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Clinical Update: Literature Abstracts

MEASURES

Development of a Self-Report Screening Instrument for Assessing Potential Opioid Medication Misuse in Chronic Pain Patients

Adams, L.L., Gatchel, R.J., Robinson, R.C., Polatin, P., Gajraj, N., Deschner, M., and Noe, C.

Journal of Pain and Symptom Management, *27* (2004), 440–459

This study constituted the first step in the psychometric development of a self-report screening instrument for risk of opioid medication misuse among chronic pain patients. A 26-item instrument, the Pain Medication Questionnaire (PMQ), was constructed based on suspected behavioral correlates of opioid medication misuse, which heretofore have received limited empirical investigation. The PMQ was administered to 184 patients at an interdisciplinary pain treatment center. Reliability coefficients for the PMQ were found to be of moderate but acceptable strength. Construct and concurrent validity were examined through correlation of PMQ scores to measures of substance abuse, physical and psychological functioning, and physicians' risk assessments. To explore high and low cutoff points for misuse risk, subgroups were formed according to the upper and lower thirds of PMQ scores and compared on validity measures. Higher PMQ scores were associated with history of substance abuse, higher levels of psychosocial distress, and poorer functioning. Future psychometric analyses will consider predictive validity and examine shortened versions of the instrument.

Measuring the Quality of Structure and Process in End-of-Life Care from the Bereaved Family Perspective

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

Journal of Pain and Symptom Management, *27* (2004), 492–501

Measurement of the structure/process of care is the first step in improving end-of-life care. The primary aim of this study was to psychometrically validate an instrument for directly measuring the bereaved family's perception of the necessity for improvement in structural/procedural aspects of palliative care. Different sets of questionnaires were sent to 800 and 425 families who lost family members at 1 of 70 certified palliative care units in Japan in the development and validation phases, respectively, and 281 families of the latter group in the follow-up phase. The participants were requested to fill out a newly developed Care Evaluation Scale (CES), along with outcome measures (the perceived experience and satisfaction levels) and potential covariates (the degree of expectation, the Center for Epidemiologic Studies Depression Scale, and the Social Desirability Scale). We obtained 485, 310, and 202 responses in the development, validation, and follow-up phases (response rates: 64%, 75%, and 72%, respectively). The 28-item CES had an overall Cronbach's coefficient alpha of 0.98; the intraclass correlation coefficient in the test–retest examination was 0.57. A confirmatory factor analysis revealed 10 subscales: physical care (by physicians, by nurses), psychoexistential care, help with decision making (for patients, for family), environment, family burden, cost, availability, and coordination/consistency. The CES subscales were only moderately correlated with the perceived-experience and satisfaction levels of corresponding areas (r = 0.36–0.52 and 0.39–0.60, respectively). The CES score was not significantly associated with the degree of expectation, the changes of depression, or the Social Desirability Scale. The CES is a useful tool to measure the bereaved family's perception of the necessity for improvement in structural/procedural aspects of palliative care. The advantages of the CES are (1) it specifically evaluates the structure and process of

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care; (2) it directly identifies needed improvements; (3) it is not affected by the degree of expectation, depression, or social desirability; and (4) it has satisfactory psychometric properties.

Mental Health Visits to Complementary and Alternative Medicine Providers

Simon, G., Cherkin, D., Sherman, K., Eisenberg, D., Deyo, R., and Davis, R.

General Hospital Psychiatry, *26* (2004), 171–177

The objective of this study was to examine the characteristics of mental health visits to Complementary and Alternative Medicine (CAM) providers. A representative sample of acupuncturists, chiropractors, massage therapists, and naturopathic physicians in four states reported on 8933 consecutive visits, including demographic characteristics, presenting complaints, referral source, treatments provided, disposition, and other sources of care for the presenting problem. The proportion of visits for a mental health complaint ranged from 7% to 11% for acupuncture, massage, and naturopathic physicians to less than 1% for chiropractors. For acupuncturists, massage therapists, and naturopaths, 69–87% of patients making mental health visits were self-referred. The CAM provider discussed care with a conventional medical provider in 6–20% of cases and was aware of concomitant conventional medical care in an additional 10–30%. Only 1–5% were subsequently referred to conventional providers. For acupuncturists, massage therapists, and naturopaths, the proportion of visits for mental health concerns is similar to that in conventional primary care. Mental health visits to chiropractors are much less common, but this may reflect differences in true prevalence or differences in presentation. Among those seeking CAM care for mental disorders, concomitant treatment by conventional medical providers is common, but communication or coordination of care is rare.

SYMPTOM CONTROL

Acupuncture for Postchemotherapy Fatigue: A Phase II Study

Vickers, A.J., Straus, D.J., Fearon, B., and Cassileth, B.R.

Journal of Clinical Oncology, *22* (2004), 1731–1735

The purpose of this study was to determine whether improvement in postchemotherapy fatigue following acupuncture treatment is substantial enough to warrant a controlled trial. We accrued patients at Memorial Sloan-Kettering Cancer Center who had completed cytotoxic chemotherapy but experienced persisting fatigue. Patients with severe anemia, clinical depression, or Karnofsky performance status score less than 70 were excluded. Thirty-seven patients were registered in two cohorts; 31 provided follow-up data. Patients received acupuncture either twice per week for 4 weeks (25 patients) or once per week for 6 weeks (12 patients). The primary end point was change in score on the Brief Fatigue Inventory between baseline and 2 weeks after the final treatment. A baseline Brief Fatigue Inventory score of four or greater was an eligibility requirement for the trial. Patients had completed cytotoxic chemotherapy an average of more than 2 years previously. Baseline fatigue scores were high, with approximately half of the sample scoring in the "severe" range. Mean improvement following acupuncture was 31.1% (95% CI, 20.6% to 41.5%), meeting our prespecified criterion for declaring acupuncture worthy of further study. Increasing age was associated with poorer response and failure to complete the study. There was no important difference in improvement following once-weekly and twice-weekly treatments. Acupuncture is worthy of further study in the treatment of postchemotherapy fatigue.

Randomized Clinical Trial of the Effectiveness of a Self-Care Intervention to Improve Cancer Pain Management

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

Journal of Clinical Oncology, *22* (2004), 1713–1720

This randomized clinical trial tested the effectiveness of the PRO-SELF Pain Control Program compared with standard care in decreasing pain intensity scores, increasing appropriate analgesic prescriptions, and increasing analgesic intake in oncology outpatients with pain from bone metastasis. Patients were randomly assigned to the PRO-SELF intervention (n = 93) or standard care (n = 81). Patients in the standard care arm were seen by a research nurse three times and were called three times by phone between the home visits. PRO-SELF group patients were seen by specially trained intervention nurses and received a psychoeducational intervention, were taught how to use a pill-box, and were given written instructions on how to communicate with their physician about unrelieved pain and the need for changes in their analgesic prescriptions. Patients were coached during two follow-up home visits and three phone calls on how to improve their cancer pain management. Pain

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intensity scores decreased significantly from baseline (all $P < 0.0001$) in the PRO-SELF group (i.e., least pain, 28.4%; average pain, 32.5%; and worst pain, 27.0%) compared with the standard care group (i.e., least increased by 14.6%, average increased by 1.9%, and worst decreased by 1.2%). The percentage of patients in the PRO-SELF group with the most appropriate type of analgesic prescription increased significantly from 28.3% to 37.0% ($P = 0.008$) compared with a change from 29.6% to 32.5% in the standard care group. The use of a psychoeducational intervention that incorporates nurse coaching within the framework of self-care can improve the management of cancer pain.

Successful Use of Zonisamide for Central Poststroke Pain

Takahashi, Y., Hashimoto, K., and Tsuji, S.

The Journal of Pain, *5* (2004), 192–194

We present two patients with severe and intractable central poststroke pain (CPSP) after right posterolateral thalamic infarcts who were successfully treated with zonisamide. The mechanism of action was presumed to be the suppression of overacting thalamic relay neurons by blockade of low voltage-activated calcium channel or by increasing gamma-aminobutyric acid (GABA) release. Zonisamide can be one of the therapeutic options for severe CPSP and might provide an insight into the pathogenesis of CPSP. PERSPECTIVE: The blockade of T-type VGCC or the increase in GABA release caused by zonisamide presumably suppresses abnormal activities of thalamic sensory neurons.

An Eicosapentaenoic Acid Supplement versus Megestrol Acetate versus Both for Patients with Cancer-Associated Wasting: A North Central Cancer Treatment Group and National Cancer Institute of Canada Collaborative Effort

Jatoi, A., Rowland, K., Loprinzi, C.L., Sloan, J.A., Dakhil, S.R., MacDonald, N., Gagnon, B., Novotny, P.J., Mailliard, J.A., Bushey, T.I., Nair, S., and Christensen, B.

Journal of Clinical Oncology, *22* (2003), 2469–2476

Studies suggest eicosapentaenoic acid (EPA), an omega-3 fatty acid, augments weight, appetite, and survival in cancer-associated wasting. This study determined whether an EPA supplement—administered alone or with megestrol acetate (MA)—was more effective than MA. Four hundred twenty-one assessable patients with cancer-associated wasting were randomly assigned to an EPA supplement 1.09 g administered bid plus placebo; MA liquid suspension 600 mg/d plus an isocaloric, isonitrogenous supplement administered twice a day; or both. Eligible patients reported a 5-lb, 2-month weight loss and/or intake of less than 20 calories/kg/d. A smaller percentage taking the EPA supplement gained ≥10% of baseline weight compared with those taking MA: 6% versus 18%, respectively ($P = 0.004$). Combination therapy resulted in weight gain of ≥10% in 11% of patients ($P = 0.17$ across all arms). The percentage of patients with appetite improvement (North Central Cancer Treatment Group Questionnaire) was not statistically different: 63%, 69%, and 66%, in EPA-, MA-, and combination-treated arms, respectively ($P = 0.69$). In contrast, 4-week Functional Assessment of Anorexia/Cachexia Therapy scores suggested MA-containing arms experienced superior appetite stimulation compared with the EPA arm, with scores of 40, 55, and 55 in EPA-, MA-, and combination-treated arms, respectively ($P = 0.004$). Survival was not significantly different among arms. Global quality of life was not significantly different among groups. With the exception of increased impotence in MA-treated patients, toxicity was comparable. This EPA supplement, either alone or in combination with MA, does not improve weight or appetite better than MA alone.

Determining the Relationship between Toxicity and Quality of Life in an Ovarian Cancer Chemotherapy Clinical Trial

Butler, L., Bacon, M., Carey, M., Zee, B., Tu, D., and Bezjak, A.

Journal of Clinical Oncology, *22* (2004), 2461–2468

This analysis of data from a randomized trial of chemotherapy in epithelial ovarian cancer sought to determine whether a relationship exists between the presence and severity of the most commonly observed toxic effects and the corresponding quality of life (QOL) items. One hundred fifty-two eligible patients accrued from Canada by the National Cancer Institute of Canada Clinical Trials Group on a randomized trial of paclitaxel and cisplatin versus cyclophosphamide/cisplatin were included in the analysis. Toxicity to the chemotherapeutic treatments was subjectively evaluated using a trial-specific checklist for ovarian cancer and the European Organization for Research and Treatment of Cancer QLQ C30+3 questionnaire. Assessments were conducted at baseline, before each cycle of treatment (3 weeks), and at each 3-month follow-up during the next 2 years (or until progres-

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sion). The most frequently observed symptoms experienced during or shortly following chemotherapy were neurosensory loss, lethargy, nausea, vomiting, and alopecia. Regression analyses revealed that change scores of QOL items related to motor weakness and gastrointestinal pain were common predictors for the change in global QOL score during protocol treatment; change scores of QOL items related to lethargy or fatigue and change in toxicity grade of mood predicted the change global QOL score after patients were off treatment. The use of the European Organization for Research and Treatment of Cancer QLQ C30+3 and trial-specific checklist was able to assess the effect of expected toxicities on patient's QOL during and following treatment, and so may be useful in addressing the concerns regarding methodological issues that have limited the acquisition of prospective, longitudinal treatment-related toxicity data.

Cognitive Impairment Associated with Chemotherapy for Cancer: Report of a Workshop

Tannock, I.F., Ahles, T.A., Ganz, P.A., and Van Dam, F.S.

Journal of Clinical Oncology, *22* (2004), 2233–2239

Cognitive dysfunction may occur in some patients who receive chemotherapy. We provide a summary of an April 2003 workshop on this topic, which included medical oncologists, radiologists, clinical and experimental psychologists, and patient advocates. Current studies indicate that cognitive deficits are often subtle, although they are observed consistently in a proportion of patients, may be durable, and can be disabling. Deficits have been observed in a range of cognitive functions. Underlying mechanisms are unknown, although preliminary studies suggest there may be genetic predisposition and that cognitive impairment may be accompanied by changes in the brain detectable by neuroimaging. The following priorities were established for future research: (1) large-scale clinical studies that use both a longitudinal design and concurrent evaluation of patients with cancer who do not receive chemotherapy—such studies should address the probability and magnitude of cognitive deficits, factors that predict them, and underlying mechanisms; (2) exploration of discrepancies between subjective reports of cognitive dysfunction and the objective results of cognitive testing; (3) studies of cognitive function in patients receiving treatment for diseases other than breast cancer, and in both men and women, to address the hypothesis that underlying mechanisms relate to changes in serum levels of sex hormones and/or to chemotherapy-induced menopause; (4) development of interventions to alleviate these problems; and (5) development of animal models and the use of imaging techniques to address mechanisms that might cause cognitive impairment associated with chemotherapy.

A Double-Blind Trial of Risperidone and Haloperidol for the Treatment of Delirium

Han, C. and Kim, Y.

Psychosomatics, *45* (2004), 297–301

To compare the clinical efficacy of haloperidol and risperidone for the treatment of delirium, the authors performed a double-blind comparative study. Twenty-eight patients with delirium were recruited and randomly assigned to receive a flexible-dose regimen of haloperidol or risperidone over 7 days. The severity of delirium was assessed by using Memorial Delirium Assessment Scale scores. Scores for each group decreased significantly over the study period. However, no significant differences in mean Memorial Delirium Assessment Scale scores between groups were found. The group by time effect was not significant. In addition, there was no significant difference in the frequency of response to the drugs between the two groups. One patient in the haloperidol group experienced mild akathisia, but no other patients reported clinically significant side effects. These data show no significant difference in the efficacy or response rate between haloperidol and risperidone in the treatment of delirium.

Atypical Antipsychotics and Risk of Cerebrovascular Accidents

Herman, N., Mamdani, M., and Lanctôt, K.

American Journal of Psychiatry, *161* (2004), 1113–1115

Randomized controlled trials have suggested that at least one atypical antipsychotic may be associated with an increased risk of stroke in older people with dementia. This study examined the association between atypical antipsychotic use and stroke in the elderly. The authors conducted a retrospective population-based cohort study of patients over the age of 66 by linking administrative health care databases. Three cohorts—users of typical antipsychotics, risperidone, and olanzapine—were identified and compared. Subjects treated with typical antipsychotics ($N = 1015$) were compared with those given risperidone ($N = 6964$) and olanzapine ($N = 3421$). Model-based estimates adjusted for covariates hypothesized to be associated with stroke risk

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revealed relative risk estimates of 1.1 (95% CI = 0.5–2.3) for olanzapine and 1.4 (95% CI = 0.7–2.8) for risperidone. Olanzapine and risperidone use were not associated with a statistically significant increased risk of stroke compared with typical antipsychotic use.

Contribution of Functional Neuroimaging to Understanding Neuropsychiatric Side Effects of Interferon in Hepatitis C

Matthews, S., Paulus, M., and Dimsdale, J.

Psychosomatics, *45* (2004), 281–286

Patients with hepatitis C who are treated with interferon may develop neuropsychiatric symptoms, including fatigue and depression. The authors discuss the potential use of functional neuroimaging in the identification and treatment of these patients. The authors provide an overview of functional neuroimaging studies of fatigue and depressive symptoms in various medical and psychiatric conditions and suggest future directions for research that may increase understanding of the specific neural substrates of neuropsychiatric side effects associated with hepatitis C and interferon treatment. This knowledge may help consultation-liaison psychiatrists identify patients at high risk for developing side effects related to hepatitis C and interferon, which would allow for implementation of validated strategies for prophylactic treatment of these patients.

Psychological Adjustment and Sleep Quality in a Randomized Trial of the Effects of a Tibetan Yoga Intervention in Patients with Lymphoma

Cohen, L., Warneke, C., Fouladi, R., Rodriguez, M., and Chaoul-Reich, A.

Cancer, *100* (2004), 2253–2260

Research suggests that stress-reduction programs tailored to the cancer setting help patients cope with the effects of treatment and improve their quality of life. Yoga, an ancient Eastern science, incorporates stress-reduction techniques that include regulated breathing, visual imagery, and meditation as well as various postures. The authors examined the effects of the Tibetan yoga (TY) practices of Tsa lung and Trul khor, which incorporate controlled breathing and visualization, mindfulness techniques, and low-impact postures in patients with lymphoma.

Thirty-nine patients with lymphoma who were undergoing treatment or who had concluded treatment within the past 12 months were assigned to a TY group or to a wait-list control group. Patients in the TY group participated in seven weekly yoga sessions, and patients in the wait-list control group were free to participate in the TY program after the 3-month follow-up assessment. Eighty-nine percent of TY participants completed at least two to three yoga sessions, and 58% completed at least five sessions. Patients in the TY group reported significantly lower sleep disturbance scores during follow-up compared with patients in the wait-list control group (5.8 vs. 8.1; $P < 0.004$). This included better subjective sleep quality ($P < 0.02$), faster sleep latency ($P < 0.01$), longer sleep duration ($P < 0.03$), and less use of sleep medications ($P < 0.02$). There were no significant differences between groups in terms of intrusion or avoidance, state anxiety, depression, or fatigue. The participation rates suggested that a TY program is feasible for patients with cancer and that such a program significantly improves sleep-related outcomes. However, there were no significant differences between groups for the other outcomes.

Relationship of Hemoglobin Levels to Fatigue and Cognitive Functioning among Cancer Patients Receiving Chemotherapy

Jacobsen, P., Garland, L., Booth-Jones, M., Donovan, K., Thors, C., Winters, E., and Grendys, E.

Journal of Pain and Symptom Management, *28* (2004), 7–18

The aim of this study was to examine the relationship of changes in hemoglobin levels to changes in fatigue and cognitive functioning in cancer patients undergoing chemotherapy treatment. Seventy-seven patients completed a self-administered measure of fatigue and a battery of psychometrician-administered measures of cognitive performance before the start of chemotherapy and again before the start of the fourth treatment cycle. Hemoglobin levels were measured at corresponding time points. Findings partially supported the hypothesis that greater declines in hemoglobin over the course of repeated chemotherapy administrations would be accompanied by greater increases in fatigue and greater declines in cognitive performance over the same interval. Among the subset of 49 patients who demonstrated a decline in hemoglobin to a final value $\leq$12 g/dL, greater declines in hemoglobin were significantly ($P < 0.05$) related to greater increases in fatigue duration and disruptiveness and more negative changes in performance on three cognitive tasks. These findings suggest that, in addition to previously reported relationships with

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fatigue, declines in hemoglobin levels during chemotherapy treatment are associated with adverse changes in cognitive functioning.

QUALITY OF PALLIATIVE CARE

Major Depression, Adjustment Disorders, and Post-Traumatic Stress Disorder in Terminally Ill Cancer Patients: Associated and Predictive Factors

Akechi, T., Okuyama, T., Sugawara, Y., Nakano, T., Shima, Y., and Uchitomi, Y.

Journal of Clinical Oncology, *22* (2004), 1957–1965

Few studies have been conducted to elucidate the psychological distress of terminally ill cancer patients. This study attempted to determine the prevalence of adjustment disorders (AD), major depression (MD), and post-traumatic stress disorder (PTSD) among terminally ill cancer patients, to identify factors that contribute to them, and to determine how they change longitudinally. Consecutive terminally ill cancer patients were recruited. Patients were assessed for psychiatric disorders by structured clinical interview twice: once at the time of their registration with a palliative care unit (baseline) and again at the time of their palliative care unit admission (follow-up). Possible contributed biomedical and psychosocial factors were evaluated. The proportions of patients diagnosed with AD, MD, and PTSD at baseline (n = 209) were 16.3%, 6.7%, and 0%, respectively, whereas at follow-up (n = 85), 10.6% were diagnosed with AD and 11.8% with MD. Lower performance status, concern about being a burden to others, and lower satisfaction with social support were significantly associated with AD/MD at baseline. There were changes in the diagnosis of AD and MD in 30.6% of the patients. Only the Hospital Anxiety and Depression Scale at the baseline was significantly predictive of AD/MD at follow-up. The factors underlying psychological distress are multifactorial. Early intervention to treat subclinical anxiety and depression may prevent subsequent psychological distress.

Association between Clinician Factors and a Patient's Wish to Hasten Death: Terminally Ill Cancer Patients and Their Doctors

Kelly, B., Burnett, P., Pelusi, D., Badger, S., Varghese, F., and Robertson, M.

Psychosomatics, *45* (2004), 311–318

This study investigated the clinical factors associated with a wish to hasten death among patients with advanced cancer receiving palliative care, with a focus on the role of clinician-related factors. Patients were grouped into high- and low-scoring groups on the basis of their wish to hasten death; doctor–patient pairs were formed. Questionnaire data collected from patients and their treating doctors were subjected to multivariate analysis. Significant predictors of a high wish to hasten death in terminally ill patients from among treating clinicians included the clinician's perception of the patient's lower optimism and greater emotional suffering, the patient indicating a wish to hasten death, the doctor willing to assist the patient in hastening death (if requested and legal), and the doctor reporting less training in psychotherapy. When these variables were combined with patient factors identified in a previous study, the model significantly predicted a wish to hasten death with the following variables—patient factors: a higher perceived burden on others, higher depressive symptom scores, and lower family cohesion; physician factors: the doctor willing to assist the patient in hastening death (if requested and legal), the doctor's perception of lower levels of optimism and greater emotional distress in the patient, and the doctor having less training in psychotherapy; and the setting of care: recent admission to a hospice. The findings support the multifactorial influences on the wish to hasten death and suggest that the role of the clinician is a vital context within which the wish to hasten death should be considered.

Recovery and Long-Term Function after Hematopoietic Cell Transplantation for Leukemia or Lymphoma

Syrjala, K., Langer, S., Abrams, J., Storer, B., Sanders, J., Flowers, M., and Martin, P.

JAMA, *291* (2004), 2335–2343

Hematopoietic cell transplantation (HCT) is an effective and widely used treatment for hematologic malignancies. The rate and predictors of physical and emotional recovery after HCT have not been adequately defined in prospective long-term studies. The objective of this study was to examine the course of recovery and return to work after HCT using a prospective, longitudinal cohort study at a U.S. academic center specializing in HCT. Function was assessed from pretransplantation to 5-year follow-up for 319 adults who had myeloablative HCT for treatment of leukemia or lymphoma and spoke English. Of the 99 long-term survivors who had no recurrent malignancy, 94 completed 5-year follow-up. Our measures were physical limitations, return to work, depression, and distress related to

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treatment or disease and they were evaluated before transplantation, at 90 days, and at 1, 3, and 5 years after HCT. Physical recovery occurred earlier than psychological or work recovery. Only 21 patients (19%) recovered on all outcomes at 1 year. The proportion without major limitations increased to 63% ($n = 57$) by 5 years. Among survivors without recurrent malignancy, 84% ($n = 74$) returned to full-time work by 5 years. Patients with slower physical recovery had higher medical risk and were more depressed before HCT (P 0.001). Patients with chronic graft-versus-host disease ($P = 0.01$), with less social support before HCT ($P = 0.001$), and women ($P < 0.001$) were more depressed after transplantation. Transplant-related distress was slower to recover for allogeneic transplant recipients and those with less social support before HCT ($P \leq 0.01$). Patients who had more experience with cancer treatment before beginning HCT had more rapid recovery from depression ($P = 0.04$) and treatment-related distress ($P = 0.009$). Full recovery after HCT is a 3- to 5-year process. Recovery might be accelerated by more effective interventions to increase work-related capabilities, improve social support, and manage depression.

Cancer Patient Preferences for Communication of Prognosis in the Metastatic Setting

Hagerty, R.G., Butow, P.N., Ellis, P.A., Lobb, E.A., Pendlebury, S., Leigh, N., Goldstein, D., Lo, S.K., and Tattersall, M.H.

Journal of Clinical Oncology, *22* (2004), 1721–1730

Our aim was to identify preferences for and predictors of prognostic information among patients with incurable metastatic cancer. One hundred twenty-six metastatic cancer patients seeing 30 oncologists at 12 outpatient clinics in New South Wales, Australia, participated in the study. Patients were diagnosed with incurable metastatic disease within 6 weeks to 6 months of recruitment. Patients completed a survey eliciting their preferences for prognostic information, including type, quantity, mode, and timing of presentation; anxiety and depression levels; and information and involvement preferences. More than 95% of patients wanted information about side effects, symptoms, and treatment options. The majority wanted to know longest survival time with treatment (85%), 5-year survival rates (80%), and average survival (81%). Words and numbers were preferred over pie charts or graphs. Fifty-nine percent (59%) wanted to discuss expected survival when first diagnosed with metastatic disease. Thirty-eight percent and 44% wanted to negotiate when expected survival and dying, respectively, were discussed. Patients with higher depression scores were more likely to want to know shortest time to live without treatment ($P = 0.047$) and average survival ($P = 0.049$). Lower depression levels were significantly associated with never wanting to discuss expected survival ($P = 0.03$). Patients with an expected survival of years were more likely to want to discuss life expectancy when first diagnosed with metastases ($P = 0.02$). Most metastatic cancer patients want detailed prognostic information but prefer to negotiate the extent, format, and timing of the information they receive from their oncologists.

Consideration of Hastening Death among Hospice Patients and Their Families

Arnold, E.M., Artin, K.A., Person, J.L., and Griffith, D.L.

Journal of Pain and Symptom Management, *27* (2004), 523–532

The purpose of this study was to describe hospice social workers' perceptions of cases where hospice patients or their family members expressed a desire to hasten the patient's death. Surveys were mailed to hospice social workers ($n = 212$) in two Southeastern states. Response rate was 36%. Of the 73 respondents, 56.2% had a patient and 26.1% had a patient's family member express a desire to hasten the patient's death. Most patients had a cancer diagnosis (70.4%) and were predominantly male (66.6%), white (94.4%), and were married/had a partner (66.7%). Poor quality of life (28.3%) and concern for suffering (28.3%) were the most common reasons reported for the request to hasten death. These data suggest that the desire for hastened death is not uncommon among hospice patients. Social workers perceive these requests to be related primarily to unmet needs.

Estimating Prognosis for Nursing Home Residents with Advanced Dementia

Mitchell, S.L., Kiely, D.K., Hamel, M.B., Park, P.S., Morris, J.N., and Fries, B.E.

JAMA, *22* (2004), 2734–2740

Survival varies for patients with advanced dementia, and accurate prognostic tools have not been developed. A small proportion of patients admitted to hospice have dementia, in part because of the difficulty in predicting survival. Our objective was to identify factors associated with 6-month mortality in newly admitted nursing home residents with advanced dementia and to create a practical risk

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score to predict 6-month mortality in this population. This was a retrospective cohort study of data from the Minimum Data Set (MDS). All Medicare or Medicaid licensed nursing homes in New York and Michigan were included. Participants had advanced dementia and were admitted to New York nursing homes between June 1, 1994, and December 30, 1998 (derivation cohort, $n = 6799$) and to Michigan nursing homes from October 1, 1998, through July 30, 2000 (validation cohort, $n = 4631$). MDS factors associated with 6-month mortality were determined in the derivation group, and the resulting mortality risk score was evaluated in the validation cohort. Risk score performance was compared with the cut point of 7c on the Functional Assessment Staging (FAST) scale. Among residents with advanced dementia, 28.3% ($n = 1922$) died within 6 months of nursing home admission in the derivation cohort; 35.1% ($n = 1626$) died in the validation cohort. The 6-month mortality rate increased across risk scores (possible range, 0–19): 0 points, 8.9% mortality; 1 to 2, 10.8%; 3 to 5, 23.2%; 6 to 8, 40.4%; 9 to 11, 57.0%; and at least 12, 70.0% in the validation cohort. The area under the receiver operating characteristic (AUROC) curve for predicting 6-month mortality was 0.74 and 0.70 in the derivation and validation cohorts, respectively. Our risk score demonstrated better discrimination to predict 6-month mortality (AUROC, 0.64 for a cutoff of ≥ 6 points vs. 0.51 for FAST stage 7c). A risk score based on 12 variables from the MDS estimates 6-month mortality for nursing home residents with advanced dementia with greater accuracy than existing prognostic guidelines.

Communicating Evidence for Participatory Decision Making

Epstein, R.M., Alper, B.S., and Quill, T.E.

JAMA, *291* (2004), 2359–2366

Informed patients are more likely to actively participate in their care, make wiser decisions, come to a common understanding with their physicians, and adhere more fully to treatment; however, currently there are no evidence-based guidelines for discussing clinical evidence with patients in the process of making medical decisions. Our aim was to identify ways to communicate evidence that improve patient understanding, involvement in decisions, and outcomes via a systematic review of MEDLINE for the period 1966–2003 and review of reference lists of retrieved articles to identify original research dealing with communication between clinicians and patients and directly addressing methods of presenting clinical evidence to patients. Two investigators and a research assistant screened 367 abstracts and two investigators reviewed 51 full-text articles, yielding 8 potentially relevant articles. Methods for communicating clinical evidence to patients include nonquantitative general terms, numerical translation of clinical evidence, graphical representations, and decision aids. Focus-group data suggest presenting options and/or equipoise before asking patients about preferred decision-making roles or formats for presenting details. Relative risk reductions may be misleading; absolute risk is preferred. Order of information presented and time frame of outcomes can bias patient understanding. Limited evidence supports use of human stick figure graphics or faces for single probabilities and vertical bar graphs for comparative information. Less-educated and older patients preferred proportions to percentages and did not appreciate confidence intervals. Studies of decision aids rarely addressed patient–physician communication directly. No studies addressed clinical outcomes of discussions of clinical evidence. CONCLUSIONS: There is a paucity of evidence to guide how physicians can most effectively share clinical evidence with patients facing decisions; however, basing our recommendations largely on related studies and expert opinion, we describe means of accomplishing five communication tasks to address framing and communicating clinical evidence: understanding the patient's (and family members') experience and expectations; building partnership; providing evidence, including a balanced discussion of uncertainties; presenting recommendations informed by clinical judgment and patient preferences; and checking for understanding and agreement.

PSYCHOSOCIAL INTERVENTIONS

Evaluation of a Short-Term Group Intervention for Informal Carers of Patients Attending a Home Palliative Care Service

Harding, R., Higginson, I.J., Leam, C., Donaldson, N., Pearce, A., George, R., Robinson, V., and Taylor, L.

Journal of Pain and Symptom Management, *27* (2004), 396–408

Despite evidence of high psychological distress and unmet needs, evaluated interventions for informal caregivers in palliative care are few. This study involved an observational outcome evaluation of attendees and a comparison group in specialist home palliative care. The measures included carer psychological status and patient physical status at baseline, 8 weeks, and 20 weeks. Qualitative data were collected regarding content, satisfaction with,

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and impact of intervention. Process data described the uptake, resources, and group activity. The intervention combined informal multiprofessional teaching with facilitated peer exchange and support, and was delivered over 6 sessions of 90 minutes per week. The uptake rate was 25%; carers were less likely to accept if they were in paid employment ($OR = 0.26$, $P = 0.06$), and more likely to accept if they utilized avoidance coping ($OR = 1.13$, $P = 0.04$) or their patient had worse physical status ($OR = 2.1$, $P = 0.03$). Attendees described significant support and knowledge gains from the multiprofessional input and peer group. Most relied on social comparison processes to appraise their situation. Potential detection of significant effects on global psychological scores (i.e., anxiety, depression, and burden) using multivariate analysis was disallowed due to attrition. This acceptable and accessible intervention provided information and support; further outcome studies are needed for a range of interventions. Short-term interventions are unlikely to affect global psychological scores, and future evaluations should include additional time points of data collection to demonstrate support during attendance.

What Works for Therapists Conducting Family Meetings: Treatment Integrity in Family-Focused Grief Therapy during Palliative Care and Bereavement

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The purpose of this study was to evaluate the treatment integrity of Family-Focused Grief Therapy (FFGT), a preventive intervention designed for families at high risk of poor functioning during palliative care and bereavement. From the 81 families participating in a randomized controlled trial (53 assigned to therapy), 28 were randomly selected for this study of treatment fidelity using the FFGT integrity measure. A total of 109 family sessions were appraised. This represented a review of 62% of treated families, 38% of total therapy sessions, and 87% of the 15 participating therapists. Weighted mean percentage occurrences of therapist behaviors permitted trends in therapy application to be observed. Interrater reliability using the FFGT integrity measure was satisfactory, with 88% overall agreement. Eighty-six percent of therapists adhered faithfully to core elements of the model. Therapist competence was evidenced by a strong therapeutic alliance (94%), affirmation of family strengths in over 90%, and focus on agreed themes in 76% of sessions. Therapists averaged 10 grief-related questions per session, 7 on communication-related issues during assessment, 7 on conflict late in therapy, and 4 on cohesiveness across the course of therapy. Consistent application of FFGT, with attention to its four key themes of family communication, cohesiveness, conflict resolution, and shared grief has been demonstrated. The model is generalizable when applied by family therapists.

An Open-Label Trial of Interpersonal Psychotherapy in Depressed Patients with Coronary Disease

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High rates of depression have been reported in patients with coronary artery disease, and depression has been repeatedly shown to adversely affect cardiac morbidity and mortality. Despite these findings, little work has been devoted to evaluating effective antidepressant treatments for this subpopulation. This open-label trial assessed the efficacy and acceptability of interpersonal psychotherapy in depressed patients with stable coronary artery disease. Seventeen patients with coronary artery disease who met DSM-IV criteria for major depression received 12 weekly sessions of interpersonal psychotherapy. Outcome was assessed with the 17-item Hamilton Depression Rating Scale and the Beck Depression Inventory II. Ten patients received medication during the trial, and seven patients received interpersonal psychotherapy alone. The patients showed a significant reduction in scores on both the Hamilton depression scale and the Beck Depression Inventory II from baseline, with 53% of the patients meeting criteria for remission, as defined by scores of ≤ 7 and ≤ 14 on the Hamilton depression scale and the Beck Depression Inventory II, respectively. Medicated and unmedicated patients responded similarly to interpersonal psychotherapy. These data provide support for the potential use of interpersonal psychotherapy in depressed patients with coronary artery disease. The therapy was well tolerated and accepted by patients, with a high proportion achieving remission. Future randomized clinical trials are needed to establish its efficacy.

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