Assessing and managing patient fear of cancer recurrence

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Low-risk cancer survivors are increasingly being discharged back to primary care after completing active cancer treatment in tertiary care settings (eg, cancer centres), shifting the responsibility of managing their complex follow-up care needs to primary care providers.[1] The purpose of this article is to provide recommendations on assessing and managing fear of cancer recurrence (FCR), one of the highest reported unmet needs of cancer survivors.[2]

Clinically significant FCR

Fear of cancer recurrence has been defined as "fear, worry or concern relating to the possibility that cancer will come back or progress."[3] Given that recurrence is a very real possibility, FCR is a normative reaction affecting most cancer survivors to some degree.[2] The severity of FCR can be conceptualized on a continuum, from transient fears (often occurring in conjunction with upcoming medical tests or results, anniversary of diagnosis, etc) to more substantial levels of fear that are difficult to control and might interfere with daily functioning and overall well-being.[3] A recent study of experts in the field of FCR identified the following key features of clinically significant FCR: high levels of preoccupation or worry, worry that is persistent, and hypervigilance or hypersensitivity to bodily symptoms, where any of these features last for at least 3 months.[4] Other important aspects include functional impairment and maladaptive coping strategies such as excessively seeking reassurance from medical professionals, excessive body checking, or avoiding medical appointments.[5] Additionally, clinically significant FCR is linked to more health care use[2]; however, a number of empirically supported interventions have been developed to treat FCR.[6]

Screening and assessing for FCR

One of the most commonly used measures of FCR is the Fear of Cancer Recurrence Inventory (FCRI).[7] The short form of this measure (FCRI-SF), consisting of 9 items, has been used as a tool to screen for clinical levels of FCR and is available for download at **CFPlus**.* Each item is rated on a scale from 0 (not at all or never) to 4 (a great deal or several), where higher scores indicate greater FCR severity, with a maximum score of 36.[7] When calculating the score, item 5 is reverse coded. The recommended cutoff score for clinical levels of FCR is 22 or greater.[8] However, a score of 16 or greater indicates high FCR and requires further assessment and discussion.[9] The differences in cutoff scores in the literature are largely attributable to differences in methodology. These include the limited number of studies, small sample sizes, and, until recently,[4] a lack of agreement on what constitutes clinical FCR. Research in this area is ongoing.[8] Further to the FCRI, a conversation assessing the persistence of worries, preoccupations, and hypervigilance or hypersensitivity to bodily symptoms related to FCR is warranted (**Table 1**).[4,10] Referrals can be made for psychosocial support contingent on the extent that the patient's FCR is reported as problematic for the patient or is interfering with the patient's ability to engage in daily life.

Managing FCR

Low to moderate severity (0 to 15 on the FCRI-SF). Because FCR is a common experience for cancer survivors, normalizing this experience for patients in a supportive and empathetic way is recommended. This could include discussion around the frequency with which survivors report FCR and common triggers of FCR (eg, hearing of someone being diagnosed with cancer, aches and pains, reminders of cancer experience in general).[10] Uncertainty is inherent to FCR; therefore, providing information to cancer survivors and their caregivers on signs and symptoms of cancer recurrence, frequency of surveillance tests, and what to expect in cancer-related follow-up care, etc, can be helpful.[5]

If maladaptive coping strategies are present, introducing more adaptive coping approaches such as engaging in enjoyed activities, meditation, yoga, physical activity, journaling about FCR, and talking to supportive friends and family about their fears can help decrease the severity of FCR among patients.[5]

High and clinically significant severity (16 to 21 and ≥22 on the FCRI-SF, respectively). For cancer survivors experiencing high (score of 16 to 21 on the FCRI-SF) and clinically significant (score of ≥22 on the FCRI-SF) levels of FCR, referral to allied health care professionals working in psychosocial cancer care might be appropriate. Psychotherapists can provide cognitive-behavioural approaches to address clinical FCR. Such interventions are empirically supported in group, online, and individual formats.[6] Additional online resources on FCR (available at **CFPlus***) can be shared with cancer survivors who present with high FCR.

*The **Fear of Cancer Recurrence Inventory–Short Form** and **additional online resources on FCR** are available at **www.cfp.ca**. Go to the full text of the article online and click on the **CFPlus** tab.

Table 1. Assessing clinically significant levels of FCR

GUIDING QUESTIONS	RESPONSES THAT MIGHT INDICATE CLINICAL SIGNIFICANCE
How frequently do you have thoughts related to the cancer returning? How long do these thoughts last? Do you find these thoughts difficult to control?	Reports frequent death-related thoughts that are hard to control and that last 30 min or longer and imagines, for example, being told the cancer has returned, the cancer invading the body, or the end of the patient's life
Do you routinely scan or pay attention to physical sensations in your body? How often?	Reports preoccupations with physical sensations in the body, attributing pain or sensations to a recurrence
On a scale of 0 to 10, how strongly do you believe the cancer will return?	Reports a strong belief that the thoughts are true and might provide reasons to support this belief (eg, previous misdiagnosis)
How have these thoughts or beliefs affected your life?	Might report panic, worry, stress, a need to escape, trouble sleeping, fatigue, or difficulties or uncertainty about planning for the future

FCR—fear of cancer recurrence.
Data from Mutsaers et al.[4,10]

Conclusion

Experiencing some level of FCR is inevitable in cancer survivors, who will present most commonly in primary care settings for their follow-up health needs. Primary care providers have a key role in managing the unmet needs of cancer survivors and are able to provide effective care for survivors experiencing low to moderate levels of FCR. They are also uniquely positioned to connect those who experience clinical levels of FCR with other providers in the community to ensure they receive appropriate psychosocial intervention.

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Competing interests
None declared

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