92 - TAKING CHARGE OF PATIENTS ON ACTIVE SURVEILLANCE: THE ROLE OF THE PSYCHOLOGIST DURING "SAPI" (THE FIRST ACCESS VISIT)

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Background

Over the past two decades, as a consequence of the increase of prostate cancer diagnoses, Active Surveillance (AS) has become an acceptable suitable option for men with low- and very low-risk clinically localized disease (1).
The choice of being included in AS protocols represents a very important transition in patients' life because it marks the beginning of an engagement process in relation to their disease.
Given the complexity of such a choice and the importance of the moment in which patient "breaks the ice" with the protocol that will have an impact on his life on multiple levels, our Institution provides for men who decide to enter the AS program a structured first visit (called SAPI – *AS first encounter*), that consists in a clinical examination aimed to offer all the information they need, useful to live this journey in the best way.
This poster aims to present the SAPI format as conceived by the Prostate Cancer Unit of Fondazione IRCCS Istituto Nazionale dei Tumori (Milan, Italy), with a particular focus on the role of the psychologist in a similar context.

Materials and method

Our Institution provides a structured first visit that consists in a clinical examination aimed to give patients all the information they need to start their AS program. Adhering to the idea that a multidisciplinary approach brings with it numerous strengths, in addition to the presence of clinicians the SAPI format also includes the presence of a clinical psychologist who meets patients with the aim of conducting an initial assessment of their psychological condition. Currently, SAPI is structured as follows:

- before the clinical visit with the oncologist, psychologist intercepts the patient and asks him to fill in two questionnaires (MAX-PC to assess anxiety and Mini-MAC to assess ways of coping with cancer);
- after fifteen minutes approximately and before the visit with the oncologist, the psychologist returns to the patient and collects the two questionnaires filled in;
- while the patient is in the room with the doctor, the psychologist elaborates the two questionnaires live, in order to outline a personal profile with respect to the two variables of interest, considered fundamental both from the literature and from the clinical practice;
- once the interview with the doctor is concluded, the patient meets the psychologist in a dedicated room where a real psychological interview is conducted to evaluate patients' general psychological health.

Results

The starting point of this psychological session is represented by an accurate presentation of the outcomes of the questionnaires, giving the patient an overview of his anxiety level and coping strategies in relation to the tumor. However, the clinical practice emphasizes how giving back the patient information regarding these two variables prompts the possibility of touching many other subjects, strictly interconnected with their management of the pathology.
In fact, the encounter with our AS patients during the post-SAPI psychological interview allowed us to identify 6 recurring thematic areas:

1. "*decompression*": this moment seems to represent a very important opportunity for patients to put order in the information received during the clinical visit, not alone but supported by an health professional involved in their care path;
2. "*from the diagnosis up to now*": another important theme is represented by the need to recall what happened from the time of diagnosis to today, going through the decision making process, with a particular reference to the emotions experienced throughout the whole route;
3. "*the sphere of intimacy*": doubts or fears related to the sphere of sexual intimacy often emerge during the post-SAPI interview with the psychologist;
4. "*cancer and couple*": patients are often accompanied by their spouse and post-SAPI clinical interview represents a useful occasion to face the disease from both perspectives, giving the couple the opportunity to confront each other with mutual fears and anxieties in a safe environment;
5. "*cancer and family*": this is also a very precious occasion to begin to face up to family issues related to cancer, for example coping strategies of other family members or system's reorganization resulting from the disease;
6. "*thinking about my life*": this moment often represents an opportunity to reflect on existential themes regarding the past or present sphere of life, also not directly related to the disease but of great importance for the patients.

If the psychologist evaluates the presence of a psychological discomfort above threshold, the case is reported to the rest of the clinical team. In any case, at the end of the interview it is presented to everyone the possibility of being taken in charge by our Institution psychologists.

Conclusion

This 10 month experience with this new format gave us the opportunity to underline the importance of such a multidisciplinary approach even with those who have already decided to take part in AS program, to assess the initial level of compliance and indicate the presence of a structure able to take care of their patients at 360 degrees.

References

1. Donovan, J. L., Hamdy, F. C. (2018). Time for a "Radical" Change to Active Surveillance for Prostate Cancer? *European Urology, 74* (281-282)