

## ISOLS/MSTS ABSTRACT N. 10767

### **Anxiety and fear of death communication-related: do they affect quality of life in bone and soft tissue sarcoma patients?**

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**Background** Orthopaedic oncologists are often too concentrated in the surgical time and forget the importance of communicating the diagnosis. They are used to demand any problem to psycho-oncologists but the first approach is fundamental in the compliance of the patient. Surgeons seldom evaluate their communication of the diagnosis whether they transmitted the right message or not. Reactions to the communication of diagnosis may vary, therefore a direct or indirect assessment (scale vs dream diary) can be used to evaluate the real internalization of the impact of the diagnosis.

**Questions/Purposes** The aim of the study is to evaluate the amount of anxiety, depression, distress and fear of death, also in relation to the perception of the severity of the diagnosis, in people after the communication of a diagnosis of sarcoma compared to a healthy subjects population.

**Patients and Methods** 10 consecutive patients with a new diagnosis of bone and soft tissue sarcomas (mean age 47,8 ys ± 14,19; female 70%). Inclusion criteria: patient not cognitive impaired (MMSE>24), no history of psychiatric diseases or previous malignancies. This group of patients was compared to a group of healthy individuals with similar demographic characteristics. IRB approval was obtained. Informed consent was singularly obtained in all patients and controls before the interview. An interview was conducted by a psychologist from the 7th to the 15th day since the communication of the diagnosis of sarcoma. Hospital Anxiety and Depression Scale (HADS), Distress Thermometer, Collett-Lester fear of death scale, patient's self-evaluation of the awareness of the perceived severity of disease (patient's VAS), surgeon's self-evaluation of the awareness of the communicated severity of disease (surgeon's VAS), and a weekly dream diary were administered. Dream contents have been analyzed according to Hall&Van de Castle coding system. Statistical analysis was performed with SPSS 20.0 and DreamSAT software (T Student, ANOVA, Chi-squared, bimodal correlation).

**Results** Statistical analysis showed no significant differences between the two groups regarding anxiety, depression, fear of death, and stress variables. Furthermore the perception of the severity of the disease was similar in patient's and surgeon's view. Dream content was statistically different and majorly presented death related contents in patients' group ( $p<0.05$ ).

**Conclusions** Even if the importance of the communication and the patient-doctor relationship in oncology has been well described in previous studies, even in rare tumours, many other factors influence the consciousness of the disease. A self-evaluation for health professionals should always be present because a balanced communication is a key-factor in patients' compliance to treatments. Observing the lack of differences in the assessment scales in our case control study, we can hypothesize that the impact on the quality of life of anxiety, stress, depression, and fear of death in patients' group is not verbalized by the patients (no pathological scores of the scales) but it is more present at a deeper and less conscious level as underlined by

the presence of death-related contents in dreams. This phenomenon could be explained by the negation of the diagnosis by the patient or it could simply be a matter of time. In fact it takes time to elaborate the medical message and fully understand its severity. An early identification of an emotional distress could prevent the development of major psychological disorders. A precocious intervention should be mandatory to improve the quality of life in patients affected by sarcomas. The psycho-oncological support is fundamental and should be part of the oncological treatment.