

Communication of Diagnosis in Elderly Lung Cancer Patients: Who is Informed, What Information is Given and What Patients Know and Want to Know

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Introduction

Lung cancer is the leading cause of cancer death in elderly patients. The diagnosis of lung cancer is often a challenging task for the clinician, and the communication of this diagnosis to the patient is a complex process. The aim of this study was to explore the communication of diagnosis in elderly lung cancer patients, focusing on who is informed, what information is given, and what patients know and want to know.

A cross-sectional study was conducted in the Medical Oncology Unit of Hospital Lluís Alcanyís, Xàtiva, Spain. The study included 15 elderly lung cancer patients (mean age 78 years). The study was approved by the local research ethics committee. The data were collected through interviews with the patients and their family members. The interviews were conducted by a research assistant who was not involved in the patients' care. The interviews lasted approximately 30 minutes. The data were analyzed using content analysis.

The results of the study showed that the majority of elderly lung cancer patients were informed of their diagnosis by their family members. The information given to the patients was often incomplete and focused on the immediate prognosis. The patients' knowledge of their disease was limited, and they often had unrealistic expectations. The patients' most common concerns were related to the impact of the disease on their quality of life and the need for palliative care.

The study highlights the need for a more structured and patient-centered approach to the communication of diagnosis in elderly lung cancer patients. The clinician should take into account the patient's individual needs, preferences, and values. The information given should be clear, concise, and tailored to the patient's level of understanding. The clinician should also provide emotional support and address the patient's concerns. The study also emphasizes the importance of involving family members in the decision-making process.

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Methods

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(n = 70) . . .
A . . . 2006 . . . 2008.

Information data collection: . . .
A . . .

Doctors' communicative behavior: . . .

Family's communicative behavior: . . .

Areas investigated	N(%)
Autonomy (ADL)	
Independent	43 (51.8%)
Dependent	40 (48.2%)
Autonomy (IADL)	
Independent	25 (30.1%)
Dependent	58 (69.9%)
Comorbidities	
Mean Charlson (range)	3 (0-9)
0	4 (5%)
1	10 (12%)
2	2 (2.7%)
3	64 (80.3%)
Comorbidities	
Mean SCS (range)	9 (4-19)
9	44 (53%)
>9	39 (47%)
Cognitive function (MMSE)	
>21/30	61 (73.6%)
21/30	22 (26.4%)
State of mind (GDS)	
<3	57 (68.7%)
3	26 (31.3%)
Nutritional status: weight loss	
No	37 (44.6%)
Yes	46 (55.4%)
Mean % weight loss (range)	8.2% (1-21%)
Mean time (range)	3 months (1-8)
Nutritional status: albuminemia (g/l)	
Mean (range)	26 (20-59)
35	29 (34.9%)
Social situation	
Place of residence:	
Home	79 (95.2%)
Institution	4 (4.8%)
Person in charge:	
Spouse	51 (61.5%)
Children	29 (34.9%)
Others	3 (3.6%)
Transport:	
Own car	14 (16.9%)
Children's car	56 (67.5%)
Public transport	2 (2.4%)
Ambulance	11 (13.3%)
Geriatric syndromes	
Yes	40 (48.2%)
No	43 (51.8%)

Table 3: Results of geriatric assessment (Ambulance) Children's car Public transport

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Physicians' attitudes

184 | Page

... (...) ... A ...

Family attitudes

... A ...

... 2493 ... 18, ... 69% ... 42% ... /17 ...

...

Patients' attitudes

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... /9 ...

... /18-20 ... /3,11,21 ...

... /22-25 ... /8,9,26,27 ...

... /28 ...

Study limitations

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... A ...

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... A510 ... / ... 7 ... 2 ...

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