

# Educational interventions improved some quality of life outcomes in prostate cancer

Lepore SJ, Helgeson VS, Eton DT, *et al.* Improving quality of life in men with prostate cancer: a randomized controlled trial of group education interventions. *Health Psychol* 2003;**22**:443–52.

Clinical impact ratings: IM/Oncology ★★★★★☆

## Q In men with prostate cancer, do educational interventions improve symptoms and quality of life (QOL) outcomes?

### METHODS

**Design:** randomised controlled trial.

**Allocation:** not concealed.\*

**Blinding:** blinded (data collectors).\*

**Follow up period:** 12 months.

**Setting:** 11 urology and radiology clinics and hospitals in Pittsburgh, Pennsylvania, USA.

**Patients:** 279 men (mean age 65 y)† who had been treated for localised prostate cancer in the previous month, had no history of other cancer, and lived within a 1 hour drive of the intervention sites.

**Interventions:** education only (EO) (n=84) consisting of 6 weekly 1 hour lectures on topics relevant to prostate cancer and printed summaries, education plus discussion (ED) (n=86) consisting of the lecture series plus 45 minutes of group discussion facilitated by a clinical psychologist and encouragement to attend lectures with a friend or family member, or usual care (UC) (n=80).

**Outcomes:** disease specific symptoms (sexual, urinary, and bowel functioning) (UCLA Prostate Cancer Index); patient-rated perceived bother of these outcomes; general health related QOL (physical [PCS] and mental health component scores [MCS] of the SF-36); and depressive symptoms (Center for Epidemiological Studies Depression Scale [CES-D]).

**Patient follow up:** 90%.

\*See glossary.  
†Based on 250 patients in the analysis.

### MAIN RESULTS

Analysis was by intention to treat, although no allowance was made for missing data. Sexual, urinary, and bowel functioning scores improved over time but were not affected by interventions or educational status. Immediately after the intervention, patients in the intervention groups were more knowledgeable about prostate cancer than the UC group, but only those in the ED group increased positive health related behaviours and they indicated less sexual bother (table). An intervention effect was seen for PCS scores in men without a college degree. No effect of the intervention was seen on MCS or CES-D scores, which remained low from baseline (table). More men in the ED group remained stably employed (93%) than did men in the EO (76%) or UC (73%) groups ( $p<0.05$ ).

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### CONCLUSION

In men with prostate cancer, educational interventions improved some quality of life outcomes more than usual care.

### Commentary

Lepore *et al* report that for some outcomes, the ED intervention was better than EO, particularly in men without a college degree. However, this does not mean that such interventions should be focused on men with lower educational attainment. Like women, men seem to value group participation to compare their experiences and progress with those of others.<sup>1</sup> Men with lower educational attainment may derive benefit from groups when, as in this study, the groups also include men with higher education attainment. The ED intervention also included separate groups for the patients' partners, and it is likely that this additional factor influenced some outcomes (eg, bother from sexual problems).

No benefits were observed from educational interventions on sexual and urinary functioning. Educational interventions are most likely to lead to improved physical outcomes when the latter can be substantially influenced by health behaviours. This is more likely to occur in illness like diabetes than in prostate cancer.

In this study, men had better initial SF-36 scores than community samples of men, and very low levels of depression. While some studies have reported levels of depression and functioning among men with early prostate cancer similar to those of other hospital outpatients, others have, like this study, reported a low prevalence of depression.<sup>2</sup> Unfortunately, this study does not provide sufficient detail to exclude the possibility that those included in the study were a selected sample. However, even if this is the case, men like those recruited to the study are probably those most likely to participate in educational or support groups.

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1 Krizek C, Roberts C, Ragan R, *et al.* Gender and cancer support group participation. *Cancer Pract* 1999;**7**:86–2.

2 Bisson JI, Chubb HL, Bennett S, *et al.* The prevalence and predictors of psychological distress in patients with early localized prostate cancer. *BJU Int* 2002;**90**:56–61.

### Outcomes for men with prostate cancer at 12 months\*

Outcomes	Education only	Education + discussion	Usual care	p Values
PCS (score range 0–100)†	48.3	49.4	47.4	<0.10
MCS (score range 0–100)†	53.1	54.0	53.4	0.95
CES-D (score range 0–3)‡	0.43	0.35	0.40	0.73
Sexual bother (score range 0–100)†	49.1	56.2	38.0	<0.01 (ED v UC)

\*Values are means. PCS=physical health component scores; MCS=mental health component scores; CES-D=Center for Epidemiological Studies Depression Scale.

†Higher scores = better functioning.

‡Higher scores = greater depressive symptoms.