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## SPECIAL ARTICLE

# Approach to the terminal stage cancer patients

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**ABSTRACT**

Sickness and death are the two unavoidable conditions for physicians to face, especially in the patients with terminal stage cancer. Approaching to dying patients may be troublesome to some physicians. Holistic approach is the hallmark, which should describe both physical and psychological aspects. Psychological approach begins when telling the diagnosis to the patients. Psychological support to the patients and their families is necessary. Physical aspect focuses on palliative care and symptoms control, especially pain management. In dying patients, physicians should provide the patients to die with dignity and peaceful. Terminal care needs to be provided under the supervision of an interdisciplinary team.

**Key word:** terminal stage cancer

Despite the advances in understanding and treatment of cancer, about one half of the patients diagnosed die of their disease.[1] Since some physicians have a feeling of omnipotence, death represents a failure with which they are unable to cope. Especially physicians who elect to specialize in obstetrics and gynecology may have relatively more problem.[2] Because a psychological profile included a strong sense of achievement in bringing life into the world,[3] sickness and dying patients have always been unavoidable to the physicians. The role of the physicians and health care team are to give the best palliative care. This being said, there are no circumstances that justify a physician's declaring to a patient or her family that "there is nothing more that can be done".[4]

This article is purposed to review about the holistic approach for the terminal stage cancer patients. That includes the psychological aspects, the physical aspects and about the dying patients.

## Psychological aspects

How to break bad news? The interview in which bad news is discussed have two components.[5]

- A divulging information : by which the physician informs the patients.
- A therapeutic dialogue: by listening and responding to the patient's reactions to the information.

Generally the six basic steps of the protocol can be used to break the bad news.

Step one - Getting started, whenever start an interview about bad news, always getting the physical context right. If possible, take the patient and/or

relative to separate room or, at least , as privacy as we can. Starting the interview by beginning with a suitable question because (1) it gives the patient the idea that you are interested in her condition; (2) it demonstrates that the conversation is going to be two-way;(3) it gets the patient talking; and (4) it allows you to assess something of the patient's current medical symptoms.

Step two - Finding out how much the patient knows. As the patient replies, listen to the response in detail. The reply will give important information on three major aspects. (1) about how much the patient understands the medical situation. (2) The style of patient's statements may reflect the patient's emotional state , educational level , and abilities in articulation. (3) The emotional content of the patient's statements by verbal and nonverbal sources.

Step three - Finding out how much the patient wants to know. Asking the patients what they want, allows them to exercise their preferences; the majority will wish for full disclosure.

Step four - Sharing the information ( aligning and educating ). When the physicians have already heard how much the patient knows about the situation. It is essential to use this as the starting point for information-giving, this process has been called "aligning". Later the physician brings the patient understands of the medical situation closer to the fact, this called "education".

Step five - Responding to the patient's feelings. Since the success or failure of the interview ultimately depends on how the patient reacts and how the physician responds to the feelings. So this step, we have to identify and acknowledge the patient's reaction.

Step six - Planning and follow through by (1) organizing and planning and (2) making a contract and follow through.

Reactions to impending death.[6] The following five stages proposed by Kubler - Ross are widely encountered .

Stage one - shock and denial. The patients may appear dazed at first and then may refuse to believe the diagnosis or denial that anything is wrong. Some patients never pass beyond this stage and may go from doctor to doctor until they find one who supports their position.

Stage two - anger. The anger may be displaced onto the hospital staff members. An empathic, nondefensive response can help defuse the patient's anger and can help the patient refocus on the deep feelings that underlie the anger.

Stage three - bargaining. In return for a cure, they will fulfill one or many promises, such as giving to charity. The treatment of such patients involves making it clear that they will be taken care of to the best of the doctor's abilities, regardless of any action or behavior on the patients' part.

Stage four - depression. Normal sadness does not require biological intervention. However, major depressive disorder and active suicidal idea should not be accepted as normal reaction.

Stage five - acceptance. The patients resolve their feelings about the inevitability of death and are able to talk about death.

In a prevalence study of psychiatric illness among cancer patients, Derogatis et al[7] estimated that approximately 50% of cancer patients would justify a psychiatric diagnosis and of those, 85% had symptoms of depression and / or anxiety. Most diagnoses (68%) were classified as an adjustment disorder.

In a similar investigation, Minagava et al[8] studied prospectively in psychiatric morbidity in terminal ill cancer patients. This study showed that more than half of the patients(53.7%) met the criteria for a DSM-III-R ; delirium was the most common type of psychiatric disturbance (28%). It's important to establish treatment modalities that promote the psychiatric well-being of patients with terminal illness.

Hietanen P.[9] reported that 60 (4.3%) of 1397 consecutive suicides were cancer patients, 25 of whom were in remission, 18 in the terminal phase. The factors connected with and motives for suicide were different in these two groups, with the remission patients having more histories of personal and family mental disorders. The health care system needs to pay greater heed to the psychological needs of cancer

patients. Effective symptom control of the terminal patients is very important.

## Physical aspect

The transition between a curative and palliative approach to the care of a cancer patient may be filled with uncertainly for patients, their families and health care professionals.[10] In long term, about 75% of all cancer patients will need palliative care.[11] The boundaries between the phrases of care are blurred. There is a guideline to judge for the beginning of terminal care that called "terminal illness syndrome"[12]

- Causal illness with a progressive evolution.
- Survival defined in days to weeks.
- Karnofsky score less than 40%, which means the patient disable, requires special care and assist.
- Single or multiple organ failure.
- Fail conventional or proven treatment.
- Absence of any potential proven or experimental therapy.
- Irreversible progressive complication.

The World Health Organization offers a definition of palliative care[13]: Palliative care is the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems are paramount. The goal of palliative care is achievement of the best possible quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness, in conjunction with anticancer treatment. Palliative care:

- Affirms life and regards dying as a normal process;
- Neither hastens nor postpones death;
- Provides relief from pain and other distressing symptoms;
- Integrates the psychological and spiritual as pects of patient care;
- Offers a supporting system to help patients live as active as possible until death
- Offers a supporting system to help the family during the patient's illness and in their own bereavement.

Planning of terminal care would be greatly facilitated if there were reasonable means of assessing how long the patient with end-stage cancer will survive. Reuben DB.et al[14] reported that the performance status was the most important clinical factor in estimating survival time, but five other symptoms had independent predictive value as well (shortness of breath, problems eating or anorexia, trouble swallowing, dry mouth, and weight loss). In prospective, multicentric study was performed by Maltoni M.[15] revealed that clinical prediction of survival, anorexia, dyspnea, palliative steroidal treatment, Karnofsky performance status, and hospitalization were independent predictors of survival. These may be useful factors in the therapeutic, assistance decision-making process and may eliminate overtreatment and undertreatment.

## Pain management

The following simple scheme may provide some guidelines in the face of the complexity of recent research and practice. Pain management may be considered as having four steps.[4]

Step one - Reduce the noxious stimulus at the periphery. This demands an adequate understanding of the mechanisms of the pain stimulus in the individual patient. Peripherally acting drugs such as *acetaminophen* and *NSAIDS* are widely used. The safe administration of nonopioid analgesics requires familiarity with their potential adverse effects.[16] Some time pain from muscle spasm requires muscle relaxants such as diazepam, as well as gentle massage.

Step two - Raise the pain threshold. The threshold for pain may well be raised by comfort, care, concern, diversion, and various forms of relaxation, and lowered by depression, anxiety, loneliness, and isolation.

Step three - The careful and precise use of opioid drugs. It is now widely recognized that opioids should be given regularly, at precisely determined doses and at fixed interval in accordance with the half-life of the

drug concerned. Opioid therapy should be administered to all patients with moderate to severe pain, regardless of the pathophysiological mechanism underlying the pain.[17-20] Morphine sulphate is usually preferred because it has a short half-life, is easy to titrate in its immediate release form, and is also available as a controlled-release preparation that allows an 8-12 hour dosing interval.

The use of meperidine is generally not recommended.[21-23] Meperidine is demethylated to normeperidine, an active metabolite that is twice as potent as convulsant and the half-life is longer than meperidine 4-5 times. Accumulation may cause central nervous system toxicity characterized by subtle adverse mood effects, tremulousness, multifocal myoclonus and, occasional, seizures.[24-26]

Opioids should be administered by the least invasive and most convenient route. In routine practice, the oral route is usually the most appropiate, starting dose of 5-10 mg. Regular doses are given every 4 hours together with the provision of one or two "break-through" doses equal to the standard dose. If oral or subcutaneous morphine is efficacious but the side effects are troublesome, the epidural route is occasionally advantageous.

Step four - Recognize neuropathic pain and treat correctly. Adjuvant analgesics, such as tricyclic antidepressants, anticonvulsants, or corticosteroids, can be used for this purpose.

Patients who are unable to achieve a satisfactory balance between analgesia and side effects from systemic analgesic therapies may be candidates for the use of invasive analgesic techniques.[27] The use of neurodestructive procedures should be based on a careful evaluation. The use of sedation therapy to manage refractory pain that fails to benefit from optimal therapy has recently received increasing attention.[28,29] The "principle of double effect", which distinguishes between relieve from suffering and the potential for accelerating death should be considered in the ethical basis.

Gastrointestinal symptoms[31,32]

- Anorexia is a common and significant symptom with serious nutritional consequences. The best initial approach includes careful preparation of small meals, elimination of constipation, emotional support, and direct nutritional supplements.

- Nausea and vomiting are common in advanced gynecologic cancer.[31,32] Once the likely mechanism has been determined by means of careful history, clinical examination, and investigations if indicated, the appropriate antinauseant can be prescribed. Three problematic causes of persistent nausea are constipation, overfeeding, and bowel obstruction. Not all nausea should be treated with antiemetics. Drug-induced nausea should be treated by withdrawing the offending drug when possible. Nausea from severe pain or anxiety will be alleviated when those symptoms are treated. Several agents are useful in symptomatic relieve. Chlorpromazine and methotrimeprazine are not the most potent agents but can very useful when patients suffer from nausea with multiple causes. Dexamethasone, which acts by an unknown mechanism, is also useful in suppressing nausea.[4]

- Constipation[32] Most cancer patients taking opioids will require a strong stimulant laxative like senna or bisacodyl. If this is not effective, an osmotic agent like sorbitol or lactulose should be added. Rectal suppositories, enemas, and disimpactions are occasionally necessary for severe cases.

- Overfeeding. Forced feeding, parenteral feeding, and tube feeding, however, can be very dangerous and should be avoided. Instead, small tolerable feeding, watch for complication, and consider an appetite stimulant lie megestrol or dexamethasone.[32] Total parenteral nutrition appears to be of little benefit in most cancer populations, especially in terminal stage.[33]

- Intestinal obstruction, surgical intervention is often not feasible in the advanced cancer patients. Supportive treatment is necessary. Hyoscine hydrobromide may serve multiple purposes in patients with bowel obstruction. Many reports have confirmed the efficacy of pharmacologic management in malignant bowel obstruction. Some not encouraged

intravenous fluid or a nasogastric or gastrostomy tube.[32]

- Ascites, recurrent paracentesis has a limited but definite place, while shunting procedures have severe limitation. Diuretics, especially spironolactone, 50-150 mg per day, may prove helpful initially.[4]

## Respiratory symptoms.

Dyspnea is common, when dyspnea is due to diffused lung involvement, the careful use of morphine, with or without a small dose of corticosteroids, may improve the situation dramatically. Opiods should be prescribed on a regular schedule, just as for pain. Usually codeine 30 mg orally or morphine 15 mg should be used. Morphine appears to improve dyspnea at suitable doses that do not compromise respiratory function. Benzodiazepines can be very useful when severe anxiety complicates dyspnea.[32] If medical management of dyspnea is optimal, oxygen is rarely necessary or truly advantageous.[34]

Other symptoms[4,30]

Leg swelling due to venous or lymphatic obstruction can be distressing and may respond either to small doses of diuretics or to careful massage toward the trunk. Compression bandages should not be applied to grossly edematous legs, as venous circulation may be further compromised.

## Hospice

The more modern definition of hospice as an interdisciplinary concept for providing comprehensive care to terminally ill patients.[30,35] The four levels of care defined by the Medicare Hospice Benefit are routine home care, continuous home care, inpatient respite care, and general inpatient care. Routine home care is the basic care provided by the hospice in the patient's home. Continuous home care may indicate during a period of crisis in the home. Inpatient respite care applies when a patient utilizes a hospice inpatient bed and does not meet a requirements for general inpatient care. General inpatient care is an integral component of a comprehensive hospice program.

Controversies in hospice management[35]

*Chemotherapy*

- Treatment should palliate patient symptoms
- Treatment should not significant alter the prognosis.
- Benefits of treatment should overweigh toxicity.
- Toxicity can be managed in a hospice environment.
- Chemotherapy today is generally incompatible with use in a hospice.

*Radiation*

- Palliate bone pain and other specific symptoms
- Use high-fraction, short-course therapy.

*Nutrition at the end of life*

- TPN is not indicated.
- Enteral nutrition ( NG or gastrostomy ) is not indicated except for gastrointestinal obstruction.

*Hydration at the end of life*

- Lethargy, drowsiness, and fatigue may be beneficial.
- Hydration may lead to increase fluid retention.
- Routine parenteral hydration should be avoided near the end of life.

## The dying patient

Once it is clear that the patient is dying, the goal is dignity and peace, best served by precise control of major symptoms. For many patients, family members are the main source of emotional support and are far more available and knowledgeable about the patient more than the doctor on the case.[6]

Brown D. et al[36] assess the gynecologic cancer patient's end-of-life preferences. A majority preferred to receive care at home. About 90% of these cancer patients could envision their conditions deteriorating to the point that they would not want ventilator support. Few of patients rejected artificial nutrition, surgery, and antibiotics. Mann WJ et al[37] found that 78% of gynecologic cancer patients died in the hospital. One possibility reason is that home care may be inadequate in meeting the needs of the terminal ill women. But in one of the prospective study,[38] 58% of patients wished

to die at home and only 20% in the hospital. Due to Catalan-Fernadez JG et al,[39] 46% of the cancer patients died at home. The family and social factors had the greatest influence in determining the place of death. And the relatives of those who died at home were significantly less distressed.

Euthanasia or mercy killing - there is an ongoing debate about the legalization and ethical of euthanasia.[40-42] The attitudes and beliefs of the general public and physicians appear to differ.[43] A slight majority of members of the public and terminally ill patients (50%-60%) agreed with the legalization of euthanasia and assisted suicide, while most physicians (60%-80%) opposed it.

## Conclusion

The major task of physicians caring for terminal stage cancer patients is to provide comfort, both physical and psychological. The patient must be helped to cope with all of the stresses she encounters. She must be comforted that she will not suffer pain or other major symptoms. She should be encouraged in every effort she exerts to combat her cancer. In the dying process, she should die peacefully without any despair. Interdisciplinary approach and family support are the hallmarks of caring these patients. In brief, to approach of terminal cancer patients, the team have to use both their "Head" and their "Heart" to take care of the patients and their family.

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