O3_A2_A_Scientific Evidence

EVALUATION OF THE PATIENT AWARENESS LEVEL OF HIS/HER DISEASE

Q1	**What are indications for cognitive assessment in palliative care patients?**
Patients	Patients elderly and/or frail and/or end of life indications in a palliative facility Frail, aged, end of life adults
Intervention	Assessment cognitive
Comparator	None
Outcome	Adherence to treatment of patient Quality of life
Methodology	Systematic reviews Randomized controlled trials

Conclusions

The feasibility and impact of a brief psychosocial and educational strategy, which is based on CBT, will be evaluated in patients with advanced cancer who start palliative chemotherapy to determine whether the patients will be in a better condition when assessed for the first time by a PC team. We believe that the benefits of psychological intervention shall be synergistic to secondary emotional benefits from the early integration of PC. Therefore, this study will evaluate a new strategy for the transition into PC. Furthermore, the inclusion of early PC with or without a brief psychosocial and educational strategy will be compared to standard oncological care in a control arm (first-line palliative chemotherapy) in which patients are referred to PC by the attending physician. This study aims to confirm this benefit and to examine whether the psychosocial and educational strategy can reduce depression symptoms over time. (1)

We employed an in-depth retrospective chart review to collect data on patient demographics, self-reported substance use, medical and psychiatric history. Cognitive impairment was diagnosed according to the nosology for HIV-Associated Neurocognitive Disorders (Antinori et al., 2007). (2)

Table 3. Reason for admission ($n = 83$).

	General admission ($n = 61$)		Respite admission ($n = 22$)	
Reason for admission	Frequency*	Percentage	Frequency*	Percentage
Supportive care/medical focus	51	83.6	21	95.5
ART adherence support	11	18.0	6	27.3
End of life care	9	14.8	0	n/a
Supportive care/psychosocial focus	7	11.5	5	22.7
Caregiver relief	1	1.6	3	13.6

Note: *Patients could be admitted for more than one reason.

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Recommendations for practice:

Make an assessment of the patient's ability to understand, asking support from family, support staff and colleagues in intellectual disability services if in doubt.

Use short, simple explanations and pictures (such as those in the 'Books Beyond Words' series, see below), and demonstrations (such as showing the patient round the clinic beforehand).

Involve close carers, including family and paid staff, in decisions around disclosure. However, avoid collusion with carers who maybe over-protective.

Support family and carers. They may be highly distressed by the illness. If they are the ones to break bad news, check they know the facts and understand the situation. Offer to support them in their task.

Create opportunities for the patient to ask questions. Many people with intellectual disabilities do not ask, or hide their lack of understanding. Answer any questions or concerns honestly and simply. 'Books Beyond Words' is a series of picture books that has been developed to make communicating easier for people with learning disabilities, and to enable discussion about difficult topics. Useful titles include 'Am I going to die?' by S. HollinsandTuffrey-Wijne, 2009 (based on the study in this paper, it tells the story of a man who has learning disabilities and who is dying. The pictures follow him in his illness and in his final days) and 'Getting on with cancer' by Donaghey et al. (2002) (which tells the story of a woman who is diagnosed with cancer, and then has surgery, radiotherapy and chemotherapy). Available from www. rcpsych.ac.uk/publications/booksbeyondwords.aspx (3)

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Q2	**The psychodynamic in these cases is routinely used or is used by clinician in a discretionary approach?**
Patients	Patients elderly and/or frail and/or end of life indications in a palliative facility Frail, aged, end of life adults Children in a palliative facility
Intervention	Psychodynamic intervention prescription
Comparator	None
Outcome	Efficacy Quality of life.
Methodology	Systematic reviews Randomized controlled trials Descriptive study
Extra	Kallergis G. Informing cancer patient based on his type of personality: The self-sacrificing patient. J BUON. 2015 Mar-Apr;20(2):645-9.

Conclusions

Highly distressed cancer patients and their partners showed a decrease in distress. Such a decrease in psychological distress in the first year for initially highly distressed patients and relatives may justify the implementation of psycho-oncological services for clinical reasons since patients use this service regularly which can be seen as a need for such an intervention [1].

Table 2 Psycho-oncological treatment effects for highly distressed patients and partners (pre–post change)

	Baseline [*M* (SD)]	12 months [*M* (SD)]	*F*	*p*	ES	[95 % CI]
Patients[a]						
Anxiety	8.48 (3.79)	7.18 (4.24)	6.26	0.01	0.32	0.05–0.58
Depression	7.45 (3.69)	5.38 (4.18)	13.58	0.001	0.52	0.21–0.83
Distress	15.94 (6.61)	12.56 (7.89)	12.04	0.001	0.46	0.18–0.74
Psychopathology	1.18 (0.68)	0.97 (0.71)	3.84	0.05	0.30	0.00–0.59
Partners[b]						
Anxiety	11.56 (4.70)	9.47 (4.45)	7.15	0.01	0.45	0.07–0.83
Depression	7.87 (3.86)	6.63 (3.94)	4.03	0.06	0.31	−0.01–0.65
Distress	19.43 (7.78)	16.09 (7.81)	6.20	0.02	0.42	0.05–0.80
Psychopathology	1.45 (1.06)	1.21 (1.10)	2.65	0.12	0.22	−0.05–0.50

M mean, SD standard deviation, *F* *F* value, *p* *p* value, *ES* effect size, *CI* confidence interval

[a] *n* patients = 37

[b] *n* partners = 16

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Table 3 Equivalence of control group (CG) and treatment group (TG) before and after matching procedure

	CG *M* (SD)	TG *M* (SD)	*p*	CG *M* (SD)	TG *M* (SD)	*p*
Patients	Before matching[a]			After matching[b]		
Anxiety	4.84 (3.53)	6.95 (4.12)	0.01	5.70 (3.41)	6.36 (3.75)	0.45
Depression	4.37 (3.56)	5.90 (3.90)	0.01	4.82 (3.31)	5.06 (3.42)	0.77
Distress	9.21 (6.39)	12.85 (7.53)	0.01	10.52 (5.78)	11.42 (6.79)	0.56
Psychopathology	0.64 (0.54)	0.94 (0.64)	0.01	0.77 (0.63)	0.82 (0.57)	0.74
Partners	Before matching[c]			After matching[d]		
Anxiety	7.10 (4.09)	9.56 (4.46)	0.01	8.27 (4.18)	8.87 (3.67)	0.61
Depression	5.78 (4.42)	6.68 (3.99)	0.25	6.45 (4.58)	6.09 (3.83)	0.77
Distress	12.88 (8.16)	16.24(7.94)	0.02	14.73 (8.46)	14.96 (7.27)	0.92
Psychopathology	0.84 (0.62)	1.12 (0.87)	0.04	1.05 (0.70)	1.06 (0.87)	0.97

[a] CG *n* patients = 92; TG *n* patients = 94
[b] CG *n* patients = 33; TG *n* patients = 33
[c] CG *n* partners = 60; TG *n* partners = 57
[d] CG *n* partners = 22; TG *n* partners = 23

Table 4 Psycho-oncological intervention effects of psycho-oncological intervention (TG) compared to persons without treatment (CG) in moderately distressed patients and partners: completer analyses

	Group	Baseline	12 months	ANOVA[a]				ES	[95 % CI]
		[*M* (SD)]	[*M* (SD)]	Time		Time × group			
				F	*p*	*F*	*p*		
Patients[b]									
Anxiety	CG	6.58 (3.48)	5.00 (3.00)	2.38	0.13	0.02	0.82	−0.04	−0.64–0.55
	TG	5.96 (3.83)	4.83 (4.27)					0.27	−0.15–0.71
Depression	CG	4.11 (2.94)	3.63 (3.04)	4.75	0.03	0.04	0.83	0.31	−0.29–0.91
	TG	4.83 (3.55)	4.67 (3.63)					0.04	−0.40–0.49
Distress	CG	10.68 (6.07)	8.63 (5.71)	3.97	0.05	0.00	0.99	0.13	−0.47–0.73
	TG	10.79 (6.94)	9.50 (7.47)					0.17	−0.25–0.61
Psychopath	CG	0.94 (0.76)	0.67 (0.50)	1.08	0.30	1.91	0.17	0.16	−0.44–0.76
	TG	0.73 (0.49)	0.76 (0.61)					−0.05	−0.48–0.38
Partners[c]									
Anxiety	CG	7.17 (3.12)	4.75 (3.16)	0.24	0.62	0.02	0.88	0.77	0.13–1.40
	TG	8.67 (3.75)	6.97 (3.74)					0.45	−0.05–0.96
Depression	CG	4.83 (3.32)	3.25 (2.52)	0.08	0.93	0.40	0.53	0.53	−0.05–1.12
	TG	5.53 (3.44)	4.93 (3.61)					0.17	−0.32–0.66
Distress	CG	12.00 (6.03)	8.00 (5.42)	0.04	0.83	0.16	0.68	0.69	0.08–1.31
	TG	14.20 (7.00)	11.91(7.14)					0.32	−0.17–0.82
Psychopath.	CG	0.80 (0.55)	0.39 (0.30)	0.09	0.76	1.52	0.22	0.92	0.19–1.65
	TG	0.83 (0.53)	0.72 (0.50)					0.21	−0.34–0.76

[a] Covariate: gender
[b] CG *n* patients = 19; TG *n* patients = 24
[c] CG *n* partners = 12; TG *n* partners = 15

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Q3	**It takes into account the presence of psychopathological evaluation of disease awareness? The POMS (Profile moods) could be useful?**
Patients	Patients elderly and/or frail and/or end of life indications in a palliative facility Frail, aged, end of life adults
Intervention	POMS
Comparator	None or not POMS
Outcome	Quality of life.
Methodology	Systematic reviews Randomized controlled trials

References

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Conclusions

Research into neurocognitive deficits in mood disorder is well advanced, to the point of there being multiple meta-analyses in different clinical groups. These consistently demonstrate broad, significant differences in multiple cognitive domains/processes, but not a distinct profile. As we have reviewed here, there are numerous factors that may impact cognitive function which contribute to heterogeneity. These include (i) clinical features such as age, stage of illness, and comorbidity; (ii) methodological factors such as cognitive test sensitivity and reliability; (iii) statistical and conceptual differences; and (iv) even unseen individual factors such as engagement, self-esteem, motivation to testing, or sensitivity to perceived feedback. Together this raises the question as to whether it is conceptually flawed to consider the notion of a single cognitive pro- file of major depression or BD. Recently there have been significant moves away from simple categorical diagnostic concepts towards a dimensional characterisation of mood disorder (e.g., the NIHM RDoC initiative) in which it may be possible to characterise specific cognitive endophenotypes (1).

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