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IMPACT OF EARLY INTEGRATION OF PALLIATIVE CARE IN IMPROVING QUALITY OF LIFE AND SURVIVAL IN METASTATIC CARCINOMA BREAST PATIENT

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ABSTRACT

Carcinoma breast is the most common malignancy in the world among female as per the globocan data 2018. It is a systemic disease hence multi-modality treatment is needed in order to achieve complete cure which include systemic chemotherapy, surgery and radiotherapy to prevent local as well systemic recurrence. The present case is interesting to discuss because the patient presented with metastatic disease with poor general condition where cancer related treatment could not be given. Palliative care works best when it is integrated early in metastatic cancer care, as seen in this patient. She had complete response symptomatically with regression of chest wall lesion and improved quality of life and survival.

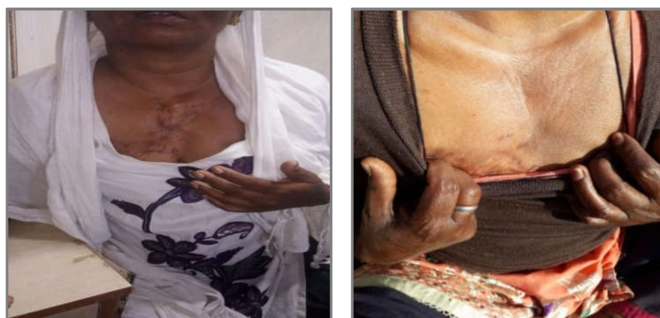
Keywords: Breast, metastasis, quality of life, recurrence, survival.

INTRODUCTION

Carcinoma breast is the 2nd most common malignancy in the world and most common cancer in female as per the globocan data 2018 with incidence of carcinoma breast is 11.6% of all new cases worldwide and death due to carcinoma breast accounts for 6.6% of all the cancer death. In locally advance metastatic carcinoma group where cure is not possible, palliative therapy play a very important role improving quality of life and survival.

CASE REPORT

A 45-year-old lady registered in radiation oncology OPD in February 2017 as a case of carcinoma right breast. She underwent right modified radical mastectomy at some private medical Centre in December 2013. Histopathology suggestive of infiltrating ductal carcinoma, grade 3, with no auxiliary lymph node positivity. Hormone receptor status was ER: negative, PR: negative, Her2nu: positive. After which she defaulted for further treatment due to some financial constraints. Patient was asymptomatic for 4 years, when she complaint of pain and swelling over the right chest wall, generalized weakness and loss of appetite and consulted our side. She was further evaluated clinically and found to have a 6 *6 cm hard fixed tender swelling present in right upper medial part of the chest and sternum with multiple other small hard fixed swelling present in its vicinity. Her full metastatic work up was done where she was found to have recurrence at chest wall with sternal metastasis and bilateral lung metastasis. Histopathology was suggestive of metastatic infiltrating ductal carcinoma. In view of metastatic disease with complaints of severe pain and weak general condition patient planned for palliative therapy. The aim of palliative care is to take care of the whole person: mind, body, and spirit. Patient underwent counseling, initiated with symptomatic and supportive treatment along with palliative radiotherapy to the chest wall lesion to provide pain relief. Once her general condition improved palliative chemotherapy was started. She received 6 cycles of cyclophosphamide, epirubicin and 5FU based chemotherapy along with zolendronic acid for bone metastasis. Palliative care staff ensured for accommodation and food to the caregiver, also counselled to bring the documents for Asadhya card in order to provide financial help. Patient had a very good response to the treatment given. After completion of 6 cycles of chemotherapy she was assessed and planned for 2nd line therapy along with targeted therapy and received 12 cycles of trastuzumab followed which she was kept on capecitabine with close follow up. However, in March 2019 she presented with severe headache, when evaluated radio logically, was found to have brain metastasis. For which she was planned for palliative radiotherapy 30 GY in 10 fractions. She improved symptomatically and again kept on tab capecitabine with close follow up. Later on her general condition deteriorated and did not allow us for further chemotherapy, thus the decision was deferred. Patient and family counselled regarding supportive care, nutrition and pain management.



- 1st figure showing status of disease at the time of registration.
- 2nd picture on right side showing response to treatment at 5 months.

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DISCUSSION

Cancer Patients in developing country often present in advance stage due to various constraints out of which financial issues are the most dominant one. In patients where cure is not possible palliative care along with disease specific treatment reduce time spent in hospitals. (1,2) and may be more effective in meeting patients' goals than usual approaches to end-of-life care practiced by oncologists. [3] Most common site of metastasis in carcinoma breast is bone (approx. 41%) followed by lung (22%), liver, brain etc. Approximately 70-80% of advanced breast cancer patients develop bone metastases during the course of their disease. [4] Bone metastatic complications can severely affect quality of life, and significantly impact healthcare system costs. [5] Pain is a major symptom of bone metastasis and bone pain management is often inadequate, even in patients referred for palliative radiotherapy. [6] When symptom control is the main goal, radiotherapy may be given as single fractions along with pain management as per WHO step ladder pattern. Almost 22% carcinoma breast patients present with lung metastasis out of which maximum are locally advance cases. Brain metastases are becoming increasingly prevalent as survival rates increase as in this patient she developed brain metastasis almost after 6 years from the date of diagnosis. Brain metastases indicate a poor prognosis. Symptoms of brain metastasis include headache, neurological disturbances, or seizures, all of which can significantly reduce quality of life. (7)Various authors enumerated the management of metastatic carcinoma breast with the aid of palliative radiotherapy, palliative chemotherapy and the most important best supportive care increases the compliance of patient for the treatment. The diagnosis of metastatic disease can generate profound anxiety and fears of death and dying and raise spiritual concerns. [8] These fears may be heightened when there are few resources to support individuals and their families, and when there is social and cultural stigma associated with cancer. Hence proper counseling of patient as well as family members are utmost important. In our patient recurrence at chest wall from the time of surgery was 4 years with concomitant bone, lung and later on brain metastasis. At the time of registration her general condition was poor enough that no treatment could be given but with best supportive and palliative care patient improved and then further disease related treatment also started. She responded well and has a very good survival along with improved quality of life, but unfortunately when she developed brain metastasis her condition deteriorated. Overall survival of this patient after diagnosis was 6 years and 3 years from the time of recurrence however she succumbed to her illness due to development of brain metastasis.

CONCLUSION

The aim of palliative care is to improve the quality of life for patients (and their families) facing a serious illness like breast cancer. It can begin as early as initial diagnosis and continue through to end-of-life care and bereavement. For metastatic breast cancer patients, palliative care is often underused. It may be important for patients and families to be proactive in getting appropriate palliative care in the course of the cancer journey. In our patient with integration of palliative care she was not only found to have improved quality of life but also improved survival.

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