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# Introduction

# New Clinical Strategies for Symptom Management and Quality of Life Enhancement in Cancer Patients

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IN THE past few decades, medical science has made it possible to prolong the lives of many patients with cancer. Yet, the time gained may be worth little to the patients if their existence continues to be marred by constant pain, anxiety, or exhaustion. The growing recognition that quality of life, not just quantity, is important marks a quantum shift in our approach to the treatment of cancer.

Today, some of the most important advances being made in oncology are in the field of supportive care. Furthermore, the emphasis in cancer education for health professionals is rightly shifting away from complex biological mechanisms and towards the day-to-day management of cancer-related symptoms such as pain, depression, breathlessness, nausea and fatigue.

It was against this background that the symposium *New Clinical Strategies for Symptom Management and Quality of Life Enhancement in Cancer Patients* was held on 29 October 1995 in Paris, France, as part of the European Cancer Conference, ECCO 8. The proceedings comprising this supplement focused on three key areas: the assessment of quality of life; the control of pain and the management of psychological symptoms.

Quality of life assessments are fast becoming a standard feature of clinical trials in oncology. In fact, in some types of trial, it may be argued that quality of life should be the primary outcome criterion. However, there is as yet no global consensus regarding which methods should be employed for quality of life assessment in clinical trials. Some kind of common measure is needed to enable comparisons to be made across studies.

A promising step forward in this direction has been taken with the development of the EORTC (European Organization for Research and Treatment of Cancer) core quality of life questionnaire QLQ-C30. The EORTC approach allows for the development of disease- and treatment-specific add-on modules, so that the core questionnaire can be adapted to different types of clinical trial.

In routine clinical practice, the place of quality of life questionnaires is somewhat less assured. The realities of life in a busy clinic make it impossible for patients to be asked to complete lengthy questionnaires. It may, perhaps, be more practical to use formal quality of life assessments only to address specific problems, identified by the physician during the clinical interview.

Control of pain plays a key role in determining quality of life for many cancer patients. Sadly, at present, many patients are treated inadequately. Both the physician's and the patient's perceptions may contribute to this unfortunate state of affairs. Many physicians have not been properly trained to assess or manage severe or chronic pain. Cancer pain, in particular, poses challenges that may defeat the oncologist working alone. Pain is ideally managed by a multidisciplinary pain team incorporating the skills of a psychiatrist, neurologist, orthopaedic specialist, radiologist and surgeon, as well as the oncologist.

Patients may unwittingly contribute to the suboptimal management of their pain. Some may be reluctant to complain for fear of being thought 'difficult'. Many more will mistakenly assume that nothing more can be done. Others may fear that the administration of morphine marks 'the beginning of the end,' or that it may hasten death.

Another barrier is the tendency of many patients to skip doses once the analgesic has begun to take effect. They do not realise that continuous pain relief depends on regular dosing, whether or not symptoms are apparent. A logical solution to the problem of missed doses is the use of transdermal patches, which ensure continuous analgesic coverage for up to three days. As described in this proceedings, transdermal fentanyl is not only as effective as the gold standard of oral morphine, but may have important benefits in terms of reduced side-effects and increased patient acceptability.

Oncologists need to be proactive in seeking signs that pain control is unsatisfactory, just as they need to be alert to signals of anxiety and depression. Sadness and grief are normal responses to the diagnosis of cancer and can be overcome by standard social nursing and medical care. However, a true reactive depression, as defined by DSM III criteria, calls for specialised intervention and the use of adequate psychological and pharmacological means. Furthermore, as many as one-fifth of patients will develop long-term depressive illness, a serious and often undiagnosed condition.

Professional training is needed to help oncologists and nursing staff communicate better with patients and to recognise depression and anxiety more effectively. Many patients will benefit from one or more sessions with a psychiatrist or clinical psychologist, but oncologists should also be prepared to manage depression and anxiety using both pharmacological and psychological methods.

Several barriers to implementing the proposals discussed in this supplement exist and only continued education, starting at Nursing and Medical School, will help to overcome them. At present, cancer centres tend to be busy and crowded, with acute care providers rightly driven by the quest for cure or remission, but perhaps at times forgetting the majority of patients for whom that goal cannot be achieved. Staff training often fails to fully comprehend the complexities of cancer care. Public pressure may help nurses and physicians to humanise cancer care, and to realise that, while cure is often not possible, treatment always is: it allows cancer patients to retain their dignity. In this manner the community may overcome its fear of cancer and perhaps view it in the same way as cardiovascular disease, something that can rarely be cured but can certainly be treated.

Today, quality of life in cancer therapy is not just a hope, it is beginning to become a reality. Many tools are already there to be used, if only we will learn how. Others will surely become available in the near future. In these proceedings we hope to provide a foundation for continuing dialogue and debate among all those health care professionals who care about improving the quality of life for patients with cancer.