatrics physicians (13.8% and 9.1% vs. family medicine 23.4%; $p = .001$). Of African American physicians, 51.4% recommended PEG for African American patients and 24.0% for the Caucasian patient. In this survey, recommendation for PEG tube feeding differed significantly by physician race and specialty, and not by race of the case patient. Additional research is needed to measure whether real-life treatment recommendations vary by physician race, physician–patient race concordance, and physician specialty.

Utility of Morbidity and Mortality Conference in End-of-Life Education in the Neonatal Intensive Care Unit

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A monthly neonatal intensive care unit (NICU) morbidity and mortality conference (M&MC) was used to study the documentation of end-of-life (EOL) care and integrate related education for staff and trainees. Our purpose was to study the current documentation of comprehensive, interdisciplinary, palliative EOL care in the NICU at the Vanderbilt Children's Hospital and improve it relative to a historical background. A survey tool was developed and used at all neonatal M&MCs for 1 year (August 2003 through July 2004) in conducting a prospective chart audit of 50% of NICU deaths. The survey ascertained documentation of EOL care to include the anticipation of death by family and staff, provision of pain management, discussion of ethical and EOL decision-making issues, and the use of supportive services. Clinical education and literature references pertaining to these elements of care were presented in the conferences. Twenty-six surveys were completed (48% of deaths in NICU over the study period). Documentation of EOL care ranged from excellent (pain management, 100%) to poor (spiritual support, 54%). Documentation of all other measures varied from 69% to 92%. Staff and trainees reported educational enhancement of the M&MC and greater awareness of issues important to EOL care throughout this period. Areas for improving EOL care exist in the NICU. The M&MC is a familiar venue for incorporating EOL care education for staff and trainees. A survey tool may serve to aid in the assessment of documentation of such care. Staff awareness of, and attention to, EOL issues may be improved through such a mechanism.