Universitätsspital Basel

Update Psychoonkologie: Was gibt es Neues?

Psychosomatik

Alexander Kiss

21.01.10 Rheinfelden

Universitätsspital Basel

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

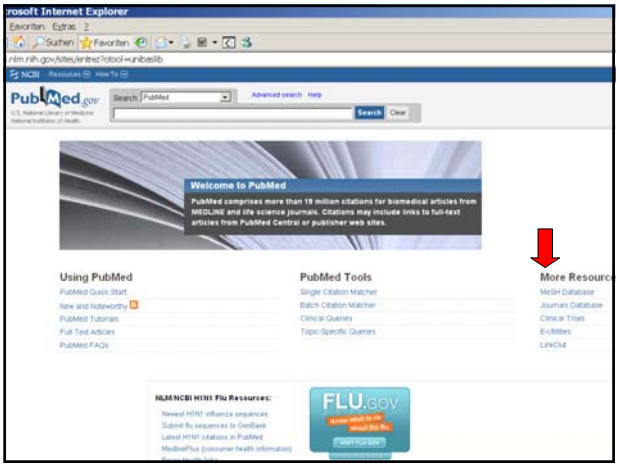
Psychosomatik

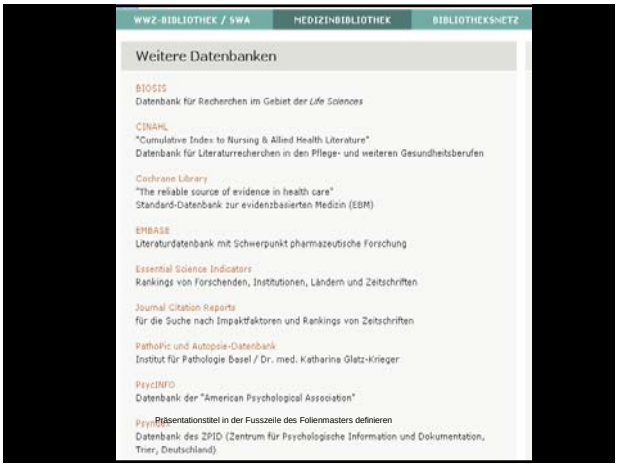
Alexander Kiss

21.01.10 Rheinfelden

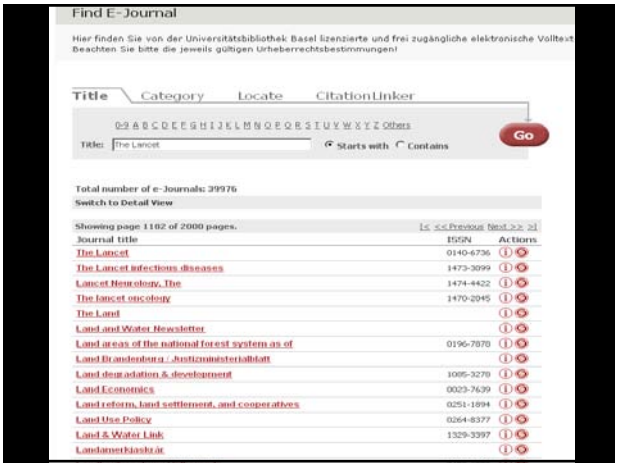
Struktur

1.) Wo und wie suchen ?
2.) Was ist neu?
2.) Kriterien der Auswahl
3.) Artikeln
4.) Noch mehr Artikeln
4.) Zusammenfassung
5.) Workshop am Nachmittag





Präsentationstitel in der Fusszeile des Folienmasters definieren



Struktur

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

Psychologisch / Psychotherapeutische Zeitungen

Psychooncology
Impact Factor: 3.2

PPmP
Impact Factor: 1.2

Psychotherapeut
Impact Factor: 0.8

Onkologische Zeitungen

J Clinical Oncology
Impact Factor: 17.2

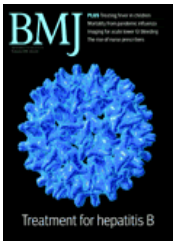
Annals of Oncology
Impact Factor: 4.9

European J Cancer
Impact Factor: 4.5

Cancer
Impact Factor: 5.2

Allgemeine Medizinische Zeitungen

JAMA
Impact Factor: 31.7



BMJ
Impact Factor: 12.8

09.15 – 10.30 **Neues in der Onkologie**
Prof. Dr. med. Thomas Cerny
Die medizinische Onkologie entwickelt sich rasend schnell, und es wird immer schwieriger, die «Spreu vom Weizen» zu trennen. Welche Informationen sind wirklich alltagsrelevant, auf welche Entwick lungen müssen wir uns vorbereiten, und wo steht die Gesundheitspolitik bei uns?

10.30 – 11.00 **Pause**

JOURNAL OF CLINICAL ONCOLOGY ORIGINAL REPORT

To Tell or Not to Tell: The Community Wants to Know About Expensive Anticancer Drugs As a Potential Treatment Option

Linda Mileshkin, Penelope E. Schofield, Michael Jefford, Emilia Agalianos, Michele Levine, Alan Herschtal, Julian Savulescu, Jacqui Ann Thomson, and John R. Zalcberg

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?

Methode: Telefonumfrage mit 3 Scenarios (Selbstbehalt: 25.000 US Dollars).

To Tell or Not to Tell: The Community Wants to Know About Expensive Anticancer Drugs As a Potential Treatment Option

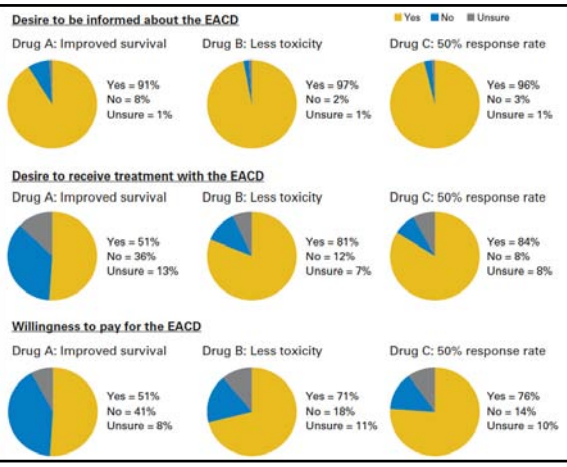
Linda Mileshkin, Penelope E. Schofield, Michael Jefford, Emilia Agalianos, Michele Levine, Alan Herschtal, Julian Savulescu, Jacqui Ann Thomson, and John R. Zalcberg

"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 Tabl.

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 theinformation causing distress.

Kommentar:

- Wie wichtig ist den Befragten QL!
- „A recent survey of 134 Australian cancer specialists found that discussing EACDs with patients was a difficult task for 78%. (63% found discussions about do-not-resuscitate orders and transition to palliative care difficult)".

Evidenzhierarchie EBM

Ia	mind. 1 systematische Review auf Basis randomized controlled trials (RCT)
Ib	mind. 1 RCT
IIa	mind. 1 Studie ohne Randomisierung
IIb	mind. 1 Studie (quasi-experimentell)
III	mehr als 1 nicht-experimentelle Studie
IV	Meinung und Überzeugung von Autoritäten, Expertenkommissionen, beschreibende Studien

Psycho-Oncology
Psycho-Oncology **19**: 21–28 (2010)
Published online 9 March 2009 in Wiley InterScience (www.interscience.wiley.com). **DOI**: 10.1002/pon.1556

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

William Breitbart[1]*, Barry Rosenfeld[2], Christopher Gibson[1], Hayley Pessin[1], Shannon Poppito[1], Christian Nelson[1], Alexis Tomarken[1], Anne Kosinski Timm[1], Amy Berg[1], Colleen Jacobson[2], Brooke Sorger[2], Jennifer Abbey[2] and Megan Olden[2]
[1]*Memorial Sloan-Kettering Cancer Center, New York, NY, USA*
[2]*Fordham University, Bronx, NY, USA*

Hintergrund: Sinnfindung und Spiritualität sind für viele Patienten mit fortgeschrittenen Leiden wichtig.(EOL).Für sie wurde Meaning Centered Group Therapy (MCGT) entwickelt.

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

(FACIT: Functional Assessment of Chronic Illness Therapy)
FACIT: Meaning and Peace
FACIT: 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.

Respondents indicate on a 5-point scale how true each statement has been for them during the past 7 days:

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.

Peterman AH, et al.Measuring spiritualwell-being in people with cancer: the Functional Assessment of Chronic Illness Therapy Spiritual Well-Being Scale (FACIT-Sp). Ann Behav Med 2002;24:49-58.

Weekly Topics Covered in MCGP versus SGP

Session	MCGP	SGP
1	Concepts and Sources of Meaning	Group Member Introductions
2	Cancer and Meaning	Group Member Introductions cont.
3	Historical Sources of Meaning (Legacy: past)	Coping with Medical Tests and Communicating with Providers
4	Historical Sources of Meaning (Legacy: present and future)	Coping with Family and Friends
5	Attitudinal Sources of Meaning: Encountering Life's Limitations	Coping with Vocational Issues
6	Creative Sources of Meaning: Creativity and Responsibility	Coping with Body Image and Physical Functioning
7	Experiential Sources of Meaning: Nature, Art, and Humor	Coping with the Future
8	Termination: Goodbyes, and Hopes for the Future	Termination: Where Do We Go From Here?

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?'

Table 1. Changes in spiritual well-being and psychological functioning following MCGP

	M Pre	M Post	d	p	M F/U	d	p
Spiritual well-being							
FACIT total	2.06	2.53	0.72	0.0001	2.80	1.46	0.0001
Meaning/Peace	2.28	2.79	0.74	0.0001	3.21	1.45	0.0001
Faith	1.60	1.99	0.40	0.02	2.01	0.89	0.006
Psychological functioning							
Depression	14.73	15.35	0.09	0.57	12.48	0.33	0.24
Hopelessness	6.76	5.81	0.31	0.07	5.92	0.52	0.08
Desire for death	4.59	3.70	0.29	0.09	3.64	0.63	0.04
Optimism	2.29	2.36	0.16	0.33	2.26	0.49	0.10
Anxiety	2.29	2.16	0.29	0.10	1.88	0.72	0.02

M pre, group mean at baseline; *M* post, group mean at end of treatment; *M* F/U, group mean at 2-month follow-up assessment. Because between-group comparisons include only those subjects available for follow-up analyses, $n = 37$ for *M* pre and *M* post; $n = 25$ for *M* F/U. *d*, *p* correspond to effect size for comparison to baseline score (*M* pre).

Table 2. Changes in spiritual well-being and psychological functioning following supportive group therapy

	M Pre	M Post	d	p	M F/U	d	p
Spiritual well-being							
FACIT total	2.07	2.15	0.13	0.58	2.28	0.19	0.50
Meaning/Peace	2.35	2.53	0.26	0.28	2.70	0.33	0.26
Faith	1.51	1.37	−0.24	0.33	1.42	−0.22	0.45
Psychological functioning							
Depression	14.50	16.22	−0.27	0.27	16.46	−0.17	0.55
Hopelessness	8.28	7.72	0.11	0.64	8.08	0.15	0.60
Desire for death	4.33	4.50	−0.04	0.19	4.00	0.10	0.71
Optimism	2.51	2.45	0.12	0.63	2.75	0.38	0.20
Anxiety	2.06	2.11	−0.13	0.61	1.93	0.07	0.80

M pre, group mean at baseline; *M* post, group mean at end of treatment; *M* F/U, group mean at 2-month follow-up assessment. Because between-group comparisons include only those subjects available for follow-up analyses, $n = 18$ for *M* pre and *M* post; $n = 13$ for *M* F/U. *d*, *p* correspond to effect size for comparison to baseline score (*M* pre).

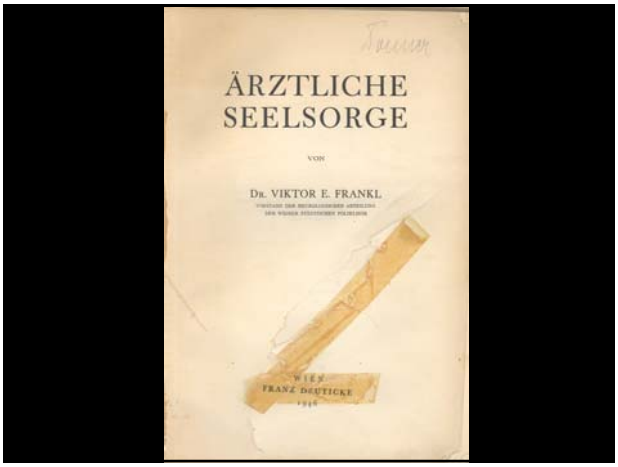
Resultate: Sinnfindung und Spiritualität ist bei Patienten in der MCGP grösser und anhaltender. Zusätzlich sind sie weniger ängstlich und haben weniger Todeswünsche. Bei den Patienten in der SGP sind keine solchen Änderungen vorhanden.

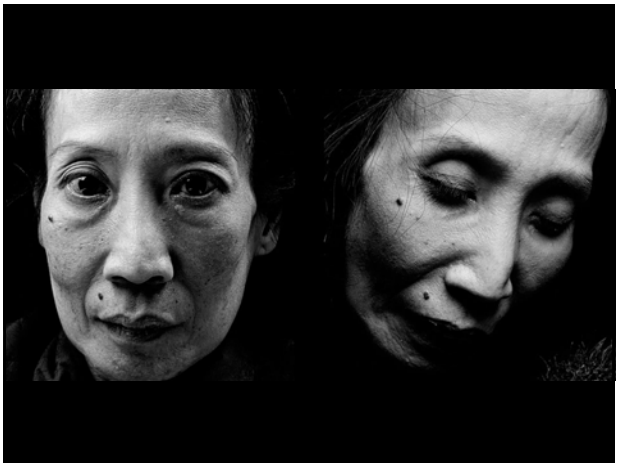
Schlussfolgerungen:

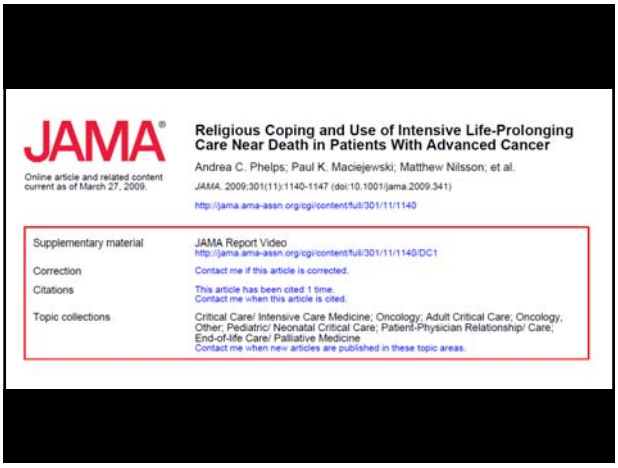
MCGP scheint von potentiellen Nutzen zu sein. Pilot-Studie

Kommentar

Spannend , methodologisch sehr gut gemacht, persönlicher Kommentar







JAMA

Online article and related content current as of March 27, 2009.

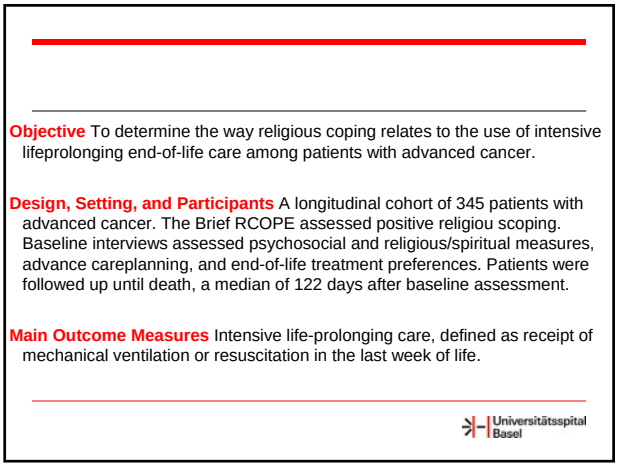
Religious Coping and Use of Intensive Life-Prolonging Care Near Death in Patients With Advanced Cancer

Andrea C. Phelps; Paul K. Maciejewski; Matthew Nilsson; et al.

JAMA. 2009;301(11):1140-1147 (doi:10.1001/jama.2009.341)

http://jama.ama-assn.org/cgi/content/full/301/11/1140

Supplementary material	JAMA Report Video http://jama.ama-assn.org/cgi/content/full/301/11/1140/DC1
Correction	Contact me if this article is corrected.
Citations	This article has been cited 1 time. Contact me when this article is cited.
Topic collections	Critical Care/ Intensive Care Medicine; Oncology; Adult Critical Care; Oncology, Other; Pediatric/ Neonatal Critical Care; Patient-Physician Relationship/ Care; End-of-life Care/ Palliative Medicine Contact me when new articles are published in these topic areas.



Objective To determine the way religious coping relates to the use of intensive lifeprolonging 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 religiou scoping. Baseline interviews assessed psychosocial and religious/spiritual measures, advance careplanning, 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.

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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.

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

	Level of Positive Religious Coping, No./Total (%)			
	High	Low	OR (95% CI)	*P* Value
Ventilation	20/177 (11.3)	6/167 (3.6)	3.42 (1.34-8.74)	.01
Resuscitation	13/176 (7.4)	3/167 (1.8)	4.36 (1.22-15.59)	.02
Intensive life-prolonging care	24/176 (13.6)	7/167 (4.2)	3.61 (1.51-8.62)	.004
Death in ICU	19/178 (10.7)	7/167 (4.2)	2.73 (1.12-6.68)	.03
Hospice care enrollment	127/178 (71.3)	122/166 (73.5)	0.90 (0.56-1.44)	.66

Table 3. Level of Positive Religious Coping and Other Coping Mechanisms

	Level of Positive Religious Coping, No./Total (%)			
	High	Low	OR (95% CI)	*P* Value
Coping mechanism				
Negative religious coping	103/178 (57.9)	46/167 (27.5)	3.61 (2.30-5.67)	<.001
Active coping	100/178 (56.2)	76/167 (45.5)	1.54 (1.00-2.35)	.05
Using emotional support	98/178 (55.1)	94/167 (56.3)	0.95 (0.62-1.46)	.82
Behavioral disengagement	48/178 (27.0)	33/167 (19.8)	1.50 (0.91-2.48)	.12
Psychospiritual variable				
Terminal-illness acknowledgment	88/174 (50.6)	60/160 (37.5)	1.71 (1.10-2.64)	.02
Support of spiritual needs	64/177 (36.2)	24/164 (14.6)	3.30 (1.94-5.62)	<.001
SCID diagnosis	21/173 (12.1)	11/159 (6.9)	1.86 (0.87-3.99)	.11
Care preference or directive				
Heroic measures	67/175 (38.3)	14/163 (8.6)	6.60 (3.53-12.36)	<.001
Life-extending care	48/177 (27.1)	39/165 (23.6)	1.20 (0.74-1.96)	.46
Do-not-resuscitate order	60/177 (33.9)	80/162 (49.4)	0.53 (0.34-0.81)	.004
Living will	50/170 (29.4)	113/166 (68.1)	0.20 (0.12-0.31)	<.001
Health care proxy/durable power of attorney	58/170 (34.1)	106/166 (63.9)	0.29 (0.19-0.46)	<.001

Abbreviations: CI, confidence interval; OR, odds ratio; SCID, Structured Clinical Interview for the *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition).

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.

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Psycho-Oncology
Psycho-Oncology **18**: 1261–1272 (2009)
Published online 20 February 2009 in Wiley InterScience (www.interscience.wiley.com). **DOI**: 10.1002/pon.1529

Randomized controlled trial of mindfulness-based stress reduction (MBSR) for survivors of breast cancer

Cecile A. Lengacher[1], Versie Johnson-Mallard[1], Janice Post-White[2], Manolete S. Moscoso[1], Paul B. Jacobsen[3], Thomas W. Klein[4], Raymond H. Widen[4,5], Shirley G. Fitzgerald[1], Melissa M. Shelton[1], Michelle Barta[1], Matthew Goodman[6], Charles E. Cox[3,4] and Kevin E. Kip[1]*

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).

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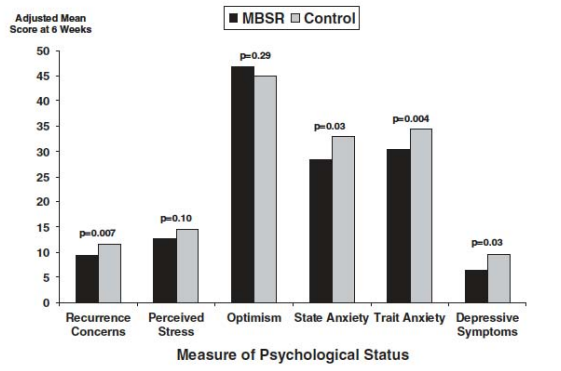
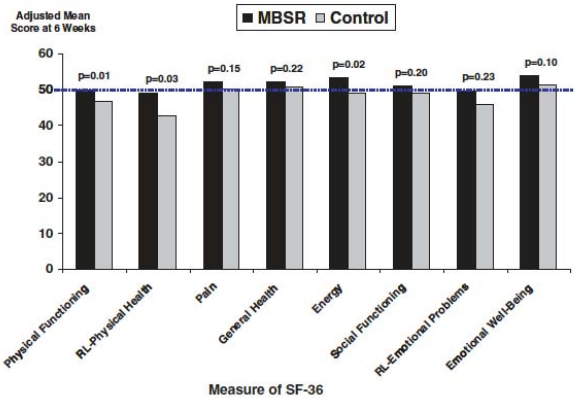
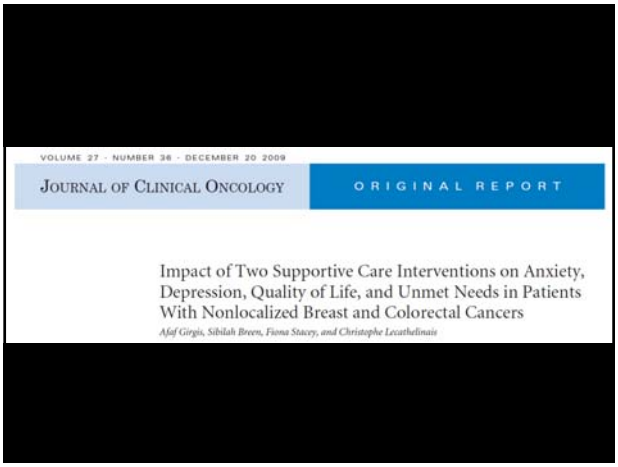




Conclusions: Among survivors a 6-week MBSR program resulted in significant improvements in psychological status and quality of life compared with usual care.

Kommentar:

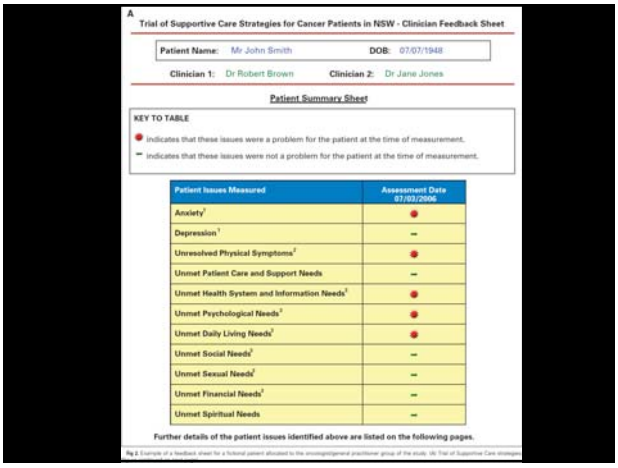
- Interessant, aber treatment as usual ist als Vergleichsgruppe fragwürdig.
- Ist nicht sinnvoller psychosoziale gestresste Patientinnen zu untersuchen?
- „Subjects received $50 at the beginning and $50 at the completion of the study“.

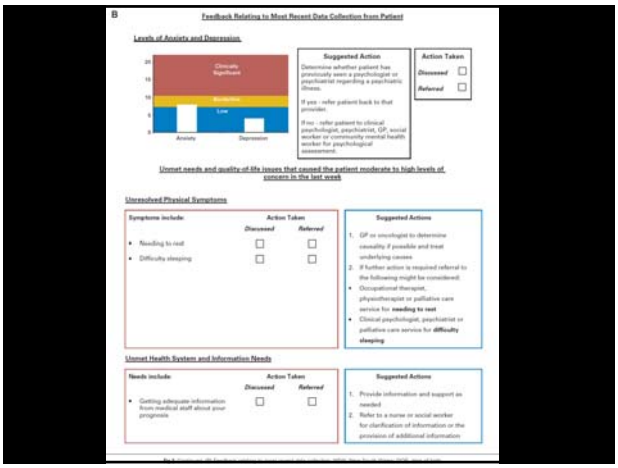


Purpose Feedback of patient-reported outcomes (PROs) to clinicians or caseworkers may result in improved patient functioning: Randomized, controlled trial against usual care (UC): a telephone caseworker (TCW) model and an oncologist/general practitioner (O/GP) model

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.





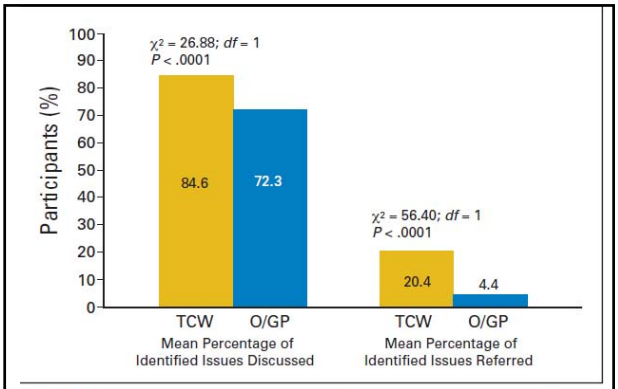


Fig 3. Mean percentage of issues identified on feedback sheets which were discussed with participants by telephone caseworkers (TCWs) or oncologists/general practitioners (O/GPs) and which resulted in referrals.

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.

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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

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Quantitative Forschung

An naturwissenschaftliches Forschung orientiert

Objektive Realität

Empirie mit systematisch entwickelten Methoden

Repräsentative Stichproben

Verteilung, Wahrscheinlichkeiten,

Prüft Hypothesen und Theorien

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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

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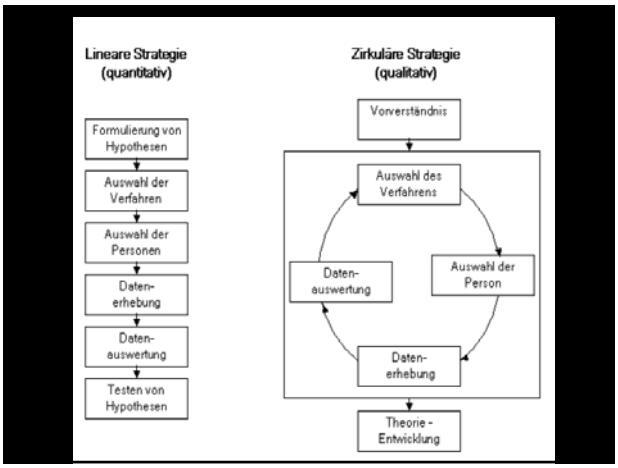

Support Care Cancer
DOI 10.1007/s00520-009-0731-2

ORIGINAL ARTICLE

Barriers to using psycho-oncology services: a qualitative research into the perspectives of users, their relatives, non-users, physicians, and nurses

Melanie Neumann · Maren Galushko · Ute Karbach · Hadass Goldblatt · Adriaan Visser · Markus Wirtz · Nicole Ernstmann · Oliver Ommen · Holger Pfaff

Received: 29 May 2009 / Accepted: 13 August 2009

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: Normacy

„...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 anf 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.

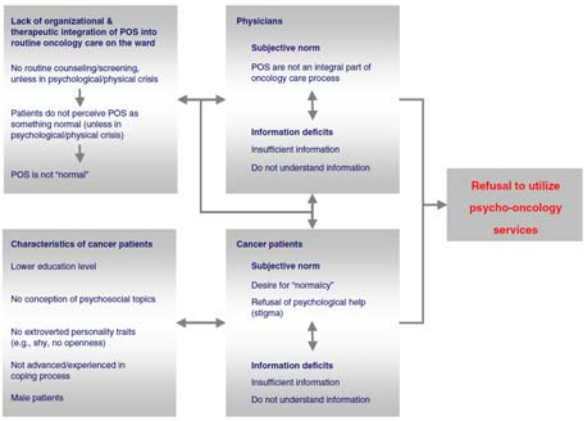

Fig. 2 Systemic model of barriers to using psycho-oncology services (POS). *POI* psycho-oncology institutions, *POS* psycho-oncology services

Struktur

1.) Wo und wie suchen ?
2.) Was ist neu?
2.) Kriterien der Auswahl
3.) Artikeln
4.) Noch mehr Artikeln
4.) **Zusammenfassung**
5.) Workshop am Nachmittag

Zitierte Literatur

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