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PHYSICIANS DIFFICULTIES AND COPING STRATEGIES IN CANCER CARE

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Object of the study: We know a lot about coping mechanisms of the patients, but we know very little about the coping style of the physicians and still the doctors' way of treating their patients is critical for the patient.
Methods: Through series of interviews we have followed the process which starts when 20 physicians have commenced treatment of a newly diagnosed cancer patient with an estimated 5 years survival expectancy of less than 50%. The physicians have been interviewed at intervals of 3 months until the patients dies, or else, over 2 years. A projective test (DMT) was made before the interview started and a self questionnaire (SASB) was given at the start and at the end of the interview series.
Result: More than 200 different themes of difficulties are outspoken and cathegorized. 18% of the stated difficulties are due to the medical and technical limitations, 26% due to difficulties in the interaction with the patient and 56% are interpreted as intrapsychic. Thirty themes of coping-strategies recur frequent over the stages and they have been grouped into 7 categories. All physicians have certain strategies in common, but there are patterns that show that men differs from women.

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STRESS AND HEALTH STATUS OF NURSES IN A CANCER HOSPITAL AND A GENERAL HOSPITAL. Rodary C, Rezvani A, Attrait O, Sarrouilhe R, Gauvain-Piquard A.
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The aim of this cross-sectional study is to measure:
- stress factors (Nursing Stress Scale, [NSS], Gray-Toft 1981)
- stress state (Mesure du Stress Psychologique, [MSP], Lemyre and Tessier 1985)
- consequences on physical and psychic health (Maslasch Burn-out Inventory, [MBI], Maslasch and Jackson 1986).

273 nurses in a cancer hospital (A) and 247 in a general hospital (B) answered self-administered questionnaires. Concerning stress, nurses have a slightly larger global NSS score in A (39.7) than in B (37.5) , p=0.03: this difference is due to higher "death and dying" and " uncertainty concerning treatment" scores in A.
Concerning health, the use of antidepressants, sedatives or sleeping pills (A:43%, B:30%) and the number of sick days (A:50%, B:37%) are significantly higher for A (p=0.01 and 0.004 resp.). Tiredness, impaired mental well being and back pain are equally frequent in A and B. Concerning Burn-out, about one out of four nurses has elevated scores for "Emotional Exhaustion" and "lack of Personal Accomplishment" in both hospitals. Nurses have higher "Depersonalization" scores in B (16%) than in A (7%), p=0.001.
Multivariate correspondence analyses show the relationships between the different sets of factors: NSS and professional factors with Burn-out and health.

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DO MASTECTOMY AND LUMPECTOMY PATIENTS DIFFER IN QUALITY OF LIFE?
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Our purpose was to compare the quality of life of mastectomy and lumpectomy patients in different time periods after surgery, in a wide range of domains and by relying on information from patients and spouses. The subjects were 71 mastectomy patients and 62 lumpectomy patients, matched in demographic variables, in disease stages I-II, 6 months to 6 years after surgery. They were administered a revised PAIS (Derogatis) questionnaire, the Profile of Mood States, an anxiety questionnaire and the Positive Emotions Checklist. The results showed that mastectomy patients had lower adjustment, more anxiety and depression and a larger patient-spouse gap in information. In the mastectomy group adjustment decreased after 5 years, but in the lumpectomy group it increased. The results indicate that the quality of life of lumpectomy patients is higher in most domains and along time.

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PSYCHOSOCIAL ADJUSTMENT SIX YEARS AFTER PRIMARY TREATMENT - RESULTS FROM A PROSPECTIVE STUDY.
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Aim: A quasi-experimental prospective study was performed to investigate psychosocial adjustment among patients with breast cancer in stage I/II, comparing breast conserving surgery (BCT) vs. mastectomy (MT).
Method: Semi-structured interviews were conducted 4 and 13 months (n=99) and 6 yrs (n=66) after primary treatment.
Results: This paper presents data from the 66 patients who participated in the third interview. 27 patients belonged to the BCT-group and 39 to the MT-group. No statistically significant difference were found between the groups concerning psychosocial adjustment as measured by Social Adjustment Scale (SAS). 60% of the patients in both groups reported unwillingness to show themselves naked. 22% in the BCT-group and 40% in the MT-group stated feelings of being less attractive related to the surgical treatment.
Conclusion: The study did not demonstrate any conclusive difference in psychosocial adjustment between the two treatment groups.

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SEXUAL DYSFUNCTIONS AMONG CANCER PATIENTS
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One-hundred and forty-eight cancer patients (cpts) sexual behaviour, anxiety and depression were assessed by semistructured interview and HAD (Hospital Anxiety and Depression) questionnaire.
Results: Mean age of cpts was 59,63 (29 to 87); they were equally distributed by sex (p=0,624). Previously to cancer diagnosis 61 (41,2%), mainly age related, had no sexual activity. Active sexual behaviour was interrupted in 39 patients (44,8%) after cancer diagnosis and 25 (26,5%) diminished frequency, with no significant differences by gender. Drive, excitement and orgasm decreased significantly ($p<0,024$, $p<0,0067$, $p<0,00005$). Neither emotional disorders (anxiety and depression) nor medical status (PS, site, staging and treatment intent) were significantly associated with disruption of sexual functioning. General sexual satisfaction, rated from 1 to 10, decreased significantly ($\bar{x}$ before = 7,83, $\bar{x}$ after = 6,35, $p<0,00005$).
Conclusion: Sexual function phases were impaired with cancer diagnosis. This is a neglected area of quality of life which merits further research.

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SURVIVAL CORRELATES OF RATINGS OF PSYCHO-PHYSICAL WELL-BEING IN LUNG CANCER (LC). **G.F.Ruschetti, D. Ferrigno, C. Brunelli, M. Tamburini. The A. Carle Hospital of Chest Diseases, Cuneo, and Psychological Dpt. of the INT, Milan, Italy.**

The interest in the possible relationship between psychosocial factors and disease outcome continues to increase. In LC, positive correlations between psychosocial factors and the length of survival have been reported, but only in one study (Ganz et al., 1990). From 1984, we are requesting to all our new patients with LC to fill out a simple questionnaire (QE), containing 3 items on a six point categorical scale, covering treatment tolerance, physical well-being (PWB), the psychological status (PCS). For this study, we were able to analyze 109 patients. In addition to the QE data, a variety of potentially important prognostic factors (in all 27 variables) were recorded for each patient. Univariate analyses of survival (product-limit analysis with the Mantel-Cox test for the statistical significance) were performed maintaining subgroups, as obtained by subjective ratings to either PWB or PCS. Tests showed, concordantly, that subjects who rated themselves poorly had in general the worst outcome (median survival time ranging from 1.10 months -the worst rating- to 12.83 -the best rating- for PWB, p=0.039; and from 1.10 to 7 for PCS, p=0.002). However, a multivariate analysis of survival (Cox model), incorporating all the 27 recorded variables on 100 patients, was unable to confirm PWB and PCS, as statistically significant independent factors of prognosis.