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Distress screening in a multidisciplinary lung cancer clinic: Prevalence and predictors of clinically significant distress

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Summary Screening for distress in cancer patients is recommended by the National Comprehensive Cancer Network, and a Distress Thermometer has previously been developed and empirically validated for this purpose. The present study sought to determine the rates and predictors of distress in a sample of patients being seen in a multidisciplinary lung cancer clinic. Consecutive patients ($N = 333$) were recruited from an outpatient multidisciplinary lung cancer clinic to complete the Distress Thermometer, an associated Problem Symptom List, and two questions about interest in receiving help for symptoms. Over half (61.6%) of patients reported distress at a clinically significant level, and 22.5% of patients indicated interest in receiving help with their distress and/or symptoms. Problems in the areas of family relationships, emotional functioning, lack of information about diagnosis/treatment, physical functioning, and cognitive functioning were associated with higher reports of distress. Specific symptoms of depression, anxiety, pain and fatigue were most predictive of distress. Younger age was also associated with higher levels of distress. Distress was not associated with other clinical variables, including stage of illness or medical treatment approach. Similar results were obtained when individuals who had not yet received a definitive diagnosis of lung cancer ($n = 134$) were excluded from analyses; however, family problems and anxiety were no longer predictive of distress. Screening for distress in a multidisciplinary lung cancer clinic is feasible and a significant number of patients can

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be expected to meet clinical criteria for distress. Results also highlight younger age and specific physical and psychosocial symptoms as predictive of clinically significant distress. Identification of the presence and predictors of distress are the first steps toward appropriate referral and treatment of symptoms and problems that contribute to cancer patients' distress.

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1. Introduction

The consensus-based guidelines set forth by the Distress Management Panel of the National Comprehensive Cancer Network (NCCN) include a recommendation for comprehensive distress screening for all patients at their initial visit and across the disease continuum [1,2]. Distress has been defined as "a multifactorial, unpleasant experience of an emotional, psychological, social, or spiritual nature that interferes with the ability to cope with cancer, its physical symptoms, and its treatment" [1,2]. In the oncology context, distress is multifactorial, as numerous areas in a patient's life contribute to his or her experience of distress, including physical symptoms, disease severity, treatment [3,4]; physical activity level/performance status [5–7]; social support (for a review see [8]); and psychological factors such as optimism [9,10], coping style [11,12], and pre-morbid or current depression [13].

In addition to the above factors, rates of distress often vary depending on age, sex, and site of cancer [11,14–16]. Younger patients and women report higher levels of distress [7,11,14,15], and individuals with lung cancer, compared to individuals with other cancer diagnoses, also report higher levels of distress [15,17]. Approximately 43% of patients with lung cancer report clinically significant levels of distress [15,18], compared to about 33% of patients with breast cancer and 32% of patients with colon cancer [15].

Just as lung cancer patients are more likely to experience distress than other cancer patients, having a diagnosis of lung cancer was predictive of oncologists' failure to correctly identify distress [19]. Categorizing distress as mild, moderate, or severe, oncologists inaccurately identified distress in 68% of patients with lung cancer (compared to 52% for other cancers with the exception of head and neck cancer, which was also high at 67% [19]). Distress and other psychosocial symptoms may not be accurately identified by oncology health care professionals for several reasons. Given the medical focus on physical symptoms and treatment, emotional and psychological symptoms may be overlooked or discounted. Physicians cite lack of time and lack of confidence as barriers to detecting certain physical and psychosocial symptoms [20]. Symptoms that practitioners may under- or misidentify include depression, pain, fatigue, and overall quality of life concerns [21–26]. Patients may be embarrassed or reluctant to report psychological problems, such as depressive symptoms [27]. Less than one in four patients with psychological problems spontaneously disclose those problems to their treatment team because of concerns about bothering the nurses or physicians or fear of being stigmatized for having an emotional problem [28]. As a result of both physician and patient barriers toward the reporting and identification of distress symptoms, such concerns may go untreated.

Left untreated, significant levels of distress may contribute not only to lower quality of life and lower satisfaction with care [29], but also to poorer adherence to treatment recommendations and possibly decreased survival [30–32]. In recognition of the potential impact of untreated distress, guidelines from the NCCN suggest:

Distress should be recognized, monitored, documented, and treated promptly at all stages of disease. All participants should be screened for distress at their initial visit, at appropriate intervals, and as clinically indicated, especially with changes in disease status (i.e., remission, recurrence, progression) [1].

1.1. Measuring distress

The Distress Thermometer (DT) is a visual-analog tool developed to efficiently screen for distress in cancer patients [7,33–35]. The sensitivity, specificity, and appropriate cut-off score of the DT are established [16], with scores of 4 or above indicative of clinically significant levels of distress. Through receiver operating characteristic (ROC) curve analyses, Jacobsen et al. compared scores on the DT to evidence-based cut-off scores on psychometrically valid measures of distress, the Brief Symptom Inventory and the Hospital Anxiety and Depression Scale [16]. Females and patients with lower self-reported performance status had higher levels of clinically significant distress. No other demographic or clinical variables, including stage of disease or type of treatment, were associated with scoring 4 or higher on the DT. The DT thus represents a brief measure that is both sensitive and specific to detecting distress in individuals with cancer.

The DT has been used to evaluate distress in patients diagnosed with prostate cancer [33], patients undergoing bone marrow transplant [34], and ambulatory cancer patients with mixed cancer diagnoses [7,16,35]. Categories of symptoms consistently associated with clinically significant levels of distress on the DT were emotional, family, and physical problems. Inconsistent results were found for the relationship between clinically significant distress and spiritual problems [16,35]. In addition to clarifying the problem categories that contribute most to distress, researchers have called for future studies to focus on homogeneous diagnostic groups [35] and expansion of the symptom problem list frequently used with the DT to include a format for patients to identify other potential sources of distress and/or the issues for which they would most like help [16]. The present study addresses these issues through our focus on patients evaluated and treated in a lung cancer clinic and through the adaptation of the symptom problem list (see Section 2.3.3).

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