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Numerous studies have examined the psychometric qualities of instruments used for screening cancer patients that focus on psychological distress. By contrast, few studies have dealt with the practical use of screening instruments (2). In one of these studies (3), 343 new patients were screened at an oncology center in Sydney, Australia, over a 16-month period. Approximately 25% of the patients fulfilled the cutoff criterion set by the Hospital Anxiety and Depression Scale (HADS), of which only 30% actually consulted a clinical psychologist. During the same period, 103 patients were referred to a clinical psychologist for reasons other than a sufficiently high HADS score, such as adjustment problems, flat affect, relationship problems, and hereditary cancer issues. In another study (4), 100 patients were screened at a radio-oncology unit over a 6-month period. Approximately one-third suffered from moderate to severe anxiety or depression, of which only 58% accepted counseling. Of those patients who fell below the HADS cutoff criterion, 45% were interested in, and actually received, counseling. Patients were also asked whether they would like psychosocial support. Of the patients who actually received supportive counseling, 38% would have been referred to counseling solely on the basis of moderate to high distress scores, whereas 71% would have been referred if based solely on the question “Are you interested in receiving supportive counseling?” These findings question the usefulness of screening for distress among cancer patients. Vodermaier et al. (1) do not reference a critical review that describes the somewhat disappointing results of studies that evaluated the usefulness of screening instruments for depression in primary medical care (5).

Another point of discussion that is rarely raised is who decides about psycho-oncological treatment, the patient or the expert? Whenever patients are asked about their symptoms and needs, they often do not mention that help with anxiety or depression is their main concern. The five most often mentioned unfulfilled needs of cancer patients in an Australian study concerned fears about the cancer spreading, family concerns, lack of energy and tiredness, uncertainty about the future, and not being able to do things one used to do (6).

Evidently, cancer patients also consider specific symptoms at least as important as anxiety or depression. Therefore, for a screening instrument to be considered useful, it should have a broader focus beyond anxiety and depression. It would be unacceptable for a health-care system to exclude patients who struggle with serious symptoms but who do not suffer from major depression or anxiety disorders from being offered psychological help.

If the common aim is to advance patient-centered psychosocial care in oncology, the simplest way to achieve this goal is to provide patients with more information about psycho-oncological care facilities and to ask whether they are interested in receiving supportive counseling. A German study among 1083 women with breast cancer showed that 46% felt inadequately informed about support options (7), indicating the necessity for improvement of this basic facility. Our point is not that psychological symptom screening is ineffective but rather that its usefulness has not been proven, and more patients in need can possibly be reached by using simpler methods other than implementing a screening checklist in oncology departments.

BERT GARSSEN
MARIJE van der LEE

Re: Screening for Emotional Distress in Cancer Patients: A Systematic Review of Assessment Instruments

Vodermaier et al. (1) describe in their review the psychometric quality of 33 instruments that are used to screen cancer patients for serious psychological symptoms. These measures were evaluated for their reliability and for concurrent and construct validity. Their analysis would be useful if these screening instruments were only used for research purposes. However, screening instruments are designed for use in a clinical setting. Therefore, the usefulness of screening instruments is a crucial aspect that should not be ignored.

Numerous studies have examined the psychometric qualities of instruments used for screening cancer patients that focus on psychological distress. By contrast, few studies have dealt with the practical use of screening instruments (2). In one of these studies (3), 343 new patients were screened at an oncology center in Sydney, Australia, over a 16-month period. Approximately 25% of the patients fulfilled the cutoff criterion set by the Hospital Anxiety and Depression Scale (HADS), of which only 30% actually consulted a clinical psychologist. During the same period, 103 patients were referred to a clinical psychologist for reasons other than a sufficiently high HADS score, such as adjustment problems, flat affect, relationship problems, and hereditary cancer issues. In another study (4), 100 patients were screened at a radio-oncology unit over a 6-month period. Approximately one-third suffered from moderate to severe anxiety or depression, of which only 58% accepted counseling. Of those patients who fell below the HADS cutoff criterion, 45% were interested in, and actually received, counseling. Patients were also asked whether they would like psychosocial support. Of the patients who actually received supportive counseling, 38% would have been referred to counseling solely on the basis of moderate to high distress scores, whereas 71% would have been referred if based solely on the question “Are you interested in receiving supportive counseling?” These findings question the usefulness of screening for distress among cancer patients. Vodermaier et al. (1) do not reference a critical review that describes the somewhat disappointing results of studies that evaluated the usefulness of screening instruments for depression in primary medical care (5).

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