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Presentation of cancers to a cancer hospital attached medical college in Anantapuramu district of Andhrapradesh - Need to integrate Palliative care services in to Oncological centers of medical college hospitals.

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Abstract:
Objective: *To study the number of patients presenting with advanced cancer and their need for palliative care services in a medical college attached cancer hospital at district level.*
Study design: *Retrospective study.*
Study area*:Department of radiotherapy and oncology, Government general hospital, Government medical college, Anantapuramu, Andhrapradesh, India*
Study period: *From January 2017 to December 2017.*
Results: *60.37% of patients presented with stage III and stage IV cancers, with physical, psychosocial and emotional problems. Integrating palliative care services in to medical college cancer hospitals were presented as per national cancer control program (NCCP) and WHO guidelines.*
Conclusions: *in view of presentation of advanced cancers at Medical college cancer departments there is a need to develop palliative care services at Medical college cancer departments as per national cancer control program (NCCP) and WHO guidelines.*
Key words: *advanced cancers - Medical college cancer hospitals - palliative care services*

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I. Introduction

Home to one-sixth of the World's population, India has a huge burden of suffering from life-limiting diseases. Less than 1% of its population has access to pain relief and palliative care[1]. It is difficult to assess the exact requirement for palliative care because of inadequate disease registration, communication problems, and cultural stigma attached to cancer and HIV/AIDS. Cultural attitudes and low literacy rates in many states of India foster an ignorance and fear of cancer, HIV/ AIDS, and other life-threatening diseases. It is estimated that one million new cases of cancer occur each year in India with over 80% presenting at stage III and IV[2]. Experience from cancer centers suggests that 2/3rds of patients with cancer are incurable at presentation need palliative care[3,4,5] and approximately one million people are experiencing cancer pain every year[6].

WHO defines palliative care as an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual[13]. It provides relief from pain and other distressing symptoms; affirms life and regards dying as a normal process; intends neither to hasten nor postpone death. It integrates the psychological and spiritual aspects of patient care and offers a support system to help patients live as actively as possible until death and a support system to help the family cope during the patient's illness and in their own bereavement. Uses a team approach to address the needs of patients and their families, including bereavement counseling

II. Material And Methods

Data was collected from hospital information system from a cancer hospital attached to a medical college Anantapuramu district of Andhrapradesh, India from January 2017 to December 2017. Statistical analysis was done using SPSS software.

III. Results

Subjects profile:

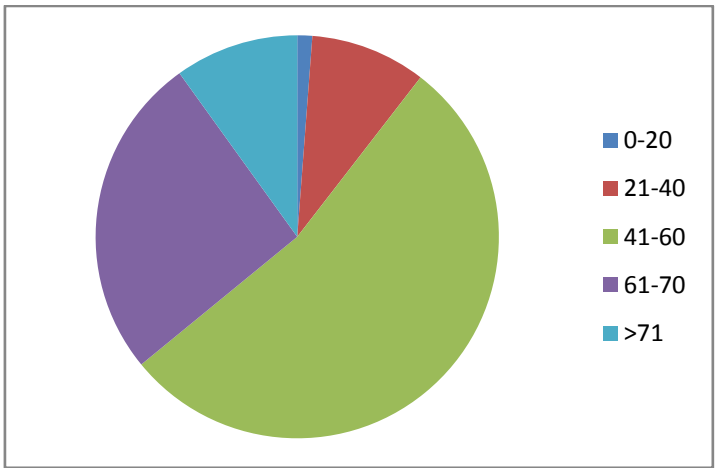
Age wise distribution of subjects as follows:

More than 50% of the subjects belong to 41 to 60 years age group (51.6%) followed by greater than 60 years age. Childhood malignancy like hepatoblastoma and malignancy less than 20 years constitute only 11 numbers (1.2%)

Table 1: Age distribution

Age	n
0-20	11
21-40	85
41-60	491
61-70	238
>71	91

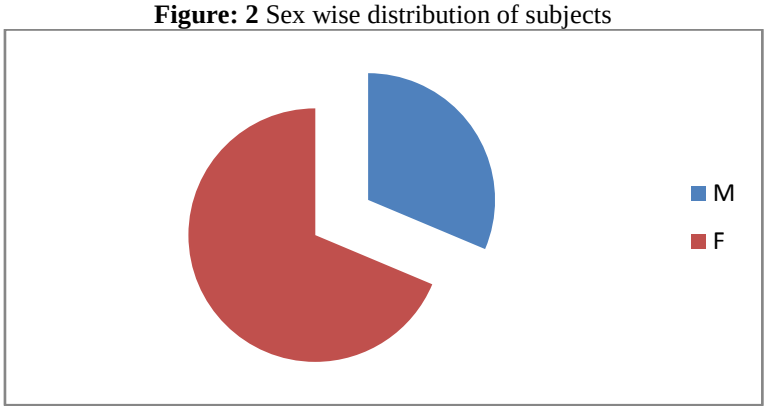
Figure 1



Sex wise distribution of subjects:

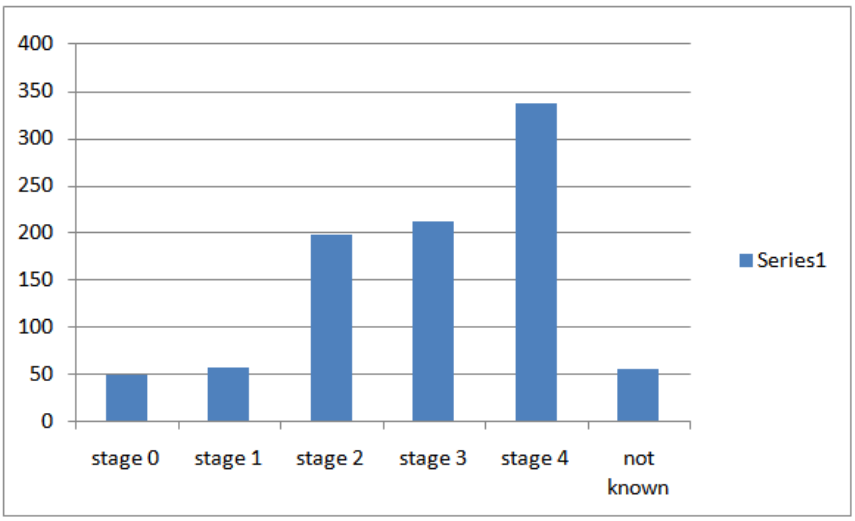
629 subjects out of 916 belong to females (68.66%).

Figure: 2 Sex wise distribution of subjects



Stage wise distribution:

Figure: 3 Stage wise distribution of subjects



Locally advanced and metastatic cancers at presentation (Stage III and stage IV) constitute 60.3% (553 patients out of 916) compared to early stage cancers (Stage I and Stage II), which constitutes 28% (257 out of 916) and remaining subjects belong to non malignant conditions.

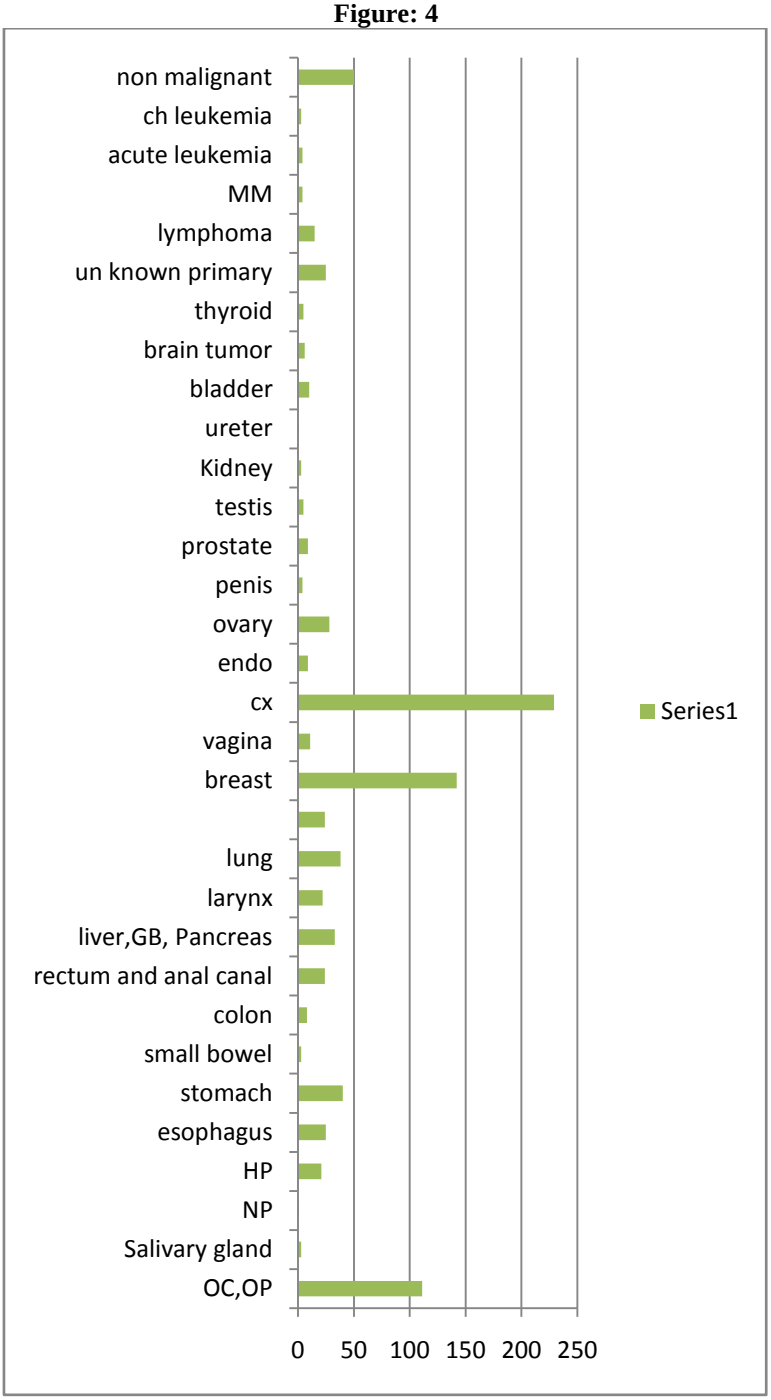
Diagnosis wise:

25% of all cancers including both sex Cervical cancer ranks high (229 patients out of 916) followed by breast cancer 15.5% (142 out of 916) and head and neck cancers.

Table: 2 Diagnosis wise distribution of subjects.

Oral Cavity and Oro pharyngeal cancers	111
Salivary gland malignancy	3
Nasopharyngeal cancers	1
Hypopharyngeal cancers	21
Esophageal cancers	25
stomach	40
small bowel	3
Carcinoma of colon	8
Carcinoma of rectum and anal canal	24
Carcinoma liver, Gall Bladder and Pancreas	33
Carcinoma of larynx	22
Carcinoma of lung	38
Carcinoma of skin, sarcoma, and connective tissues	24
breast	142
Carcinoma of Vagina	11
Uterine cervix	229
Endometrial carcinoma	9
Ovarian carcinoma	28
Carcinoma of penis	4
Carcinoma of Prostate	9
Testicular malignancy	5
Kidney	3
Ureter	1
Urinary bladder	10
Brain tumor	6
Thyroid malignancy	5
Un known primary	25
Lymphoma	15
Multiple Myeloma	4
Acute leukemia	4
chronic leukemia	3
Non malignant	50

Figure: 4



IV. Discussion

In India Rural – Urban population distribution as per 2011 statistics was 68.84% & 31.16%[7] . All regional cancer centers are situated only in 16 states or union territories. These services are usually concentrated in large cities and regional cancer centers, with the exception of Kerala, where services are more widespread[8]. In majority of the states coverage is poor. Most of the private cancer centers with advanced cancer facility are situated only in metro cities and their main focus is on "we cure" campaign. Hardly have we seen palliative care services in private or corporate hospitals.

More than 60% of subjects presenting to our medical college attached district level cancer hospital belong to stage III and stage IV. In these patients already treated at some other hospital and requesting for symptom control after completion of definitive therapy for residual or recurrences and also for complications of chemotherapy and radiotherapy were 30%. Usually after completion of definitive therapy, if any subject develops recurrence, oncologist at regional center suggests family members to attend to a local physician for symptom management. But no physician at local place is interested to manage these subjects because of medico

legal issues and fear of death related issues or they are not trained in managing advanced cancer patients. They refer back to their treating physician or treating hospital. Patients neither they can go to treating hospital which is situated very far in a state capital nor to a local doctor and suffer not only from physical problems but also with psychological, social, emotional and financial problems.

Palliative Care is a developing Specialty in India which needs to be highlighted to the general public who don't know about the benefits of it. There is a huge need to expand Palliative Care in the whole of India. At the moment no one gets good quality of palliative care in most parts of India. The poor die in neglect because there is no one to look after them at the time of death, the middle class die in ignorance because they are unaware of its benefits and they could pay for palliative care services if they were available but at the moment in a market health care system, there is no one selling palliative care as there is no one buying palliative care. The rich die in agony on a ventilator because there is no understanding of terminal care and prognosis. Patients with very poor prognosis who are not appropriate for resuscitation end up on a ventilator with no benefit to them and suffer from distress. Families of persons who get a referral to palliative care during a hospitalization incur fewer costs than people with similar conditions who do not get a palliative care referral[14]. We have to change this terrible situation.

With a population of over a billion, spread over a vast geo-political mosaic, the reach of palliative care may appear insurmountable. It is estimated that in India the total number who need palliative care is likely to be 6 million people a year. These figures are likely to grow because of the increasing life span and a shift from acute to chronic illnesses. It is estimated that 60% of the people dying annually will suffer from prolonged advanced illnesses. This means there will be a sizeable population of the aged who will have several spells of hospitalization interspersed with long periods of being confined to their beds at home. In addition to the challenges posed by illnesses, many of the patients in India are extremely poor and do not have access to clean water, food, or even shelter. When chronic or life-threatening illnesses strike, it is a crippling blow for them and their families. The results of a 2010 study in The New England Journal of Medicine showed that people with lung cancer who received early palliative care in addition to standard oncologic care experienced less depression, increased quality of life and survived 2.7 months longer than those receiving standard oncologic care[15]. There is therefore a crucial need for a system of care at home that can best be built by a community-based palliative care movement.

Palliative care is an essential part of cancer control, both for adults and children. In the WHO Global Action Plan for the Prevention and Control of Non-communicable Diseases (NCDs) 2013-2020, palliative care is explicitly recognised as part of the comprehensive services required for the management of non-communicable diseases. Governments acknowledged the need to improve access to palliative care in the Political Declaration of the High-Level Meeting of the UN General Assembly on the Prevention and Control of Non-communicable Diseases in 2011, and access to opiate pain relief is one of the 25 indicators in the global monitoring framework for NCDs16.In 2014, the first ever global resolution on palliative care, World Health Assembly resolution WHA67.19, called upon WHO and Member States to improve access to palliative care as a core component of health systems, with an emphasis on primary health care and community/home-based care[17].

In 1975, the Government of India initiated a National Cancer Control Program. By 1984, this plan was modified to make pain relief one of the basic services to be delivered at the primary health care level. Unfortunately, this policy was not translated into extensive service provision[9]. Palliative care is an important and essential part of cancer care therapy and twelfth 5-year plan makes a special provision for it. At least 10% of the budget needs to be earmarked for these services at level of cancer care services. For palliative care there will be dedicated 4 beds at the district hospital. Doctors, nurses, and health workers will be trained in basics of palliative care. One of the doctors in the District hospital needs to have a 2 weeks training in palliative care[10]. A system based on outpatient care has proven cost-effective, empowering families to care for patients at home. Whenever possible, inpatient facility and home visits should be available for those who need them. Some measures of quality assurance should develop concurrent with growth of the palliative care movement.

In this study at government medical college attached cancer hospital 60.3% of subjects present with stage III and stage IV cancers. These patients are usually neglected or often receive futile anticancer treatment (s).What they really need is maximum medical management in the form of palliative care and psychosocial support. Since advanced and incurable cancer cases are mostly referred for radiotherapy (RT), palliative care (PC) clinic should be started in all the Radiotherapy department of Medical college cancer departments[11].

Despite its limited coverage, palliative care has been present in India for about 20 years. Obstacles in the growth of palliative care in India are too many and not only include factors like population density, poverty, geographical diversity, restrictive policies regarding opioid prescription, workforce development at base level, but also limited national palliative care policy and lack of institutional interest in palliative care[12].

Effective approaches:

Effective palliative care requires a broad multidisciplinary approach that includes the family and makes use of available community resources; it can be successfully implemented even if resources are limited. It can be provided in tertiary care facilities, in community health centers and in patient's homes. Core components to strengthen palliative care include:

1. National policy (including integrating palliative care into NCD, cancer and HIV/AIDS strategies)
2. Training for health professionals.
3. Improving access to opioid pain relief (including revising national legislation and prescribing rules)

V. Conclusions

In Anantapuramu district of Andhrapradesh, more than 60% of cancer patients present with locally advanced and metastatic disease, where definitive therapy plays a minor role and pain management and supportive care plays a major role. As most of the subjects live in rural and sub-urban regions there is huge need to integrate palliative care services in to medical college cancer departments to provide palliative care to the people who cannot attend to regional cancer centers located at very long distance.

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