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**Feature Editor: Donna S. Zhukovsky, MD, FACP, FAAHPM**

**PC-FACS** (Fast Article Critical Summaries for Clinicians in Palliative Care) provides hospice and palliative care clinicians with concise summaries of the most important findings from more than 100 medical and scientific journals. If you have colleagues who would benefit from receiving PC-FACS, please encourage them to join the AAHPM at [aahpm.org](http://aahpm.org). Comments from readers are welcomed at [pc-facs@aahpm.org](mailto:pc-facs@aahpm.org).

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## Summaries With Commentary

### Pediatric Palliative Care Research Priorities

**Background.** Controlled trials of pediatric palliative care (PPC) are sparse,<sup>1</sup> and research priorities are also limited.<sup>2-4</sup> What do U.S. clinicians and parents

of pediatric patients say are the highest research priorities for PPC?

**Design and Participants.** PPC experts (identified from PPC conference distribution lists and parents whose children had received hospice or palliative care) participated in a four-round iterative Delphi technique<sup>5,6</sup> administered via an investigator-developed, anonymous online questionnaire. In round 1, participants named the top five PPC research priorities. Content analysis was used to identify and group priorities. In rounds 2 and 3, participants ranked items to enable priority convergence. A list of priority items that reached >80% consensus was developed. From this list, participants ranked the top 10 priorities in round 4. Priorities were then considered "high priority" if they constituted >10% of the total.

**Results.** Of the round 1 participants ( $n=242$ ), 72 were parents. Among them, 73% self-identified as bereaved<sup>7</sup> and 54% as professionals in a pediatric-related field. Experts included 96 nurses, 82 physicians, and 102 multidisciplinary health care providers. All but two round 1 participants had PPC experience; 52% had >10 years. Round 1 yielded 1010 unique responses that were organized into 78 priorities. Rounds 2 ( $n=130$ ) and 3 ( $n=98$ ) yielded 31 priorities that achieved >80% consensus as "very" or "moderately" important. Round 4 ( $n=57$ ) resulted in 20 high research priorities in four thematic categories: decision making, care coordination, symptom management, and quality improvement (QI).

**Commentary.** This study uses a well-suited method of consensus-building among professional and parent experts to synthesize concepts and determine PPC research priorities. The authors build on categories of prioritized research (decision making, care coordination, symptom management, and QI) by elucidating specific examples of investigation. For example, within

the decision-making category, research studies like comparative longitudinal analyses of communication training were recommended.

The methods capture a heterogeneous expert base but do not ensure full representation of all specialties or disciplines. In addition, parents were nominated by professionals, potentially creating selection bias, and the majority of parents were health care professionals, which might introduce inclusion bias. The ultimate value lies in building a foundation of PPC research priorities across interdisciplinary professionals and parents for academicians in PPC to better refine research aims.

*Bottom Line.* This tool should promote PPC research by outlining a roadmap of current priorities including decision making, care coordination, symptom management, and QI.

*Reviewer.* Christopher A. Collura, MD, FAAP, Mayo Clinic College of Medicine, Rochester, MN.

*Source.* Baker JN, Levine DR, Hinds PS, et al. Research priorities in pediatric palliative care. *J Pediatr* 2015;167:467-470.e3.

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#### **Prevalence of Depression in Patients with Cancer**

*Background.* The result of depression screening in people with cancer varies by the self-report scale used. What is the variability and relationship of scores

among scales commonly used to screen for depression?

*Design and Participants.* This cross-sectional study compared and cocalibrated depression scales utilizing a convenience sample of adult oncology outpatients at a cancer center in Australia. Participants completed a computerized survey comprising five depression scales: Hospital Anxiety and Depression Scale-Depression subscale (HADS-D), Center for Epidemiologic Studies Depression Scale (CES-D), Patient Health Questionnaire-9 (PHQ-9), Beck Depression Inventory-II (BDI-II), and Depression Anxiety and Stress Scale-Depression subscale (DASS-D). As a comparator and gold standard, participants completed the Structured Clinical Interview for Diagnostic and Statistical Manual of Mental Disorders, 4th edition (SCID). Rasch and fit analyses and person-item maps evaluated the scales' measurement properties. Test characteristic curves assessed cocalibration. Receiver operating characteristic curves examined the scales' ability to detect major depression compared with the SCID.

*Results.* One hundred seven people completed the study. Forty-four percent had breast cancer, 70% were married, and 25% had advanced cancer. SCID depression prevalence was 14.2%. Cutoff scores among scales were not equivalent. The HADS-D cutoff for possible depression corresponded with other scales' moderate or severe depression. Scores representing the best balance of sensitivity and specificity, positive and negative predictive values (PPV/NPV), were PHQ-9  $\geq 9$ , HADS-D  $\geq 7$ , CES-D  $\geq 22$ , DASS-D  $\geq 6$ , BDI-II  $\geq 16$ . The CES-D's broad measurement range and best balance of PPV, NPV, sensitivity, and specificity suggested its overall utility for measuring depression in cancer. The DASS-D had the highest specificity and PPV. The PHQ-9 identified more cases of mild depression. The BDI-II had the lowest overall accuracy.

*Commentary.* Thoughtful clinicians still wonder about the true prevalence of depression in patients with cancer. This clever study compared various screener results to one another, and to a "gold standard" diagnostic interview for major depression, the latter of which noted a prevalence rate of about 14%. Different screeners have different cut-points for mild/moderate/severe ratings. Compared with other instruments, the PHQ-9—likely to be the most familiar of these scales to North American readers—screens positive for less severe depression. Screening results alone are not sufficient to make a diagnosis or to indicate treatment but rather to support referral to a qualified mental health professional. Clinical validation also compensates for variation among screeners and rationalizes treatment planning.

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