83 - IS THERE DECISIONAL CONFLICT ON TREATMENT OPTIONS ONCE MEN CHOOSE ACTIVE SURVEILLANCE? THE ROLE OF THE MULTIDISCIPLINARY SETTING

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Background: The diagnosis of low-risk prostate cancer (PCa) implies understanding the nature of the disease and facing the possibility of being offered more than one options, including **Active Surveillance (AS)**. AS is a management strategy for men diagnosed with low or very low risk class, potentially indolent prostate cancer (PCa) proposed in alternative to active treatment (surgery, external radiotherapy and brachytherapy). In offering more than one options, men may enter a phase of decision making characterized by **feeling uncertain about the course of action to be taken** (1). The **treatment decision making** has often been defined as a simple matter: it means to choose the option that prolongs life. However, in case of more than one treatment, the issue becomes to choose the one that maximizes quality of life. But how can a patient choose the best option? Literature on treatment decision making in PCa is growing and shows the complexity of the decision-making process (2); however, still scarce knowledge is available on the potential decisional conflict that may persist after the decision is taken. Do patients on AS suffer from decisional conflict after the dice is cast? Our study aims to answer this question providing an analysis on decisional conflict experienced by men when entering AS. Understanding the decisional conflict of men who decided to enter AS and who experienced the decision-making phase, may help clinicians and psychologist provide adequate support in case of distress related to uncertainty.

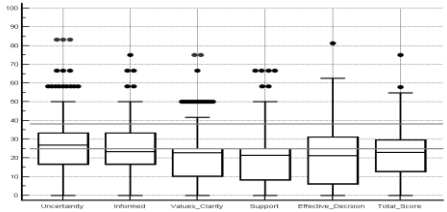
Materials and Methods: Data were collected from patients enrolled in the Prostate cancer Research International: Active Surveillance (PRIAS) Quality of Life (QoL) study at entrance in AS protocol (T0). Patients were asked to fill in questionnaires among which the **Decisional Conflict Scale (DCS)**, used to explore patients' uncertainty in regards of their decision (score range from 0 to 4, with 4 indicating certainty). Subscales were: 1) uncertainty (i.e. feeling uncertainty about the choice), 2) informed (i.e. feeling informed about the choice), 3) values clarity (i.e. feeling clear about personal values and risk/side effects of the choice), 4) support (i.e. feeling supported in decision making), and 5) effective decision (i.e. feeling the goodness of the decision). Scores were then recoded (range from 0 -low uncertainty- to 100 -high uncertainty). Descriptive analyses were performed. Scores lower than 25 were associated with implementing decision, while scores higher than 37.5 were associated with decision delay or feeling unsure about the implementation.

Results: **219** patients completed the DCS at the inclusion in AS. Median age was 65 years (range 45 - 79 years), 34.2% had a job, 38.4% had a high school degree, 89.6% had a partner/were married and 28% had a relevant disease beyond PCa diagnosis. Table 1 and Figure 1 show descriptive analyses of each subscales of DCS. Findings suggested that **50%** patients had median scores on the threshold of 25, meaning that they were implementing the decision. **More than 75%** patients had scores lower than 37.5, indicating no delay of the decision or feeling unsure about the implementation. In details, men reported the lowest scores in effective decision (M= 21.318; DS= 15.31) and support subscales (M= 21.38; DS= 15.18).

Table 1: Descriptive analyses of each SCD subscales.

	Minimum	Maximum	Mean	Median	SD	25 - 75 P
Clarity	0.00	75.00	22.86	25.00	15.246	10.41 to 25.00
Effective decision	0.00	81.25	21.31	25.00	15.315	6.25 to 31.25
Uncertainty	0.00	83.33	26.97	25.00	17.629	16.66 to 33.33
Information	0.00	75.00	23.44	25.00	14.645	16.66 to 33.33
Support	0.00	66.66	21.38	25.00	15.184	8.33 to 25.00
Total score	0.00	75.00	23.08	25.00	13.148	12.89 to 29.68

Figure 1: Descriptive results for each DCS subscales.



Discussion and conclusion: Our findings suggested that most men on AS in our Institution **were convinced of their choice** and having been informed of protocol's details, they also reported to have **clear personal values** and **to know well risks and side effects** of the choice they had made. Dealing with the same issue, Vasarainen et al.(3) highlighted the relevant impact of offering AS patients more information and support, suggesting that adequate information is needed in order to help patient during the decision-making phase. As regards with our results, the presence of a **multidisciplinary setting**, in which a team of **psychologists** might help patients avoid feeling confused or distressed, is essential in order to support men in this process. In our Institution, men received information on the opportunity of AS upfront, during the multidisciplinary first consultation in which a urologist, a radiation oncologist, a psychologist, and an on-demand medical oncologist are present) or the first urologic/radiotherapeutic visit. After the decision-making phase (2), when entering AS a new appointment with a medical oncologist participating in AS protocols is scheduled aimed to give the patient all information he needs and to answer his questions. Immediately after the visit the psychologist conducts a brief meeting aimed **to value patients' psychological health** (i.e. anxiety and coping styles). Supporting men and their families in the treatment decision making process can be challenging and time-consuming, but in light of our clinical experience and our findings a multidisciplinary management of patients who are eligible for AS might be recommended. In conclusion, our findings support **recommendations about the importance of a psychological assessment** at the entrance of assessing decisional conflict on AS, so that patients who may feel uncertain and/or distress about choosing AS can receive adequate multidisciplinary support.

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3 Vasarainen H, Lokman U, Ruutu M, Taari K and Rannikko A: Prostate cancer active surveillance and health-related quality of life: results of the Finnish arm of the prospective trial. BJU Int *109(11)*:1614-1619, 2012. PMID: 22044485. DOI: 10.1111/j.1464-410X.2011.10677.x.

ts for each DCS subscales.

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