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Review Article

Palliative Care for Cancer Patients: A Review

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Introduction

There is an ever – growing number of cancer patients in the world today. Of the estimated nine million new cancer cases diagnosed in 1997 worldwide, 52% occurred in developing countries [1]. Cancer rates could increase by 50% to 15 million new cases in the year 2020 [2]. The mortality from cancer too is expected to rise around the globe. About 7 million deaths per year occur in the world due to cancer, of which, approximately 0.8 million occur in India [1]. In India one in 10 deaths is related to cancer and a sizeable section of this huge population die in unrelieved pain and suffering [3]. More than 70% of all cancer patients in India require palliative care for relief of pain, other symptoms and psychosocial distress [1,3]. There is no cure to date for this disease but definitely a lot can be done to make the lives of these people meaningful and productive. With this idea the concept of palliative care was initiated.

What is palliative care?

Palliative care is interdisciplinary care that provides support for the physical, emotional, psychological suffering of patients and their families with any advanced illness, regardless of age, diagnosis or life expectancy [4].

Figure 1: Model of palliative care.
(www. Google. balkan-mco-2011-r-curca-palliative-and-supportive-care-in-lung-cancer-3-728).

Components and principles of palliative care [4]

Key components of palliative care of cancer patients include compassionate communication

- Affirm life and regards dying as a normal process
- Neither hastens nor postpones death.
- Provides relief from pain and other distressing symptoms.
- Aims " To put life intio their days and not just days into their life"- I.e. to improve quality bof life.
- Aims at total care – physical, social, psychological and spiritual
- Is a team approach.
- Is individual specific – depends on assessment of patient and family needs.
- Shifts emphasis from technology to people –"high touch – low tech"
- Is a partnership between the patient and the team.
- Emphasizes an open and sensitive communication.

Figure 2: Components of palliative care.
(www.google.geriatric -population-geriatric-palliative-and-endoflife-care-9-638).

Principles of palliative care [4]

The four cardinal principles are

1) Non – Maleficence (Do no harm)
2) Beneficence (Do good)
3) Patient autonomy (Patient's right to be informed and involved in decision making)
4) Justice (balancing needs of individuals with that of society)

The four cardinal principles need to be applied against a background of

- Respect for life
- Accaptance of the ultimate inevitability of death.
- The potential benefits of treatment as against the potential risks and burdens
- Striving to preserve life but, when the burdens of life-sustaining treatments outweigh the potential benefits, withdrawing or withholding such treatments and providing comfort in dying.
- Individual needs balanced against those of society (manual)

Concept of Home care [2,5]

Caring for a patient with terminal illness at home is the preferred option for most people with a terminal illness

- The benefits of palliative care at home include a sense of normality, choice and comfort; and it is more cost – effective than hospital care.
- The responsibilities of a family caregivers may encompass some or all of the following: Personal care (hygiene, feeding);domestic care (cleaning, meal preparation); auxiliary care(shopping, transportation);social care (informal counselling, emotional support, conversing); nursing care (administering medication, changing catheters);and planning care(establishing and coordinating support for the patient).Good palliative care can be delivered to patients at home by general physicians (supported by specialist palliative care teams) and community nurses.
- Home care involves a considerable commitment on the part of family caregivers;

Need for palliative Care [3]

Patients diagnosed with a disease like cancer require not only physical control of disease and symptoms but also need help incoming to terms with their disease.

- Assistance in planning for life.
- It is necessary to show that you care about the patient as a person and not just concerned about physical symptoms.

Figure 3: Concept of Home care.

Problems contributing to suffering in incurable illness [3]

- Pain
- Nausea/vomiting
- Fungating wounds /disfigurement
- Anorexia
- Breathlessness
- Loss of social needs
- Social isolation
- Dependency
- Change in faith/beliefs
- Personality changes
- Sadness
- Depression
- Denial
- Anger
- Fatique
- Anxiety
- Neglect

Financial difficulties

- Suffering in chronic diseases is more than just simple summation of the individual problems.
- The interaction of each problem with others causes suffering to multipy. Also, suffering caused by the same problem may differ among individuals.

- Therefore such patients require expert trained support that is holistic in scope.
- Patient's families also undergo a great deal of trauma while caring for the patients.Hence, palliative care includes support the patient's families also.

Main symptoms in a terminal cancer patient

In cancer patients, the symptoms may be caused by primary malignancy, as well as by treatment (surgery, radiotherapy as chemotherapy).

1.	General: Pain, cachexia, hiccups, lymhedema etc.
2.	Oral Cavity:Stomatitis /mucositis,dry mouth
3.	GIT:Anorexia,vomiting,dysphagia,peptic ulcers,hematemesis,malaena,intestinal obstruction, ascites,constipation,diarrhoea
4.	Respiratory symptoms :Dyspnoea,cough,hemoptysis,pleural effusion
5.	Hematological :Anemia,leucopenia,thrombocytopenia,neutropenia
6.	CNS:Headache ,papilloedema,altered sensorium,sensory-motor deficit,dilpopia,seizures

Table 1: Main symptoms in a Terminal cancer patient [2,6,7].

Symptoms	Causes	Treatment
General		
Pain	*Directly related to tumor	Non-opioids-NSAIDs, paracetamol in the first step
	*Indirectly	Weak opioids-Codeine, dextrapropoxyphene in the 2nd step
	*Due to therapeutic interventions	Strong opioids-Morphine, methadone, bupranephrine etc. in the 3rd step
Hiccups	Gastric distention, diaphragmatic irritation, phrenic nerve irritation, brain tumor	Antiflatulents Metoclopramide Domperidone Nasogastic intubation
Lymphodema	Surgery/radiotherapy, postoperative Infection, recurrent disease	Cannot be cure Diuretics and steroids Care with moisture
Gastrointestinal symptoms		
Vomiting	Gastrointestinal obstruction ,infiltration of the wall of GI tract, liver metastasis, brain or meningeal metastasis, chemotherapy, electrolyte problems	Antiemetics-Metoclopramide or domperidome Non-drug measure-small frequent feeds H2 receptor blocker
Anorexia	Vomiting, unappetizing food, dysphagia, uremia, radiotherapy, chemotherapy	Installment of palatable and easily digestable food Appetite stimulant Hyperelimentation
Diarrhoea	Laxatives, tube feeding, post gastrectomy dumping syndrome, carcinoid tumor, radiotherapy, chemotherapy	Discontinuation of chemotherapy or suspected medication Oral rehydration Opioids
Constipation	Mass in anorectal region, neurologic and mechanical changes from surgery, decrease oral intake	Movement and ambulation Adequate hydration Use of laxatives

Ascites	Peritoneal metastasis, subphrenic lymphatic obstruction, carcinoma of ovary, pancreas, gall bladder	Chemotherapy Diuretics
Respiratory symptoms		
Dyspnoea	Pleuropericardial effusion, obstuction of main bronchus, radiotherapy	Antibiotics Physiotherapy Bronchodilator Breathing exercise
Cough	Mechanical irritation of tracheobronchial tree, chest infection, pleural infection	Antihistamines Bronchodilators Diuretics Antibiotics
Oral cavity symptoms		
Xerostomia	Anxiety, depression, hypercalemia, invasion of salivary gland by cancer	Meticulous mouth care Chewing gum Flavoured candies Artificial saliva
Oral candidiasis	Dry mouth, corticosteroids and bacterial antibiotics	Antifungal agent like Nystatin Ketoconazole furconazole
Metallic taste	Decreased sensitivity of tastebuds, decreased number of taste buds, toxic dysfunction of taste buds, nutrional deficiencies or poor dental hygiene	Reduce area content of diet. Consumptiom of white meats, diary products,eggs Consumption of more liquid, fresh fruits and vegetables.
Halitosis	Infection, gastric outlet obstruction, smoking or ingestion of substances like garlic, onion, alcohol	Orodental hygiene Adequate fluid intake Treatment of oral candidiasis Uses of mouthwash
Psychiatric symptoms		
	Anxiety, depression guilt and self-blame	Supportive therapy, hyporosis Relaxation therapy Pharmocological drugs Lorazepams, diazepam Antidepressants Evaluation tools to assess Psychological distress.

Table 2: Common symptoms encountered in patients with Head and Neck cancer and suggested treatments [1,8-19].

Role of Radiotherapy in palliative care

Radiotherapy is an indispensable modality in the palliation of cancer. All palliative care programs should be acquainted with its indications (that include pain relief control of hemorrhage, ulceration etc.) and have a close working relationship with a radiation oncology department.

The doses and schedule applies include 500cGy/fraction, 800cGy/fraction, 20Gy in 5 fractions, 30 Gy in 10 fractions and 40 Gy in 20 fractions [2,20].

Medical education in palliative care

Medical education in palliative care is very important. Particular attention should be given towards basic medical education of clinical student and the training of junior doctors, communication skills and bereavement care.

The cost of palliative care and the optimum place to deliver it, the symptoms of advanced care, pain relief and symptom control method and quality in life in end stage cancer patients are some aspects that should be an integral part of clinical residency program [2,21].

Medicolegal aspects

The fear of diversion of certain drugs for non medical uses has led to severe control on its availability. The courts have issued directives to improve the availability of the drugs, yet 97% of Indian patients have very poor access to the drugs.

The government should enforce laws necessitating more hospice and palliative care centers to provide free medical care to terminal cancer patients [2,22].

Conclusion

Palliative care should be provided by a interdisciplinary and dedicated team consisting of doctor, nurse and ancillary staff.

These patients have unique physical symptoms and emotional needs relating to both the disease and its treatments. Including palliative care clinicians on the treating interdisciplinary team is a key element to improve care for patients with head and neck cancers, as well as for their family caregivers.

Ensuring that these patients-and their families-receive comprehensive supportive services can increase that likelihood that patients will be able to complete life-sustaining treatments and thus obtain the best possible outcomes and quality of life In India,the standard of palliative care is still disappointing as far as facilities are concerned Newer centers for palliative care of cancer patient need to be made available and the public should be made aware in this regard as a form of treatment option.

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