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Illness Perceptions and Quality of Life in Patients with Non-Small-Cell Lung Cancer: A 3-Month Follow-Up Pilot Study

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Patient Related Outcome Measures

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Purpose: Examine illness perceptions, functional health and quality of life of lung cancer patients throughout chemotherapy treatment.

Patients and Methods: Longitudinal design with baseline measure 12 days after the first chemotherapy and follow-up measure 3 months later, where illness perceptions (BIPQ), functional health, and quality of life (EORTC QLQ-C-30) were measured. A total of 21 patients with non-small-cell lung cancer took part. Non-parametric testing was performed given the pilot nature of the study and the associated relatively small sample size.

Results: Small to medium changes in illness perceptions and functional health between the two measurement points were detected, with both becoming more positive. More negative illness perceptions at the beginning of the treatment were associated with less functioning and lower quality of life at both beginning and end of treatment.

Conclusion: Addressing illness perceptions seems a clinically relevant approach in improving functioning and quality of life of patients with non-small-cell lung cancer.

Keywords: lung cancer, illness perceptions, quality of life, longitudinal design, patient reported outcomes

Introduction

In the past decade, a number of advances in the medical treatment and diagnosis of lung cancer have notably increased survival rates.¹ Due to this development, the investigation of psychological outcomes as assessed via patient reported outcome measures in lung cancer patients becomes more and more relevant.^{2,3} Quite a few studies even showed that QOL is a positive predictor of survival in lung cancer patients.⁴⁻⁸ Therefore, understanding determinants of the psychological outcomes such as QOL is crucial in order to maximize QOL and consequently survival.

One of the most promising psychological concepts that is related to various illness outcomes in chronic patients appears to be illness perceptions (IPs). IPs are the cognitive and emotional responses of patients to their illness and its medical management.⁹ IPs do not necessarily reflect “medically correct facts” and differ quite substantially from accepted medical wisdom. In line with the assumptions of the common-sense model of self-regulation of health and illness,⁹ various empirical studies showed that IPs have an impact on illness outcomes, such as functional health and QOL, directly and indirectly via illness behavior.¹⁰⁻¹² Therefore, addressing IPs and attempting to change them can contribute to the overall well-being of patients.

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The aim of the current paper is to investigate the course of IPs and psychological outcomes, ie, functional health and QOL, in lung cancer patients over a 3-month period during chemotherapy. Moreover, the relationships between illness perceptions and psychological outcomes is examined.

Methods

The presented data are part of a larger international, bicenter study on illness perceptions and QOL in cancer patients.¹³ The study was conducted in line with the Helsinki Declaration. The study protocol was approved by the Medical Ethics Committee of the Leiden University Medical Center, the Netherlands (#P12-090) and written informed consent was obtained from all participants.

Procedure

Patients were recruited in the Leiden University Medical Center, the Netherlands. Patients were included if they had the diagnosis of non-small-cell lung carcinoma (NSCLC) of any stage and were undergoing first-line adjuvant or neo-adjuvant chemotherapy. Patients with EGFR or ALK mutations and patients undergoing concurrent radiotherapy and chemotherapy were excluded, in order to obtain a homogenous sample regarding clinical characteristics and type of therapy.

Data were collected at two-time points, ie, at the beginning of the treatment, approximately 12 days after the first round of chemotherapy and 1 month after the last round of chemotherapy, approximately 3 months later.

Measures

The Dutch version of Brief Illness Perception Questionnaire (Brief IPQ)¹⁴ was used to measure five cognitive illness perceptions (ie, consequences, timeline, personal control, treatment control, identity), two emotional illness perceptions (ie, concern, emotions) and illness comprehensibility with one item each (range 0–10). Higher scores indicate stronger perceptions that lung cancer affects the life, has a long duration, can be controlled by own behavior or medical treatment, involves much complaints, elicits concerns, produces negative emotions, and is understandable.

The Dutch version of the EORTC Quality of Life Questionnaire version 3.0 (EORTC QLQ-C30)¹⁵ was used to assess functional health and global QOL. Functional health was measured with 15 items that were combined into five subscales, ie, physical, role, emotional,

cognitive, and social functioning. Global QOL was measured with two items. All subscales were linearly transformed (range 0 to 100), with higher scores indicating better functional health and higher QOL.

Participants

Thirty patients were included and completed the baseline measurement. Of these, nine patients did not return the follow-up questionnaires, which resulted in a final sample of 21 patients (female: $n=13$, 61.9%). The sample included 1 patient (4.8%) with stage IIA, 2 patients (9.5%) with stage IIB, 5 patients (23.8%) with stage IIIA, and 13 patients (61.9%) with stage IV non-small-cell lung carcinoma. Most patients ($n=17$, 81.0%) had no comorbidity. The mean age of the patients was 64.62 years ($SD=7.70$; range 53–82 years).

Data Analyses

Due to the small sample size, the data were analyzed by using nonparametric statistical tests. To explore the course of IPs, functional health, and QOL throughout chemotherapy, Wilcoxon signed-rank tests comparing scores at baseline with scores at follow-up were computed. The relationships between IPs at baseline and functional health and QOL at baseline and at follow-up were examined by means of Kendall's tau-b correlations. Due to the small sample size and consequently suboptimal power, significance from $p<0.10$ is reported and the effect size was taken into account when interpreting the results.

Results

IPs, Functional Health, and QOL at Baseline and Follow-Up

Table 1 (upper part) shows some small changes in IPs between baseline and follow-up. After the chemotherapy, patients reported less perceived consequences, less personal control, less experienced symptoms, and less concern compared to the beginning of the chemotherapy. These changes seem to be discernible also on a few dimensions of functional health. Emotional and cognitive functioning improved moderately and slightly, respectively (lower part Table 1).

Relationships Between IPs and Functional Health and QOL

Table 2 shows a large number of meaningful relationships of IPs at baseline with functional health and global QOL at baseline and follow-up. The IPs consequences, timeline, personal control, identity, concern, and understanding showed the

Table 1 Comparisons of Illness Perceptions, Functional Health, and Quality of Life at Baseline and Follow-Up (Wilcoxon Signed-Rank Test)

| | N ^a | M (SD) Md Baseline | M (SD) Md Follow-Up | Z (r ^b) |
|---------------------------------------|----------------|---------------------|---------------------|-----------------------------|
| Illness Perceptions | | | | |
| Consequences | 20 | 6.60 (2.95) 8.00 | 5.65 (2.81) 6.00 | -1.13 (0.25) |
| Timeline | 19 | 6.37 (2.61) 5.00 | 6.79 (3.01) 7.00 | -0.52 (0.12) |
| Personal control | 20 | 4.68 (3.01) 5.00 | 4.00 (2.90) 4.00 | -1.31 (0.29) |
| Treatment control | 20 | 7.70 (1.75) 8.00 | 7.65 (2.03) 8.00 | -0.20 (0.04) |
| Identity | 20 | 5.20 (2.61) 5.00 | 3.75 (2.69) 5.00 | -1.68 ^(*) (0.38) |
| Concern | 19 | 6.26 (2.77) 7.00 | 5.32 (2.91) 5.50 | -1.19 (0.27) |
| Understanding | 19 | 7.53 (2.34) 8.00 | 7.21 (2.02) 7.50 | -0.55 (0.13) |
| Emotions | 20 | 4.80 (3.05) 4.00 | 4.45 (2.78) 4.0 | -0.61 (0.14) |
| Functional Health and Quality of Life | | | | |
| Physical functioning | 21 | 74.29 (19.47) 80.00 | 71.19 (18.19) 73.34 | -0.97 (0.21) |
| Role functioning | 21 | 60.32 (26.07) 66.67 | 53.17 (31.89) 50.00 | -0.84 (0.18) |
| Emotional functioning | 21 | 73.02 (24.57) 83.34 | 81.35 (22.96) 83.34 | -1.99* (0.43) |
| Cognitive functioning | 21 | 78.57 (24.80) 83.34 | 83.33 (16.67) 83.34 | -0.98 (0.21) |
| Social functioning | 21 | 73.81 (21.46) 83.34 | 71.43 (26.43) 83.34 | -0.18 (0.04) |
| Global QOL | 21 | 59.52 (23.76) 66.67 | 63.10 (18.55) 66.67 | -0.24 (0.05) |

Notes: ^aN varies due to missing data. ^bEffect size $r = Z/\sqrt{N}$. $r \geq 0.1$ = small effect, $r \geq 0.3$ = medium effect, $r \geq 0.5$ = large effect. * $p < 0.05$, ^(*) $p < 0.10$.

Table 2 Kendall's Tau-b Correlations Between Illness Perceptions at Baseline and Functional Health and Quality of Life at Baseline and Follow-Up

| | Physical Functioning | | Role Functioning | | Emotional Functioning | | Cognitive Functioning | | Social Functioning | | Global QOL | |
|-------------------|----------------------|----------------------|----------------------|----------------------|-----------------------|--------------------|-----------------------|--------------------|--------------------|--------------------|--------------------|----------------------|
| | Baseline/Follow-Up | Baseline/Follow-Up | Baseline/Follow-Up | Baseline/Follow-Up | Baseline/Follow-Up | Baseline/Follow-Up | Baseline/Follow-Up | Baseline/Follow-Up | Baseline/Follow-Up | Baseline/Follow-Up | Baseline/Follow-Up | |
| Consequences | -0.56** | -0.31 ^(*) | -0.39* | -0.37* | -0.35 ^(*) | -0.01 | -0.42* | -0.31 | -0.39* | -0.41* | -0.25 | -0.15 |
| Timeline | -0.31 ^(*) | -0.39* | -0.13 | -0.32 ^(*) | -0.08 | 0.05 | -0.31 ^(*) | -0.17 | -0.08 | -0.42* | -0.03 | -0.07 |
| Personal control | -0.08 | -0.01 | -0.30 ^(*) | -0.22 | -0.22 | -0.27 | -0.27 | -0.12 | -0.21 | -0.40* | -0.26 | -0.10 |
| Treatment control | 0.34 ^(*) | -0.08 | 0.33 ^(*) | -0.02 | 0.18 | -0.02 | 0.38* | 0.30 | 0.01 | -0.15 | 0.41* | -0.16 |
| Identity | -0.62*** | -0.18 | -0.58** | -0.04 | -0.31 ^(*) | -0.08 | -0.36 ^(*) | -0.08 | -0.18 | -0.09 | -0.69*** | -0.07 |
| Concern | -0.42* | -0.08 | -0.29 | -0.15 | -0.41* | -0.14 | -0.36 ^(*) | -0.11 | -0.15 | -0.19 | -0.52** | -0.05 |
| Understanding | -0.01 | -0.38* | -0.04 | -0.40* | -0.09 | -0.16 | -0.13 | 0.07 | 0.10 | -0.39* | -0.15 | -0.34 ^(*) |
| Emotions | -0.19 | -0.01 | -0.49** | -0.20 | -0.15 | -0.10 | -0.24 | 0.01 | -0.12 | -0.18 | -0.44* | -0.35* |

Notes: N ranges between 19 and 20 due to missing data. $\tau_b \geq 0.1$ = small effect, $\tau_b \geq 0.3$ = medium effect, $\tau_b \geq 0.5$ = large effect. *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$, ^(*) $p < 0.10$.

most and the strongest correlations with various dimensions of functional health and QOL at both measurement points.

Discussion

IPs and psychological outcomes of our patients at the beginning of the chemotherapy are comparable to earlier findings in lung cancer patients.¹³ Previous research showed that chemotherapy negatively affects the generalized health-related quality of life.¹⁶ We expand this finding by showing that IPs become slightly more positive and aspects of functional health slightly increase after chemotherapy. Interestingly, in the present study, QOL seems not to improve after chemotherapy.

At the beginning of chemotherapy, IPs were significantly associated with various aspects of functional health and QOL. More importantly, IPs at the beginning of chemotherapy were also prospectively related to these outcome measures after chemotherapy. Specifically, the perception of more serious consequences, a longer timeline, more personal control, more negative emotions, and a better understanding of lung cancer predict lower functional health and QOL. These findings are largely in line with previous research in cancer patients,¹⁷ except from the remarkable finding that a better understanding of lung cancer has a negative effect on the outcome measures.

Conclusion and Future Directions

The number of respondents in our study must be deemed to be rather small. Patients in whom NSCLC has been diagnosed become quite ill quite soon, and they find it burdensome to fill out questionnaires, limiting empirical studies on quality of life (in a broad sense) in these patients.^{18–20} Despite this limitation, our findings suggest that IPs of lung cancer patients play an important role in functional health and QOL, and should therefore be taken into consideration during medical treatment. Communicating about emotions and concerns seems to be most critical.²¹ Purely providing patients with clinical information in order to satisfy their information needs²² without discussing psychosocial issues²³ might be detrimental as our findings indicate that a better understanding of lung cancer worsens functioning and QOL in the long run. Teaching physicians to address, discuss and help adjust unhelpful illness perceptions in patients with NSCLC leads to less adjustment problems in the patients and their caregivers.^{24,25} Future studies with larger sample sizes should investigate whether addressing IPs in lung cancer patients impact on patient related outcome measures.

Abbreviations

ALK, anaplastic lymphocyte kinase; BIPQ, Brief Illness Perception Questionnaire; EGFR, epidermal growth factor receptor; EORTC QLQ -C30, European Organisation for the Treatment of Cancer Quality of Life Questionnaire C30; IPs, illness perceptions; NSCLC, non-small-cell lung cancer; QOL, Quality of Life.

Ethics Statement

The study complied with the Declaration of Helsinki. Ethics approval for the study was provided by the Leiden University Medical Center Medical Ethics Committee (#P12-090), and written informed consent was obtained from all participants.

Data Sharing Statement

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

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Author Contributions

All authors made substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data; took part in drafting the article or revising it critically for important intellectual content; gave final approval of the version to be published; and agree to be accountable for all aspects of the work.

Disclosure

Professor Kunihiko Kobayashi reports personal fees from AstraZeneca, Boehringer, Pfizer, Onto Pharmaceutical company, and Chennai Pharmaceutical company, outside the submitted work. Professor Kaoru Kubota reports grants and personal fees from Boehringer Ingelheim and Ono, personal fees from Chugai MSD, AstraZeneca, Eli Lilly, Daiichi Sankyo, and Bristol Myers Squibb, outside the submitted work. Dr Kenichi Inoue reports grants and personal fees from Eisai, Chugai, Pfizer, Eli Lilly, grants from Novartis, Daiichi-Sankyo, Parexel/Puma Biotechnology, MSD, and Bayer, outside the submitted work. The authors report no other conflicts of interest in this work.

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