

REVIEW ARTICLE

CANCER TREATMENT - OBJECTIVES AND QUALITY OF LIFE ISSUES

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The first aim of cancer treatment is to achieve a cure, and when cure is not possible, a good palliation (life prolongation and relief of sufferings) is warranted. This article highlights the aim of cancer treatment and also attempts to assess the issues of quality of life experienced as a result of the disease and its treatment. Palliative therapy should be less intensive than radical treatment and should cause less morbidity than disease itself. It must be effective, completed in a short time and should be tolerable. It is also essential for a physician to give a clear explanation of illness to the patient and realistic advice regarding the likely outcome of therapy and the long and short term morbidities which may occur. The patient may opt for a palliative treatment with a reduced chance of cure but a better quality of life than accepting a radical treatment with a potentially higher degree of morbidity. Quality of life in oncology practice should be seen as a process and as a part of this process it seems sensible to pursue several different lines of questionnaire development rather than constructing one 'perfect' quality of life instrument.

Key words : QOL issues, cancer treatment

The most important aim of cancer treatment is to achieve cure and secondly to palliate (life prolongation and relief of sufferings) where cure is not possible due to advanced disease. Nowadays, 30% of all cancers are routinely cured. Treatment should achieve cure whenever possible and that the quality of life is acceptable. The relief of symptoms may follow on from curative treatment, but where cure is not possible the speedy relief of symptoms becomes important.

Treatment undertaken with a curative intent is "radical therapy" while that given solely to relieve symptoms is "palliative". Palliative therapy should be less intensive than radical treatment and should cause less morbidity than the disease itself. When doctors undertake to treat patients with cancer, they should have a clear idea of the purpose of treatment before therapy is started. If the probability of cure is high and the patient is reasonably fit, considerable short and long term morbidity are acceptable. For example, bowel surgery, necessitating a colostomy causes great inconvenience but may result in long

term benefit. However, if the patient is old and frail, even if there is a possibility of cure, careful consideration must be given to the expected side effects, the resulting quality of life and the anticipated life span of the patient. When the patient is suffering from an advanced incurable cancer, the palliative therapy given must cause as little morbidity as possible. It must be effective, completed in a short time and its acute morbidity must be tolerable. It is also essential for the doctor to give a clear explanation of the illness to the patient and realistic advice regarding the likely outcome of therapy and the long and short term morbidities which may occur. The patient may opt for "palliative" treatment with a reduced chance of cure but a better quality of life than accepting a radical treatment with a potentially higher degree of morbidity. For example, a total laryngopharyngectomy for a pyriform fossa tumour may have a higher chance of cure but the morbidity of the operation, the extensive resection and permanent loss of voice may be too high a price to

pay. Radiotherapy which is non-invasive may have a smaller chance of cure but this modality preserves the anatomy and normal function and may be more acceptable to the patient. In treating terminal cancer, the wise use of adequate doses of analgesics such as morphia coupled with steroids may prove more effective than high technology therapies or chemotherapy. Additional support from the local health facilities may enable the patient to have satisfactory symptom control and in many cases to die in the comfort of home.

Quality of Life

An operational definition of quality of life has been advanced by WHO to capture the three dimensions of health(1). Health is not only the absence of infirmity and disease, but the state of physical, mental and social well being. Only the patient can make a truly valid assessment of quality of life. Early attempts to quantify the general condition of the patient resulted in development of scales of performance status, such as Karnofsky (KPS) and WHO scales, which extended from totally normal activity with no complaints through lesser states involving the presence of symptoms to morbidity (in fact death).

Survival and Life Quality

Favourable prognosis of patients, e.g. with malignant gliomas, has been shown to be mainly related to age, tumour grade, level of function at diagnosis and the completeness of surgical resection (2,3,4,5). Thus young patients who had gross resection of low grade astrocytoma have the best prognosis. How is the duration of survival (prognosis) linked to the quality of life? The KPS has been widely used as a simple and reliable scale of quality of life. Lieberman et al⁶ were among the first to examine this problem and evaluated these patients at New York University who lived two or more years after treatment. Of the 57 patients treated with surgical resection, radiation and chemotherapy, 8 patients lived two or more years. Median survival for these patients was 143 weeks and 50% died of their tumour. The conclusion drawn from this study is that a small but gratifying gains have been made in the treatment of patients with malignant astrocytomas with some patients achieving a good quality of life for at least two years.

More recently, there has been an attempt to broadly define quality of life end points in the

treatment of patients with cancer (7). While KPS measures external level of function based on factors that can quickly be estimated in a patient encounter, it is not sensitive to a wide range of more intrinsic and psychosocial aspects of the patient. This concept has also been regarded as too abstract and complex to be measured. Various other studies (8,9) suggest that it is possible to devise an indicator of the quality of life that has wide applicability. Aaronson et al (10,11) have recommended that 12 components be evaluated in an assessment in clinical trials: pain and pain relief, fatigue and malaise, psychological distress, nausea and vomiting, psychological functions, symptoms and side effects, body image, sexual functions, social functioning, memory and concentration, economic disruption and global quality of life. Physicians often focus on the disease-related outcomes like tumor response, but patients are often equally concerned with the impact of the disease and therapy on their life and daily function. Such a scale if properly devised and applied may permit a way of translating the medical approach to outcomes that are more meaningful and understandable to patients and their families. More recently many quality of life instruments have been developed like the European Organization for Research and Treatment of Cancer quality of life questionnaire C30 (EORTC QLQ - C30) and Functional Assessment of Cancer Therapy General (FACTG) (12). Both the FACTG and EORTC QLQ-C30 seems to have their specific merits and there may be scope for the development of a new instrument. However, in our opinion, the availability of several widely used assessment instruments for the quality of life of cancer patients has its advantages.

Conclusion

Quality of life issues are at the core of treatment of all malignant neoplasms. As therapy becomes more effective, the quality of survival will emerge as an important consideration. This concern has been regarded by basic scientists and oncologists as a meaningful information. Quality of life research in oncology practice should be seen as a process and as a part of this process it seems sensible to pursue several different lines of questionnaire development rather than constructing one “perfect” quality of life instrument.

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