




BMJ Open Scanxiety: a scoping review about scan-associated anxiety

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ABSTRACT

Objectives To identify available literature on prevalence, severity and contributing factors of scan-associated anxiety ('scanxiety') and interventions to reduce it.

Design Systematic scoping review.

Data sources Ovid MEDLINE, Ovid EMBASE, Ovid PsycINFO, Ovid Cochrane Central Register of Controlled Trials, Scopus, EBSCO CINAHL and PubMed up to July 2020.

Study selection Eligible studies recruited people having cancer-related non-invasive scans (including screening) and contained a quantitative assessment of scanxiety.

Data extraction Demographics and scanxiety outcomes were recorded, and data were summarised by descriptive statistics.

Results Of 26 693 citations, 57 studies were included across a range of scan types (mammogram: 26/57, 46%; positron-emission tomography: 14/57, 25%; CT: 14/57, 25%) and designs (observation: 47/57, 82%; intervention: 10/57, 18%). Eighty-one measurement tools were used to quantify prevalence and/or severity of scanxiety, including purpose-designed Likert scales (17/81, 21%); the State Trait Anxiety Inventory (14/81, 17%) and the Hospital Anxiety and Depression Scale (9/81, 11%). Scanxiety prevalence ranged from 0% to 64% (above prespecified thresholds) or from 13% to 83% ('any' anxiety, if no threshold). Mean severity scores appeared low in almost all measures that quantitatively measured scanxiety (54/62, 87%), regardless of whether anxiety thresholds were prespecified. Moderate to severe scanxiety occurred in 4%–28% of people in studies using descriptive measures. Nine of 20 studies assessing scanxiety pre- and postscan reported significant postscan reduction in scanxiety. Lower education, smoking, higher levels of pain, higher perceived risk of cancer and diagnostic scans (vs screening scans) consistently correlated with higher scanxiety severity but not age, gender, ethnicity or marital status. Interventions included relaxation, distraction, education and psychological support. Six of 10 interventions showed a reduction in scanxiety.

Conclusions Prevalence and severity of scanxiety varied widely likely due to heterogeneous methods of measurement. A uniform approach to evaluating scanxiety will improve understanding of the phenomenon and help guide interventions.

INTRODUCTION

Anxiety may increase when people have scans to screen for, diagnose, or stage cancer, or to monitor cancer for recurrence or

Strengths and limitations of this study

- This is the first scoping review on scanxiety.
- A comprehensive search strategy and broad inclusion criteria have resulted in an extensive summary of all available literature.
- Summary statistics for prevalence and severity of scanxiety were not possible due to heterogeneity in the type and timing of measurement tools between the studies.

progression. Scan-associated anxiety, or the distress before, during or after a scan, was first dubbed 'scanxiety' by a patient writing for the Time Magazine in 2011.¹

Qualitative research on the experience of having a scan has shown some people experience dread in the weeks before a scan,² perceive scans as dehumanising, unpleasant or causing claustrophobia,^{2–5} and find scans trigger fear of the unknown and fear of cancer recurrence.^{2,3,6} Scanxiety is recognised as a common clinical concern on social media and public forums, and is acknowledged by international cancer institutions^{7,8} and cancer-specific support networks.^{9–11} Despite this, scanxiety is not uniformly recognised or measured in published studies. We conducted a systematic scoping review to identify the available literature on scanxiety in people having cancer-related scans.

METHODS

We conducted a systematic scoping review based on the six-step methodological framework developed by Arskey and O'Malley¹² and modified by Levac *et al*,¹³ and guided by the Preferred Reporting Items for Systematic review and Meta-Analysis protocols extension for Scoping Reviews (PRISMA-ScR) checklist.¹⁴ The study protocol and amendments are available (online supplemental files 1 and 2).

#	Search	#	Search	#	Search	#	Search
1	Exp Neoplasms/	10	Exp Diagnostic Imaging/	15	exp Anxiety/	22	or/1-9
2	Exp Medical oncology/	11	imaging.ti,ab	16	exp Anxiety Disorders/	23	or/10-14
3	neoplasm*.ti,ab	12	scan.ti,ab	17	exp Fear/	24	or/15-21
4	cancer*.ti,ab	13	tomography.ti,ab	18	anxi*.ti,ab	25	22 and 23 and 24
5	neoplasm*.ti,ab	14	ultraso*.ti,ab	19	fear.ti,ab		
6	malignan*.ti,ab			20	worr*.ti,ab		
7	tum??r*.ti,ab			21	distress*.ti,ab		
8	oncolog*.ti,ab						
9	carcinoma*.ti,ab						

Figure 1 Search strategy used for Ovid MEDLINE (1946 onwards).

Step 1: research question

Our aim was to increase the understanding of scanxiety by: determining the prevalence and severity of scanxiety; identifying contributing factors to scanxiety; identifying interventions to reduce scanxiety in people having cancer-related scans; and, exploring patient experiences with scanxiety.

Step 2: search strategy

Published studies were identified from seven electronic databases: Ovid MEDLINE (1946 onwards), Ovid EMBASE (1947 onwards), Ovid PsycINFO (1806 onwards), Ovid Cochrane Central Register of Controlled Trials (1991 onwards), Scopus (any year), EBSCO CINAHL (any year) and PubMed (any year). The search strategy combined the subject headings and keywords of cancer, imaging and anxiety. An example is provided in [figure 1](#). Reference lists of included articles were hand-searched for additional studies. All references were imported into Endnote V.9.

The initial search was conducted on 11 April 2019 and updated on 3 July 2020.

Step 3: study selection

Inclusion criteria were full-text original research studies that recruited adults (≥ 18 years old) who had a non-invasive scan for a cancer-related reason, and which quantitatively assessed the prevalence or severity of scanxiety, reported a statistical comparison between prescan and postscan scanxiety, reported a statistical comparison between scanxiety and possible contributing factors, or evaluated the impact of an intervention on scanxiety.

Cancer-related reasons included screening (detection of cancer in asymptomatic person), diagnosis (detection of cancer in symptomatic person), staging (determining extent of cancer in person with confirmed or suspected cancer), surveillance (detection of recurrence in person with cancer treated with curative intent) or monitoring (detection of progression in person with cancer treated with non-curative intent).

The measurement of scanxiety was defined as any measure of anxiety, distress or worry occurring around the time of a scan. This included any period before, during or after a scan where the scan was used as a reference point for the measurement of scanxiety. All non-invasive

imaging modalities were accepted. No date restrictions were applied. Foreign language material was included if an English translation was available.

After initial review of citations and based on increasing familiarity with the literature, and in line with recommendations on scoping review methodology,¹² exclusion criteria were developed post hoc. Exclusion criteria were: studies involving invasive scans (eg, transvaginal ultrasound, ultrasound with fine needle aspirate or endoscopic ultrasound) due to differences in scan preparation and risk of adverse events and studies of scans performed to investigate a positive initial screening result because the psychological experiences of asymptomatic persons facing a potential new cancer diagnosis may lead to higher anxiety than is attributable to scanxiety. Due to feasibility of conducting quantitative and qualitative analysis with the volume of literature identified, studies reporting only a qualitative assessment of scanxiety were also excluded, and the objective to explore patient experiences was abandoned.

After removal of duplicate citations, two authors (KTB and RL) independently reviewed and screened publication titles and abstracts based on the eligibility criteria. Of the studies deemed potentially eligible, full texts were evaluated for final inclusion. Discrepancies were resolved by discussion between the two authors (KTB and RL) and were escalated to all authors if a consensus could not be reached.

Step 4: charting the data

Relevant data were independently extracted by two authors (KTB and RL) into an electronic data extraction form in Microsoft Excel, which included study demographics and methodology, scanxiety measurement tools, and the outcome measures of prevalence and severity of scanxiety, contributing factors to scanxiety, and interventions to reduce scanxiety.

Step 5: collating, summarising and reporting the results

Study data were tabulated to assist with a descriptive numerical summary of the range of cancer types, imaging modalities, study methodology and scanxiety measurement tools. Associations between scanxiety and potential contributing factors were tabulated if three or more studies reported a statistical comparison.

The prevalence of scanxiety was identified in two ways:

- ▶ The percentage of people who scored above the prespecified clinically important anxiety threshold, if reported.
- ▶ The percentage of people who scored any degree of anxiety, if no prespecified threshold was reported.

Severity of scanxiety was defined in three ways:

- ▶ Any mean score of the anxiety measure above the prespecified clinically important anxiety threshold, if reported.
- ▶ Any mean score of the anxiety measure that was at least half the total score, if an anxiety threshold was not reported.
- ▶ At least 'moderate' anxiety (or its equivalent) on a descriptive range.

The definitions of prevalence and severity were purposive-designed to allow descriptive comparisons between the studies as we anticipated heterogeneity in scanxiety measurement would preclude meaningful summary statistics.

The components of intervention studies and their effect on scanxiety were summarised and reported descriptively.

Step 6: consultation

Medical oncologists (PB and BEK), a behavioural scientist (HD) and a statistician (CB) were consulted for content expertise to develop the study objectives and to improve clarity on clinically relevant interpretations of the data.

Patient and public involvement

This research did not directly involve patients and public. Our research was initiated by repeated observations of scanxiety in oncology patients.

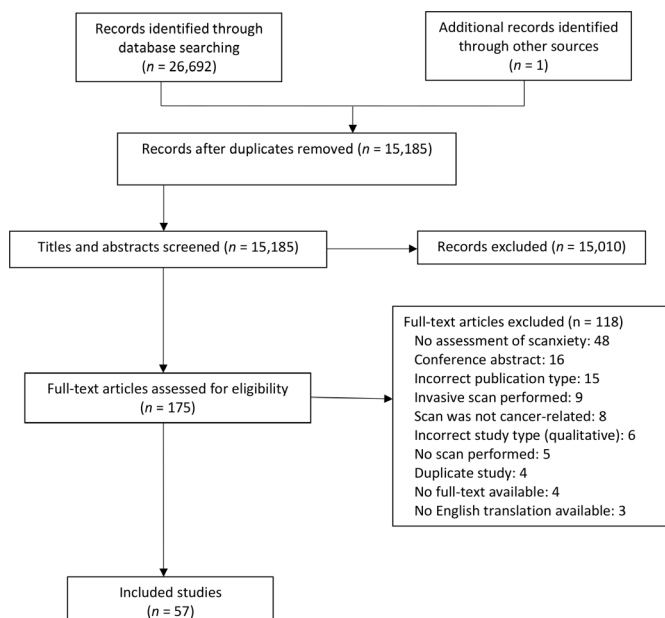


Figure 2 Study search and selection flow diagram.

RESULTS

The study search identified 26 693 citations. The selection process is outlined in [figure 2](#). After removal of duplicates, abstract and title screening, and full-text review, 57 eligible studies involving 21 352 people were included.

Demographics and study details

Observational studies

There were 47 observational studies ([table 1](#)) involving 19 498 people.^{15–61} Participants most commonly had scans for breast cancer (22 studies, n=14 338 women^{16 18–27 29 31 36 38 40 42 43 45 48 56 58}), the most common scans were mammograms (21 studies^{16 18–27 29 31 36 38 40 42 43 45 48 56}), and most studies used self-report surveys to assess scanxiety (40 studies^{15 16 18–36 38 40–54 56 58 59}).

Twenty-one studies were conducted in people having scans for screening.^{15 16 18 20 21 24–27 29–32 35 38 43 45 54 57 58 61}

In the remaining studies, reasons for scanning included diagnosis,^{23 48} staging,^{34 44 52} monitoring,^{49 55 60} surveillance to detect recurrence^{28 37 56} or a combination of reasons in people with known or suspected cancers (17 studies^{17 39 41 46 47 50 51 53 59}). Five studies permitted scans for both screening and non-screening reasons (namely, diagnosis^{22 36 40} or surveillance^{19 42}).

The mean age of participants, reported by 33 studies, was 56.9 years (range 38–66 years).^{20 21 25 26 28–33 35 36 39 41–48 50–61}

The majority of participants were women (87%).^{15 16 18–61} When studies involving scans for breast cancer were excluded, there were similar proportions of men and women (women 49% and men 51%).^{15 27 28 30 32–35 37 39 41 44 46 47 49–55 57 59–61}

There was variation in the reporting and proportion of participants who were married (22 studies, range 34%–97%^{20 21 24–26 29 31 32 34–38 41 45–49 54 56 58}), who received at least secondary education (29 studies, range 10%–99%^{20–22 24–29 31 32 34 36 37 41–43 45–47 49–51 54 55 57–60}) and who were attending their first scan (18 studies, range 0%–100%^{17 21 24 27 29 32 36 38 39 41 45 46 48 50 51 55 56 59}).

Intervention studies

There were 10 intervention studies ([table 2](#)) involving 1854 people.^{62–71} This included people having scans for breast cancer (six studies, n=1449 people^{62–65 69 70}) and lung cancer (one study, n=16 people⁶⁸). Scans included mammogram (five studies^{62–64 69 70}), positron emission tomography (PET) with CT (three studies^{66 67 71}), MRI,⁶⁵ CT⁶⁸ and ultrasound⁷⁰ (one study each). Four studies involved scans for screening,^{63 64 68 69} one for diagnosis,⁶⁵ three for any reason in people with known or suspected cancers^{66 67 71} and two where scans for screening, surveillance and/or diagnosis were permitted.^{62 70}

The mean age of participants was reported by five studies and ranged from 47 to 65 years.^{63 65 68 69 71} The majority were women (94%^{62–66 68–71}). There was variation in the reporting and proportion of participants who were married (two studies, 73% and 75%^{64 65}), received at least secondary education (six studies,

Table 1 Demographics and study details for the 47 observational studies

First author	Year	N	Country of study	Cancer type	Age (years) (mean*)	Female (%)	Married or de facto (%)	At least secondary education (%)	First scan (%)	Scan type	Reason for scan	Methods
Andolf ¹⁵	1990	275	Sweden	Ovarian	NR	100	NR	NR	NR	Abdominal ultrasound	Screening	Cross-sectional survey
Bull ¹⁶ †‡	1991	541	UK	Breast	50–54: 23% 55–59: 29% 60–64: 34% 65–70: 7% Unknown: 7%	100	NR	NR	NR	Mammogram	Screening	Longitudinal surveys
Peteet ¹⁷	1992	79	USA	Any	NR	NR	NR	NR	4	CT	Any (except screening)	Cross-sectional interview
Cockburn ¹⁸ †	1994	200	Australia	Breast	NR	100	NR	NR	NR	Mammogram	Screening	Longitudinal surveys
Ellman ¹⁹ ‡	1995	331	UK	Breast	50–54: 52% 65–78: 48%	100	NR	NR	NR	Mammogram	Screening or surveillance	Cross-sectional survey
Sutton ²⁰ †§	1995	306	UK	Breast	58	100	76	50	NR	Mammogram	Screening	Longitudinal surveys
Bakker ²¹	1998	315	Canada	Breast	61	100	71	76	50	Mammogram	Screening	Longitudinal surveys
Gupta ²²	1999	167	Kuwait	Breast	Range 14–63	100	NR	82	NR	Mammogram±ultrasound	Screening or diagnosis	Cross-sectional survey
Hafslund ²³	2000	170	Norway	Breast	NR	100	NR	NR	NR	Mammogram	Diagnosis	Longitudinal surveys
Meystre-Agostoni ²⁴	2001	887	Switzerland	Breast	50–54: 36% 55–59: 22% 60–64: 20% 65–69: 22%	100	77	62	27	Mammogram	Screening	Longitudinal surveys
Drossaert ²⁵	2002	2657	The Netherlands	Breast	58	100	78	32	NR	Mammogram	Screening	Longitudinal surveys
Sandlin ²⁶ †§	2002	598	Spain	Breast	51	100	77	41	NR	Mammogram	Screening	Longitudinal surveys
Brunton ²⁷	2005	584	New Zealand	Breast	50–54: 38% 55–59: 35% 60–64: 27%	100	NR	74	<20%	Mammogram	Screening	Cross-sectional survey
Geurts ²⁸	2006	106	The Netherlands	Head and neck	56	36	NR	29	NR	Chest X-ray	Surveillance	Cross-sectional survey
Tyndel ²⁹ ‡	2007	1174	UK	Breast	43	100	83	33	87	Mammogram	Screening	Longitudinal surveys
Bunge ³⁰ †	2008	324	The Netherlands, Belgium	Lung	60	49	NR	NR	NR	CT	Screening	Longitudinal surveys
Brown Sofair ³¹ †	2008	47	USA	Breast	50	100	34	80	NR	Mammogram	Screening	Longitudinal surveys
van den Bergh ³² †	2008	324	The Netherlands, Belgium	Lung	60	49	64	82	66	CT	Screening	Longitudinal surveys

Continued

Table 1 Continued

First author	Year	N	Country of study	Cancer type	Age (years) (mean*)	Female (%)	Married or de facto (%)	At least secondary education (%)	First scan (%)	Scan type	Reason for scan	Methods
Westerterp ^{35,†}	2008	82	The Netherlands	Oesophageal	64	18	NR	NR	NR	CT+PET	Diagnosis and staging	Cross-sectional survey
Bastiaannet ³⁴	2009	59	The Netherlands	Melanoma	Median: 59	44	69	66	NR	CT, PET±chest X-ray	Staging	Cross-sectional survey
Vierikko ^{35,†}	2009	601	Finland	Lung	65	0	36	NR	NR	CT	Screening	Longitudinal surveys
Böyükbaş ³⁶	2010	93	Turkey	Breast	48	100	97	10	45	Mammogram	Screening or diagnosis	Cross-sectional survey
Thompson ³⁷	2010	70	USA	Lymphoma	Median: 47	64	53	97	NR	CT	Surveillance	Cross-sectional interview
Hutton ^{38,†}	2011	527	UK	Breast	Median: 40	100	79	NR	75	Mammogram±MRI	Screening	Longitudinal surveys
Pifarré ³⁹	2011	200	Spain	Any	52	51	NR	NR	67	PET/CT	Any (except screening)	Cross-sectional interview
Steinemann ⁴⁰	2011	227	USA	Breast	NR	100	NR	NR	NR	Mammogram	Screening or diagnosis	Cross-sectional survey
Yu ⁴¹	2011	398	Brazil	Any	54	79	56	57	27	Any	Any (except screening)	Cross-sectional survey
Brédiart ^{42,†}	2012	637	France	Breast	50	100	NR	87	NR	Mammogram±ultrasound±MRI	Screening or surveillance	Longitudinal surveys
Hafslund ^{43,†}	2012	4249	Norway	Breast	58	100	NR	52	NR	Mammogram	Screening	Cross-sectional survey
Adams ^{44,†}	2014	36	The Netherlands	Lymphoma	50	42	NR	NR	NR	CT and MRI	Staging	Cross-sectional survey
Baena-Cañada ⁴⁵	2014	434	Spain	Breast	54	100	72	43	18	Mammogram	Screening	Cross-sectional survey
Andersson ⁴⁶	2015	169	Sweden	Any	64	47	62	62	100	PET/CT	Any (except screening)	Cross-sectional survey
Elboga ⁴⁷	2015	144	Turkey	Any	63	46	83	52	NR	PET/CT	Any (except screening)	Cross-sectional survey
Hobbs ⁴⁸	2015	49	Australia	Breast	55	100	79	NR	75	Mammogram±MRI	Diagnosis	Longitudinal surveys
Baum ⁴⁹	2016	103	USA	Lung	Median: 67	61	73	53	NR	CT, PET±MRI	Monitoring	Cross-sectional survey
Abreu ⁵⁰	2017	232	Portugal	Any	61	51	NR	73	71	PET/CT	Any (except screening)	Longitudinal surveys
Grilo ⁵¹	2017	81	Spain and Portugal	Any	55	53	NR	41	47	PET/CT	Any (except screening)	Longitudinal surveys
Evans ⁵²	2018	115	UK	Colorectal or lung	66	33	NR	NR	NR	Whole body MRI, PET+CT	Staging	Longitudinal surveys
Goense ⁵³	2018	27	The Netherlands	Oesophageal	64	15	NR	NR	NR	MRI+PET/CT	Staging and monitoring	Cross-sectional survey

Continued

Table 1 Continued

First author	Year	N	Country of study	Cancer type	Age (years) (mean*)	Female (%)	Married or de facto (%)	At least secondary education (%)	First scan (%)	Scan type	Reason for scan	Methods
Hall ⁵⁴	2018	169	USA	Lung	64	51	58	96	NR	Low-dose CT	Screening	Cross-sectional survey
Derry ⁵⁵	2019	94	USA	Any	61	72	NR	69	0	Any	Monitoring	Longitudinal interview
Soriano ⁵⁶	2019	57	USA	Breast	58	100	93	NR	0	Mammogram	Surveillance	Longitudinal survey
Taghizadeh ⁵⁷	2019	1237	Canada	Lung	63	56	NR	85	NR	CT	Screening	Longitudinal interview
Bancroft ⁵⁸	2020	88	UK and Ireland	Breast	38	61	50	83	NR	MRI	Screening	Longitudinal survey
Grilo ⁵⁹	2020	94	Portugal	Any	61	54	NR	99	77	PET+bone scan	Staging, monitoring and surveillance	Longitudinal survey
Morreale ⁶⁰	2020	87	USA	Gastrointestinal and lung	62	55	NR	92	NR	CT or MRI	Monitoring	Longitudinal interview
Paiella ⁶¹	2020	54	Italy	Pancreatic	50	61	NR	NR	NR	MRI – MRCP	Screening	Cross-sectional interview

All percentages were rounded to the nearest whole number.

*Unless otherwise stated.

†Demographic data are based on participants who completed the first survey.

‡These studies collected data from other groups who were not included in this review as they did not meet eligibility criteria. This included people having invasive procedures such as fine-needle aspirate or open surgical biopsy,^{16 33} people with abnormal screening results,^{18,26,29} and people who did not have a scan.^{18–20,43}

\$Demographics based on the entire population even if not all participants were eligible for this review.

¶Four paediatric participants were included in this study.

‡‡MRCP, magnetic resonance cholangiopancreatography; NR, not reported; PET, positron emission tomography.

Table 2 Demographics and study details for the 10 intervention studies to reduce scanxiety

First author	Year	N	Country of study	Cancer type	Age (years) (mean*)	Female (%)	Married or de facto (%) ^c	At least secondary education (%) ^c	First scan (%)	Scan type	Reason for scan	Allocation	Intervention and control groups
Mainiero ⁶²	2001	613	USA	Breast	<40: 8% 50–50: 39% 50–60: 28% >70: 9%	100	NR	95	7	Mammogram	Screening or surveillance	Consecutive†	Educational or entertaining video in waiting room
Domar ⁶³	2005	143	USA	Breast	52	100	NR	81	8	Mammogram	Screening	Randomised	Relaxation, music or blank audiotape in waiting room and during scan
Fernández-Feito ⁶⁴	2005	436	Spain	Breast	50–54: 24% 55–59: 30% 60–64: 23% 65–69: 22%	100	73	28	4	Mammogram	Screening	Randomised	Prescan nursing intervention or usual care
Caruso ⁶⁵	2006	44	Italy	Breast	47	100	75	89	NR	MRI	Diagnosis	Randomised	Prescan informative-emotive psychological support or routine information
Vogel ⁶⁶	2012	101	The Netherlands	Any	Median: 58	51	NR	NR	41	PET/CT	Any (except screening)	Randomised	Audio/visual installation or usual care during FDG uptake
Acuff ⁶⁷	2014	180	USA	Any	NR	NR	NR	NR	NR	PET/CT	Any (except screening)	Unclear	Handheld communication device or usual care during scan
Raz ⁶⁸	2014	16	USA	Lung	65	75	NR	100	NR	CT	Screening	Sequential‡	Prescan multimedia education or usual care
Zavotzky ⁶⁹	2014	100	USA	Breast	54	100	NR	98	NR	Mammogram	Screening	Non-randomised§	Music or no music during scan
Ashton ⁷⁰	2019	113	USA	Breast	18–39: 3.6% 40–59: 51.8% 60–79: 39.3% >80: 5.4%	100	NR	NR	NR	Mammogram±ultrasound	Screening, surveillance or diagnosis	NA¶	Shoulder and neck massage±hand massage
Lorca ⁷¹	2019	108	Spain	Any	59	57	NR	NR	54	PET/CT	Any (except screening)	Randomised	Mindfulness meditation or usual care during FDG uptake

All percentages were rounded to the nearest whole number.

*Unless otherwise stated.

†Each intervention was administered during one half of the study period.

‡Participants were enrolled into the control arm first, followed by the intervention arm.

§Participants attending on Mondays, Wednesdays and Fridays were allocated to the intervention arm, and participants attending on Tuesdays and Thursdays were allocated to the control arm.

¶All participants received the intervention.

‡FDG, fluorodeoxyglucose; NR, not reported; PET, positron emission tomography.

range 28%–100%^{62–65 68 69}) and participants attending their first scan (five studies, range 4%–54%^{62–64 66 71}).

Eight studies allocated participants to an intervention or control group,^{63–69 71} one study compared two interventions⁶² and one study delivered the intervention to all participants.⁷⁰ Two interventions were multifaceted.^{64 65} Types of interventions included: relaxation, distraction and/or meditation (six studies^{62 63 66 69–71}); education (four studies^{62 64 65 68}); emotional or psychosocial support (two studies^{64 65}); or adjustments to routine logistics of the scan (one study⁶⁷).

Scanxiety measurement

Anxiety measurements varied across the studies, with different measurement tools, variants of the same tool, and different range and thresholds applied to tools.

Observational studies

The 47 observational studies (table 3) used a total of 81 measures of anxiety, with 30 studies using one measure only,^{15–19 21 22 25–28 30 33 34 36 39 40 43 44 46 48–51 53 55–57 59 61} and 17 studies using at least two measures.^{20 23 24 29 31 32 35 37 38 41 42 45 47 52 54 58 60}

The most common measures used were: purpose-designed Likert scales (17 studies); the State-Trait Anxiety Inventory (STAI) (14 studies); the anxiety subscale of the Hospital Anxiety and Depression Scale (HADS) (nine studies); the Impact of Event Scale (IES) (six studies); the Psychological Consequences Questionnaire (PCQ) (three studies), the Cancer Worry Scale (three studies); and the Perceived Stress Scale (two studies). There were 17 measures used by one study only.^{15 20 22 26 31 32 35 52 54 56 58 60}

Likert scales were varied, with a numerical lower range limit of 0 or 1, and an upper range limit between 3 and 12.^{17 20 24 25 33 40 44 46 48 50 52 53} Seven studies used a descriptive range.^{21 25 27 28 33 34 55} Two studies used both a numerical and a descriptive range.^{25 33}

The STAI comprises state and trait anxiety subscales with a possible subscale range of 20–80. It has no validated anxiety threshold and is usually calculated as a sum of four-point response options.⁷² Included studies used and reported the STAI as a total score,^{37 39} using one or both subscales,^{20 23 36 37 41 42 47 51 57 59} or as a variant (eg, STAI-6^{32 38 58}). There were different ranges: none reported^{47 57}; no reported lower limit⁴¹; no reported upper limit³⁶; 0–60;^{39 51} or based on a mean of individual item scores.²⁰ Some studies prespecified an anxiety threshold of 39,⁵⁷ 40 and^{37 41} 46,⁴² calculated based on the relationship between the anxiety and trait subscales,³⁹ or based on investigator-determined categories.³⁶ One study used a different method to calculate scores (ie, subtracting the points of reversed statements from direct statements, which were valued at 1, 2, 3 and 20, and then added to a constant of 50³⁶).

The HADS anxiety subscale has a range of 0–21 and a validated anxiety threshold of 11.⁷³ One study reported a range of 0–14,³⁸ one study reported anxiety categories rather than a threshold,⁶⁰ two studies reported an anxiety

threshold of 8^{41 43} and one study reported an anxiety threshold of 10 (though there was overlap the ‘tendency to anxiety’ and ‘anxiety’ categories, classified as scores of 8–10 and 10 or more, respectively).⁴⁷

The IES was used in its original form^{30 32 38 42 58} or as a variant (IES-6⁴⁹) and was reported as a total score^{30 32 38 49} or as intrusion and avoidance subscale scores.^{42 58} The two studies using subscale scores reported threshold levels of 20 or 21⁴² and 8.5.⁵⁸ When using the PCQ, researchers used either the emotional subscale¹⁸ or the negative consequences subscale.^{24 29} The Cancer Worry Scale and the Perceived Stress Scale were used in original^{45 61} or variant^{29 54 58} forms. The Symptom Checklist-90-Revised score could not be interpreted because the authors did not report a range,³¹ and a raw score or a transformed score could have been used.⁷⁴

Intervention studies

The 10 intervention studies (table 4) used 19 measures of anxiety, with five studies using one measure only,^{62 66 67 69 70} and five studies at least two.^{63–65 68 71} The measures included subscales of the STAI (seven studies), Likert scales (five studies), a variant of the Psychological Consequences Questionnaire (one study⁶⁸) and the Crown Crisp Experimental Index (one study⁶⁵).

Likert scales were varied, with a lower range limit of 0 or 1, and an upper range limit between 5 and 10.^{62 63 69–71} The STAI was used and reported using one or both subscales,^{63–65 67 68 71} or as a variant (eight-item STAI⁶⁶). There was variation from the usual STAI parameters, with studies using a different range (ie, not reported,^{63 65} 0–60,⁶⁴ or 18–32⁶⁶) or prespecified anxiety thresholds of 40⁶⁸ or 16.⁶⁶

Scanxiety outcomes

Prevalence and severity of scanxiety for each study are provided in table 3. Summary statistics for prevalence and severity were not calculated due to heterogeneity in the type and timing of measurement between the studies.

Prevalence of scanxiety

Twenty-four of the 47 studies reported the prevalence of scanxiety. The prevalence of scanxiety above prespecified anxiety thresholds ranged between 0% and 64% across the 16 measures,^{16 19 31 38 41 43 45 52 54 58} though eight of these measures came from only two studies.^{41 58} In the 14 measures without a prespecified anxiety threshold, the prevalence of any degree of scanxiety ranged between 13% and 83%.^{15 21 22 24 27 28 32–34 37 39 41 48 49}

There were insufficient numbers to compare the prevalence of scanxiety using measures with prespecified anxiety thresholds of people having scans for screening (11 measures^{16 31 38 43 45 54 58}), reasons other than screening (four measures^{41 52}) and for screening or non-screening reasons (one measure¹⁹). When no threshold was reported, the prevalence of scanxiety had a similar range (screening 23%–81%, five measures^{15 21 24 27 32}; reasons other than

Table 3 Prevalence and severity of scanxiety

First author	Year	Measurement of scanxiety			Results of scanxiety measurement			
		Name of tool	Range of tool (anxiety threshold*)	Timing of assessment	Prevalence (%)	Severity (mean±SD†)	Prescan and postscan comparison	
Andoif ¹⁵	1990	Visual analogue scale	0–100 (NA)	Postscan: 1–3 years	81	Median 3.5 (range 0–100)	NA	
	1991	HADS: anxiety subscale	0–21 (≥11)‡	Prescan: specific timing NR Postscan: postresult, specific timing NR	4.9	4.97 (range 0–20) 4.43 (range 0–17)	Less severe postscan scanxiety, p<0.001	
Peteet ¹⁷	1992	10-point Likert scale	1–10 (NA)	Postscan: specific timing NR	NR	First scan 5.5, recent scan 3.5	NA	
Cockburn ¹⁸	1994	PCQ: emotional subscale	0–15 (NA)	Prescan: day of scan Postscan: preresults, 1 week postresult and at 8 months	NR	<2 <2	No difference	
	1995	HADS: anxiety subscale	0–21 (≥11)	Prescan: day of scan	6	NR	NA	
Sutton ²⁰	1995	STAI: state anxiety subscale	1–4 (NA)	Prescan: at invitation to screening, specific timing NR Periscan: day of scan Postscan: 9 months	NR	Between 1.65 and 1.95	No significant differences scanxiety at any time point	
		STAI: trait anxiety subscale	1–4 (NA)	Prescan: at invitation to screening, specific timing NR Periscan: day of scan Postscan: 9 months	NR	Between 1.65 and 1.95	No significant differences in scanxiety at any time point	
		GHQ: anxiety subscale	0–3 (NA)	Prescan: at invitation to screening, specific timing NR Periscan: day of scan Postscan: 9 months	NR	<1	Less severe postscan scanxiety, p<0.001	
		3-point Likert scale	1–3 (NA)	Prescan: at invitation to screening, specific timing NR Postscan: 9 months	NR	<1	Less severe postscan scanxiety, p<0.001	
Bakker ²¹	1998	5-point Likert scale	Descriptive range (NA)	Postscan: immediate and at 3 weeks	39–40	Somewhat, very or extremely: 9%–15%	NA	
Gupta ²	1999	HSCL-25	0–3 (NA)	Postscan: specific timing NR	40	Moderate to severe: 25%	NA	
Hafslund ²³	2000	STAI: state anxiety subscale	20–80 (NA)	Prescan: day of scan Postscan: day of scan	NR	35.5±11.0 32.1±10.9	No statistical comparison reported	
		STAI: trait anxiety subscale	20–80 (NA)	Prescan: day of scan Postscan: day of scan	NR	35.9±9.1 NR	No statistical comparison reported	
Meystre-Agostoni ²⁴	2001	PCQ: negative consequences subscale	0–36 (NA)	Prescan: day of scan Postscan: preresult, 2 weeks postresult and 8 weeks postresult	NR	<1 <2	No statistical comparison reported	
		6-point Likert scale	0–5 (NA)	Prescan: immediate Postscan: preresult, 2 weeks postresult and 8 weeks postresult	26	<1 <1	No statistical comparison reported	
Drossaert ²⁵	2002	Composite seven-item score of 4-point Likert scales	1–4 (NA)	Baseline: 8 weeks post-first scan Prescan: 6 weeks (second and third scans) Postscan: 6 weeks (second and third scans) Baseline: 8 weeks post-first scan	NR	1.6 1.6 to 1.7 1.5 Moderate to severe: 10%	No statistical comparison reported	

Continued

Table 3 Continued

First author	Year	Measurement of scanxiety			Results of scanxiety measurement		
		Name of tool	Range of tool (anxiety threshold*)	Timing of assessment	Prevalence (%)	Severity (mean±SD†)	Prescan and postscan comparison
Sandiri ²⁶	2002	HSCL-90-R: anxiety subscale	0–4 (NA)	Pr-scan: day of scan Postscan: 2 weeks	NR	0.41±0.33 0.28±0.30	No statistical comparison reported
Brunton ²⁷	2005	4-point Likert scale, three items	Descriptive range (NA)	Postscan: within 4 years	56–77	Quite or very: 11%–28%	NA
Geurts ²⁸	2006	4-point Likert scale	1–4 (NA)	Periscan: specific timing NR	61	Moderate to severe: 21%	NA
Tyndel ²⁹	2007	PCQ: negative consequences subscale	0–36 (NA)	Prescan: 1 month Postscan: 1 month post result and 6 months postresult	NR	5.1±6.7 3.8±6.0 to 4.2±6.2	Less severe postscan scanxiety, p=0.000
		Cancer Worry Scale – Revised	6–24 (NA)	Prescan: 1 month Postscan: 1 month post result and 6 months postresult	NR	11.0±2.9 10.1±2.5 to 10.6±2.6	Less severe postscan scanxiety, p=0.000
Bunge ³⁰	2008	IES in low affective risk people	0–75 (NA)	Prescan: 1 day Postscan: 6 months	NR	5.6±7.9 4.3±7.2	Less severe postscan scanxiety in both low and high affective risk groups, p<0.05
		IES in high affective risk people	0–75 (NA)	Prescan: 1 day Postscan: 6 months	NR	14.7±14.4 10.3±11.0	
Brown Sofair ³¹	2008	Penn State Worry Questionnaire	16–80 (60)	Prescan: within 1 month Postscan: day of scan (postresult)	NR	50.18 (range 40–60) NR	No statistical comparison reported
		SCL-90-R: anxiety subscale	NR (NA)	Prescan: within 1 month Postscan: day of scan (postresult)	NR	48.75 42.07	No difference
		Individualised Questionnaire: anxiety response	1–3 (2)	Prescan: within 1 month Postscan: day of scan (postresult)	35	NR	No statistical comparison reported
van den Bergh ³²	2008	STAI-6	20–80 (NA)	Prescan: 1 day Postscan: within 1 week and at 6 months	NR	34.1±7.7 32.7±8.4 to 34.3±9.1	Less severe postscan scanxiety, p<0.01
		IES	0–75 (NA)	Prescan: 1 day Postscan: within 1 week and at 6 months	NR	6.9±9.6 5.1±8.0 to 5.6±8.8	Less severe postscan scanxiety, p<0.01
		EuroQol questionnaire: anxiety subscale	1–3 (NA)	Prescan: 1 day Postscan: 6 months	23	NR	No statistical comparison reported
Westerterp ³³	2008	5-point Likert scale	1–5 (NA)	Postscan (after both scans): 2 weeks Postscan (after both scans): 2 weeks	NR	CT 1.2±0.6, PET 1.4±1.0	NA
Bastiaannet ³⁴	2009	5-point Likert scale	Descriptive range (NA)	Postscan (after both scans): 2 weeks Postscan: 2–6 weeks after lymph node dissection	CT 13, PET 23	Moderate to severe: CT 4%, PET 10%	NA
Vierikko ³⁵	2009	Health anxiety inventory	0–24 (NA)	Prescan: specific timing NR Postscan: 1 year	NR	6.7±4.7 5.8±4.6	Less severe postscan scanxiety, p<0.001
		Worry about lung cancer	0–8 (NA)	Prescan: specific timing NR Postscan: 1 year	NR	3.0±2.4 3.1±2.3	No difference
Böyükbaş ³⁶	2010	STAI: state anxiety subscale	0–NR (20–39 mild, 40–59 moderate, 60–79 severe, ≥80 help needed)	Periscan: specific timing NR	NR	46.2±4.9	NA

Continued

Table 3 Continued

First author	Measurement of scanxiety			Results of scanxiety measurement			
	Year	Name of tool	Range of tool (anxiety threshold*)	Timing of assessment	Prevalence (%)	Severity (mean±SD†)	Prescan and postscan comparison
Thompson ³⁷	2010	STAI	40–160 (NA)	Postscan: specific timing NR	37	65.8±21.0	NA
		STAI: state anxiety subscale	20–80 (≥40)	Postscan: specific timing NR	NR	30.4±10.9	NA
		STAI: trait anxiety subscale	20–80 (≥40)	Postscan: specific timing NR	NR	35.4±11.3	NA
Hutton ³⁸	2011	HADS: anxiety subscale	0–14 (≥11)	Baseline: 4 weeks pre-first scan	20	6.9±4.2	No difference
				Prescan: day of each scan (for five scans)	MRI 17, mammogram 20	MRI 5.2±4.0 to 6.5±4.2, mammogram 5.0±3.9 to 6.5±4.1	
		STAI-6	20–80 (NA)	Postscan: 6 weeks (for five scans) Prescan: day of scan (for five scans)	ten to 13 NR	5.1±4.2 to 5.9±4.1 MRI 10.8±3.8 to 12.1±4.0, mammogram 10.1±3.9 to 11.3±4.1	Less severe postscan scanxiety for MRI (p<0.0005) and mammogram (p=0.002)
IES		0–75 (NA)		Postscan: day of scan (for five scans)	NR	MRI 9.6±3.2 to 10.7±3.8, mammogram 9.7±3.1 to 10.5±3.9	
				Postscan: 6 weeks (for five scans)	NR	MRI 17.8±5.8 to 19.3±7.0, mammogram 17.2±4.4 to 18.6±5.2	NA
				Prescan: day of scan	68	NR	NR
Pifarré ³⁹	2011	STAI	0–60 for each subscale (state more than 10 than trait)	Prescan: day of scan	NR	NR	NA
Steinmann ⁴⁰	2011	7-point Likert scale	1–7 (NA)	Prescan: day of scan	NR	4.1	NA
		HADS: anxiety subscale	0–21 (≥8)	Prescan: day of scan	38	NR	NA
		STAI: state anxiety subscale	NR-80 (≥40)	Prescan: day of scan	46	39.4±12.2	NA
Yu ⁴¹	2011	STAI: trait anxiety subscale	NR-80 (≥40)	Prescan: day of scan	46	39.9±12.2	NA
		Dichotomous reporting§	Yes/No (NA)	Prescan: day of scan	41	NR	NA
		STAI: state anxiety subscale	20–80 (≥46)	Prescan: 1 week	NR	MRI 42.1, mammogram 41.1	No statistical comparison reported
Bredart ⁴²	2012	IES: intrusion subscale	0–35 (≥20)	Postscan: day of scan and between 15 days to 3 months	NR	MRI 34.9, 40.8, mammogram 34.3, 38.8	No statistical comparison reported
		IES: avoidance subscale	0–40 (≥21)	Prescan: 1 week	NR	MRI 8.9, mammogram 8.4	No statistical comparison reported
				Postscan: day of scan and between 15 days to 3 months	NR	MRI 8.5, mammogram 7.7	No statistical comparison reported
Hafslund ⁴³	2012	HADS: anxiety subscale	0–21 (≥8)	Prescan: 1 week	NR	MRI 12.1, mammogram 9.8	No statistical comparison reported
		4-point Likert scale	1–4 (NA)	Postscan: day of scan and between 15 days to 3 months	NR	MRI 11.8, mammogram 8.9	
		HADS: anxiety subscale	0–21 (≥11)	Prescan: within 2 weeks	15	4.1±3.3	NA
Adams ⁴⁴	2014	4-point Likert scale	1–4 (NA)	Postscan: day of scan (after each scan)	NR	MRI 1.5±0.7, CT 1.8±0.8	NA
Baena-Cañada ⁴⁵	2014	HADS: anxiety subscale	0–21 (≥11)	Postscan: specific timing NR	4	1.86±3.26	NA
		Cancer Worry Scale	6–24 (NA)	Postscan: specific timing NR	NR	9.4±3.0	NA
Andersson ⁴⁶	2015	Sum of three items on 5-point Likert scale	0–12 (NA)	Postscan: within 4 weeks	NR	4 (range 0–10)	NA

Continued

Table 3 Continued

First author	Year	Measurement of scanxiety			Results of scanxiety measurement			Prescan and postscan comparison
		Name of tool	Range of tool (anxiety threshold*)	Timing of assessment	Prevalence (%)	Severity (mean±SD†)		
Elboga ⁴⁷	2015	HADS: anxiety subscale	0–21 (≥10)	Prescan: day of scan	NR	9.2±3.8	NA	
		STAI: state anxiety subscale	NR (NA)	Prescan: day of scan	NR	40.4±8.5	NA	
		STAI: trait anxiety subscale	NR (NA)	Prescan: day of scan	NR	46.6±7.8	NA	
Hobbs ⁴⁸	2015	5-point Likert scale	1–5 (NA)	Postscan (after both scans), specific timing NR	Mammogram 17, MRI 44	NR	NA	
Baum ⁴⁹	2016	IES-6	0–24 (NA)	Postscan: specific timing NR	83	6.4±5.3	NA	
Abreu ⁵⁰	2017	10-point Likert scale	1–10 (NA)	Prescan: day of scan	NR	6.4±2.7	Less severe postscan scanxiety, p=0.000	
				Postscan: day of scan	NR	5.7±2.6		
Girlo ⁵¹	2017	STAI: state anxiety subscale	0–60 (NA)	Prescan: day of scan	NR	31.1±5.2	More severe postscan scanxiety, p=0.000	
				Postscan: day of scan	NR	33.9±4		
Evans ⁵²	2018	GHQ-12	0–12 (≥4)	Periscans: specific timing NR	42	NR	NA	
		7-point Likert scale	1–7 (NA)	Postscan: 1 month	NR	MRI 2.5±1.3, CT or PET/CT 2.2±1.2	NA	
Goense ⁵³	2018	5-point Likert scale	1–5 (NA)	Postscan (after both scans): day of scan	NR	MRI 1.0±0.2, PET 1.0±0.2	NA	
		Generalised Anxiety Disorder two-item	0–6 (≥3)	Periscan: specific timing NR	26	1.62±1.78	NA	
Hall ⁵⁴	2018	Perceived Stress Scale 4	0–16 (NA)	Periscan: specific timing NR	NR	5.14±3.35	NA	
		4-point Likert scale	Descriptive range (NA)	Periscan: preresult	NR	'A great deal' or 'completely': 23%	NA	
Soriano ⁵⁶	2019	PROMIS Anxiety Short Form	1–5 (NA)	Prescan: 2 weeks	NR	1.55±0.64	NA	
Taghizadeh ⁵⁷	2019	STAI: state anxiety subscale	NR (39)	Baseline	NR	30.9	More severe postscan scanxiety, p<0.001	
				Postscan: 1 month postresult and at 12 months	NR	33.1, 31.7		

Continued

Table 3 Continued

First author	Year	Measurement of scanxiety		Results of scanxiety measurement					
		Name of tool	Range of tool (anxiety threshold)*	Timing of assessment	Prevalence (%)	Severity (mean±SD†)	Prescan and postscan comparison		
Bancroft ⁵⁸	2020	HADS: anxiety subscale	0–21 (11)	Baseline	Carriers: 14 Controls: 7	Carriers: 6.2±3.9 Controls: 4.9±3.3	No difference in prevalence Less severe postscan in carriers (p=0.04)		
		Cancer Worry Scale – Revised	8–32 (NA)	Baseline	NR	Carriers: 14.4±3.6 Controls: 12.2±1.7	No difference		
		IES-cancer: intrusion subscale	0–35 (8.5)	Postscan: at 12 weeks, 26 weeks and 52 weeks	NR	Carriers: 13.6±4.4 to 14.7±4.2 Controls: 11.9±1.4 to 12.1±1.9			
		IES-cancer: avoidance subscale	0–40 (8.5)	Postscan: prerevents, at 12 weeks, 26 weeks and 52 weeks	Carriers: 35 to 58 Controls: 5 to 13	Carriers: 8.3±9.1 to 11.4±9.1 Controls: 1.7±3.5 to 3.0±4.9	NA		
		IES-MRI: intrusion subscale	0–35 (8.5)	Postscan: at 12 weeks, 26 weeks and 52 weeks	Carriers: 55 to 64 Controls: 12 to 37	Carriers: 9.9±9.0 to 13.3±10.5 Controls: 2.6±4.6 to 7.0±8.2	NA		
		IES-MRI: avoidance subscale	0–40 (8.5)	Postscan: at 12 weeks, 26 weeks and 52 weeks	Carriers: 4 to 7 Controls: 0 to 3	Carriers: 1.2±3.2 to 3.1±8.8 Controls: 0.1±0.3 to 0.5±1.8	NA		
		STAI-6	6–24 (NA)	Prescan: day of scan	NR	Carriers: 7.2±3.3 Controls: 7.3±3.2	NA		
		Health Questionnaire	0–14 (NA)	Baseline	NR	Carriers: 7.0±2.6 Controls: 6.8±2.2	No difference		
		Girlo ⁵⁹	2020	STAI: state anxiety subscale	20–80 (NA)	Prescan: day of scan	NR	Bone scan: 51.75±3.77 PET/CT: 44.76±10.0	Less severe postscan scanxiety for both: bone scan, p=0.02 PET/CT, p<0.001
				Distress thermometer	0–10 (4)	Postscan: day of scan	NR	Bone scan: 36.70±12.12 PET/CT: 38.82±11.33	No statistical comparison
Morreale ⁶⁰	2020	HADS: anxiety subscale	0–21 (0–7 none, 8–10 mild, 11–14 moderate, 15–21 high)	Postscan: 1 week postresult	NR	6.12±3.98	No statistical comparison		
		Perceived Stress Scale	0–40 (15–18 moderate, ≥19 high)	Postscan: 1 week postresult	NR	5.32±4.31			
Patella ⁶¹	2020	Perceived Stress Scale	0–40 (15–18 moderate, ≥19 high)	Postscan: prerevent	NR	14.8	NA		

All percentages were rounded to the nearest whole number.

*NA is listed as the anxiety threshold when the study did not state a prespecified threshold. In these cases, the definition of scanxiety prevalence was the percentage of people who reported any degree of anxiety.

†Mean listed unless otherwise described; SD listed only when available.

‡This study did not specify an anxiety threshold; however, the Anxiety subscale of the Hospital Anxiety and Depression Scale has validated thresholds. These thresholds were included in this table

§Stochastic reporting assumed given description of question (self-perception of anxiety) and results: 40.5% of the patients considered themselves to be anxious.⁶¹

¶This study included participants who were 77–93 mutation carriers and population controls.

|||Hopkins Symptom Checklist; HSC-90-R, Hopkins Symptom Checklist 90-Revised; IES, Impact of Event Scale; NA, not applicable; NR, not reported; PCQ, Psychological Consequences Questionnaire; PET, positron emission tomography; PROMIS, Patient-Reported Outcomes Measurement Information System; SCL-90-R, Symptom Checklist-90-Revised; STAI, State-Trait Anxiety Inventory.

Table 4 Effect of interventions to reduce scanxiety

First author	Year	Intervention	Measurement of scanxiety		Impact of intervention on scanxiety		
			Name of tool	Range of tool (anxiety threshold)	Timing of assessment	Description of results	P value
Mainiero ⁶²	2001	Arm A: an educational video about breast cancer and mammography Arm B: an entertaining movie (from the 1940s to 1960s)	6-point Likert score	0–5 (NA)	Prescan: immediate Postscan: immediate	No difference	NR
Domar ⁶³	2005	Arm A: relaxation audiotape or Arm B: music audiotape or Arm C: control (blank audiotape)	STAI: state anxiety subscale	NR (NA)	Prescan: immediate Postscan: immediate	No difference Arm A versus arm B versus arm C: 34.8 versus 33.6 versus 33.2 No difference Arm A versus arm B versus arm C: 30.4 versus 30.9 versus 33.2	0.18 0.78
			STAI: trait anxiety subscale	NR (NA)	Prescan: immediate	No difference	0.99
			11-point Likert scale	1–10 (NA)	Postscan	No difference Arm A versus arm B versus arm C: 2.6 versus 3.2 versus 2.8	0.43
Fernández-Feito ⁶⁴	2005	Arm A: a protocolised nursing intervention (information and emotional support) and usual care or arm B: usual care alone	STAI: state anxiety subscale	0–60 (NA)	Prescan: immediate (postintervention) Postscan: immediate	Less severe Less severe if fear of cancer present Less severe if no fear of cancer present No difference if fear of cancer outcome present Less severe if no fear of scan outcome	<0.001 0.002 0.003 0.09 <0.001
			STAI: trait anxiety subscale	0–60 (NA)	Prescan: immediate (postintervention)	No difference	0.34

Continued

Table 4 Continued

			Measurement of scanxiety		Impact of intervention on scanxiety		
First author	Year	Intervention	Name of tool	Range of tool (anxiety threshold)	Timing of assessment	Description of results	P value
Caruso ⁶⁵	2006	Arm A: routine information and 45 min of informative-emotive psychological support with a psychologist or arm B: routine information	Crown Crisp Experimental Index	NR (0–96)	Prescan: immediate (postintervention)	Less severe Arm A versus arm B: 39.4 versus 42.3	0.03
			STAI: state anxiety subscale	NR (NA)	Prescan: immediate (postintervention)	No difference Arm A versus arm B: 57.7 versus 58.6	0.77
			STAI: trait anxiety subscale	NR (NA)	Postscan: immediate	Less severe	0.048
					Prescan: immediate (postintervention)	NR	NR
Vogel ⁶⁶	2012	Arm A: uptake room with an audio-visual installation involving a video of nature scenes on a 119cm television, dynamic lighting and ambient electronic music Arm B: uptake room without the audio-visual installation	8-item STAI	18–32 (≥16)	Prescan: immediately before and immediately after fluorodeoxyglucose uptake period	Less severe Arm A versus arm B: reduction by 2.39 versus 1.02	0.04
Acuff ⁶⁷	2014	Arm A: receive a handheld device to contact imaging staff during the scan Arm B: no device	STAI: state anxiety subscale	20–80 (NA)	During scan: immediately before completion of the scan	Less severe Arm A versus arm B: 22.87 versus 26.45	0.014
						Less severe if previous PET/CT	0.023
						Arm A versus arm B: 20.78 versus 24.64	0.77
						No difference if first time PET/CT	0.249
						Arm A versus arm B: 23.09 versus 27.25, p=0.249	
Raz ⁶⁸	2014	Arm A: multimedia education session and usual care or arm B: usual care	STAI: state anxiety subscale STAI: Trait Anxiety subscale PCQ: lung cancer adaptation, anxiety subscale	20–80 (≥40) 20–80 (≥40) 0–18 (NR)	Prescan: within 2 weeks Postscan: immediate, at 1 week and 3–7 months postscan	No difference at any time point	NR
Zavotsky ⁶⁹	2014	Arm A: music of their choice played via dock during the scan Arm B: no music	11-point Likert scale	0–10 (NA)	Postscan: immediate	No difference Arm A versus arm B: 2.36 versus 2.98	0.21
Ashton ⁷⁰	2019	All participants: 10min shoulder and neck massage and/or hand massage before, during or after imaging, or between two imaging tests	11-point Likert scale	0–10 (NA)	Postintervention (prescan or postscan)	81% had a reduction in anxiety following massage*	<0.01

Continued

Table 4 Continued

First author	Year	Intervention	Measurement of scanxiety		Impact of intervention on scanxiety		
			Name of tool	Range of tool (anxiety threshold)	Timing of assessment	Description of results	P value
Lorca ⁷¹	2019	Arm A: mindfulness meditation Arm B: routine care	STAI: State Anxiety subscale	NR (NA)	Postscan: immediate	Less severe Arm A versus arm B: 10.47 versus 29.07	0.000
			STAI: Trait Anxiety subscale	NR (NA)		No difference	NS
			11-item Likert scale	0–10 (NA)		Less severe Arm A versus arm B, 1.07 versus 5.70	0.000

*Mean scores for overall study population not provided.

NA, not applicable; NR, not reported; PCQ, Psychological Consequences Questionnaire; STAI, State-Trait Anxiety Inventory.

screening 14% to 83%, eight measures^{28 33 34 37 39 41 48 49}; either screening or reasons other than screening 40%, one measure²²).

Severity of scanxiety

Severity of scanxiety was reported in 44 of 47 observational studies. Mean severity scores appeared low in almost all measures, which quantitatively measured scanxiety (54/62, 87%).

The mean severity scores were below prespecified anxiety thresholds on 17 of the 19 measures where a threshold was reported.^{16 31 37 38 41–43 45 47 54 57 58} The two exceptions were observed in a study comparing people with *TP53* mutations ('carriers') to controls, with all participants undergoing screening scans. In carriers, mean scores were maximally 11.4 (IES intrusion subscale, threshold 8.5) and 13.3 (IES avoidance subscale, threshold 8.5). Mean severity scores for controls were below the thresholds.⁵⁸

Of the 43 measures without a prespecified threshold, the majority had mean scores that were less than half the total scores.^{15 18 20 23–26 29 30 32 33 35 37 38 44–46 49 52–54 56 58 60 61}

There were six exceptions, which reported maximal mean severity scores of: 5.5 out of 10 (Likert scale)¹⁷; 6.4 out of 10 (Likert scale)⁵⁰; 4.1 out of 7 (Likert scale),⁴⁰ 33 out of 60 (STAI state anxiety subscale),⁵¹ 8.1 out of 14 (Health Questionnaire)⁵⁸; and 51.75 out of 80 (STAI).⁵⁹ Four of these scores occurred in studies where scans were performed for reasons other than screening,^{17 50 51 59} one allowed scans for diagnosis or screening⁴⁰ and one allowed scans for screening only.⁵⁸

Eight measures used a descriptive range of severity, with more severe levels of scanxiety in 4%–28% of participants.^{21 22 25 27 28 33 34 55}

Four measures could not be interpreted because they failed to report a range and anxiety threshold.^{31 36 47}

Scanxiety before and after a scan

Of the 20 studies that reported a prescan and postscan scanxiety measurement, 14 studies reported a statistical comparison^{16 18 20 29–32 35 38 50 51 57–59} and six did not^{23–26 42 60} (table 3).

There was variation in the timing of scanxiety measurement before a scan from 4 weeks before the scan until immediately before the scan, and after a scan from immediately after the scan until 1 year after the scan. Five studies reported a postscan reduction in scanxiety severity compared with prescan levels.^{16 29 30 32 50 59} Two studies reported an increase in postscan scanxiety severity^{51 57} and two studies no difference in prescan and postscan scanxiety severity.^{18 31}

Four studies reported mixed findings on the change in scanxiety severity across different measures (table 5).

Although Bancroft *et al*⁵⁸ reported a reduction in scanxiety severity using HADS (anxiety subscale), there was no difference in scanxiety prevalence.

Contributing factors to scanxiety

Multiple comparisons were made between scanxiety and possible contributing factors across the included studies (table 6).

Table 5 Studies with discrepant results on prescan and postscan scanxiety severity using different measures

First author	Measurement tool	
	Postscan reduction in scanxiety	No difference in prescan or postscan scanxiety
Sutton ²⁰	General Health Questionnaire: anxiety subscale 3-point Likert scale	STAI: state anxiety subscale STAI: Trait Anxiety subscale
Vierikko ³⁵	Health Anxiety Inventory	Worry about lung cancer
Hutton ³⁸	6-item STAI	HADS: anxiety subscale
Bancroft ⁵⁸	HADS: anxiety subscale	Cancer Worry Scale – Revised Health Questionnaire

HADS, Hospital Anxiety and Depression Scale; STAI, State Trait Anxiety Inventory.

In summary, higher scanxiety severity was associated with people with:

- ▶ Lower education (compared with higher education, eight of 14 studies^{22–24 27 36 37 42 43 49 51 59 62 63 69}).
- ▶ A history of smoking (compared with non-smoking, three of five studies^{40 43 47 49 54}).
- ▶ Higher pain levels during the scan (compared with no pain, all six studies^{22 23 25 27 62 69}).
- ▶ Higher perceived risk of cancer (compared with lower perceived risk of cancer, all three studies^{27 30 42}).
- ▶ Diagnostic scans (compared with screening scans, all three studies^{36 41 62}).

The prevalence or severity of scanxiety was not consistently affected by age (13 of 19 comparisons^{20 22 24 27 28 36 37 41–43 45 49–51 59 62 63 70}), gender (6 of 11 comparisons^{28 37 39 41 47 49–51 57 59}), ethnicity (five of seven comparisons^{22 24 27 37 40 49 63}), income (all three comparisons^{27 37 49}), marital status (five of six comparisons^{24 36 37 42 49}) or having children (all three comparisons^{24 37 43}).

Inconclusive results occurred in the following comparisons:

- ▶ Employment (unemployed compared with employed, four of six comparisons^{23 27 37 41–43}).
- ▶ Scan-naivety (first scan compared with subsequent scans, six of 13 comparisons^{19 24 25 27 36 38 39 41 50 51 62 66 67}).
- ▶ Risk of cancer (higher compared with lower risk of cancer, 7 of 19 comparisons^{15 24 27 36 37 40 42 45 58}).

Although nine studies reported differences in scanxiety between different imaging modalities, the number of comparisons between specific scans were insufficient to draw conclusions.^{33 34 41 42 44 48 52 53 59}

Interventions that reduce scanxiety

Five of the 10 intervention studies showed a reduction in scanxiety compared with controls.^{64–67 71} Four studies reported no difference in scanxiety between the intervention arms.^{62 63 68 69} The study where all participants received the same intervention showed a reduction in anxiety.⁷⁰ Details of these results are listed in [table 4](#).

Both multifaceted interventions studies incorporating education and emotional or psychological support showed a reduction in scanxiety.^{64 65}

Of the six studies with relaxation, distraction and/or meditation components, three studies showed a reduction in scanxiety,^{66 70 71} while three studies did not.^{62 63 69}

Interventions with only educational components did not show a reduction in scanxiety.^{62 68}

A reduction in scanxiety severity was also observed when a handheld device was available to communicate with radiology staff. This reduction was observed in the subgroup of participants who had had a previous scan but not in participants having their first scan.⁶⁷

DISCUSSION

This is the first systematic scoping review aimed at quantifying the phenomenon of scanxiety in people having cancer-related scans. Scanxiety is a common and important clinical problem, as supported by the large number of studies identified by our search. There is a wide range of reported scanxiety prevalence (0%–83%), and scanxiety is generally not severe. Severity of scanxiety may be lower after a scan and is higher in people who have a lower education, currently smoke, experience pain during a scan, have higher perceived risk of cancer and who are having diagnostic (rather than screening) scans. Interventions may be more likely to reduce scanxiety if they involve active participation (eg, psychological and emotional support, meditation or a handheld communication device) rather than passive participation (listening to music or education only).

Firm conclusions about prevalence and severity could not be drawn due to considerable methodological heterogeneity of the included studies, especially in relation to scanxiety measurement tools. None were designed and validated for scanxiety, and some tools and their thresholds were not designed and/or validated for anxiety. This review did use purpose-designed definitions of prevalence and severity to allow some comparison between studies; however, the lack of a universal definition or specific measurement tool for scanxiety limits confidence in the interpretation of the results and interstudy comparisons. This highlights the need for a universally accepted measure to quantify scanxiety and evaluate scanxiety interventions in the future. A recent literature review by

**Table 6** Contributing factors to scanxiety

Variable	Comparison	Effect on scanxiety	Studies	N	P value*
Age	Younger versus older	More prevalent	1	398	0.008 ⁴¹
		No difference in prevalence	2	338	NS ^{28 50}
		More severe	5	1883	0.005, ⁴⁵ <0.01, ²⁰ <0.01 (for screening), ⁷⁰ 0.01, ²⁴ NR ⁶³
		No difference in severity	11	6804	NS, ^{22 27 36 37 42 43 49 51 59 62} NS (for surveillance) ⁷⁰
Gender	Men versus women	More prevalent	1	200	<0.001 ³⁹
		Less prevalent	1	298	0.021 ⁴¹
		No difference in prevalence	1	106	NS ²⁸
		More severe	1	232	0.033 (postscan) ⁵⁰
		Less severe	2	1381	0.000, ⁴⁷ <0.05 ⁵⁷
		No difference in severity	5	580	NS ^{37 49 51 59} , NS (prescan) ⁵⁰
Ethnicity	White versus other races	More severe	1	143	NR ⁶³
	Maori and Pacific Islanders versus New Zealand European or Asian	More severe	1	584	<0.001 ²⁷
	Any	No difference in severity	5	1454	NS ^{22 24 37 40 49}
Education	Lower versus higher	More prevalent	1	398	<0.001 ⁴¹
		No difference in prevalence	2	338	NS ^{28 50}
		More severe	8	7400	0.003, ⁶² 0.007, ³⁶ <0.01, ²² ≤0.01, ⁴² 0.012, ²⁴ 0.018, ²⁷ 0.04, ⁴³ <0.05 ²³
		No difference in severity	6	591	NS ^{37 49 51 59 63 69}
Employment	Unemployed versus employed	More prevalent	1	398	0.046 ⁴¹
		More severe	3	5056	0.01, ⁴³ 0.05, ²³ ≤0.05 ⁴²
		No difference in severity	2	654	NS ^{27 37}
Income	Higher versus lower	No difference in severity	3	757	NS ^{27 37 49}
Marital status	Married or de facto versus single	More severe	1	637	≤0.01 (using IES – intrusion subscale) ⁴²
		No difference in severity	5	1790	NS ^{24 36 37 49} , NS (using STAI – state anxiety subscale) ⁴²
Children	Children versus no children	No difference in severity	3	5206	NS ^{24 37 43}
Smoking status	Current versus non-smoking†	More severe	3	4562	<0.001, ^{43 54} 0.031 ⁴⁷
		No difference in severity	2	330	NS ^{40 49}
Reason for scan	Diagnostic versus screening	More severe	3	1104	0.007, ⁴¹ 0.047, ³⁶ NR ⁶²
	Staging or surveillance versus monitoring	More severe	1	200	<0.001 ³⁹
	Lower versus higher referral clarity	More severe	1	169	0.048 ⁵⁴

Continued

Table 6 Continued

Variable	Comparison	Effect on scanxiety	Studies	N	P value*
Type of scan	MRI versus mammogram	More severe	1	49	0.009 ⁴⁸
		Less severe	1	637	NR ⁴²
	CT versus MRI	More severe	1	36	0.007 ⁴⁴
		Less severe	1	115	NR ⁵²
	PET versus CT	More severe	1	82	0.01 ³³
	Nuclear medicine scan versus non-nuclear medicine scan	More severe	1	398	0.004 ⁴¹
	MRI versus PET/CT	No difference in severity	2	142	NS ^{52 53}
	CT versus PET versus chest X-ray	No difference in severity	1	59	NS ³⁴
Bone scan versus PET scan	More severe	1	94	<0.001 (postscan) ⁵⁹	
	No difference in severity	1	94	NS (prescan) ⁵⁹	
Scan-naïve	First versus subsequent scans	More prevalent	1	398	0.001 ⁴¹
		No difference in prevalence	1	200	NS ³⁹
		More severe	5	3796	<0.0005, ³⁸ <0.01, ²⁵ <0.02, ¹⁹ <0.05, ⁶⁷ NR ⁶⁶
		Less severe	1	93	0.038 ³⁶
Pain	Pain versus no pain during scan	More severe	6	4291	NS ^{24 27 50 51 59 62}
		No difference in severity	6	2491	NS ^{24 27 50 51 59 62}
Risk of cancer	Past history versus no history of cancer	More severe	6	4291	<0.0001, ²⁵ <0.001, ²⁷ 0.001, ⁶² <0.01, ^{23 69} <0.05 ²²
		Less severe	2	864	≤0.001, ⁴² <0.05 ⁴⁰
		No difference in severity	1	434	0.013 ⁴⁵
	Family history versus no family history of cancer	More severe	3	1206	NS ^{15 24 58}
		No difference in severity	1	584	0.002 ²⁷
	Mutation carrier versus not a carrier	More severe	3	1255	NS ^{15 24 36}
		No difference	1	88	<0.05 (three comparisons, using IES cancer – Intrusion and Avoidance subscales, and postscan Health Questionnaire) ⁵⁸
Higher, not otherwise specified versus lower	More severe	1	88	NS (five comparisons, using HADS-Anxiety subscale, Cancer Worry Scale – Revised, IES MRI – Intrusion and Avoidance subscales, and prescan Health Questionnaire) ⁵⁸	
	No difference	1	70	<0.05 ³⁷	
Perceived risk of cancer	Higher versus lower	More severe	3	1545	<0.001, ²⁷ ≤0.001 ⁴² <0.01 ³⁰

*The p values listed in this table were reported by individual studies based on their own datasets. This scoping review has not performed additional analysis or attempted quantitative comparisons between studies.

†One study compared current smokers versus former smokers,⁵⁴ and one study compared current and former smokers versus never smokers.⁴⁹ HADS, Hospital Anxiety and Depression Scale; IES, Impact of Event Scale; NR, not reported; NS, not significant; STAI, State Trait Anxiety Inventory.

Al-Dibouni⁷⁵ provided a narrative overview of scanxiety in people having scans for any reason and also recognised the lack of a specific measurement tool for scanxiety and variable scanxiety prevalence among studies.⁷⁵

Given the STAI and Likert scales were the most common tools used, we propose that future studies use the state

anxiety subscale of the STAI, with a range of 20–80 and no specific anxiety threshold⁷² (or variants, such as the STAI-6⁷⁶), and/or the distress thermometer, with a range of 0–10 and a clinically significant threshold of ≥4,⁷⁷ to measure scanxiety. These tools can be combined with other validated anxiety measures, such as the HADS,

to further refine the relationship between tools. Using existing measures rather than developing a scanxiety specific tool allows scanxiety assessment to occur immediately and broadly in clinical research.

Strengths of this scoping review include the rigorous methodology using a published framework,^{12 13} two independent researchers for study selection and data extraction and the implementation of a comprehensive search strategy and broad inclusion criteria to achieve an exhaustive review of the available literature. Limitations include the use of purpose-designed definitions of prevalence and severity and the limited generalisability of the results due to heterogeneity in cancer type, reason for scan, imaging modality and timing of scanxiety measurement between the studies and because the search strategy was restricted to English language databases. Finally, scanxiety in people who were recalled after an abnormal screening result were excluded from this review due to confounding and feasibility. These populations may be at higher risk of scanxiety, and further research may provide further insight about the scanxiety experience in this population.

Additional research implications of our review include the need for research into high-risk populations for scanxiety, including people with advanced cancer. This population was included in only three studies^{49 55 60}; however, people with cancer have higher rates of anxiety compared with the general population.⁷⁸ As they may be more likely to develop scanxiety, experience more severe scanxiety, or have higher postscan scanxiety while waiting for scan results, longitudinal assessment of scanxiety is required. Further research into effective and feasible interventions is also required, though these will face implementation challenges due to variations in health systems and available resources.

CONCLUSIONS

Prevalence and severity of scanxiety varied widely, although heterogeneity in scanxiety measurement interpretation. A uniform approach to evaluating scanxiety will improve understanding of the phenomenon and help guide the development of interventions to high-risk populations.

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REFERENCES

- Feiler B, Scanxiety FB. Scanxiety. fear of a postcancer ritual. *Time* 2011;177:56.
- Brandzel S, Rosenberg DE, Johnson D, *et al*. Women's experiences and preferences regarding breast imaging after completing breast cancer treatment. *Patient Prefer Adherence* 2017;11:199–204.
- Evans R, Taylor S, Janes S, *et al*. Patient experience and perceived acceptability of whole-body magnetic resonance imaging for staging colorectal and lung cancer compared with current staging scans: a qualitative study. *BMJ Open* 2017;7:e016391.
- Mathers SA, McKenzie GA, Robertson EM. A necessary evil: the experiences of men with prostate cancer undergoing imaging procedures. *Radiography* 2011;17:284–91.
- Strand T, Törnqvist E, Rask M, *et al*. The experience of patients with neoplasm metastasis in the spine during a magnetic resonance imaging examination. *J Radiol Nurs* 2014;33:191–8.
- Truesdale-Kennedy M, Taggart L, McIlpatrick S. Breast cancer knowledge among women with intellectual disabilities and their experiences of receiving breast mammography. *J Adv Nurs* 2011;67:1294–304.
- Memorial Sloan Kettering. Coping with “Scanxiety” during and after Cancer Treatment, 2013. Available: <https://www.mskcc.org/blog/coping-scanxiety-during-and-after-treatment/> [Accessed May 2020].
- Dana-Farber Cancer Institute. Scan Anxiety (or ‘Scanxiety’): 5 Approaches to Coping, 2019. Available: <https://blog.dana-farber.org/insight/2019/02/5-tips-for-reducing-scanxiety/> [Accessed May 2020].
- Barter K. Scans + anxiety = Scanxiety, 2019. Available: <https://pinkhope.org.au/scans-anxiety-scanxiety/> [Accessed May 2020].
- brainstrust. Scanxiety. Available: <https://brainstrust.org.uk/brain-tumour-support/quality-of-life/living-well-with-a-brain-tumour/scanxiety/> [Accessed May 2020].
- Fight Colorectal Cancer. Waiting for test results: 5 tips to minimize Scanxiety, 2019. Available: <https://fightcolorectalcaner.org/blog/scanxiety/> [Accessed May 2020].
- Arksey H, O'Malley L. Scoping studies: towards a methodological framework. *Int J Soc Res Methodol* 2005;8:19–32.
- Levac D, Colquhoun H, O'Brien KK. Scoping studies: advancing the methodology. *Implement Sci* 2010;5:69.
- Tricco AC, Lillie E, Zarin W, *et al*. PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation. *Ann Intern Med* 2018;169:467–73.
- Andolf E, Jørgensen C, Uddenberg N, *et al*. Psychological effects of ultrasound screening for ovarian carcinoma. *J Psychosom Obstet Gynaecol* 1990;11:155–62.
- Bull AR, Campbell MJ. Assessment of the psychological impact of a breast screening programme. *Br J Radiol* 1991;64:510–5.
- Peteet JR, Stomper PC, Ross DM, *et al*. Emotional support for patients with cancer who are undergoing CT: semistructured interviews of patients at a cancer Institute. *Radiology* 1992;182:99–102.

- 18 Cockburn J, Staples M, Hurley SF, *et al.* Psychological consequences of screening mammography. *J Med Screen* 1994;1:7–12.
- 19 Ellman R, Thomas BA. Is psychological wellbeing impaired in long-term survivors of breast cancer? *J Med Screen* 1995;2:5–9.
- 20 Sutton S, Saidi G, Bickler G, *et al.* Does routine screening for breast cancer raise anxiety? results from a three wave prospective study in England. *J Epidemiol Community Health* 1995;49:413–8.
- 21 Bakker DA, Lightfoot NE, Steggle S, *et al.* The experience and satisfaction of women attending breast cancer screening. *Oncol Nurs Forum* 1998;25:115–21.
- 22 Gupta R, Nayak MB, Khoursheed M, *et al.* Emotional distress in women presenting for breast imaging. *Ann Saudi Med* 1999;19:511–4.
- 23 Hafslund B. Mammography and the experience of pain and anxiety. *Radiography* 2000;6:269–72.
- 24 Meystre-Agustoni G, Paccacu F, Jeannin A, *et al.* Anxiety in a cohort of Swiss women participating in a mammographic screening programme. *J Med Screen* 2001;8:213–9.
- 25 Drossaert CHC, Boer H, Seydel ER. Monitoring women's experiences during three rounds of breast cancer screening: results from a longitudinal study. *J Med Screen* 2002;9:168–75.
- 26 Sandin B, Chorot P, Valiente RM, *et al.* Adverse psychological effects in women attending a second-stage breast cancer screening. *J Psychosom Res* 2002;52:303–9.
- 27 Brunton M, Jordan C, Campbell I. Anxiety before, during, and after participation in a population-based screening mammography programme in Waikato Province, New Zealand. *N Z Med J* 2005;118:U1299.
- 28 Geurts TW, Ackerstaff AH, Van Zandwijk N, *et al.* The psychological impact of annual chest X-ray follow-up in head and neck cancer. *Acta Otolaryngol* 2006;126:1315–20.
- 29 Tyndel S, Austoker J, Henderson BJ, *et al.* What is the psychological impact of mammographic screening on younger women with a family history of breast cancer? findings from a prospective cohort study by the PIMMS management group. *J Clin Oncol* 2007;25:3823–30.
- 30 Bunge EM, van den Bergh KAM, Essink-Bot M-L, *et al.* High affective risk perception is associated with more lung cancer-specific distress in CT screening for lung cancer. *Lung Cancer* 2008;62:385–90.
- 31 Brown Sofair J, Lehlbach M. The role of anxiety in a mammography screening program. *Psychosomatics* 2008;49:49–55.
- 32 van den Bergh KAM, Essink-Bot M-L, Bunge EM, *et al.* Impact of computed tomography screening for lung cancer on participants in a randomized controlled trial (Nelson trial). *Cancer* 2008;113:396–404.
- 33 Westerterp M, van Westreenen HL, Deutekom M, *et al.* Patients' perception of diagnostic tests in the preoperative assessment of esophageal cancer. *Patient Prefer Adherence* 2008;2:157–62.
- 34 Bastiaannet E, Hoekstra-Webers JE, Francken AB, *et al.* Perception of burden experienced during diagnostic tests by melanoma patients with lymph node metastases. *Melanoma Res* 2009;19:36–41.
- 35 Vierikko T, Kivistö S, Järvenpää R, *et al.* Psychological impact of computed tomography screening for lung cancer and occupational pulmonary disease among asbestos-exposed workers. *Eur J Cancer Prev* 2009;18:203–6.
- 36 Bölükbaş N, Erbil N, Kahraman AN. Determination of the anxiety level of women who present for mammography. *Asian Pac J Cancer Prev* 2010;11:495–8.
- 37 Thompson CA, Charlson ME, Schenkein E, *et al.* Surveillance CT scans are a source of anxiety and fear of recurrence in long-term lymphoma survivors. *Ann Oncol* 2010;21:2262–6.
- 38 Hutton J, Walker LG, Gilbert FJ, *et al.* Psychological impact and acceptability of magnetic resonance imaging and X-ray mammography: the MARIBS study. *Br J Cancer* 2011;104:578–86.
- 39 Pifarré P, Simó M, Gispert JD, *et al.* [Diagnostic imaging studies: do they create anxiety?]. *Rev Esp Med Nucl* 2011;30:346–50.
- 40 Steinemann SK, Chun MBJ, Huynh DH, *et al.* Breast cancer worry among women awaiting mammography: is it unfounded? does prior counseling help? *Hawaii Med J* 2011;70:149–50.
- 41 Yu LS, Chojniak R, Borba MA, *et al.* Prevalence of anxiety in patients awaiting diagnostic procedures in an oncology center in Brazil. *Psychooncology* 2011;20:1242–5.
- 42 Brédart A, Kop J-L, Fall M, *et al.* Anxiety and specific distress in women at intermediate and high risk of breast cancer before and after surveillance by magnetic resonance imaging and mammography versus standard mammography. *Psychooncology* 2012;21:1185–94.
- 43 Hafslund B, Espehaug B, Nortvedt MW. Health-Related quality of life, anxiety and depression related to mammography screening in Norway. *J Clin Nurs* 2012;21:3223–34.
- 44 Adams HJA, Kwee TC, Vermoolen MA, *et al.* Whole-Body MRI vs. CT for staging lymphoma: patient experience. *Eur J Radiol* 2014;83:163–6.
- 45 Baena-Cañada JM, Rosado-Varela P, Expósito-Álvarez I, *et al.* Women's perceptions of breast cancer screening. Spanish screening programme survey. *Breast* 2014;23:883–8.
- 46 Andersson C, Johansson B, Wassberg C, *et al.* Patient experience of an 18F-FDG-PET/CT examination: need for improvements in patient care. *J Radiol Nurs* 2015;34:100–8.
- 47 Elboga U, Elboga G, Can C. Assessment of procedure related anxiety and depression in oncologic patients before F-18 FDG PET-CT imaging. *J Psychiatry* 2015;18.
- 48 Hobbs MM, Taylor DB, Buzynski S, *et al.* Contrast-Enhanced spectral mammography (CESM) and contrast enhanced MRI (CEMRI): patient preferences and tolerance. *J Med Imaging Radiat Oncol* 2015;59:300–5.
- 49 Bauml JM, Troxel A, Epperson CN, *et al.* Scan-associated distress in lung cancer: Quantifying the impact of "scanxiety". *Lung Cancer* 2016;100:110–3.
- 50 Abreu C, Grilo A, Lucena F, *et al.* Oncological patient anxiety in imaging studies: the PET/CT example. *J Cancer Educ* 2017;32:820–6.
- 51 Grilo A, Vieira L, Carolino E, *et al.* Anxiety in Cancer Patients during ¹⁸F-FDG PET/CT Low Dose: A Comparison of Anxiety Levels before and after Imaging Studies. *Nurs Res Pract* 2017;2017:3057495.
- 52 Evans RE, Taylor SA, Beare S, *et al.* Perceived patient burden and acceptability of whole body MRI for staging lung and colorectal cancer; comparison with standard staging investigations. *Br J Radiol* 2018;91:20170731.
- 53 Goense L, Borggreve AS, Heethuis SE, *et al.* Patient perspectives on repeated MRI and PET/CT examinations during neoadjuvant treatment of esophageal cancer. *Br J Radiol* 2018;91:20170710.
- 54 Hall DL, Lennes IT, Carr A, *et al.* Lung cancer screening uncertainty among patients undergoing LDCT. *Am J Health Behav* 2018;42:69–76.
- 55 Derry HM, Maciejewski PK, Epstein AS, *et al.* Associations between anxiety, poor prognosis, and accurate understanding of scan results among advanced cancer patients. *J Palliat Med* 2019;22:961–5.
- 56 Soriano EC, Perndorfer C, Siegel SD, *et al.* Threat sensitivity and fear of cancer recurrence: a daily diary study of reactivity and recovery as patients and spouses face the first mammogram post-diagnosis. *J Psychosoc Oncol* 2019;37:131–44.
- 57 Taghizadeh N, Tremblay A, Cressman S, *et al.* Health-Related quality of life and anxiety in the PAN-CAN lung cancer screening cohort. *BMJ Open* 2019;9:e024719.
- 58 Bancroft EK, Saya S, Brown E, *et al.* Psychosocial effects of whole-body MRI screening in adult high-risk pathogenic TP53 mutation carriers: a case-controlled study (SIGNIFY). *J Med Genet* 2020;57:226–36.
- 59 Grilo AM, Vieira L, Carolino E, *et al.* Cancer Patient Experience in a Nuclear Medicine Department: Comparison Between Bone Scintigraphy and ¹⁸F-FDG PET/CT. *J Nucl Med Technol* 2020;48:254–262.
- 60 Morreale MK, Moore TF, Kim S, *et al.* Preferences for notification of imaging results in patients with metastatic cancer. *Patient Educ Couns* 2020;103:392–7.
- 61 Paiella S, Marinelli V, Secchettin E, *et al.* The emotional impact of surveillance programs for pancreatic cancer on high-risk individuals: a prospective analysis. *Psychooncology* 2020;29:1004–11.
- 62 Mainiero MB, Schepps B, Clements NC, *et al.* Mammography-related anxiety: effect of preprocedural patient education. *Womens Health Issues* 2001;11:110–5.
- 63 Domar AD, Eyvazzadeh A, Allen S, *et al.* Relaxation techniques for reducing pain and anxiety during screening mammography. *AJR Am J Roentgenol* 2005;184:445–7.
- 64 Fernández-Feito A, Lana A, Baldonado-Cernuda R, *et al.* A brief nursing intervention reduces anxiety before breast cancer screening mammography. *Psicothema* 2015;27:128–33.
- 65 Caruso A, Bongiorno L, Vallini L, *et al.* Breast cancer and distress resulting from magnetic resonance imaging (MRI): the impact of a psychological intervention of emotional and informative support. *J Exp Clin Cancer Res* 2006;25:499–505.
- 66 Vogel WV, Valdés Olmos RA, Tijs TJW, *et al.* Intervention to lower anxiety of 18F-FDG PET/CT patients by use of audiovisual imagery during the uptake phase before imaging. *J Nucl Med Technol* 2012;40:92–8.
- 67 Acuff SN, Bradley YC, Barlow P, *et al.* Reduction of patient anxiety in PET/CT imaging by improving communication between patient and technologist. *J Nucl Med Technol* 2014;42:211–7.



- 68 Raz DJ, Nelson RA, Kim JY, *et al.* Pilot study of a video intervention to reduce anxiety and promote preparedness for lung cancer screening. *Cancer Treat Res Commun* 2018;16:1–8.
- 69 Zavotsky KE, Banavage A, James P, *et al.* The effects of music on pain and anxiety during screening mammography. *Clin J Oncol Nurs* 2014;18:E45–9.
- 70 Ashton JC, Bousquet D, Fevrier E, *et al.* Massage therapy in the breast imaging department: repurposing an ancient anxiety reducing method. *Clin Imaging* 2020;67:49–54.
- 71 Lorca AM, Lorca MM, Criado JJ, *et al.* Using mindfulness to reduce anxiety during PET/CT studies. *Mindfulness* 2019;10:1163–8.
- 72 Spielberger CD, Gorsuch RL, Lushene R. *Manual for the State-Trait anxiety inventory*. Palo Alto, CA: Consulting Psychologists Press, 1983.
- 73 Zigmond AS, Snaith RP. The hospital anxiety and depression scale. *Acta Psychiatr Scand* 1983;67:361–70.
- 74 Rush Jr AJ, First MB, Blacker D. *Handbook of psychiatric measures: symptom Checklist-90-Revised (SCL-90-R); brief symptom inventory (BSI)*. 2nd edn. Arlington, VA: American Psychiatric Publishing, Inc, 2008.
- 75 Al-Dibouni Z. Scanxiety. Improving the patient's experience. Part 1. *Imaging & Therapy Practice* 2019;21–5.
- 76 Marteau TM, Bekker H. The development of a six-item short-form of the state scale of the Spielberger State-Trait anxiety inventory (STAI). *Br J Clin Psychol* 1992;31:301–6.
- 77 Ownby KK. Use of the distress thermometer in clinical practice. *J Adv Pract Oncol* 2019;10:175–179.
- 78 Pitman A, Suleman S, Hyde N, *et al.* Depression and anxiety in patients with cancer. *BMJ* 2018;361:k1415.