Update Psychoonkologie: Was gibt es Neues?

Psychosomatik

Alexander Kiss

21.01.10 Rheinfelden
Update (Wovon?) Psychoonkologie: Was gibt es Neues? (Was ist das Alte?)

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Hintergrund: Neue Therapien (Expensive AntiCancer Drug EACD) sind teuer, müssen in vielen Ländern vom Patienten bezahlt werden und Onkologen vermeiden darüber ein Gespräch. Was denkt die Bevölkerung in Australien davon?


"If you had incurable cancer and a very expensive cancer drug that you would have to pay for could treat your cancer, would you want your doctor to tell you about this new drug?"
Drug A - improved survival: “What if there was a new drug that if given with standard chemotherapy might allow you to live an extra 4-months?"

Drug B - less toxicity: “Now consider if the new drug could be given instead of standard chemotherapy with many fewer side effects and better quality of life but no improvement in how long people"

Drug C - Better survival: “What about if there was no effective standard treatment available for your cancer, but a recent study using a new drug showed promising early results with the cancer getting smaller in one out of every two people treated?”

Results
Responses were obtained from 1,255 respondents (response rate, 43%). 11% had a prior cancer diagnosis. Results see Tab.

Those more likely to want to be informed were younger, employed, better-educated, or had higher income levels (P < .05).

Responses did not vary with the person’s personal experience of cancer.

Of the 9% who did not wish to be informed, half of these were concerned about their information causing distress.

Evidenzhierarchie

<table>
<thead>
<tr>
<th>Evidenzklasse</th>
<th>Beschreibung</th>
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<tbody>
<tr>
<td>Ia</td>
<td>mind. 1 systematische Review auf Basis randomized controlled trials (RCT)</td>
</tr>
<tr>
<td>Ib</td>
<td>mind. 1 RCT</td>
</tr>
<tr>
<td>Ia</td>
<td>mind. 1 Studie ohne Randomisierung</td>
</tr>
<tr>
<td>Ib</td>
<td>mind. 1 Studie (quasi-experimentell)</td>
</tr>
<tr>
<td>III</td>
<td>mehr als 1 nicht-experimentelle Studie</td>
</tr>
<tr>
<td>IV</td>
<td>Meinung und Überzeugung von Autoritäten, Expertenkommissionen, beschreibende Studien</td>
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Hintergrund: Meaning-centered group psychotherapy for patients with advanced cancer: a pilot randomized controlled trial

Meaning-centered group psychotherapy for patients with advanced cancer: a pilot randomized controlled trial

Methods: 90 Patienten werden entweder in die MCGT oder Supportive Group Psychotherapy (SGT) randomisiert.

(FACTIT: Functional Assessment of Chronic Illness Therapy)

FACTIT: Meaning and Peace

FACTIT: Faith

BHS: Beck Hoplessness Scale

SAHD: Schedule of Attitudes toward Hastened Death

LOT : Life Orientation Test

HADS: Hospital Anxiety and Depression Scale
Respondents indicate on a 5-point scale how true each statement has been for them during the past 7 days:

**Meaning and peace items:**
I feel peaceful.
I have a reason for living.
My life has been productive.
I have trouble feeling peace of mind.
I feel a sense of purpose in my life.
I am able to reach down deep into myself for comfort.
I feel a sense of harmony within myself.
My life lacks meaning of purpose.

**Faith items:**
I find comfort in my faith or spiritual beliefs.
I find strength in my faith or spiritual beliefs.
Difficult times have strengthened my faith or spiritual beliefs.
Even during difficult times, I know that things will be okay.


**Weekly Topics Covered in MCGP versus SGP**

<table>
<thead>
<tr>
<th>Session</th>
<th>MCGP</th>
<th>SGP</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Concepts and Sources of Meaning</td>
<td>Group Member Introductions</td>
</tr>
<tr>
<td>2</td>
<td>Cancer and Meaning</td>
<td>Group Member Introductions conts.</td>
</tr>
<tr>
<td>3</td>
<td>Historical Sources of Meaning (legacy, past)</td>
<td>Coping with Medical Tests and Communicating with Providers</td>
</tr>
<tr>
<td>4</td>
<td>Historical Sources of Meaning (legacy, present and future)</td>
<td>Coping with Family and Friends</td>
</tr>
<tr>
<td>5</td>
<td>Attitudinal Sources of Meaning: Encountering Life’s Limitations</td>
<td>Coping with Vocational Issues</td>
</tr>
<tr>
<td>6</td>
<td>Creative Sources of Meaning: Creativity and Responsibility</td>
<td>Coping with Body Image and Physical Functioning</td>
</tr>
<tr>
<td>7</td>
<td>Experiential Sources of Meaning: Nature, Art, and History</td>
<td>Coping with the Future</td>
</tr>
<tr>
<td>8</td>
<td>Termination: Goodbyes, and Hope for the Future</td>
<td>Termination: Where Do We Go From Here?</td>
</tr>
</tbody>
</table>

3. "The most significant memories, relationships, traditions, etc., that have made the greatest impact on who you are today"  
5. "What would you consider a good or meaningful death? How can you imagine being remembered by your loved ones?"
Objective
To determine the way religious coping relates to the use of intensive life-prolonging end-of-life care among patients with advanced cancer.

Design, Setting, and Participants
A longitudinal cohort of 345 patients with advanced cancer. The Brief RCOPE assessed positive religious coping. Baseline interviews assessed psychosocial and religious/spiritual measures, advance care planning, and end-of-life treatment preferences. Patients were followed up until death, a median of 122 days after baseline assessment.

Main Outcome Measures
Intensive life-prolonging care, defined as receipt of mechanical ventilation or resuscitation in the last week of life.
Brief RCOPE: 14-item questionnaire assessing religious coping.

- 7 types of positive religious coping (eg, "seeking God’s love and care")
- 7 types of negative religious coping (eg, "wondering whether God has abandoned me")

4-point Likert scale from 0 (not at all) to 3 (a great deal)

Positive and negative religious coping are not mutually exclusive.

Patients who scored at or above the median were designated as having a high (51.6%) level of positive religious coping and patients who scored below the median were designated as having a low (48.4%) level of positive religious coping.

**Table 2. Level of Positive Religious Coping and End of Life Care**

<table>
<thead>
<tr>
<th>Level of Positive Religious Coping</th>
<th>No/Total (%)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>Verbal communication</td>
<td>20/177 (11.5)</td>
<td>6/167 (3.6)</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>3/147 (2.6)</td>
<td>11/138 (8.1)</td>
</tr>
<tr>
<td>Intensive life-prolonging care</td>
<td>24/175 (13.8)</td>
<td>7/167 (4.2)</td>
</tr>
<tr>
<td>Death in ICU</td>
<td>19/175 (10.7)</td>
<td>7/167 (4.2)</td>
</tr>
<tr>
<td>Hospice care enrollment</td>
<td>13/175 (7.5)</td>
<td>10/167 (6.0)</td>
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**Results**

A high level of positive religious coping at baseline was significantly associated with receipt of mechanical ventilation compared with patients with a low level and intensive life-prolonging care during the last week of life (after adjusting for age and race).

**Conclusions**

Positive religious coping associated with receipt of intensive life-prolonging medical care near death.

**Kommentar**

Erstaunlich! Nur bedingt auf Schweizer Verhältnisse anwendbar.

**Objectives:** Considerable morbidity persists among survivors of breast cancer within 18 months of treatment completion.

**Methods:** Randomized controlled trial of 84 female BC survivors 6-week Mindfulness-Based Stress Reduction program (n=41) or to usual care (n=43)

Outcome measures compared at 6 weeks by validated measures of psychological status (depression, anxiety, perceived stress, fear of recurrence, optimism, social support) and quality of life (SF-36).
Conclusions: Among survivors a 6-week MBSR program resulted in significant improvements in psychological status and quality of life compared with usual care.

Kommentar:
- Interessant, aber treatment as usual ist als Vergleichsgruppe fragwürdig.
- Ist nicht sinnvoller psychosoziale gestresste Patientinnen zu untersuchen?
- „Subjects received $50 at the beginning and $50 at the completion of the study“. 

Purpose: Feedback of patient-reported outcomes (PROs) to clinicians or caseworkers may result in improved patient functioning: Randomized, controlled trial against usual care (UC): a telephone caseworker (TCW) model and an oncologist/general practitioner (O/GP) model

Patients and Methods: 356 participants were surveyed by computer-assisted telephone interview (CATI) at three time points: baseline, 3 months, and 6 months.

Data collected from participant CATIs were used to generate feedback to either each participant’s designated TCW, or their nominated O/GPs. Data obtained from participants in the UC model were used only to assess the impact of supportive care models.
Results

No overall intervention effect. Physical functioning was significantly improved at the third CAT. For participants in the TCW model ($P < .01$), and there was a trend toward fewer participants with unmet needs ($P = .07$). TCW group participants also were more likely to have the following: identified issues of need discussed ($P < .0001$); referrals made ($P < .0001$); and strong agreement that the intervention improved communication with their health care team ($P < .0005$).

Conclusion

The TCW model holds some promise; however, additional work in at-risk populations is required before we recommend implementation.

Struktur

1.) Wo und wie suchen?          Pubmed   Zeitungen   IF
2.) Was ist neu?                        2009
2.) Kriterien der Auswahl          EBM   Klinische Relevanz
3.) Artikeln
4.) Noch mehr Artikeln
4.) Zusammenfassung
5.) Workshop am Nachmittag

Quantitative Forschung

An naturwissenschaftliches Forschung orientiert
Objektive Realität
Empirie mit systematisch entwickelten Methoden
Repräsentative Stichproben
Verteilung, Wahrscheinlichkeiten,
Prüft Hypothesen und Theorien

Qualitative Forschung

An geistes/kulturwissenschaftlicher Forschung orientiert
Subjektive Realität (Subjekt als Konstrukteur seiner Wirklichkeit)
Verstehen und Interpretation
Kleine Stichproben, keine Standardisierung
Bildet Hypothesen und Theorien
Seven focus groups (n=27) and five individual interviews were conducted with POS users, their relatives, and POS non-users, as well as with oncology physicians and nurses.

1. How did users, their relatives, and non-users subjectively perceive the POS, in terms of advantages, disadvantages, strengths, and weaknesses?

2. How did oncology physicians and nurses in the affiliated hospital experience POS? How did they assess the benefits and outcomes for their patients? And how did psycho-oncology care delivery influence their everyday work?

Subjective Patients Norms: Nornacy

"...not to see everything from the psychological and illness point of view"

"...an invitation to spontaneous, fun activities, rather than therapies..." and "When I paint, I want to paint... paint and not interpret what was painted..."

"many patients can’t handle the idea of mental or psychological counseling, but somehow they're okay with religious or spiritual counseling, "psycho-barrier“

Information Deficits/ Patients and Relatives

Many patients did not understand the term psycho-oncology

"Painting" rather than "Art therapy" which is too abstract.

"Exercise therapy" is similar to sports?
Subjective Physicians Norms

One subjective norm of physicians and some nurses was that POS were not integral to routine oncology care. Only terminal patients undergoing a psychological crisis would be referred to POS.

Information Deficits/ Physicians

Most of the hospital physicians lacked a clear idea of what psycho-oncology involves and of the evidenced-based effects of its services.

Zitierte Literatur


