

## A PROSPECTIVE STUDY ON PALLIATIVE CARE SURGERY IN ADVANCED MALIGNANCIES

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### **ABSTRACT**

Palliative care has deservedly received more attention in recent years. Palliative treatment is explored by surgeons when excision of all known tumour locations is no longer feasible or desirable. Because a cure, as widely conceived, is not attainable, the objective of treatment, and finally the effectiveness of therapy, is based on symptom management and pain relief. Providing the best palliative care for a cancer patient is a complicated and difficult task. The process of delivering palliative care may differ from the typical surgical gratification received from the full excision of a cancer, but surgeons who achieve excellence in palliative care will most certainly find it fulfilling.

### **Aims and Objectives:**

- To take down proportion of patients suffering from specific advanced disease that needs palliation
- To study the various options of palliative care available in the hospital for patients with surgically incurable cancer.
- To evaluate different methods of palliation that can be provided to specific advanced disease

### **RESULTS**

9 patients underwent Palliative surgical procedure, out of total 50 cancer surgeries. The incidence of Palliative surgery is 18%. M: F 3.5:1. In most cases occurred after 50 years of age. Highest was occurred in 82 years of male and lowest is recorded in 31 years of female. Highest incidence of carcinoma is recorded in >50 years age groups and lowest incidence is found in younger age group. Maximum palliation was done for carcinoma stomach

### **CONCLUSION**

Providing the best palliative care possible to a patient with terminal disease is a difficult and involved task. The surgeon may be in a special position to help patients understand their options for palliative care and to give them realistic expectations of what they may hope to achieve. The best palliative care is provided by a multidisciplinary team

that tailors treatment to the needs of each patient, allowing for the greatest possible relief of symptoms, the greatest possible length of life, and the shortest possible hospital stay (measured in terms of the ratio of hospital days to remaining days of life).

## INTRODUCTION

Palliative cancer treatments including radiation therapy and chemotherapy play a major role in improving quality of life in patients with advanced cancer by controlling symptoms and relieving pain.<sup>1</sup> Whilst providing prolonged disease control with many current techniques, they do not, however, offer a cure for the disease. Considerable evidence suggests that patients receiving palliative therapies commonly have misunderstandings about their prognosis,<sup>2</sup> intentions of such treatments<sup>3</sup> and they hold unrealistic hopes of their cancer being cured.<sup>4, 5</sup> In the United States, Nationwide study conducted by Weeks et al.<sup>6</sup> among 1193 patients receiving chemotherapy for stage IV cancers, 69% of patients with lung cancer and 81% of those with colorectal cancer did not understand that their treatment was not at all likely to cure their cancer. Another study looked into the expectations of patients with incurable lung cancer from palliative radiation therapy, and found that 64% did not report understanding that the treatment was not at all likely to cure them.<sup>7</sup> This study also found that 92% of patients with inaccurate beliefs about radiation therapy also had inaccurate beliefs about chemotherapy, indicating that this gap in patients' understating exists for multiple treatment modalities and provider types.<sup>8</sup>

## Components and Principles of Palliative Care

Compassionate communication; exploration of patient and family values and goals of care; expert attention to relief of suffering; management of pain, depression, delirium, and other symptoms; awareness of the manifestations of grief; and sensitivity to the concerns of bereaved survivors are key components of palliative care for cancer patients.<sup>9</sup> The general Principles of palliating most distressing symptoms in terminal cancer are:

1. To define and treat the underlying cause of symptom wherever possible and reasonable for the patient.
2. To relieve the symptom without adding new problems by way of side effects, interactive effects, social or financial burdens.
3. To consider whether a treatment will be worthwhile for the patient and his family bearing in mind his prognosis and adverse effects of invasive procedures.
4. To discuss all reasonable treatment options (including the decision of "no intervention") with the patient and his family, allowing them to make the final decision as far as possible by themselves.

## Need for Palliative Care:

Patients diagnosed with cancer need not just physical management of sickness and symptoms, but also assistance in coming to grips with their diagnosis. If the condition has progressed to the point where a treatment is unlikely, they will want aid in making life plans. Patients suffering from any chronic condition, particularly cancer, suffer greatly. To be the

most helpful, demonstrate that you care about the patient as a person, not simply about his or her physical issues.

## **Need for Palliative Surgery:**

Although some medical specialities have started to include palliative care into residency training and have even formed palliative care fellowship programmes, surgeons have had relatively little formal instruction or training in palliative care.<sup>10</sup> Palliative care receives little consideration in typical surgical textbooks.<sup>11, 12</sup> Palliative surgery is best characterised as surgery aiming at relieving patient symptoms and improving patient QOL with little influence on overall patient survival.<sup>13</sup> Palliative surgery may prolong the duration of living for certain patients, but cure is only predicted in a tiny percentage of patients.

## **Aims and Objectives:**

- To take down proportion of patients suffering from specific advanced disease that needs palliation
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## **METHODS**

### ***Study design***

A prospective study.

### ***Period of study***

The study was conducted from July 2022 to June 2023.

### ***Selection criteria of the patients***

#### ***Inclusion criteria***

- Elderly patient with new dyspepsia, unexplained anaemia and weight loss.
- Cases of advanced oesophageal & stomach cancers
- All patient of gastric outlet obstruction without suggestive evidence of pyloric stenosis.
- Elderly patient with advanced colorectal cancers
- Advanced cancers of liver, biliary tree and Ca GB
- Cases of advanced Cancers of breast with fungation, ulceration & pain
- Advanced intraperitoneal spread with intractable ascites
- All cancers with intractable pain.

#### ***Exclusion criteria***

- Early stage.

- Paediatric patients.
- All cases of advanced oral cancers

**Patient evaluation includes:**

- History of presenting symptoms that is duration, severity and location.
- Physical examination to access the extend of the disease.
- Confirmation of diagnosis with suitable cytology/histopathology.
- Imaging studies to confirm the extent of the disease (CXR, USG, CT SCAN and MRI) and staging of the disease.

**Surgical Procedures performed:**

- Palliative resection of tumour mass.
- Oesophageal stenting for distal tumour to palliate dysphagia.
- Toilet mastectomy to palliate ulceration and bleeding.
- Colostomy to relieve obstruction.
- Bilateral sub capsular orchidectomy in prostate cancer.
- Cholecystojejunostomy and Hepaticojejunostomy to palliate obstructive jaundice in pancreatic cancer.
- Thyroidectomy or isthmectomy to relieve airway compression for thyroid cancer.
- Gastro-Jejunostomy and Feeding Jejunostomy for gastric carcinoma.

**OBSERVATION:**

**Incidence of Palliative surgery:**

9 patients underwent Palliative surgical procedure, out of total 50 cancer surgeries. The incidence of Palliative surgery is 18%.

Total number of cancer surgeries	50
Total number of Palliative surgeries	9 (18%)

**Age Incidence:**

Age Group	Number of Cases	Percentage
20-29 years	0	0
30-39 years	1	11.1
40-49 years	3	33.3
>50	5	55.5
<b>Total</b>	<b>9</b>	<b>100.00</b>

In most cases occurred after 50 years of age. Highest was occurred in 82 years of male and lowest is recorded in 31 years of female.

Highest incidence of carcinoma is recorded in >50 years age groups and lowest incidence is found in younger age group.

**Sex Incidence:**

Sex Variation	Number of Cases	Percentage
Male	7	77.7
Female	2	22.2
<b>Total</b>	<b>9</b>	<b>100.00</b>

In this study the ratio between male and female is equal to 3.5:1

**Incidence of Carcinoma:**

Description	Number of cases	Percentage
Carcinoma Oesophagus	0	0
Carcinoma Stomach	5	55.5
Carcinoma Colorectal	1	11.1
Hepatobiliary Cancer	1	11.1
Breast Cancer	02	22.2
<b>Total</b>	<b>63</b>	<b>100.00</b>

Out of 9 Palliative surgical procedures, highest number of Palliative procedures done for Carcinoma Stomach (55.5%).

**Surgical Procedures:**

Surgical Procedure	Number of Cases	Percentage
Gastro-Jejunostomy (G.J.)	2	22.2
Feeding Jejunostomy (F.J.)	3	33.3
Colostomy	1	11.1
Hepatico-Jejunostomy (H.J.)	1	11.11
Toilet Mastectomy	2	22.2
<b>Total</b>	<b>63</b>	<b>100.00</b>

## **DISCUSSION:**

### **Disease incidence:**

In the present series incidence of palliative surgery is 18%, this data correlates with **Essan et al** and **Manisha Bisht et al 2008** observed 23% and **E.V Ussiri et al 2005** observed 21% of palliative surgery.

But another two studies by **Alan A. Thomay et al 2009** and **Robert S. Krouse et al 2001** shows an incidence of 12.5%. Our incidence is bigger than these studies.

Most probable reason may be due to early detection and wide range of screening methods for malignancy is more in developed countries than Indian set up.

### **Age distribution:**

In this study most of the patients presented with terminal ill during their 3<sup>rd</sup> to 6<sup>th</sup> decade of life. Lowest age patients is younger age group and highest age is >60 years.

Similar finding were observed by an Indian study conducted by **Manisha Bisht et al 2009**. According to that study median age group is 55 years and lowest age is 13 years and highest age is 82 years.

### **Sex distribution:**

Sex incidence of our study is male to female ratio is 3.5:1 but other studies by **P.T Lam et al 2007** found a ratio of 1.7:1, another Indian study by **Manisha Bisht et al 2009** says sex incidence of 1.5:1.

Both these studies shows a male predominance in advanced cancer than our study.

### **Disease distribution:**

In one study conducted by **P.T Lam et al 2007** shows incidence of lower G.I. malignancy is 14%. In another study by **E.V Essini et al** were found colorectal carcinoma 20%, oesophagus 16% and pancreas 12%.

Our study correlates with this study which shows lower G.I malignancy of 11.1%, Hepatobiliary 11.1%. It differs from above studies in upper G.I. malignancy which is 55.5% in present study due to increased incidence of upper G.I. malignancy in this geographic area.

### **Symptoms resolution:**

According to a study conducted by Alan A. Thomay et al 2008 ( Surgical Clinics of North America), symptoms resolution were 75% in Gastro-Jejunostomy and Feeding Jejunostomy and 91% in lower G.I. resection or bypass and 90% in biliary bypass.

Present study correlates to above studies which shows 75% symptom resolution in upper G.I. obstruction, 84% symptom resolution in lower G.I. obstruction and 80% resolution of symptoms in biliary bypass.

Surgeons have lately taken the initiative in setting the critical clinical, educational, research, and policy goals for interdisciplinary palliative patient care. However, there is a lack of widespread investment among surgeons, and there are misunderstandings and differing viewpoints on how to best advance the discipline and what exactly "palliative surgery" entails.

Thankfully, efforts have been made to bring surgeons and other members of the palliative care team together to work towards the same aims. It is still unclear what palliative surgical clinical programmes should include, what function they should play, and how they

should be integrated into the palliative care system. But initiatives to formally educate surgeons on palliative care and include them more in the clinical decision-making process could provide light on workable forms of integration. Surgeons from many different fields who are enthusiastic about and dedicated to interdisciplinary palliative care research need to work together for the greater good of the discipline.

## CONCLUSION:

Patients with advanced cancer and patients with advanced cancer who are incurable are treated as people rather than a disease process in palliative care. In this way, terminally ill patients may make choices about how they wish to spend their remaining time.

When it comes to cancer patients, palliative surgery is a crucial part of all-encompassing palliative treatment. In palliative care, enhancing quality of life rather than prolonging life is emphasised. In an ideal world, palliative surgery would have well-defined therapeutic aims. When surgery is conducted with palliative aim, it is important for both the patient and the physician to understand the reasons for the procedure and its restrictions. Surgical procedures have been utilised for a long time to alleviate patients' suffering, and they hold much promise for providing more alternatives for patients with terminal cancer. Guaranteeing high-quality end-of-life care via the provision of several treatment options.

Providing the best palliative care possible to a patient with terminal disease is a difficult and involved task. The surgeon may be in a special position to help patients understand their options for palliative care and to give them realistic expectations of what they may hope to achieve. The best palliative care is provided by a multidisciplinary team that tailors treatment to the needs of each patient, allowing for the greatest possible relief of symptoms, the greatest possible length of life, and the shortest possible hospital stay (measured in terms of the ratio of hospital days to remaining days of life). However, because of the potential for a positive impact on patients with advanced cancer, surgeons who achieve excellence in palliation are likely to find this a rewarding endeavour. The goals involved in providing palliative surgical care may differ from the traditional surgical satisfaction derived from the complete excision of malignancy.

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