

ADVANCES IN ONCOLOGY

Current Developments in the Management of Solid Tumor Malignancies

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Managing Cancer-related Symptoms: Advances in Supportive Oncology

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H&O What has been the most important recent development in supportive oncology?

EB In the last decade, we have made great progress in our understanding of the main challenges facing our patients—and their families—as they receive active cancer care. The focus of our attention now is on appropriately assessing patients at the point of service for the multiple physical and psychosocial symptoms they experience and integrating symptom control and palliative care into the early stages of cancer care. It is highly important that we conduct assessment and management of symptoms as early as possible in the disease course, rather than later in the illness.

H&O What are some of the methods of assessment?

EB There are simple patient-completed assessments, like the Edmonton Symptom Assessment Scale (ESAS), which we use at the University of Texas M. D. Anderson Cancer Center, that the patient can complete in the waiting room or the inpatient area on a daily basis. In just a few minutes, the patient can describe nine or ten symptoms in a very reliable way. This information can then be represented in a graphic display in the patient's chart as a guide for physicians, nurses, and other healthcare professionals. With this information, it is possible to determine whether, in addition to needing a modification in medication pre-

scribed, the patient requires the attention of a symptom control and palliative care team for the management of pain, fatigue, depression, or any other issues that may be appearing. We know that when we use these assessment tools, we find many more problems than when we use simple 0–10 pain assessment scales or wait for patients to express symptom-related distress.

H&O Is the patient's family included in the assessment?

EB In most of the settings where cancer care is delivered, the emphasis is on patient-based description of the main symptoms and problems. However, there is no doubt that particularly as the patient's disease progresses, the burden on the family increases dramatically; therefore, assessment of the characteristics of the family, the presence of the family, and how the family is coping with the patient's illness is of great importance. This assessment is done on a regular basis by symptom control and palliative care teams as part of their routine care. When the treating oncologist detects distress in the patient and refers the patient to a symptom control and palliative care team, nearly 100% of the time, an assessment of the family occurs. Regular bedside assessment of the family in outpatient and inpatient settings by oncology teams has not yet begun, but it would be very useful for those assessments to occur in the future.

H&O Can you describe in more detail who comprises the symptom control and palliative care team and what the role of these individuals is?

EB The role of the symptom control and palliative care team is to take care of a patient, in an integrated fashion with the primary oncology team, when a patient presents to the outpatient or inpatient area with symptoms such as pain, vomiting, fatigue, depression, and anxiety that the primary oncology team is not able to control well. The team includes a specially trained, board-certified palliative care consultant, the oncology nurse, and other interdisciplinary team members including a social worker, counselor, dietician, and physical therapist. Also, pastoral

care is available if required. Working in concert, the team is often able to quite rapidly decrease the level of distress in the patient and his or her family, allowing the patient to adhere much better to the cancer treatment. The work of the team is much easier if it is consulted early in the trajectory of illness and is able to work jointly with the primary oncologist in the follow-up of patients. When the disease progresses and cancer care is no longer appropriate or necessary, the transition to hospice or community care is simplified enormously by having a symptom control and palliative care team that is as familiar with the patient and the family as possible.

H&O How does the care itself vary between different hematologic or solid-tumor malignancies or by the age of the patient?

EB Different types of cancer present with different sentinel problems. For example, many of the solid tumors are associated with symptoms such as pain earlier than some of the hematologic malignancies. Because symptoms such as pain and dyspnea occur earlier in some of these cancers, an earlier referral to a symptom control and palliative care team also occurs. Furthermore, the age of the patient varies according to different cancers. Some lymphoma patients and testicular cancer patients are young, which has major implications in the planning of the care, particularly end-of-life care. Some of the associated problems with certain cancers have an impact on how we approach the counseling and overall planning of care as patients become more ill. For example, lung cancer patients frequently develop shortness of breath and that becomes a major issue for them. Also, alcoholism may have an impact on the way patients use opioid analgesics when they develop pain. Alcoholism is a major component in some cancers, such as head-and-neck cancer, whereas it is a minor component in others, such as breast cancer. We do know that depending on their type of cancer, patients will have slightly different symptom burdens, demographics, and social characteristics. It is useful for the symptom control and palliative care team to take those characteristics into consideration in order to plan the care better.

H&O Can you discuss some of the nonpain symptoms that warrant the attention of the symptom control and palliative care team?

EB From the point of view of symptom distress, the most common symptom in our patients is fatigue. The way we understand fatigue is the same as the way we understand pain, nausea, and most of the symptoms in our patients: these symptoms are always a multidimensional construct. Symptoms are almost never due to a single cause in cancer patients. In the case of fatigue, there are always a number

of contributors, which may vary from patient to patient. For example, two patients may both rate their fatigue as 8 on a scale of 1–10. In one patient, the reason for fatigue may be predominantly depression, whereas in the other patient, the reason may be profound weight loss and an opioid taken for pain. The management of fatigue will thus be quite different in the first as compared to the second patient, even though they are both complaining of the same symptom at the same intensity. As far as treatment, different methods can be effective at different stages of the illness. A number of drugs, including corticosteroids, psychostimulants, and some antidepressants (in the case of depression) can be very effective at controlling fatigue. Additionally, we do know that increased physical activity is helpful. In the past, it was consistently recommended that patients conserve energy, but we have now learned that doing so actually leads to deconditioning. Encouraging increased physical activity is a useful way to prevent patients from becoming further deconditioned and therefore more fatigued. Finally, expressive supportive therapy and counseling are useful for helping patients adapt to the progressive loss of energy and tiredness that accompanies cancer. Counseling helps patients accept measures that will help them increase their autonomy, such as wheelchairs, walkers, hospital beds, and improved safety in their bathrooms to prevent falls. All these measures, if framed in the wrong way, may be perceived by the patient as a marker of illness rather than as a way to enhance autonomy. Proper communication and counseling about these changes in the patients' lives is extremely important.

With regard to delirium, we do know that the vast majority of cancer patients will die in delirium, which is the most common neuropsychiatric problem associated with cancer, occurring in more than 85% of patients. The reasons for delirium are also multiple, but underlying these are the metabolic changes brought by cancer. A number of episodes of delirium are likely to happen before the terminal episode. Approximately half the episodes are completely reversible. Useful ways to find and treat reversible causes of delirium include identifying drugs like opioids and other analgesics that might cause the patient to become confused or delirious, decreasing antidepressants, decreasing sleeping pills, identifying metabolic abnormalities (eg, high calcium, low sodium, renal failure), and identifying and treating dehydration and infection. At a certain point, one of the episodes will become progressively irreversible, and therefore part of our preparation is to educate families about the fact that delirium is generally the normal way in which people die of cancer. Fortunately, we do have good pharmacologic interventions to prevent agitated delirium, so that most patients fall into a little confusion, hypoactivity, and sleep. If hyperactivity takes place, neuroleptics are frequently effective in decreasing agitation.

H&O Is pain conceptualized in a multidimensional way, similar to the nonpain symptoms you discussed?

EB Yes. The assessment of pain is similar to that of fatigue, in that it is a multidimensional construct. Though for the doctor and nurse, pain is the somatosensory impact of spinothalamic afferent stimulation, for patients, pain comprises the ache in their back, but also the losses they are experiencing in function, concern about the future, their depression, and so on. The term pain encompasses all those losses, not only for patients, but culturally, for our novelists or poets, as well as for laypeople. Thus it is important that we interpret the patient's complaint of pain not simply as afferent somatosensory impact but as a holistic concern. Many of the components of that complaint cannot be fixed with a nerve blocker or a higher dose of a painkiller, rather they require an interdisciplinary care plan. When pain responds to normal doses of regular opioids and management with laxatives and antiemetics, we have no reason to be concerned, and it is managed until the patient's end of life. When pain does not appear to respond or when the dose of painkiller is escalating, that is when consulting a symptom control and palliative care team is particularly important. The team might be able to identify factors that are contributing to the pain expression that integrated, holistic management, rather than analgesic management, can address.

Though fatigue is more common than pain and delirium is more common at the end of life, pain continues to be the most distressing symptom for cancer patients and their families. This concern may be attributable to their perception of what happened to a friend or relative who was diagnosed with cancer, who suffered through severe pain. Part of our task is to recognize pain and manage it early and appropriately. In an overwhelming majority of patients, pain can be controlled simply with opioid medications and occasionally some other drugs, but when this is not the case, it is very important to take advantage of the symptom control and palliative care team.

H&O Where do you see research in supportive care headed in the future?

EB We have made great progress in the management of the iatrogenic complications of our therapies, including spectacular improvement in chemotherapy-induced vomiting during the last 20 years and very significant improvement in the pain associated with procedures, such as surgical pain. We are now making progress in mucositis, which is a very serious symptom. We have been able to make this progress because we have a very clean inception cohort, meaning that patients present relatively

symptom-free. Thus, we are able to see if a specific intervention results in the development of a symptom that was not previously present. The main challenge in supportive care, however, is brought to us by patients with chronic, progressive illness, because with these patients, the inception is not clean and it is more difficult to discern whether the symptom is resulting from the intervention. We have much better understanding than we did before about the reasons why patients experience pain, fatigue, anorexia, depression, and confusion concomitantly. We know that some of these symptoms share common mechanisms, such as tumor-byproduct and host-related cytokines. Our research challenge is to cut the link between those mediators and the brain's perception of the symptoms. Twenty years ago, we assumed that pain was a natural complication of cancer, because we assumed that the only way to rid a patient of pain was to decrease the tumor burden. We have learned since then that it is quite possible to achieve reasonable pain control—and it's something we must achieve—even in those cases where reducing the tumor burden is not possible. In the next 5 or 10 years, I hope we will develop the same attitude toward fatigue, cachexia, and confusion, meaning that we will not accept them as a natural outcome of progressive cancer. Rather, once we understand the mechanisms behind these symptoms, it might be possible to reduce or delay their presence even though patients' cancer is progressing.

Finally, I would like to reiterate that there has been a misunderstanding of supportive care, wherein it has been equated with end-of-life or hospice care only. As a result, many cancer specialists believe that it is appropriate to speak to a symptom control and palliative care team only at a late stage of the illness. On the contrary, the team can be more helpful when clinicians take advantage of it early in the disease. Not only can the team make the lives of the patient and family easier, the team's care also benefits the primary oncologist, who is able to focus on the cancer care with the team's assistance. It would be best for everyone if the symptom control and palliative care team were present throughout the whole trajectory of the illness.

Suggested Readings

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