Reply: benefits of screening cancer patients for distress still not demonstrated

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Sir,

We would like to thank Dr Coyne (2013) for providing the opportunity to further clarify the findings of our extensive evaluation programme of screening for distress interventions. As anyone who has conducted large-scale randomised clinical intervention trials would know, this type of evaluation research is difficult, expensive and time-consuming, yet incredibly important, as randomised, controlled trials are the one methodology that helps us to answer the key questions that Dr Coyne continues to raise: does screening for distress actually improve patient outcomes?

To directly respond to several of Coyne’s comments:

(1) ‘Viable’ is meant to convey that the intervention is feasible, which we (Carlson et al, 2010) and others (Shimizu et al, 2004; Ito et al, 2011) have repeatedly demonstrated.

(2) ‘Does screening improve patient outcomes relative to the results achieved in routine care without screening?’ and ‘screening for distress would be judged efficacious if it were shown to improve patient outcomes beyond what would be achieved in routine care’. As stated in the paper, we cannot answer, nor did we attempt to answer, this question from the design of this trial, as there was no randomised usual care comparison group. This trial answered a different question: is screening followed by personalised triage better for patients than screening followed by computerised triage?

(3) ‘Simply providing patients with an opportunity for a minimal screening, respectively’ (p. 4888) (Carlson et al, 2011). Although Coyne may continue to debate this point, we personally find the evidence from our own research and other studies that have been conducted (see Carlson et al, 2012 for a review), convincing enough to support the value of screening for distress programmes. Hence, the current trial was designed with this premise in mind and in an attempt to find low cost yet effective means to surmount some of the difficulties Coyne mentions.

(4) ‘Despite having the resources and focused attention of a funded clinical trial, these investigators lost a substantial proportion of their patients initially screened to follow-up.’ We did lose about 1/3 of the patients to follow-up, which we believe was a consequence of the trial design. We contacted the patients at 3, 6 and 12 months post diagnosis by e-mail or phone, not for screening purposes, but rather for follow-up assessment of trial to provide screening followed by triage in a simpler and cheaper format—via computer. Given that there were no group differences on rates of change in anxiety, depression, distress, pain and fatigue between groups, it does appear that a computerised screening programme with automated referrals may be a good alternative to programmes that, as pointed out by Coyne, can be costly.

(5) ‘Despite having the resources and focused attention of a funded clinical trial, these investigators lost a substantial proportion of their patients initially screened to follow-up.’ We did lose about 1/3 of the patients to follow-up, which we believe was a consequence of the trial design. We contacted the patients at 3, 6 and 12 months post diagnosis by e-mail or phone, not for screening purposes, but rather for follow-up assessment of trial

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outcomes. Recommendations for clinical implementation of screening for distress call for routine screening in the clinic, at critical care points. Hence, the drop-outs from this study do not reflect at all upon the feasibility of implementing clinic-based screening programmes, rather on the usual attrition seen in clinical trials over an extended period of time.

(6) 'Furthermore, only a minority of distressed patients in either condition accessed services, with no group differences in outcome associated with group assignment, but those who accessed services improved more.' This is the second large study in which we have seen that patients who accessed services improved more over time; hence, our take-home message has come to be that screening alone is not enough—it must be effective in connecting patients with appropriate services. The fact that personalised triage was so much more effective in connecting patients with resources in this trial supports the recommendation for this screening format, particularly for 'at-risk' populations.

(7) 'Screening for distress should not be implemented without demonstration that it actually improves patient outcomes over routine care and that benefits exceed costs at patient and system levels'. We agree with this statement and challenge Dr Coyne to use his analytical skills and obvious interest in this area to help add to the evidence base, rather than detract from the evidence that currently does exist. No one study is going to answer these questions; a body of research is certainly needed to help incrementally advance our understanding of the benefits, potential drawbacks and alternatives to screening for distress in oncology populations. That is exactly what we are attempting to do within our research programme, and invite Dr Coyne and his team to join in the effort.

REFERENCES
Carlson LE, Groff S, Waller A, Bultz BD (2011) Reply to S. Palmer et al clinical trial did demonstrate benefits for screening cancer patients for distress. J Clin Oncol 29: e279–e280.
Carlson LE, Groff SL, Maciejewski O, Bultz BD (2010) Screening for distress in lung and breast cancer outpatients: a randomized controlled trial. J Clin Oncol 28(35): 4884–4891.
Carlson LE, Waller A, Groff SL, Giese-Davis J, Bultz BD (2013) What goes up does not always come down: patterns of distress, physical and psychosocial morbidity in people with cancer over a one year period. Psycho Oncol 22(1): 168–176.
Carlson LE, Waller A, Mitchell AJ (2012) Screening for distress and unmet needs in patients with cancer: review and recommendations. J Clin Oncol 30(11): 1160–1177.
Coyne JC (2013) Benefits of screening cancer patients for distress still not demonstrated. Br J Cancer 108: 736–737.
Ito T, Shimizu K, Ichida Y, Ishibashi Y, Akizuki N, Ogawa A, Fujimori M, Kaneko N, Ueda I, Nakayama K, Uchitomi Y (2011) Usefulness of pharmacist-assisted screening and psychiatric referral program for outpatients with cancer undergoing chemotherapy. Psycho Oncol 20(6): 647–654.
Palmer SC, van Scheppingen C, Coyne JC (2011) Clinical trial did not demonstrate benefits of screening patients with cancer for distress. J Clin Oncol 29(10): e277–e278.
Shimizu K, Akechi T, Okamura M, Akizuki N, Uchitomi Y (2004) Feasibility and usefulness of the distress and impact thermometer as a brief screening tool to detect psychological distress in clinical oncology practice. Psycho Oncol 13(8): S68–S69.
Waller A, Williams A, Groff SL, Bultz BD, Carlson LE (2011) Screening for distress, the sixth vital sign: examining self-referral in people with cancer over a one-year period. Psycho Oncol; doi:10.1002/pon.2102.