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Palliative care among elderly cancer patients: Own experience

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ABSTRACT

Background: Annually, more than 27,000 persons die of cancer in the Czech Republic. It is known that in addition to the demographic aging of the Czech population, the cancer burden is increased.

Aim: These data clearly demonstrate the need for affordable and good follow-up care for patients, especially for older patients and/or patients with no other cancer treatment due to irreversible progression of tumor.

Materials and methods: We are talking about so-called palliative cancer care, which can be provided at different levels. One of the most common forms of palliative cancer care is hospice care.

Results: Our clinic in the years 2008–2010 received a total of 446 patients. 288 of them were women and 158 men. The average age of women was 61 years (age range 20–81 years). The average age of men was 56 years (age range 18–96 years). The performance status was in the fitness category PS-0 (8%), PS-1 (54%), PS-2 (33%) and PS-3 (5%).

Conclusion: Currently the outpatient palliative cancer care are coming more into the forefront. This type of care allows patients to stay as long as possible at home among their close relatives. Prerequisite for a well working outpatient palliative care is cooperation with general practitioners and home health care agencies.

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1. Background

The Czech Republic is ranked among those countries with the highest cancer burden in Europe and worldwide.¹ All

neoplasms, including non-melanoma skin cancer, reached a crude incidence rate of almost 736 cases per 100,000 men and 648 cases per 100,000 women in 2007. The annual mortality rate exceeded 263 deaths per 100,000 population; each year, more than 27,000 persons die of cancer.¹ It is

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known that Czech population is getting older. Consequently, this leads to a steady increase of the overall incidence of malignancies.¹ Cancer has much higher incidence among older people, particularly among those aged over 80, and older persons are also at higher risk for developing multiple chronic, life-threatening diseases (stroke, heart disease, respiratory diseases). This combination gives rise to symptoms and psychosocial needs comparable to those experienced by severely ill cancer patients and their families, even if cancer in older patients is not so extensive. These data clearly demonstrate the need for affordable and good follow-up care for patients, especially for elder patients and/or patients with no other cancer treatment due to irreversible progression of tumor.

2. Aim

This article aims to tell readers the authors' own experience with the provision of palliative cancer care to geriatric oncology patients. We point out not only the positive aspects of this care, but also the pitfalls associated with this type of cancer care.

3. Palliative care among elderly cancer patients: own experience

Palliative cancer care (PCC) among elderly cancer patients is essentially similar to PCC and it has also similar rules. PCC is an active medical and nursing intervention. The main aim of this intervention is to ensure the best possible level of quality of life (QoL) for cancer patients and their family members.^{2–4} In geriatric oncology, further aims are maintaining functional independence and managing multiple chronic illnesses. PCC respects the individuality of the person in accordance with the basic conceptual model of QoL, which consists of four basic dimensions: medical, psychological, spiritual and social.^{5,6}

PCC is provided in two forms: general and specialized. General PCC includes treatment of symptoms associated with cancer progression and previous anticancer therapy. Specialized PCC includes nutritional, psychosocial, psychiatric and analgesic interventions or invasive procedures leading to relief (e.g. puncture of hydrothorax or ascites). General PCC is provided at all levels of a health care system. Important role in providing this type of PCC is played by general practitioners, because they are usually the first point of contact with the medical system for patients. Essential in general PCC is also the role of medical facilities like internal medicine or surgery and primarily aftercare hospitals.^{2,7,8} Specialized PCC is provided by home hospice care or inpatient hospice care, by outpatient palliative clinics established in comprehensive cancer centers or regional cancer centers.^{2,7,8}

One form of specialized PCC is the outpatient palliative cancer care clinic. As part of our Cancer Center, this clinic was established and put into operation in 2008. Our clinic provides general and specialized PCC. It also coordinates PCC and the level of the whole of our teaching hospital, regional hospitals, home and inpatient hospices and general practitioners (see Fig. 1).

Our clinic in the years 2008–2010 received a total of 446 patients. 288 of them were women and 158 men. The average age of women was 61 years (age range 20–81 years). The average age of men was 56 years (age range 18–96 years). The performance status was in the fitness category PS-0 (8%), PS-1 (54%), PS-2 (33%) and PS-3 (5%). The average number of outpatient visits (based on the patient) for which oncologist or radiotherapist examinations were performed (interval of 1 month) was 2.4×. The average number of outpatient consultations and consultative examinations (based on the patient) in our teaching hospital (interval of 1 month) was 23.7×. The average number of consultations requested by the nursing home patient or family (interval of 1 month) was 7.4×. The average number of consultations requested by the general practitioner (in relation to the patient at intervals of 1 month) was 1.2×. The total number of patients who died during the period was 169. 95 of them were women, mean age 69 years (age range 20–81) and 74 men with a mean age of 59 years (age range 18–96 years). The number of patients who died at home was 77 (45.6%), the number of patients who died in the clinics of our teaching hospital and regional hospitals was 51 (30.2%), the number of patients who died in the hospital for the chronically ill was 4 (2.3%) and inpatient hospice 37 (21.9%).

PCC is offered to patients with no active cancer treatment or to patients where no further active cancer treatment is indicated because of advanced age, poor performance status or because of associated severe comorbidities.^{2,7,8} For each patient enrolled in PCC the plan of PCC has to be created.^{2,7–9} The plan of PCC is created in accordance with the following four main principles: 1. respect of wishes of the patient and their family, 2. providing appropriate cooperation among general practitioner, home hospices, health care agencies, hospices and regional hospitals, 3. solution of emergency situations, usually associated with a sudden worsening of patient condition, and 4. providing effective respite care, which involves the provision of short-term, temporary relief to those who are caring for family members who might otherwise require permanent placement in a facility outside home. Respite programs provide planned short-term and time-limited breaks from the often exhausting challenges faced by the family caregiver and other unpaid care givers.^{2,7–9} The plan of PCC consists of five basic investigations^{2,7–9}: 1. Physical survey checks for problems limiting patient in daily activities and their current treatment. Major emphasis is placed on the presence of pain, its etiology, nature, location, intensity, and its current treatment, including the impact on overall patient's quality of life. 2. Basic nutritional screening, including nutritional history (appetite, the possibility of food and fluid intake, swallowing difficulties, weight loss within 3 last months), basic anthropometric measurements (weight, height, body mass index) and the Karnofsky Performance Status. The aim of nutritional screening is to evaluate symptoms of cancer anorexia and cachexia. 3. Psychological or psychiatric evaluation of patient's attitude and understanding of the disease with a life prognosis and focusing on symptoms of anxiety, depression, psychomotor agitation, suicidal thoughts, delirious states, and secondary sleep disorders. 4. Spiritual investigation focused on religious and spiritual

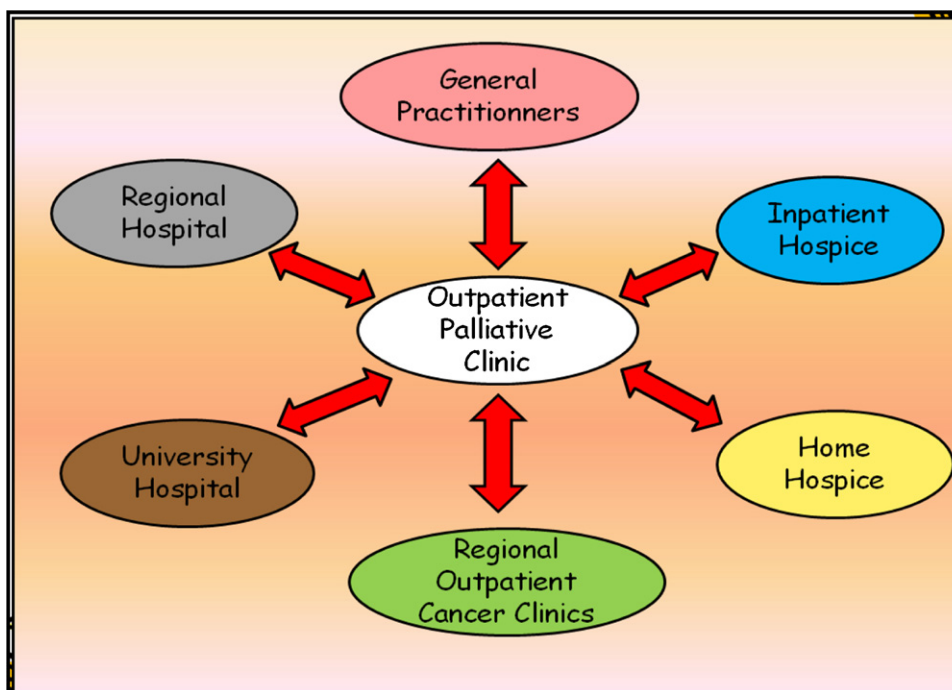


Fig. 1 – Organization of palliative care among elderly cancer patients in the Hradec Králové region.

rituals. 5. Social survey evaluating patient's family relationships, communication between the patient and family members, financial and living conditions of the patient and their family, the availability of domestic facilities for possible nursing care.

Based on the results of all investigations, we categorize the enrolled patient to PCC in to following groups^{2,7-9}: 1. Patients with advanced, but relatively compensated stage of cancer with a survival of 3–6 months. 2. Patients in preterminal stage of cancer with a survival of 1–2 months. 3. Patients with end-stage of cancer with a survival time of up to 3 weeks. Patients in the terminal stage can be further divided into three sub-categories: 1. Patients who are fully conscious with the feeling of hunger and thirst, 2. patients who are fully conscious but without the feeling of hunger and thirst and 3. patients in agony.

In patients with advanced but compensated stage of cancer and in patients in preterminal stage, the main goal is to achieve the best possible PCC and QoL of both the patient and their family. In patients in the terminal stage, the main goal is to help make the person more comfortable as death approaches (pain and breathing control) and to avoid the artificial and undignified prolongation of life. The main concern of PCC in patients in the terminal stage is the control of food and fluid intake with supportive parenteral infusion therapy, if indicated, the control of pain with administration of potent opioid, if needed, and especially the nursing care in cooperation with palliative care services. The goals of nursing care in patients in the terminal stage are: pain and symptom control, prevention of decubitus, basal rehabilitation (positioning, breathing gymnastics), care of excretion, care of invasive exit points (drains catheters, stomas, etc.),^{2,7-9}

4. Pitfalls of palliative care among elderly cancer patients

Providing of palliative care among elderly cancer patients has its pitfalls, which can be summarized into several points^{2,7-13}: 1. lack of interdisciplinary cooperation. It labors under the misapprehension that there is nothing more to offer to the patient without active cancer treatment, regardless of the type and extent of tumor, the age and performance status, 2. lack of education of patients and their family members and medical staff in the issue of coping with situations associated with the dying process, 3. lack of information about home hospice and general hospice care. Hospice care is still seen as a place of hopelessness, social isolation, death and dying, 4. insufficient cooperation with general practitioners in providing of general palliative care (indications and prescription of medicaments),^{7,14} and 5. underestimation of pain monitoring and overall QoL.

5. Conclusion

PCC is an essential part of cancer treatment, which provides continuous care for patients with finished active oncological treatment. Its main objective is to improve the QoL in patient's last period. PCC care can be provided by an outpatient palliative clinic in cooperation with general practitioners, home health care agencies, hospitals and inpatient hospice. This type of care allows patients, despite the overall severity of their condition, to remain at home among their relatives until the last moments.

Conflict of interest

None declared.

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