

REHABILITATION MEDICINE AND PALLIATIVE CARE OF BREAST CANCER PATIENTS

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Summary

Breast cancer is the most common cancer affecting women worldwide. It represents a huge burden not only for individuals but also for their families and their societies. Early diagnosis and multidisciplinary approach to the treatment increases the survival rate. However, treatment can be intensive and may result in comorbid conditions which decrease the quality of life. Rehabilitation medicine and palliative care have a huge role regarding the impact of breast cancer and its' treatment on patient's quality of life. Studies have shown a correlation between the quality of life and survival rates. This results in the necessity to include rehabilitation medicine and palliative care in the complex treatment of breast cancer patients from the beginning of the disease to the end of life.

KEY WORDS: *breast cancer, multidisciplinary approach, quality of life, rehabilitation medicine, palliative care*

REHABILITACIJSKA MEDICINA I PALIJATIVNA SKRB BOLESNIKA S RAKOM DOJKE

Sažetak

Rak dojke je najučestaliji rak u žena diljem svijeta. Predstavlja veliki teret ne samo za bolesnike nego i za njihove obitelji i društvenu zajednicu. Ranim otkrivanjem i multidisciplinarnim pristupom u liječenju povećava se stopa preživljenja. Međutim, liječenje može biti intenzivno s posljedičnim nuspojavama koje smanjuju kvalitetu života. Rehabilitacija i palijativna skrb imaju veliku ulogu glede utjecaja bolesti i liječenja na kvalitetu života bolesnika. Studije upućuju na korelaciju između kvalitete života i stope preživljenja. Sve to rezultira potrebom za uključivanjem rehabilitacije i palijativne skrbi u kompleksno liječenje raka dojke od početka bolesti do kraja života.

KLJUČNE RIJEČI: *rak dojke, multidisciplinarni pristup, kvaliteta života, rehabilitacijska medicina, palijativna skrb*

Breast cancer survivors are often faced with physical, functional, occupational, psychosocial and spiritual impairments that adversely affect their quality of life. Curative care describes the dynamic approach required to treat the patient whose cancer treatment is aiming to kill all cancer cells in order to produce a cure. The potential side effects are severe as healthy cells are also damaged or killed. Potential side effects of breast cancer and/or its treatment may include: pain, shoul-

der dysfunction, lymphoedema, peripheral nerve damage, radiation induced brachial plexopathy, chemotherapy induced peripheral neuropathy, body image problems (scar management, skin changes, weight gain/loss, muscle strength loss, hair loss, nail damage and postural adaptations), osteoporosis, menopausal symptoms, sexuality, generalized weakness, paraneoplastic syndromes, fatigue, nausea, sleep disturbances, anxiety and depression.

Rehabilitation medicine and palliative care have a huge role in reduction of potential side effects and achievement of the best possible quality of life for patients and their families. Procedures of rehabilitation medicine and palliative care are intertwined from the time of diagnosis to the end of life. As the disease progresses the role of rehabilitation reduces and the role of palliative care increases. Rehabilitation medicine and palliative care share many characteristics and goals. Both are multidisciplinary in nature. Many disciplines are included in the palliative care team model: oncology, neurology, psychiatry, anesthesiology, nursing, nutrition, social work, pharmacy, clergy and rehabilitation. The rehabilitation team model is comparable to the palliative care team model. It includes physical medicine, physical therapy, nursing, social work, occupational work, art therapy, psychiatric therapy, psychological therapy and clergy. Both involve the patient and his/her family in care planning. Both strive to maximize the quality of life to the highest extent possible given the nature of the underlying disease process. Both aspire to the early identification of persons at risk for pain and disability to minimize suffering and functional loss (1,2,3,4).

Rehabilitation medicine brings added value to palliative care. It aims to improve quality of survival, so that patients will be as comfortable and productive as possible and can function at a minimum level of dependency regardless of life expectancy. The primary goal of rehabilitation medicine is to return the patient to pre-cancer status, to help individuals achieve the fullest physical, psychological, social, vocational and educational potential, consistent with his or her limitations and goals. In patients with metastatic breast cancer the major goals of rehabilitation are to achieve optimal pain relief and comfort; to enable self care and resumption of mobility as much as possible; to increase endurance and strength; to provide education for patients and their families, to prepare them to continue care at home, to ensure a safe discharge to home and to provide support while being realistically hopeful. Dietz (1980) describes four recognised cancer rehabilitation stages:

1. Preventive: reducing the impact of expected disabilities and assistance in learning to cope with any disabilities.
2. Restorative: returning the patient to pre-illness level without disability.

3. Supportive: in the presence of persistent disease and the continual need for treatment, the goal is to limit functional loss and provide support.
4. Palliative: further loss of function, put in place measures which eliminate or reduce complications and to provide support (symptom management).

Rehabilitation needs must be assessed on a continuing basis and met throughout all stages of care. It is provided by a team of health care professionals from different fields united towards the common goal: physiatrist, physical therapist, occupational therapist, social worker, rehabilitation nurse, psychoterapist, spiritual counselor, art therapist, dietitian, prothetical therapist, vocational rehabilitation specialist and Reach for Recovery volunteer (woman who has undergone breast cancer treatment). The physiatrist (physician specializing in physical and rehabilitation medicine) is a head of the team, evaluates the patient (concentrates on the neuromusculoskeletal system and the impact that it has on function) and determines an appropriate setting for rehabilitation (acute hospital, subacute hospital, home care and ambulatory care) and an individualized therapeutic programme. The planned rehabilitation programme must be adequately presented to the patient to ensure the best possible cooperation during the treatment (1, 2, 3,5,6).

Palliative care, as defined by the World Health Organization, is the active and total care of patients whose disease is not responsive to curative treatment. Patients with advanced progressive cancer are classified as palliative patients. The goal of palliative care is to prevent and relieve suffering, to improve the quality of life of patients and their families with life-threatening or serious debilitating disease. The treatment of patients with advanced breast cancer may still include oncology cancer treatment to maintain and prolong life. A recent focus in the field of palliative care has highlighted the contribution of rehabilitation medicine to the care of a dying patient. Palliative care is provided by two distinct groups of health and social care professionals:

1. Non-specialist palliative care services. These are delivered by the professionals providing the day to day care for cancer patients either in the community or in hospital, to share information and help.

2. Specialist palliative care services. These are provided by multiprofessional care teams who should be able to provide: a) assessment, advice and care for patients and families in all care settings, including home, hospital and care home; b) specialist inpatient care (hospital or hospice); c) intensive coordinated home care for patients with complex needs who wish to remain in their own home; d) day care facilities; e) advice and support to all people involved in a patient's care; f) bereavement support; g) education, training and research.

The specialist palliative care team includes palliative medicine consultant and nurse specialist, together with physical therapist, occupational therapist, social worker, pharmacist, dietitian and others able to provide physical, spiritual and psychosocial support. The palliative medicine consultant is a head of the team. The therapeutic relationship which palliative team has with their patients is very important. Their input can facilitate patients to live in their own home, maintain their independence for as long as possible and maximize quality of life before death (1,7–13).

Palliative care includes supportive care and end-of-life care.

1. Supportive care helps the patient to maximize the benefits of therapy and to live as well as possible with the effects of the disease and its' treatment. Medical oncologists and midlevel providers significantly prefer the name supportive care. It is more likely they will refer patients on active primary and advanced cancer treatments to a service named supportive care. The name palliative care was perceived by medical oncologists and midlevel providers as more distressing and reducing hope to patients and families. All too often palliative care is thought to be synonymous with hospice or end-of-life care. This perception can be a barrier to patient's access to palliative care. Supportive care is a term that facilitates integration between oncology and palliative care. Patients who were first seen as outpatients by the palliative care team were referred earlier after the name changed to supportive care. Supportive care is not a distinct specialty and

may be delivered in part by the patient's family and other carers rather than by professionals. It includes self help and support, information, education, psychological support, social support, spiritual support, rehabilitation, symptom control, terminal care, bereavement support and care. The background of physicians and nurses running a clinical supportive care program is similar to that of the palliative care program (1,14–21).

2. End-of-Life Care (EOLC) requires an active compassionate approach that treats comforts and supports individuals who are living with or dying from a progressive or chronic life threatening conditions. Such care is sensitive to personal, cultural and spiritual values, beliefs and practices and encompasses support for families and friends up to and including the period of bereavement. End-of-life care raises issues regarding resuscitation, advance directives, decision-making capacity, resource allocation and medical futility (1,22).

Dr. Balfour Mount, a Canadian oncologist, introduced the term "palliative care" in 1973. The name has its origin in the Latin word "pallium" the outer cover for people or objects. At first the name is expanded in the USA and Canada, and later in Europe, primarily as a replacement for the ambiguous word hospice which regularly includes the concept of imminent death (23).

Palliative medicine is defined as the study of progressive active diseases with emphasis on the end of life quality for both the patients and their families. In 1987 in England the first specialization and later the first chair and professorship in palliative medicine were acknowledged. England has passed the law that every oncology department acknowledged as such should have a palliative care unit. In 1967 the first modern hospice was established in London by Cicely Saunders. St. Christopher's Hospice remains the leading teaching and research centre in the world. Hospice care is a specific type of palliative care for patients at the end of their life, usually meaning a life expectancy of six months or less. At the same time hospice is a philosophy of care for the dying and a modern medical institution with a range of programs to assist people at the end of life and their carers/families, and bereavement support and care. Hos-

pice and palliative medicine have an important task in dealing with ethical issues related to the end of life (23,24).

CONCLUSION

Breast cancer and its increasingly intensive treatment have a major impact on patients, families and carers. Cancer rehabilitation is defined as an attempt to maximize patients' ability to function, to promote their independence and to help them adapt to their condition. Palliative care is defined as the active holistic care of patients with advanced progressive disease. Management of pain and other symptoms and provision of psychological, social and spiritual support is of outmost importance. The goal of rehabilitation medicine and palliative care is achievement of the best possible quality of life for patients and their families. Procedures of rehabilitation medicine and palliative care are intertwined from the time of diagnosis to the end of life. Continuing educational activities need to be developed for oncologists, primary care physicians and others taking care of patients with breast cancer to make them more aware of benefits that rehabilitation medicine and palliative care can provide.

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