PALLIATIVE AND SUPPORTIVE CARE IN ORAL CANCER:

A Review



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INTRODUCTION

Palliative care (derived from the Latin root palliare or "to cloak") is an interdisciplinary medical care giving approach aimed at optimizing quality of life and mitigating suffering among people with serious, complex illness.1Within the published literature, many definitions of palliative care exist. The World Health Organization describes palliative care as "an approach that improves the quality of life of patients and their families facing the problems 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." An interdisciplinary team that may consist of doctors, nurses, physical and occupational therapists, psychologists, social workers, chaplains, and nutritionists provides it.[1,2] Hospitals, outpatient settings, skilled nursing facilities, and residential settings are just a few of the venues where palliative care can be offered. Palliative care is not only for those who are approaching the end of life, although being a crucial component of end-of-life care. Whether the goal of treatment is curative or not, patients with head and neck cancer are a group in which both specialist palliative and supportive care is particularly appropriate because the disease and its treatments cause a significant burden of morbidity: short and long term, even lifelong for survivors. These individuals frequently have very major co-morbidities, such as alcohol and tobacco addiction, as well as complicated psychological problems, in addition to the medical symptoms.[3]

Palliative care strives to enhance the quality of life for patients and those who are caring for them as they deal with the challenges brought on by life-threatening disease. Palliative care is an option when there is little hope of recovery. Palliative care involves both surgical and non-surgical procedures with the goal of symptom relief, life extension, and slowing the progression of the disease.[3] Effective medical treatment for neoplastic illnesses has coexisted with the emergence of supportive care for cancer patients. Supportive care for cancer patients has evolved into a paradigm for oncology treatment. Now that we have standards and ongoing research in that area, clinical oncology is a discipline that is authoritative and developing quickly.[4] A holistic

Abstract

Palliative care is an interdisciplinary approach to medical care that aims to improve quality of life and lessen suffering in patients with life-threatening, complicated illnesses. An interdisciplinary team that may consist of doctors, nurses, physical and occupational therapists, psychologists, social workers, chaplains, and nutritionists provides it. Whether the goal of treatment is curative or not, patients with head and neck cancer are a group in which both specialist palliative and supportive care is particularly appropriate because the disease and its treatments cause a significant burden of morbidity: short and long term, even lifelong for survivors. These individuals frequently have very major co-morbidities, such as alcohol and tobacco addiction, as well as complicated psychological problems, in addition to the medical symptoms. Palliative care strives to enhance the quality of life for patients and those who are caring for them as they deal with the challenges brought on by life-threatening disease. This can be accomplished by preventing and alleviating suffering, providing comfort and dignity, and by managing pain and other medical, psychosocial, and spiritual concerns early on. The urgent need is for widespread palliative care at several facilities/institutions that aims to preserve patient comfort and dignity in cases of oral cancer.

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approach is used in palliative care to address the patient's, their caregivers', and their family's medical, psychological, social, and spiritual needs. The field of palliative care is interdisciplinary and encompasses medical, dentistry, nursing, social work, psychology, nutrition, and rehabilitation; albeit the level of support provided by each profession differs from facility to facility.[5,6] When such treatment is suggested, care should be made to ensure that patients understand that palliative care does not provide the possibility of a cure and that the goal is to enhance quality of life. Potential advantages and negative consequences must be carefully weighed in order to reach a treatment decision. The urgent demand therefore is for widespread palliative care at numerous facilities/institutions that aims to preserve patient comfort and dignity under such circumstances.[7]

A THOROUGH APPROACH TO SUPPORTIVE CARE

When the idea of supportive care was first put into writing[11,12] it was presented as a comprehensive "umbrella" designed to address all of the requirements of cancer patients (in addition to the specialized oncological management) in order to give them the highest possible quality of life. At that time, it was already evident that supportive care addressed all stages of cancer, including curative, palliative, and terminal care—the latter of which quickly evolved into palliative care in and of itself, as was already indicated. Understanding that palliative care (or terminal care) is still a part of supportive care—clearly an essential one—is crucial to understanding the concept of supportive care. Supportive care should be viewed as the internal and psycho-social medicine that applies to the cancer patient throughout the course of the disease.[8] Because studies using that terminology do not effectively characterize best supporting care, considering supportive care as a type of generic "best supportive care" is unacceptable.[9] Furthermore, it is ethically required to fully inform a cancer patient before beginning any form of treatment about every aspect of what the oncological and supportive therapy will entail; this is crucial if a particular oncological therapy starts to lose its effectiveness or if the patient agrees to participate in clinical studies that offer a no-treatment alternative. Based on these factors, it would seem that a patient receiving oncological therapy in a curative or palliative setting should be fully informed about both the potential benefits and risks of their specific anti-cancer treatment as well as the options available to them to ensure an optimal quality of life overall. Patients with terminal illnesses must receive the same information, mutatis mutandis.[8]

EARLY PALLIATIVE CARE

Early palliative care was likely developed to better inform cancer patients about the true treatment options available to them and to prevent overtreatment that would compromise their ability to maintain their best possible health. Many cancer patients who are in advanced stages of the disease still hold out hope that receiving palliative care can considerably extend their lives or even cure them. As was already said, this misunderstanding is the result of both patients and oncologists, and it must be avoided at all costs. Early palliative care is an idea that moves in that way.[10] According to Temel et al.[11], in their prospective randomized study of early palliative care, particular attention was paid to assessing physical and psycho-social symptoms, setting care goals, and coordinating care based on the individual needs of the patients. Throughout the study period, all patients continued to receive routine oncologic care (specific cancer therapy and general supportive care). Patients who benefited from the early palliative approach lived longer and had a higher quality of life than those who received standard treatment.[12] Once the disease is no longer treatable, several other studies supported the early integration of palliative care, or psychosocial support, into the management of cancer patients.[13,14] Then, in order to avoid demanding supportive care and protracted hospital stays, it is crucial to balance the cancer treatment's aggressivity against its anticipated advantages and tailor it to a low risk of problems. The lengthy and diverse list of potential side effects following chemoradiotherapy in cancer patients calls for special consideration during a close follow-up. As the awareness of potential sequelae represents a psychological burden for those patients who are cured[15], in addition to the always present fear of a late relapse, specific measures are needed to allow for optimal social adjustment.[16]

PALLIATIVE CARE INTERVENTIONS' TARGETS

Palliative care strives to enhance the quality of life (QoL) of patients and those who are caring for them as they deal with the difficulties brought on by life-threatening disease. This can be accomplished by preventing and alleviating suffering, providing comfort and dignity, and by managing pain and other medical, psychosocial, and spiritual concerns early on. These individuals frequently have very major co-morbidities, such as alcohol and tobacco addiction, as well as complicated psychological problems, in addition to the medical symptoms.[16]

A holistic approach is used in palliative care to address the patient's, their caregivers', and their family's medical, psychological, social, and spiritual needs. Oncological and surgical techniques, medication management, and psychological support are interventions that may be suitable for palliative care. The following are some of the primary priorities for palliative care therapies in head and neck cancer are medical and surgical care, pain relief, hydration and nourishment, relieving gastrointestinal symptoms, anxiety, agitation, dysphagia, dyspnea, bleeding, airway management, hypercalcaemia, counseling, psychological support, emotional support, breaking terrible news, patient's ambitions and expectations, holistic, psychosocial, and complementary support.[17]

MANAGEMENT OF ORAL COMPLICATIONS

Every form of HNC treatment, including surgery (such as mutilation and physiological changes), radiation therapy (such as mucositis, dysphagia, hyposalivation, and osteoradionecrosis), and neoadjuvant, adjuvant, and/or concurrent chemotherapy (such as mucositis, taste changes, and immune suppression), causes oral side effects. Additionally, oral mucosal problems could be a side effect of more recent targeted medicines. These medications' long-term oral side effects necessitate meticulous long-term oral care as well as oral and dental follow-up. In order to effectively manage oral needs, oncologists must understand the significance of preoperative dental care and make use of the resources at their disposal.[18]

Oral care for head-and-neck cancer survivors before and after cancer treatment:

Pre-Cancer Therapy

- Comprehensive head and neck, oral mucosa, dental, and periodontal examinations, radiographs to evaluate dental and periodontal status,
- Baseline jaw range of motion (interincisal opening), baseline resting and stimulated saliva,
- Advanced caries, advanced periodontal disease: definitive treatment may require surgery with a goal of 1-2 weeks of healing time,
- Periodontal debridement maintenance and oral hygiene are all part of the pre-treatment assessment 2-3 weeks prior to cancer therapy.

Throughout Cancer Treatment

- Individualized care based on cancer type and anticipated treatment outcomes
- Small carious lesions may be treated with fluoride and/or sealants; daily fluoride treatments for small carious lesions
- Symptom control: Dry mouth: hydration, oral rinses, and coating agents; lip care; pain: topical analgesic and anesthetic agents; systemic analgesics
- Patient education can reduce mucositis.
- Consistent brushing, flossing, and cleaning of prosthetics
- Water-based lip lubricants, wax, or lanolin; bland mouthwashes; fluoridated toothpaste; or daily use of home fluoridation trays in patients at high risk
- Soft toothbrushes; ultrasonic or electric brushes for patients who are tolerated
- If brushing is impossible, use a foam brush with chlorhexidine or a super-soft brush for severe mucositis.
- Nutritional advice, cigarette and alcohol abstinence, and dietary instruction

After Cancer Therapy

- Monitoring, preventing, and managing oral problems (such as soft tissue/osteonecrosis, dry mouth, mucosal pain, taste changes, infection, tooth demineralization, dental caries, and periodontal disease).
- Determine the frequency of dental hygiene follow-up interval based on level of hyposalivation, demineralization/caries rate, and patient's oral hygiene following radiotherapy; patients with dry mouth may need hygiene and recall every three to four months.
- Checking for cancer recurrence or secondary primary cancer • Dental caries prevention, periodontal maintenance
- Education for patients
- Fluoridated toothpaste; daily use of home fluoride trays in high-risk individuals; good oral hygiene practices such as using soft toothbrushes or electric or ultrasonic brushes and flossing; and maintaining mouth and lip lubrication.
- Promote a non-cariogenic diet and the cessation of alcohol and tobacco use.[18]

The utmost levels of assistance in supportive care

A growing number of cancer patients are being cured at this time, and turning cancer into a chronic or curable illness would have significant negative economic and social repercussions. The lengthy and diverse list of potential side effects following chemoradiotherapy in cancer patients calls for special consideration during a close follow-up. The awareness of potential sequelae poses a psychological burden on patients who are cured, in addition to the persistent fear of a late relapse. Sequelae such as metabolic syndrome, growth deficiency, sexual dysfunction, neurocognitive deficits, and many other aspects require specific measures to permit optimal social adjustment. It is important to note that problems, some of which are potentially fatal, can persist 20 to 30 years following treatment; this necessitates a lengthy follow-up and is inevitably stressful psychologically. The bereavement that follows the patient's death represents the other extreme of supportive care. When dying at home in the presence of receptive family members was the norm, death was viewed as a natural part of life and accepted as such by society (and religion). As a result, the grieving process could be hampered and drawn out. Families of cancer patients may adjust to the fatal outcome more easily, especially if the disease had a protracted course, if the care received and the availability of psychosocial support have been satisfactory. It has been demonstrated that families of patients who suffered from spiritual and psychological suffering were more likely to go through a prolonged and difficult bereavement process and were more susceptible to ill health and mortality. The provision of caregivers with psycho-social, spiritual, and bereavement support is another essential aspect of late-stage palliative care.[19]

ASPECTS OF SUPPORTIVE AND PALLIATIVE CARE IN PRACTICE

Supportive treatment for cancer patients is a multidisciplinary endeavor that gives the clinical oncologist a complete strategy to ensure that the patients have the best quality of life possible throughout the course of the disease. Clinical oncologists should not only be knowledgeable about cancer therapy but also capable of providing basic supportive care to manage acute side effects like infection, nausea and vomiting, pain, cancer-related metabolic and ionic disorders, and the widening range of side effects associated with recently developed targeted biological cancer therapy. An active supportive/palliative team with expertise in the management of many chronic and/or recurrent symptoms, such as pain, malnutrition, obstructive syndromes, psychiatric disorders, and neurological disorders to name only the most common ones, should be called upon to assist the oncologist in accordance with each patient's unique needs. The oncologist should ideally continue to be in contact with the patients even if cancer therapy is rendered ineffective, specifically when a very limited survival is anticipated; this clearly demands geographic cohesion. With the ultimate goal of improving the patient, morbid manifestations, and discharging him back home or the place he used to live, the active supportive palliative team ideally assumes a triple role: it is available for consultations aimed at hospitalized patients, it provides out-patient contacts, and finally, it runs a limited in-patient unit for admission of patients with acutization of chronic symptoms (pain, obstruction, depression, malnutrition, etc).[19]

CARE FOR THE DYING

Good palliative care must take good care of the dying. Patients who are nearing death may experience severe symptoms that change quickly, as well as the realization that no more active intervention is necessary. These factors make prompt assessment, frequent reassessment, and confident symptom control crucial. Family members also have crucial things going on at this time. It is crucial to have open lines of communication and to be forthright and thoughtful in your decision-making. Consideration should be given to reversible explanations for a patient's decline, and appropriate action may be taken depending on previous talks, professional judgment, and the patient's best interests. The physical changes that occur before death typically include a decline in mobility, a loss of consciousness and

social engagement, a reduction in oral intake, a decline in urine output, a worsening in hemodynamics, and changes in breathing rhythm. Even though nourishment is typically improper for dying patients, receiving medications or intravenous liquids is not automatically disallowed, even though the advantages are sometimes quite limited. For certain patients, enteral tubes offer another option.. While individualized care is essential for individuals who are dying, some symptoms are widespread enough to justify "anticipatory prescribing." This is appropriate for the following four main symptoms: pain, nausea, vomiting, agitation, and excessive secretions. Mouth care, tracheostomy and wound care, pressure areas, and continence are examples of places that need constant observation and alertness. At the end of life, the focus of treatment is on providing comfort while providing a personalised and individualized management of the patient's quality of life (QoL) and impending death. Therefore, early palliative and supportive care integration in oncology is crucial. Comfort care emphasizes the interrelationship between physical, psychosocial, and spiritual difficulties and is holistic and person-centered.[20]

SUMMARY AND CONCLUSION

Due to its recurrence and the aftereffects of treatment, oral cancer is a difficult and enduring disease. Implementing supporting measures is becoming increasingly important for cancer patients. A multidisciplinary approach should be used for management, supportive care, and palliative care, involving professionals from different specialties like oncology, nutrition, speech therapy, and physical therapy as well as maxillofacial surgery, oral medicine, special care dentistry, and restorative dentistry. From diagnosis until the conclusion of the rehabilitation process and any later follow-up, dentists are an important part of this team. Patients with oral cancer should get comprehensive palliative care planning, in which the effects of the entire process on quality of life as well as the physical and functional issues cannot be isolated from their psychological effects, such as guilt and sadness.

These patients' palliative care requires a multidisciplinary approach that should consider the patient's physical, emotional, spiritual, and social statuses. The primary goal of treating cancer patients is to maintain their quality of life. Numerous symptoms were experienced by oral cancer patients receiving radiotherapy, and the majority of these were side effects that might last for several months to a year after the treatment was over. A crucial component of both curative and palliative cancer care is radiotherapy. Family doctors can help cancer patients receive comprehensive primary care by having a basic understanding of radiotherapy's side effects and its primary management of mouth problems. Palliative dental care aids in reducing cancer treatment-related side effects. It underlines the significance of the dentist's contribution to these patients' improved quality of life.

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