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Clinical Update: Literature Abstracts

MEASURES

Using the American Pain Society's Patient Outcome Questionnaire to Evaluate the Quality of Po

Dihle, A., Helseth, S., Kongsgaard, U., Paul, S., and Miaskowski, C.

The Journal of Pain, *7* (2006), 272–280

In the United States, quality improvement (QI) approaches have been used to evaluate pain management. However, the use of QI approaches to evaluate the quality of patient care is just emerging in many European countries. The purposes of this study, using the American Pain Society's QI Standards, were: to describe changes over time, in pain severity, in pain interference with function, and in the doses of analgesics administered; to describe patients' level of satisfaction with postoperative pain management; and to determine the relationships between pain severity and patient outcomes. Results from a sample of patients who underwent orthopedic surgery suggest that undertreatment of pain persists across the first 5 postoperative days and that pain's level of interference with function decreases significantly between the third and fifth postoperative days. As in other studies, despite high pain intensity scores, patients reported high levels of satisfaction with postoperative pain management. Findings suggest that the undertreatment of pain results in significant decrements in function over the first 5 postoperative days. Future studies designed to improve the quality of postoperative pain management need to use multimodal approaches and evaluate not only pain intensity, but improvements in function as critical outcome measures.

Validating the Use of Two-Item Measures of Pain Beliefs and Coping Strategies for a Veteran Population

Tan, G., Nguyen, Q., Cardin, S., and Jensen, M.

The Journal of Pain, *7* (2006), 252–260

Previous research has demonstrated that two-item versions of subscales from the Chronic Pain Coping Inventory, Coping Strategy Questionnaire, and the Survey of Pain Attitudes appear adequately reliable and valid for use in studies with large sample sizes. It was suggested that use of the abbreviated scales might help to expand the testing and application of cognitive–behavioral models of pain to new settings and with new populations where assessment burden might be a key issue. This study explored the utility of these brief scales among veterans in a Veterans Affairs setting. Strong associations were found between the two-item versions and their respective parent scales. In addition, the two-item scales were found to be associated with other pain-related measures, supporting their predictive validity. The results of this study replicate previous findings and offer support for the use of the two-item versions for both screening and research purposes in Veterans Affairs settings with a veteran population. This article presents the psychometric properties of brief versions of three commonly used pain coping and belief questionnaires in a unique population. These measures could be used clinically for initial screening purposes, as well as for treatment monitoring.

A Practical Tool to Identify Patients Who May Benefit from a Palliative Approach: The CARING Criteria

Fischer, S., Gozansky, W., Sauaia, A., Min, S., Kutner, J., and Kramer, A.

Journal of Pain and Symptom Management, *31* (2006), 285–292

Palliative care is often offered only late in the course of disease after curative measures have been ex-

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hausted. To provide timelier symptom management, advance care planning, and spiritual support, we propose a simple set of prognostic criteria that identifies persons near the end of life. In this retrospective cohort study of five prognostic indicators, the CARING criteria (Cancer, Admissions ≥ 2, Residence in a nursing home, Intensive care unit admit with multiorgan failure, ≥2 Noncancer hospice Guidelines), logistic regression modeling demonstrated high sensitivity and specificity for mortality at 1 year (*c* statistic > 0.8). A simple set of clinically relevant criteria applied at the time of hospital admission can identify seriously ill persons who have a high likelihood of death in 1 year and, therefore, may benefit the most from incorporating palliative measures into the plan of care.

The Edmonton Symptom Assessment System as a Screening Tool for Depression and Anxiety

Vignaroli, E., Pace, E., Willey, J., Palmer, J.L., Zhang, T., and Bruera, E.

Journal of Palliative Medicine, *9* (2006), 296–303

Mood disorders are among the most important psychiatric problems in patients with cancer. However, they are frequently underdiagnosed and therefore undertreated. This may lead to difficulties with symptom control, social withdrawal, and poor quality of life. This study was conducted to evaluate the screening performance of the Edmonton Symptom Assessment System (ESAS) for depression and anxiety, compared to the Hospital Anxiety and Depression Scale (HADS).

We retrospectively reviewed and analyzed ESAS and HADS data collected from three previous clinical trials conducted by our group. The diagnosis of depression and/or anxiety, and moderate/severe depression and/or anxiety made when patients scored 8 or more and 11 or more in HADS questionnaire, respectively. The sensitivity, specificity, positive, and negative predictive values for ESAS were calculated. Of 216 patients analyzed, the median (range) score for depression was 2 (0–10) and anxiety 3 (0–10) using ESAS, and 6 (0–16) and 7 (0–19) using HADS, respectively. A cutoff of 2 out of 10 or more in the ESAS gave a sensitivity of 77% and 83% with a specificity of 55% and 47% for depression and moderate/severe depression, respectively. A cutoff of 2 out of 10 or more in the ESAS gave a sensitivity of 86% and 97%, and a specificity of 56% and 43% for anxiety and moderate/severe anxiety, respectively. Our data suggest that the ideal cutoff point of ESAS for the screening of depression and anxiety in palliative care is 2 out of 10 or more. More research is needed to define the ideal cutoff point for screening of severe depression and anxiety.

The Validity and Reliability of the Affective Competency Score to Evaluate Death Disclosure Using Standardized Patients

Quest, T., Ander, D., and Ratcliff, J.

Journal of Palliative Medicine, *9* (2006), 361–370

Our objective was to explore the validity and reliability of the affective competency score (ACS), compared to a global rating measure to predict overall competency to perform a death disclosure in a standardized patient exercise and to investigate useful thresholds of the ACS.

Thirty-seven fourth-year students underwent standardized patient training in death disclosure during a fourth-year emergency medicine clerkship. Students were evaluated using a checklist, an ACS, and a global rating assessment. ACS interrater reliability, interitem reliability, item-total reliability, and split-half reliability were calculated. Area under the curve (AUC) measurements were used to establish criterion validity. For the ACS, item-total correlations ranged from .76 to .85, .76 to .93, and .42 to .87; the split-half reliability was .82 ($p = .0001$), .86 ($p = .0001$) and .55 ($p = .0007$) for the standardized patient (SP), the faculty, and the medical students, respectively. Interitem correlations were adequate. A moderate interrater correlation of the ACS was observed between the faculty observer and the SP ($r = .47$; $p = .04$); however, the medical students' self-evaluation did not correlate significantly with either the SP ($r = -.04$; $p = .79$) or the faculty observer ($r = .00$; $p = .99$). The AUC was .98 (95% confidence interval [CI] .94 to 1.00), .87 (95% CI .73 to .99), and .74 (95% CI .53 to .95) for the faculty, SP, and medical student, respectively. The ACS may be a valid, reliable, and useful measure to assess communication skills by faculty or SPs in this setting. At an ACS score of 16, 19, and 21 points for faculty, SPs, and medical students, respectively, there is 100% specificity for the detection of competency assessed on a global rating. However, the ACS appears to have limited reliability and validity when used by medical students.

SYMPTOM CONTROL

Clinical Benefits of Once-Weekly Epoetin Alfa in Anemic Patients with Colorectal Cancer Receiving Chemotherapy

Chu, E., Einhorn, L., and Lefebvre, P.

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In a large, 16-week, prospective study of 2,964 anemic patients with various cancers undergoing chemotherapy, once-weekly subcutaneous administration of 40,000 U of epoetin alfa, with potential escalation to 60,000 U, increased hemoglobin (Hgb) levels, decreased transfusion requirements, and improved quality of life (QOL) as assessed using the Linear Analog Scale Assessment (LASA) for energy, activity, and overall QOL and the Functional Assessment in Cancer Therapy–Anemia (FACT–An) QOL instrument. A retrospective subset analysis conducted in 244 colorectal cancer patients enrolled in the study showed statistically significant improvements from baseline to final readings in LASA energy, activity, and overall QOL and FACT–An Anemia Symptoms and Fatigue subscale scores ($p <$ .02). Moreover, patients who achieved larger improvements in Hgb levels also demonstrated greater percentage improvements in QOL over baseline measurements. Mean Hgb levels increased by 1.2 g/dl after 4 weeks of treatment and by 1.6 g/dl by study end, independent of red blood cell transfusion within 28 days prior to the Hgb assessment. Hematopoietic response (Hgb level $\geq$ 12 g/dl and/or increase in Hgb level $\geq$ 2 g/dl, independent of transfusion) was observed in 61% of patients (139/229). Additionally, the proportion of patients receiving transfusions decreased from 17% at baseline to 4% during the final month of therapy. Epoetin alfa was well tolerated, with no evidence of unexpected adverse events. Except for significantly higher QOL scores at baseline, results for the cohort of colorectal cancer patients were similar to those for patients with other cancer types in the main study population.

Cancer-Related Bone Pain Is Attenuated by a Systemically Available δ-Opioid Receptor Agonist

Brainin-Mattos, J., Smith, N., Malkmus, S., Rew, Y., Goodman, M., Taulane, J., and Yaksh, T.

Pain, *122* (2006), 174–181

Patients with bone cancer report severe pain and receive μ-opioids. We developed a family of peptidomimetic δ-agonists, one of which, H2N-Tyr-dVal-Gly-Phe-Ala-OH ([$dVal^2_L$,Ala^5_L]E), binds with a 1700× affinity at the δ versus μ receptor. To examine the systemic analgesic efficacy of this δ-agonist versus morphine in osteosarcoma pain, osteosarcoma cells are injected into one femur of the anesthetized mouse. After 10–18 days, a decalcification of the injected femur occurs along with a pronounced tactile allodynia. IP morphine and [$dVal^2_L$,Ala^5_L]E produced a dose-dependent reversal of allodynia with the respective ED50 values being 5.3 ± 1.9 mg/kg for morphine and 1.3 ± 0.3 mg/kg for [$dVal^2_L$,Ala^5_L]E. Plotting peak effect versus area under the analgesic curve for doses of morphine and [$dVal^2_L$,Ala^5_L]E revealed overlapping curves suggesting that for a given effect, [$dVal^2_L$,Ala^5_L]E produced a duration of action similar to morphine. These effects were reversed by IP naloxone (3 mg/kg). IP naltrindole (1 mg/kg) preferentially reversed [$dVal^2_L$,Ala^5_L]E. The upper dose effects of morphine but not [$dVal^2_L$,Ala^5_L]E were limited by pronounced hyperactivity. No other effects were noted. These results show that IP [$dVal^2_L$,Ala^5_L]E through a δ receptor produces analgesia equal in efficacy to that of morphine but with a 4.5-fold greater potency. Over the doses examined, morphine actions were side-effect limited. The δ side effects were not so limited, suggesting a favorable therapeutic ratio for δ-agonists in this pain model. These studies suggest that a systemically delivered δ-opioid agonist has pronounced analgesic properties on a preclinical cancer pain model.

Opioid Prescriptions by U.S. Primary Care Physicians from 1992 to 2001

Olsena, Y., Daumit, G., and Ford, D.

The Journal of Pain, *7* (2006), 225–235

Little is known about primary care physicians' (PCPs) prescribing of opioids. We describe trends and factors associated with opioid prescribing during PCP visits over the past decade. Using the National Ambulatory Medical Care Survey, we found an opioid prescribed in 2,206 (5%) PCP visits from 1992 to 2001. The prevalence of visits where an opioid was prescribed increased from a low of 41 per 1000 visits in 1992–1993 to a peak of 63 per 1000 in 1998–1999 ($p <$ .0001 for trend) and then stabilized (59 per 1000 in 2000–2001). Several factors increased the odds of receiving an opioid: having Medicaid (odds ratio [OR] 2.09; 95% confidence interval [CI] 1.82–2.40) or Medicare (OR 2.00; 95% CI 1.68–2.39), having a visit between 15 and 35 min (OR 1.16; 95% CI 1.05–1.27), and receiving an NSAID (OR 2.27; 95% CI 2.04–2.53). Patients of hispanic (OR 0.67; 95% CI 0.56–0.81) or other race/ethnicity (OR 0.68; 95% CI 0.52–0.90), patients in health maintenance organizations (OR 0.74; 95% CI 0.66–0.84), and those living in the northeast (OR 0.60; 95% CI 0.51–0.69) or midwest (OR 0.75; 95% CI 0.66–0.85) had lower odds of receiving an opioid. Substantial variation exists in opioid prescribing by PCPs. Now that pain management standards are advocated, understanding the dynamics of opioid prescribing is necessary.

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This study describes a decade-long increase in opioid prescribing by U.S. primary care physicians and identifies important geographic-, racial/ethnic-, and insurance-related differences in who receives these medications. Several underlying factors, including regulatory and legal pressures, attitudes and knowledge of opioids, and publicized opioid-related events, may contribute to these differences.

Effect of Pilocarpine during Radiation Therapy: Results of RTOG 97-09, a Phase III Randomized Study in Head and Neck Cancer Patients

Scarantino, C., LeVeque, F., Swann, R.S., White, R., Schulsinger, A., Hodson, I., Meredith, R., Foote, R., Brachman, D., and Lee, N.

Journal of Supportive Oncology, *4* (2006), 252–258

Radiation therapy is an important curative modality in the treatment of patients with head and neck cancer. However, radiation-induced changes in the oral cavity, such as xerostomia and mucositis, are among the most debilitating treatment sequelae experienced by patients undergoing radiation therapy, and attempts at ameliorating these side effects have been poor at best. Pilocarpine has been approved for post-radiation xerostomia, and the effect of its use during radiation therapy on salivary flow, xerostomia, mucositis, and quality of life (QOL) was assessed in a phase III study conducted by the Radiation Therapy Oncology Group (RTOG 97-09). In total, 245 evaluable patients were randomized to pilocarpine or placebo. Selected patients were required to have $\geq$ 50% of the volume of the major salivary glands receive $\geq$ 50 Gy; to agree to provide stimulated and unstimulated samples of saliva (measured in grams) before treatment, at the end of treatment, and 3 and 6 months after completion of radiation therapy and to complete the University of Washington Head and Neck Symptom Scale. Following the completion of radiation therapy, the average unstimulated salivary flow was statistically greater in the pilocarpine group, whereas no difference was noted following parotid stimulation. There was no effect on the amelioration of mucositis. The results of the QOL scales did not reveal any significant difference between the pilocarpine and placebo groups with regard to xerostomia and mucositis. The significant difference in unstimulated salivary flow supports the concomitant use of oral pilocarpine to decrease radiation-associated xerostomia. However, the absent correlation between improved salivary flow and QOL scores is of some concern (though not a new finding) and may be related to the existence of comorbidities and the lack of effect on mucositis.

QUALITY OF PALLIATIVE CARE

Integrating Palliative Care for Liver Transplant Candidates: "Too Well for Transplant, Too Sick for Life"

Larson, A. and Curtis, J.R.

JAMA 295 (2006), 2168–2176

Chronic liver disease results in more than 1 million physician visits and more than 300,000 hospitalizations per year in the United States. More than 27,000 patients annually progress to end-stage liver disease (ESLD), liver failure, or death. Patients with ESLD experience such complications as encephalopathy, malnutrition, muscle wasting, ascites, esophagogastric variceal hemorrhage, spontaneous bacterial peritonitis, fatigue, and depression. Despite significant improvements in palliation, patients' quality of life diminishes and their disease will often inexorably progress. Liver transplantation, a valid treatment option, increases life and reduces many symptoms. With the current shortage of organs, up to 10% to 15% of these patients die without receiving an organ. Many patients also are not candidates for transplantation due to comorbid illness. In addition, some patients receive a transplant but succumb to complications of the transplant itself. Such patients and families face the conundrum of a potentially treatable yet often fatal illness. Through the case of a 55-year-old woman with a life-long history of hepatitis B virus infection who is awaiting transplant, we discuss the transplant eligibility process and the struggle with maintaining hope for a cure in the face a life-threatening illness. In all of these circumstances, the health care team must combine elements of palliative care with life-sustaining therapy to maximize the patient's quality and quantity of life.

Perceptions of Inadequate Health Care and Feelings of Guilt in Parents after the Death of a Child to a Malignancy: A Population-Based Long-Term Follow-Up

Surkan, P., Kreicbergs, U., Valdimarsdóttir, U., Nyberg, U., Onelöv, E., Dickman, P., and Steineck, G.

Journal of Palliative Medicine, *9* (2006), 317–331

Parental feelings of guilt can be a serious problem after the death of a child due to a malignancy. This study identified predictors of feelings of guilt in parents during the year after a child's death. The

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Swedish Cause of Death Register and Swedish Cancer Register were used to identify all parents in Sweden who had a child who died of a malignancy between 1992 and 1997. Among parents not reporting recent depression, those who were not confident that their child would immediately receive help from the staff in the hospital while he or she was sick with a malignancy (compared to those who felt partly or entirely sure, relative risk [RR] 4.0; 95% confidence interval [CI] 2.1–7.6), were at increased risk for reporting daily or weekly feelings of guilt in the year after the child's death. Parents who perceived that the staff in the pediatric cancer ward were incompetent were at increased risk (compared to parents reporting partial or total competence, RR 3.7; 95% CI 1.6–8.6). Compared to parents reporting that their children had moderate or much access, those who felt their children had little or no access to pain relief, dietary advice, anxiety relief, and relief of other psychological symptoms beside anxiety were at more than two times greater risk for reporting feelings of guilt. Bereaved parents' perceptions of inadequate health care were associated with subsequent feelings of guilt during the year following their child's death due to a malignancy.

End-of-Life Decisions and Palliative Care in a Children's Hospital

Tan, G., Totapally, B., Torbati, D., and Wolfsdorf, J.

Journal of Palliative Medicine, 9 (2006), 332–342

Our objective was to investigate clinical and demographic factors affecting the nature of end-of-life decisions and pediatric palliative care. Charts of 236 expired children were retrospectively reviewed for presence of end-of-life care (EOLC) discussions and spiritual support, the nature of EOLC decisions, and the degree of opioid analgesic (OA) and sedative (SDT) administration. Approximately 60% of patients had EOLC discussion, of whom 87.4% obtained an EOLC decision, mostly opting for withholding therapy (68.8%). Presence of EOLC discussion was associated with a longer hospital stay (univariate analyses: odds ratio [OR] = 1.9; $p < .029$), higher number of failed organs (OR = 2.5; $p < .003$), chronic illnesses (OR = 2.4; $p < .002$), spiritual support (OR = 1.8; $p < .028$), and respiratory diseases (OR = 3.1; $p < .0006$). Younger patients and those with higher number of failed organs were more likely to have withdrawal of therapy (OR = 10.9 and 6.0; $p < .0001$ and $< .002$, respectively), whereas patients with chronic illness opted for withholding of therapy (OR = 3.1; $p < .006$). Spiritual support was associated with higher use of both OA and SDT (OR = 1.9 and 2.3; $p < .014$ and $p < .005$, respectively). Younger patients received less OA and SDT (OR = 0.2 and 0.4, respectively; $p < .0001$). Multivariate analyses showed that EOLC discussion is associated with higher use of OA and SDT (OR = 4.4 and 4.2; $p < .00001$ and $p < .0001$, respectively), whereas younger age is associated with withdrawal of therapy (OR = 8.3; $p < .0005$) and lower use of SDT (OR = 0.23; $p < .0001$). Patterns of care at the end of life vary in children with differing clinical and demographic characteristics. Because EOLC discussions are associated with greater focus on palliative care, strategies to enhance EOLC communications for pediatric patients should be further evaluated.

What Is Most Important for You to Achieve? An Analysis of Patient Responses when Receiving Palliative Care Consultation

Quill, T., Norton, S., Shah, M., Lam, Y., Fridd, C., and Buckley, B.

Journal of Palliative Medicine, *9* (2006), 382–388

Hospitalized patients with a wide range of serious but not necessarily terminal illnesses are now receiving palliative care consultations. The purpose of this report is to describe what palliative care patients say is "most important to achieve" at the time of initial consultation. We conducted a retrospective descriptive content analysis of patient responses to the question "What is most important for you to achieve?" recorded at the time of initial inpatient palliative care consultation. Two hundred fifteen patient records had documented first-person patient responses recorded. These responses were independently reviewed and categorized in a four-phase iterative process.

Responses were divided into four major categories: (1) Improving quality and meaning ("I want to be able to sit on my front porch and watch the farm go by.") (52%); (2) Achieving relief or comfort ("Can you get rid of my pain?") (34%); (3) Altering the trajectory of illness ("If there is a treatment that can make me well, I want it.") (22%); and (4) Preparing for dying ("I am not afraid of dying. I just don't want to suffer.") (11%). Five percent of responses were unable to be reliably categorized ("You ask hard questions."). Some respondents gave more than one response, so the total is greater than 100%. Patients receiving palliative care consultation give a wide range of responses to the question "What is most important for you to achieve?" Such patient-centered inquiry about priorities deserves more systematic study in the future if patient-specific goals are to be a marker of high-quality palliative care.

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COMMUNICATION

Manualized Communication Interventions to Enhance Palliative Care Research and Training: Rigorous, Testable Approaches

Weiner, J., Arnold, R., Randall Curtis, J., Back, A., Rounsaville, B., and Tulsky, J.

Journal of Palliative Medicine, *9* (2006), 371–381

Palliative care practice requires excellent communication between the patient, family, and clinical team. Experts in the field have proposed a variety of communication interventions that can be used in the palliative care setting. However, these interventions are at a high level of generality: the specifics of each intervention are not well codified; the individual steps in each intervention are not easily reproducible and thus not comparable between practitioners; the methods to measure adherence to these communication protocols have not been established; and there is little detail on how to adapt these general interventions to the individual patient and family. Therefore, we lack good evidence for the efficacy of these recommendations. This paper makes the case for development of structured, testable approaches to communication that will inform clinical practice and communication training. To do so, palliative care communication should be conceived as a formal medical and psychosocial intervention—a potential treatment with risks and benefits to be systematically researched and operationalized in the same manner as medication interventions. As we illustrate, psychotherapy research has faced the same challenges in the past and has utilized manualized treatments to meet its goals. Through such approaches, we can begin to address the most basic intervention questions such as protocol efficacy, dose-response, side effects, and the optimal process and content of communication with the patient and family. The advantages of manualized communication approaches, some concepts underlying manual construction, and challenges to extending manualized communication to the palliative care domain are discussed.

Avoiding Iatrogenic Harm to Patient and Family while Discussing Goals of Care Near the End of Life

Weiner, J. and Roth, J.

Journal of Palliative Medicine, *9* (2006), 451–463

Treatment of suffering is a core mission of medicine. Communication about treatment planning with the patient and family, called the goals of care discussion, offers the opportunity to provide effective relief. Such communication is particularly important near the end of life, because many medical decisions are determined then by emotional considerations and personal values.

Our objectives were to define common unintended clinician behaviors, which impair discussion about goals of care near the end of life, and to discuss the relationship between (1) the medical decision-making responsibilities of patient and family, (2) clinician communication, (3) iatrogenic suffering, (4) the impact on medical decision making, and (5) patient and family outcomes. We used a thematic literature review. The authors discuss how omission of the integral emotional and social elements of the goals of care discussion are reflected in five unintended clinician behaviors, each of which may impair medical decision making and unknowingly induce patient and family suffering. We posit that such impaired decision making and suffering may contribute to demands for ineffective, life-sustaining interventions made by the patient and family or, conversely, to requests for hastened death. Understanding the challenges in the discussion about goals of care near the end of life will facilitate the development of more effective approaches to communication and shared decision making. The authors hypothesize how decreased suffering through improved communication should diminish the occurrence of depression, anxiety disorders, and complicated grief in the patient and survivors, potentially improving medical outcomes. Proposed experiments to test this hypothesis will address important public health goals.

PSYCHOSOCIAL INTERVENTIONS

The Risk of Suicide with Selective Serotonin Reuptake Inhibitors in the Elderly

Juurlink, D., Mamdani, M., Kopp, A., and Redelmeier, D.

American Journal of Psychiatry, *163* (2006), 813–821

The authors explored the relationship between the initiation of therapy with selective serotonin reuptake inhibitor (SSRI) antidepressants and completed suicide in older patients. The authors linked population-based coroner's records with patient-level prescription data, physician billing claims, and hospitalization data for more than 1.2 million Ontario residents 66 years of age and older from 1992 to 2000. For each suicide case, four closely matched comparison subjects were selected using propensity score methods. The authors determined the odds ratio for suicide with SSRIs versus other antidepressant treatment, calculated at discrete

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monthly intervals from the start of treatment. Of 1,329 suicide cases, 1,138 (86%) were each fully matched to four comparison subjects using propensity scores. During the first month of therapy, SSRI antidepressants were associated with a nearly fivefold higher risk of completed suicide than other antidepressants (adjusted odds ratio: 4.8, 95% confidence interval = 1.9–12.2). The risk was independent of a recent diagnosis of depression or the receipt of psychiatric care, and suicides of a violent nature were distinctly more common during SSRI therapy. Numerous sensitivity analyses revealed consistent results. No disproportionate suicide risk was seen during the second and subsequent months of treatment with SSRI antidepressants, and the absolute risk of suicide with all antidepressants was low. Initiation of SSRI therapy is associated with an increased risk of suicide during the first month of therapy compared with other antidepressants. The absolute risk is low, suggesting that an idiosyncratic response to these agents may provoke suicide in a vulnerable subgroup of patients.

Meaning-Making and Psychological Adjustment to Cancer: Development of an Intervention and Pilot Results

Lee, V., Cohen, R., Edgar, L., Laizner, A., and Gagnon, A.

Oncology Nursing Forum, *33* (2006), 291–302

Our objective was to develop an intervention that uniquely addresses the existential impact of cancer through meaning-making coping strategies and to explore the intervention's impact on psychological adjustment. We used a descriptive, qualitative approach to develop the intervention; one-group pre- and posttest design to pilot test the intervention. The setting was patients' homes or ambulatory oncology clinics affiliated with a university health center in eastern Canada. We studied 18 participants who were newly diagnosed in the past three months ($n = 14$), had completed treatment ($n = 1$), or were facing recurrence ($n = 3$) of breast ($n = 10$) or colorectal ($n = 8$) cancer. Data were collected during interviews using a prototype intervention for trauma patients, and content was analyzed on an ongoing basis to fit the needs of the cancer population. Pretest and posttest questionnaires were administered to determine the intervention's effect.

The main research variables were meaning-making intervention (MMI), patients' background variables, disease- or treatment-related symptoms, and psychological adjustment. The MMI for patients with cancer consisted of as many as four 2-h, individualized sessions and involved the acknowledgment of losses and life threat, the examination of critical past challenges, and plans to stay committed to life goals. At posttest, participants significantly improved in self-esteem and reported a greater sense of security in facing the uncertainty of cancer. Findings suggest that meaning-making coping can be facilitated and lead to positive psychological outcomes following a cancer diagnosis. The MMI offers a potentially effective and structured approach to address and monitor cancer-related existential issues. Findings are useful for designing future randomized, controlled trials.

Efficacy of Darbepoetin Alfa in Alleviating Fatigue and the Effect of Fatigue on Quality of Life in Anemic Patients with Lymphoproliferative Malignancies

Littlewood, T., Kallich, J., San Miguel, J., Hendricks, L., and Hedenus, M.

Journal of Pain and Symptom Management, *31* (2006), 317–325

Anemia-related fatigue in cancer patients reduces health-related quality of life (HRQOL). These analyses evaluate the effect of hemoglobin level on fatigue and examine the relationship between improved fatigue and HRQOL. Data were collected during a multicenter, randomized trial involving 344 anemic patients with lymphoproliferative malignancies receiving chemotherapy and darbepoetin alfa or placebo. At baseline, interim study visits, and end of treatment, patients completed an HRQOL questionnaire. Improved hemoglobin levels were significantly associated ($p < .001$) with improved fatigue. Mean change in the Functional Assessment of Cancer Therapy (FACT) Fatigue score was 5.9 points greater when hemoglobin improved >2 g/dl than when it declined. Patients experiencing a clinically meaningful improvement in fatigue reported significantly ($p < .001$) greater improvements in all other scales, except the FACT Social subscale. Managing anemia-related fatigue appears to have a positive impact on HRQOL, enhancing cancer patients' activity levels, mood, and perceived overall health.

A Thematic Review of the Spirituality Literature within Palliative Care

Sinclair, S., Pereira, J., and Raffin, S.

Journal of Palliative Medicine, *9* (2006), 464–479

Research related to spirituality and health has developed from relative obscurity to a thriving field of study over the last 20 years both within palliative

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care and within health care in general. This paper provides a descriptive review of the literature related to spirituality and health, with a special focus on spirituality within palliative and end-of-life care. CINAHL and MEDLINE were searched under the keywords "spirituality" and "palliative." The review revealed five overarching themes in the general spirituality and health literature: (1) conceptual difficulties related to the term spirituality and proposed solutions, (2) the relationship between spirituality and religion, (3) the effects of spirituality on health, (4) the subjects enrolled in spirituality-related research, and (5) the provision of spiritual care. Although the spirituality literature within palliative care shared these overarching characteristics of the broader spirituality and health literature, six specific thematic areas transpired: (1) general discussions of spirituality in palliative care, (2) the spiritual needs of palliative care patients, (3) the nature of hope in palliative care, (4) tools and therapies related to spirituality, (5) effects of religion in palliative care, and (6) spirituality and palliative care professionals. The literature as it relates to these themes is summarized in this review. Spirituality is emerging largely as a concept void of religion, an instrument to be utilized in improving or maintaining health and quality of life, and focussed predominantly on the "self" largely in the form of the patient. While representing an important beginning, the authors suggest that a more integral approach needs to be developed that elicits the experiential nature of spirituality that is shared by patients, family members, and health care professionals alike.

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