TOWARD INTEGRATING DISTRESS MANAGEMENT INTO ROUTINE CANCER CARE: EXPERIENCES AMONG THE ASIAN PACIFIC PSYCHO-ONCOLOGY NETWORK – UNDERSTANDING THE DISTRESS FOLLOWING A CANCER DIAGNOSIS

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SCHOOL OF PUBLIC HEALTH, HKU, & JOCKEY CLUB INSTITUTE OF CANCER CARE, HONG KONG
ASIA-PACIFIC PSYCHO-ONCOLOGY NETWORK (APPON)

- Bi-annual meetings thereafter; 2010 Hong Kong; 2012 Beijing; 2014 Taipei; 2016 Singapore; 2018 Hong Kong/IPOS World Congress of Psychosocial Oncology – October 31-Nov 2nd, 2018
- Purpose: to provide a forum to promote and support the development of integrated psychosocial cancer care across Asia-Oceania.
- Function: provides a common platform that brings people together to network, mentor and share expertise and experience on developing integrated cancer care across Asia-Pacific countries.
CANCER RELATED DISTRESS

• Definition: Relatively non-specific, involves emotional, cognitive, existential responses to social, structural and functional disruption, most often operationalized as anxiety/depression/anger.

• Common in most cases of cancer at some point in the disease trajectory.

• Point prevalence reported between 20-80+%\textsuperscript{1,2} depending on when and with what instrument it is measured. Mean prevalence “distress” \textasciitilde35\%\textsuperscript{3}

• Point prevalence for depression \textasciitilde17-20\%; anxiety (GAD) 10-11\%; However, similar levels of distress – especially anxiety and depression – are seen in general population with other co-morbid diseases, and while less intense, dysphoria and anxiety are around the same levels in the general population.

• Specific to cancer, chronic illness or life difficulties generally?

1-3. Zabora et al 201; 2014;
PREVALENCE OF PSYCHOLOGICAL DISTRESS IN PATIENTS WITH CANCER

• Active phase of illness trajectory
  • Major depression (16%)
  • Anxiety (10%)

• Survivorship (at least 2 years post-diagnosis)
  • Major depression (11.6%)
    • Healthy controls (10.2%)
  • Anxiety (17.9%)
    • Healthy controls (13.9%)

• Palliative settings
  • Major depression (14.3%)
  • Anxiety (9.6%)

Mitchell, Chan, Bhatti, et al., 2011
Mitchell, Ferguson, Gill, et al., 2013
Mitchell, Chan, Bhatti, et al., 2011
• Depression prevalence ranged from 3-31%;
• Pooled mean prevalence from 211 studies was 8-24%
Figure 1. Prototypical Patterns of Disruption in Normal Functioning Across Time Following Interpersonal Loss or Potentially Traumatic Events

Identification and Prediction of Distress Trajectories in the First Year After a Breast Cancer Diagnosis

Inge Henselmers
University Medical Center Groningen

Howard Selzman
Carnegie Mellon University

Vicki S. Helgeson
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Identification and Prediction of Distress Trajectories in the First Year After a Breast Cancer Diagnosis

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The evolution of psychological distress trajectories in women diagnosed with advanced breast cancer: a longitudinal study

W. W. T. Lam1, T. Sung1, T. K. You1, K. Y. Wong1, J. Tsang1, W. Ye2, J. Suen1, W. M. Ho1, W. K. Szeto2, A. W. Y. Ng2, A. Kwong1, D. Suen1 and R. Fielding1


IDENTIFICATION OF DISTINCT DEPRESSIVE SYMPTOM TRAJECTORIES IN WOMEN FOLLOWING SURGERY FOR BREAST CANCER

Laura B. Dunn, MD,1 Bruce A. Cooper, PhD,2 John Neuhaus, PhD,1 Claudia West, RN, MS2, Steven Paul, PhD,1 Bradley Aulizer, MAS, PhD2,2 Gary Abrams, MD,1 Janet Edrington, RN, PhD,2 Debby Hamoysky, RN, MS2, and Christine Mlieskowsk, RN, PhD, FAA2

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2School of Nursing, University of California, San Francisco, CA
3Institute for Human Genetics, University of California, San Francisco, CA

Trajectories of psychological distress among Chinese women diagnosed with breast cancer

Wendy W. T. Lam1,2, George A. Bonanno2, Anthony D. Manoni2, Samuel Ho1,3, Miranda Chan1, Wai Ka Hung1, Amy On1 and Richard Fielding1

1Centre for Psycho-Oncology Research & Training, Department of Community Medicine & Unit for Behavioural Sciences, The University of Hong Kong, Hong Kong
2Department of Counseling and Clinical Psychology, Teachers College, Columbia University, USA
3Department of Psychology, The University of Hong Kong, Hong Kong

Trajectories of psychological distress after colorectal cancer

Jeff Dunn1,2,3,4, Qin Ke Ng2,5,6,7, Jimmy Holland1,2,7, Joanne Atkin1,2,3,7,8,9, Pip Youl1,2,3,7,10, and Suzanne K. Chambers12,3,7,8,9

1Griffith Health Institute, Griffith University, Brisbane, Queensland, Australia
2Cancer Council Queensland, Brisbane, Queensland, Australia
3School of Social Science, University of Queensland, Brisbane, Queensland, Australia
4Memorial Sloan-Kettering Cancer Center, New York, NY, USA
5School of Public Health, Queensland University of Technology, Brisbane, Queensland, Australia
6Conjoint School of Health Sciences, University of South Australia, Adelaide, South Australia
7Cancer Institute, Health and Wellness Institute, Edith Cowan University, Perth, Western Australia, Australia
8Institute for Clinical Research, University of Queensland, Brisbane, Queensland, Australia
9Cancer Institute, University of Western Australia, Perth, Australia
10Department of Psychology, Pennsylvania State University, University Park, PA, USA

Published online in Wiley Online Library (wileyonlinelibrary.com). DOI: 10.1002/pon.3210
Psychological and Physical Adjustment to Breast Cancer Over 4 Years: Identifying Distinct Trajectories of Change

Vicki S. Helgeson, Pamela Snyder, and Howard Selman
Carnegie Mellon University

Figure 1. Four trajectories of mental functioning from 4 to 55 months (mos) after breast cancer diagnosis. MCS = Mental Health Component Score; T = time postdiagnosis.
Identification and Prediction of Distress Trajectories in the First Year After a Breast Cancer Diagnosis

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University Medical Center Groningen

Robbert Sanderman and Adelita Y. Ranchor
University Medical Center Groningen

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**Chronic (n = 26)**

**Recovery (n = 57)**

**Late (n = 26)**

**No distress (n = 62)**

**Stage in the illness trajectory**

- T1 after diagnosis
- T2 after surgery
- T3 after RT/CT
- T4 two months after end treatment
- T5 six months after end treatment

Diagrams showing trends in distress levels over time for different categories.
Table 2

Group Means, Standard Deviations, and Analysis of Variance (ANOVA) Test Results for Continuous Characteristics

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Total sample (M [SD])</th>
<th>Trajectory groups weighted (M [SD])</th>
<th>ANOVA results (F [df])</th>
<th>p</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No-distress</td>
<td>Recovery</td>
<td>Late</td>
</tr>
<tr>
<td>Age (≤75)</td>
<td>54.8 (9.0)</td>
<td>56.6 (8.9)</td>
<td>53.8 (9.6)</td>
<td>55.6 (8.5)</td>
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<tr>
<td>Complaints due to surgery (0–8)</td>
<td>2.4 (1.6)</td>
<td>2.1 (1.7)</td>
<td>2.3 (1.4)</td>
<td>2.6 (1.7)</td>
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<tr>
<td>Complaints due to RT, CT, HT (0–29)</td>
<td>7.3 (4.9)</td>
<td>5.8 (4.4)</td>
<td>8.0 (4.6)</td>
<td>8.5 (4.8)</td>
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<tr>
<td>Mastery (7–35)</td>
<td>25.5 (4.3)</td>
<td>27.7 (4.5)</td>
<td>24.3 (3.3)</td>
<td>25.9 (2.8)</td>
</tr>
<tr>
<td>Optimism (6–30)</td>
<td>23.4 (3.1)</td>
<td>24.7 (2.8)</td>
<td>22.7 (2.8)</td>
<td>23.8 (3.2)</td>
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<tr>
<td>Neuroticism (12–60)</td>
<td>28.1 (6.2)</td>
<td>25.4 (5.6)</td>
<td>29.3 (5.5)</td>
<td>27.1 (6.8)</td>
</tr>
</tbody>
</table>

Note. Sample sizes differ because of missing values on the predictors, that is, no-distress, 52–56; recovery, 39–45; late, 19–21; and chronic, 22–24. RT = radiotherapy; CT = chemotherapy; HT = hormone therapy.
IDENTIFICATION OF DISTINCT DEPRESSIVE SYMPTOM TRAJECTORIES IN WOMEN FOLLOWING SURGERY FOR BREAST CANCER

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2School of Nursing, University of California, San Francisco, CA
3Institute for Human Genetics, University of California, San Francisco, CA

![Graph showing CES-D scores over time for different groups.](image)

**Figure 1.**
Observed and estimated mean Center for Epidemiologic Studies Depression (CES-D) trajectories for patients in each of the latent classes, as well as the mean CES-D scores for the full sample. Dashed and dotted black line indicates the cutoff score on the CES-D for clinically meaningful levels of depressive symptoms (i.e., ≥16).
Trajectories of psychological distress after colorectal cancer

Jeff Dunn1,2,3, Shu Kay Ng1, Jimmie Holland1, Joanne Atkin1,2,3, Pip Youl1,2, Peter D. Baade1,2,4 and Suzanne K. Chambers5

1Griffith Health Institute, Griffith University, Brisbane, Queensland, Australia
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5School of Public Health, Queensland University of Technology, Brisbane, Queensland, Australia
6Health and Wellness Institute, Edith Cowan University, Perth, Western Australia, Australia
7Centre for Clinical Research, University of Queensland, Brisbane, Queensland, Australia

Abstract

Figure a: Graph showing the trajectories of psychological distress over time for different classes of patients post-colorectal cancer.

Figure b: Another graph illustrating distinct patterns of psychological distress among various patient groups.

[Graphical representations of the data are shown here, depicting the trajectories of distress over time for different classes of patients.]
Trajectories of psychological distress among Chinese women diagnosed with breast cancer

Wendy W. T. Lam\textsuperscript{1,}\textsuperscript{*}, George A. Bonanno\textsuperscript{2}, Anthony D. Mancini\textsuperscript{2}, Samuel Ho\textsuperscript{1,2}, Miranda Chan\textsuperscript{3}, Wai Ka Hung\textsuperscript{4}, Amy Oh\textsuperscript{5} and Richard Fielding\textsuperscript{6}

\textsuperscript{1}Centre for Psycho-Oncology Research & Training, Department of Community Medicine & Unit for Behavioural Sciences, The University of Hong Kong, Hong Kong
\textsuperscript{2}Department of Counseling and Clinical Psychology, Teachers College, Columbia University, USA
\textsuperscript{3}Department of Psychology, The University of Hong Kong, Hong Kong
\textsuperscript{4}Breast Centre, Department of Surgery, Kwong Wah Hospital, Kowloon, Hong Kong, Hong Kong

Trajectories of distress following breast cancer surgery

![Graph showing trajectories of distress following breast cancer surgery]

- Chronic distress 15.4%
- Delayed-recovery 6.6%
- Recovered 11.6%
- Resilient 66.3%

Time after surgery: 5 days, 1 month, 4 month, 8 month
<table>
<thead>
<tr>
<th>Predictors</th>
<th>“Recovered” group</th>
<th>“Chronic distress” group</th>
<th>“Delayed-recovery” group</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Odds ratio (95% CI)</td>
<td>SE</td>
<td>P value</td>
</tr>
<tr>
<td>Optimism</td>
<td>.90 (.72 – 1.11)</td>
<td>.11</td>
<td>NS</td>
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<tr>
<td>Physical symptom distress</td>
<td>1.22 (1.13 – 1.33)</td>
<td>.04</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>TDM difficulties</td>
<td>1.44 (1.27 – 1.64)</td>
<td>.07</td>
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<tr>
<td>Satisfaction with medical consultation</td>
<td>.98 (.87 – 1.10)</td>
<td>.06</td>
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<tr>
<td></td>
<td>.62 (.51 - .77)</td>
<td>.11</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Physical symptom distress</td>
<td>1.28 (1.18 – 1.34)</td>
<td>.04</td>
<td>&lt;.001</td>
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<tr>
<td>TDM difficulties</td>
<td>1.45 (1.28 – 1.65)</td>
<td>.07</td>
<td>&lt;.001</td>
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<tr>
<td>Satisfaction with medical consultation</td>
<td>1.03 (.91-1.17)</td>
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<td>NS</td>
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<tr>
<td></td>
<td>.90 (.71 – 1.14)</td>
<td>.12</td>
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<td>1.23 (1.13 – 1.34)</td>
<td>.04</td>
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<td>.08</td>
<td>NS</td>
</tr>
<tr>
<td>Satisfaction with medical consultation</td>
<td>.77 (.66-.89)</td>
<td>.07</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>
The evolution of psychological distress trajectories in women diagnosed with advanced breast cancer: a longitudinal study

SUMMARY

• Most patients are psychologically resilient in response to cancer diagnosis.

• Chronic distress
  • Breast cancer 10% to 15%
  • Colorectal cancer 4% to 20%

• Predictors
  • Poor social support
  • Poor personal resources (e.g. pessimism, low self-esteem, negative intrusive thoughts)
  • Unmanaged physical symptom distress
  • Poor satisfaction with treatment decision making
IMPACTS OF CHRONIC DISTRESS ON LONG-TERM SURVIVORSHIP

Psycho-Oncology
Psycho-Oncology (2010)
Published online in Wiley Online Library (wileyonlinelibrary.com). DOI: 10.1002/pon.1876

Distress trajectories at the first year diagnosis of breast cancer in relation to 6 years survivorship

Wendy W. T. Lam¹*, Yee Ting Shing¹, George A. Bonanno², Anthony D. Mancini³ and Richard Fielding¹
¹Department of Community Medicine and Unit for Behavioural Sciences, Centre for Psycho-Oncology Research and Training, School of Public Health, The University of Hong Kong, Pokfulam, Hong Kong
²Department of Counseling and Clinical Psychology, Teachers College, Columbia University, New York, USA
³Department of Psychology, Pace University, New York, USA
## Multiple regression modeling of predictors of 6-year psychosocial outcome measures

<table>
<thead>
<tr>
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<th>HADS-A</th>
<th>HADS-D</th>
<th>CIES-R Intrusive</th>
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<th>ChSAS Family</th>
<th>ChSAS Self-image</th>
<th>ChSAS Appearance &amp; Sexuality</th>
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</thead>
<tbody>
<tr>
<td><strong>Distress Trajectory Resilient</strong></td>
<td>Referent</td>
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<tr>
<td>Recovered</td>
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<td>-0.04</td>
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<td>0.08</td>
<td>0.03</td>
<td>-0.17*</td>
<td>-0.15*</td>
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<tr>
<td>Delay Recovery</td>
<td>0.17**</td>
<td>0.05</td>
<td>0.15*</td>
<td>0.06</td>
<td>0.13</td>
<td>0.01</td>
<td>-0.05</td>
<td>-0.22**</td>
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<tr>
<td><strong>Chronic Distress</strong></td>
<td>0.31**</td>
<td>0.22**</td>
<td>0.40***</td>
<td>0.25***</td>
<td>0.32***</td>
<td>-0.17*</td>
<td>-0.36***</td>
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<td>C-LOT-R</td>
<td>-0.29**</td>
<td>-0.33***</td>
<td>-0.19**</td>
<td>-0.17*</td>
<td>-0.12</td>
<td>0.21**</td>
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<td>-0.14*</td>
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<td>Arm</td>
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<td>-0.15*</td>
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</table>

Distress trajectory: 1-8 months post-surgery. All variable measured concurrently at 6 years, except † based on 1-8 months distress trajectory. Significance: *<0.05, **<0.01, ***<0.001
• Evidence suggests different natural histories of cancer-related distress:
  • 1. distress arising from the initial shock (adaptation) and other issues (financial, role function) associated with a cancer diagnosis – tends to decline over time;
  • 2. distress arising from the impact of treatments on function and appearance – symptom related, increases over time and can become chronic;
  • 3. Pre-existing distress exacerbated by 1 and 2 above – associated with chronic, high levels of distress, persists many years;
  • 4. “Existential” distress, issues regarding meaning, purpose, spirituality, fear of recurrence, financial issues, etc. Often arise later in disease trajectory/survivorship.
Integration of psychosocial care in routine cancer care

Wendy Lam, RN, PhD, F.F.P.H
The University of Hong Kong
Psychological distress in cancer survivors

• Most patients were psychologically resilience in response to cancer diagnosis

• Chronic distress
  • Breast cancer 10% to 15%
  • Colorectal cancer 4% to 20%

• Predictors
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Impacts of chronic distress on long-term survivorship

Distress trajectories at the first year diagnosis of breast cancer in relation to 6 years survivorship

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<td>0.19**</td>
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<td>0.21**</td>
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<td>-0.35***</td>
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<td>0.14*</td>
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<td>-</td>
<td>-</td>
<td>-0.15*</td>
<td>-0.14*</td>
</tr>
</tbody>
</table>

Distress trajectory: 1-8 months post-surgery. All variable measured concurrently at 6 years, except † based on 1-8 months distress trajectory. Significance: *<0.05, **<0.01, ***<0.001
Implications

• Cancer patients who experienced chronic distress during the acute phase reported the worst longer-term outcomes

• Interventions should be targeted to differentiate those who are at risk of chronic distress during the acute phase of illness trajectory
  • Ensuring optimal communications and decision-making support are essential
  • Assessing symptom distress and optimizing symptom management should be implemented at early post-operative phase
  • Screening patients with poor social and personal resources
1. Psychosocial cancer care should be recognised as a universal human right;

2. Quality cancer care must integrate the psychosocial domain into routine care;
Psychosocial cancer care in Hong Kong

Distribution of Public Hospitals and 6 Clinical Oncology Centres in HA

Cancer support services in the community
New Initiatives

Cancer support services in the community

Nurse-led symptom clinic

Distribution of Public Hospitals and 6 Clinical Oncology Centres in HA
Stepped assessment

• Broad symptom assessment as first level
  • Memorial Symptom Assessment Scale (MSAS)*
  • Edmonton Symptom Assessment Scale (ESAS)
  • MD Anderson Symptom Assessment Scale (MDASAS)

• Then for patients scoring above a given cut-off or indicating particularly strong symptoms, give targeted assessments for sleep, pain, fatigue (most common symptom complaints), distress and other symptoms
Targeted assessments

• Sleep
  • Pittsburgh Sleep Quality Index – Score >=5

• Fatigue
  • Brief Fatigue Inventory – score >=7 severe fatigue

• Neuropathy
  • ID Pain – score >=3

• Pain
  • Brief Pain Inventory – no cut off

• Anxiety & Depression
  • Hospital Anxiety and Depression Scales – Anxiety & Depression subscales – 8-10 borderline; > 10 probably clinical case

• Recurrence-related anxiety
  • Fear of Cancer Recurrence (Short Form) - >= 13
Management

• Workload management is critical to prevent overload

• Specialty Symptom Clinic – nurse psycho-oncologist. (NPO)
  • Triage to existing services including Non-government Organizations, then provide additional services as needed.
    • Pain – referral to oncologist or if needed pain specialist – aim: to effectively control pain.
    • Sleep – Full sleep assessment by NPO. - Recommendations for sleep hygiene and follow up
      • Is pain a component? If so assess, is the patient depressed? Assess. Psycho-education/CBT
      • Referral to oncologist/pain specialist for assessment and management. Follow up
    • Fatigue – education, referral to NGO-based exercise programme e.g. yoga. Follow up.
    • Anxious/depressed/Demoralized – assess –
      • mild/moderate – education, CBT, follow-up
      • Moderate severe – referral to psychologist/psychiatrist. Follow up.
Sample assessment-referral protocol

- Symptom screen: MSAS (sleep symptom)
- Follow up – targeted assessment
- Referral to oncologist/pain specialist
- Follow up – targeted assessment
- Education/CBT
- Depressed/Anxious?
  - Yes: Pain assessment
  - No: Follow up
- Psychological distress assessment
- Is pain involved?
  - Yes: Pain assessment
  - No: Sleep hygiene and education
- PSQI
- Follow up
Integration into services

• Make use of existing services, triage, onward referral to specialists.

• Most of clinic work is assessment, triage and appropriate referral.

• Requires education and “buy-in” by clinicians, support by NGOs

• Administration support and encouragement.
第一部分

說明：列舉一些症狀。如果你在過去一星期曾經出現以下症狀，請在括號中填寫合適的數字以表示症狀對你造成困擾的程度有多少。

<table>
<thead>
<tr>
<th>症狀描述</th>
<th>沒有症狀</th>
<th>完全沒困擾</th>
<th>少許困擾</th>
<th>有一些困擾</th>
<th>不少困擾</th>
<th>很多困擾</th>
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<tbody>
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<td>5</td>
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<td>5</td>
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<td>2</td>
<td>3</td>
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<td>5</td>
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<td>手部有麻痛、刺痛、或隱痛的感覺</td>
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<td>5</td>
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<td>5</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>口腔乾燥或生口破</td>
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<td>2</td>
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<td>4</td>
<td>5</td>
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<td>對性生活提不起興趣、或緩解困難</td>
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<td>1</td>
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<td>4</td>
<td>5</td>
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<tr>
<td>食慾不振</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tbody>
</table>
BREAST CANCER SURVIVORSHIP PROGRAM

SYMPTOM ASSESSMENT

Client No: [Redacted] Date of visit: 20/11/2021 Start Time: 3:30PM End Time: 5:45PM

I. PRESENTING SYMPTOMS (Refer to Memorial Symptom Assessment Scale (MSAS) screening survey)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Level of distress (0 to 4)</th>
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<tbody>
<tr>
<td>Fatigue</td>
<td>3</td>
</tr>
<tr>
<td>Sleep</td>
<td>3</td>
</tr>
<tr>
<td>Nausea</td>
<td>3</td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
</tr>
</tbody>
</table>

II. INDIVIDUAL SYMPTOM ASSESSMENT (please check the following tools that are used for further assessment)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Assessment tool</th>
<th>Checklist</th>
<th>Scores</th>
</tr>
</thead>
</table>
| Fatigue     | Brief Fatigue Inventory  
Score 7 or above, Severe fatigue | ✓          | 3.85   |
| Sleep       | Pittsburgh Sleep Quality Index  
Cutoff: Score 5 or greater indicates poor sleep quality | ✓          | 3      |
| Neuropathy  | ID-pain Cutoff: Score 3 or above |            |        |
| Pain        | Brief Pain Inventory  
(No cutoff)  
Measure of pain severity and interference as a result of pain |            |        |
| Anxiety     | HADS-Anxiety subscale  
Score between 8 and 10 (borderline case)  
Score 11 or above (clinical case) | ✓          | 10     |
| Depression  | HADS-Depression subscale  
Score between 8 to 10 (borderline case)  
Score 11 or above (clinical case) | ✓          | 5      |
| Worry about cancer recurrence | Fear of cancer recurrence (short form)  
Cutoff: score of 13 or above |            |        |
### III. Details of Symptom Assessment

<table>
<thead>
<tr>
<th>Symptom(s)</th>
<th>Comments on the recommended treatment/supports by the client</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
<td>- Yet has been seen by psych: @ Drs. Medications had been adjusted. Symptoms had been improved but she continues to feel tired.</td>
</tr>
<tr>
<td>-</td>
<td>- Still poor quality sleep had remained - was trying to find sleep at the end of the day</td>
</tr>
<tr>
<td>-</td>
<td>- Yet had actually found activities of</td>
</tr>
<tr>
<td>Scales</td>
<td>No. of completed questionnaires</td>
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<tr>
<td>--------------------------------------------</td>
<td>---------------------------------</td>
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<tr>
<td>MSAS (Memorial Symptom Assessment Scale)</td>
<td>316</td>
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<tr>
<td>PSQI (Pittsburg sleep Quality Inventory)</td>
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<tr>
<td>BFI (Brief fatigue inventory)</td>
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<tr>
<td>1D Pain – neuropathy</td>
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<tr>
<td>Pain (Brief pain inventory)</td>
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<tr>
<td>HADS (Hospital anxiety and depression scale)</td>
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<tr>
<td>FCR (Fear of cancer recurrence)</td>
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</table>
HKU Jockey Club Institute of Cancer Care (ICC)

• A critical platform to provide supportive care in collaboration with clinical oncology units and non-government organizations.

• Two programmes
  • Screening for psychosocial health need and symptom management services
  • Education programme targeting health care providers, as well as the general public

Bi-annual meetings thereafter; 2010 Hong Kong; 2012 Beijing; 2014 Taipei; 2016 Singapore; 2018 Hong Kong/IPOS World Congress of Psychosocial Oncology – October 31-Nov 2nd, 2018

Purpose: to provide a forum to promote and support the development of integrated psychosocial cancer care across Asia-Oceania.

Function: provides a common platform that brings people together to network, mentor and share expertise and experience on developing integrated cancer care across Asia-Pacific countries.