

RESEARCH HIGHLIGHTS

Cynthia R. King, PhD, NP, MSN, RN, FAAN
Associate Editor

Study Examines Quality of Life After Diagnosis of Prostate Cancer Among Minority Men of Lower Socioeconomic Status

The goal of prostate cancer treatment is to lengthen survival and maintain quality of life. Currently, however, some debate exists about which treatment yields the best outcomes. Treatment options for localized prostate cancer are radical prostatectomy, radiotherapy, and watchful waiting. For newly diagnosed patients with metastatic prostate cancer, treatment options are immediate or delayed medical or surgical castration.

Although several studies have examined quality of life in patients with prostate cancer, a study by Siston et al. (2003) had two unique attributes. First, few studies have included baseline data before treatment initiation. Second, the study focused on patients who were ethnic minorities and had lower socioeconomic status, whereas the majority of current studies have focused on mostly white, middle-class patients. The purpose of the study was to evaluate quality of life in patients with localized and metastatic prostate cancer at baseline and during the first year of treatment according to treatment choice. The patients were treated in the Veterans Affairs (VA) system.

The European Organization for Research and Treatment of Cancer Quality-of-Life Questionnaire was administered in person in the clinic setting or by telephone by trained interviewers. The sample consisted of newly diagnosed patients who met eligibility criteria at five VA medical centers across the United States. Of all enrolled patients ($N = 140$), 70% ($n = 98$) had localized disease. Their mean age at baseline was 69 years, 39% were black, and 29% had less than a high school education. Treatment options included radical prostatectomy ($n = 29$), radiotherapy ($n = 30$), and watchful waiting ($n = 39$). The remaining 30% ($n = 42$) of subjects had metastatic disease. Their mean age at baseline was 75 years, 71% were black, and 38% had less than a high school education.

For patients with localized disease who received surgery or radiotherapy, the results were similar in that significant declines from baseline were noted at three months at a statistically significant level. The declines occurred in role function and control of urination ($p < 0.01$) for the surgery group and increased hot flashes, weight gain, and erectile problems. Decreased physical functioning, sexual interest, and activity occurred in the group receiving radiotherapy

($p < 0.05$). Thirty percent of patients in the watchful-waiting group reported increased symptoms such as difficulty urinating ($p < 0.05$), whereas 70% reported no increase in symptoms during the first three months. By 12 months, all groups reported increases in symptoms, ranging from increased difficulty urinating and decreased sexual activity ($p < 0.05$) to painful urination and worsening hot flashes ($p < 0.05$). Interestingly, in the group with metastatic disease, QOL worsened from baseline to three months with respect to role function and social function ($p < 0.01$) but returned to baseline rates by 12 months.

The study has a few notable limitations. Although it was similar to others, results may not be directly comparable because sociodemographic characteristics differed. Patients in other studies were predominately white. Also, low literacy rates required that a staff member read the questionnaire to patients.

Among veterans with newly diagnosed localized prostate cancer, QOL changes during the first year varied and, in some cases, were associated with type of treatment received rather than the disease itself. In the prostatectomy group, greater sexual and urinary problems were noted when compared to baseline. Patients who received radiotherapy reported decreased sexual interest, function, and activity; watchful-waiting patients reported worsening urinary function, which may have been part of the normal aging process.

The study is important because it is one of the first to describe changes in QOL from before initiation of treatment to one year after in a unique group of individuals. Patients with localized prostate cancer who undergo surgery or radiotherapy should be counseled regarding treatment-specific changes. For patients with metastatic disease, clinicians should discuss the immediate negative effects of treatment but explain that QOL might improve by one year after diagnosis.

Siston, A.K., Knight, S.J., Slimack, N.P., Chmiel, J.S., Nadler, R.B., Lyons, T.M., et al. (2003). Quality of life after a diagnosis of prostate cancer among men of lower socioeconomic status: Results from the Veterans Affairs Cancer of the Prostate Outcomes Study. *Urology*, 61, 172–178.

Bradley Trent Praytor, RN, BSN
Quality Improvement Coordinator
Quality Resource Center
Wake Forest University
Baptist Medical Center
Winston-Salem, NC

Aggressive Care at the End of Life Continues to Escalate

Interesting results regarding care at the end of life were presented at the 2006 annual meeting of the American Society of Clinical Oncology. Earle et al. (2006) found a steadily increasing propensity to use aggressive interventions very near death. The study linked data from the Surveillance, Epidemiology, and End Results program and the Medicare database to examine trends in cancer care at the end of life in patients older than 65 years. Data were examined on more than 215,000 patients treated from 1991–2000 in 77 healthcare service areas across the country.

The data demonstrated that patients were more likely to still be receiving care within 14 days of dying, with the rate rising from 9.7% in 1991 to 11.6% in 2000. The trend was similar for patients visiting an emergency department in the last month of life, rising from 23.9% in 1991 to 28.2% in 2000. Similarly, the fraction of patients admitted to intensive care in their final 30 days of life rose from 7.8% to 11%, and an increased trend was found for multiple hospitalizations, from 6.7% to 8.7%. The researchers also discovered an increase in the fraction of patients who entered hospice care within three days of death, from 12.1% to 14.7% over the course of the decade.

The study points out the need to address care at the end of life and poses some interesting questions. Is the number of hospice beds adequate? Do financial pressures direct care decisions? The authors distinguished between giving aggressive treatment with hope for a cure and giving aggressive treatment to terminal patients, when little hope exists for extending life or palliating symptoms.

Earle, C.C., Landrum, M., Jeffrey, S., Neville, B., Weekes, J., & Ayanian J. (2006, June). *Consistency in regional trends of aggressiveness in cancer care near the end of life for elderly Americans, 1991–2000* [Abstract 6004]. Abstract presented at the annual meeting of the American Society for Clinical Oncology, Atlanta, GA.

Suzanne A. Carroll, RN, MS, AOCN®
Oncology Clinical Nurse Specialist
Wake Forest University
Baptist Medical Center
Winston-Salem, NC

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