find successful ways to hit home runs for patients, to prevent and treat this disorder.

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Comment on Sun et al, page 4723

Complacency is not an option

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Hematopoietic stem cell transplantation (HSCT) survivors do not have an increased risk for anxiety and depression.

Despite the title of a report in this issue of Blood by Sun et al, “Adverse psychological outcomes in long-term survivors of HSCT: A report from the Bone Marrow Transplant Survivor Study (BMTSS),” adverse psychological outcomes are not a significant long-term issue for the majority of transplant survivors. While the impact of an HSCT on the psychological health of a patient and his or her family is not trivial, this finding supports previous research suggesting that the procedure itself does not place long-term survivors at risk for clinical levels of anxiety and depression. This is great news!

Despite this finding, it is important to realize that not all survivors are free of adverse psychological outcomes, and the large sample size from the BMTSS allowed Sun and colleagues to thoroughly examine predictors of psychological distress. Their results suggest that 2 prevailing factors place survivors at risk for psychological distress: perceiving their health status as limited (fair/poor) or receiving prednisone therapy (an agent with a known impact on mood). The degree to which these 2 variables suggest an increased illness burden associated with HSCT or its common effects such as chronic GVHD is less clear; chronic GVHD was not associated with anxiety or depression in this study.

One crucial finding from this study is that survivors who are economically disadvantaged (household annual income $60 000/year) are at risk for psychological distress. This finding deserves serious consideration because HSCT has long been recognized as an economically burdensome procedure. However, the impact of the financial consequences of the procedure, loss of income, or impact on employability has not been well studied despite reports that HSCT survivors are more likely to report difficulty in holding a job as a result of a health problem such as chronic GVHD. This begs for an operational understanding of how the psychological and social health dimensions overlap, a standard that is recommended in an Institute of Medicine report, “Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs,” which cites specific areas of focus such as financial planning and resources and managing disruptions in work.

While anxiety and depression are common criteria of psychological distress, Sun et al reported somatic distress as an adverse psychological outcome in this study. Somatic distress as assessed by the Brief Symptom Inventory—18 is intended to identify individuals with physical symptoms that represent a mental health disorder. The reader should use caution when interpreting this finding because of the prevalence of late physical effects in this population, well elucidated by other analyses that have been disseminated from the BMTSS sample. When somatic distress can be predicted by a series of clinical factors that suggest a high level of illness burden (eg, active chronic GVHD, severe/life threatening chronic health conditions, and total body irradiation–based regimens), the overlap between the physical aspects of mood disturbances and the common treatment side effects needs to be seriously considered.

While Sun et al concluded that depression and anxiety are not long-term psychological issues in this population, the challenge is to avoid a state of complacency. Routine screening at key intervals throughout the transplant trajectory is critical in identifying individuals experiencing or at risk for adverse psychosocial or quality-of-life effects after HSCT.

This study was well designed with a large sample size and a control group of unaffected siblings. Although there are other questions to explore with HSCT survivors, providers need to incorporate the knowledge related to the risks for adverse psychosocial outcomes in this population, as well as cancer patients at large, into standard care for long-term survivors.

In theory, this seems acceptable. In practice, barriers still exist. When an oncology patient presents with complex medical needs, providers are less likely to address their psychosocial health needs, regardless of overwhelming evidence that patients and families can suffer a tremendous emotional burden during complex treatments. While distress screening in HSCT patients has been found to be feasible and accurate, a need still exists to continue to evaluate simple methods of screening such as single item measures like the distress thermometer or an electronic data collection system such as the Patient Reported Outcomes Measurement Information System. If routine screening can start early in the transplant trajectory, an important dialogue can be initiated with HSCT patients about their important psychosocial needs along with self-care approaches related to the management of their whole health (physical, emotional, and social) that will support quality care for many years to come.

Conflict-of-interest disclosure: The author declares no competing financial interests.

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