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Palliative Care Experience in Breast and Uterine Cervical Cancer Patients in Ibadan, Nigeria

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Abstract

Introduction: World Health Organisation defined 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. Palliative care is a newly emerging field of health care with little or no documentation of its services in Nigeria. With the establishment of the first hospice and palliative care unit in University College Hospital (UCH), Ibadan, patients have had access to palliative care since the last three years. The purpose of this study is to evaluate the pain management and palliative care services accessed by patients with advanced cervical and breast cancer.

Methodology: This is a retrospective study reviewing treatment notes of all patients with advanced uterine cervical and breast cancer that received palliative care at the newly established Hospice and Palliative Care Unit of University College Hospital (UCH), Ibadan, from June 2008 to December 2010. Informatiom retrieved included dermography, histological diagnosis, patients symptoms (Pain and other symptoms) on presentation, Palliative measures applied including medications, assessment of response to care, assessment of level of satisfaction to care provided.

Results: In the period under review, 178 patients with advanced uterine cervical (80) and breast (98) cancers were seen. The age range for the two groups of patients was 17 to 96 years; mean age was 55 and 54 for cervical and breast cancer respectively. 93.82% of patients had pain as one of their symptoms at presentation to palliative care team with over 80% having pain scores indicating mild to severe pain. Most commonly used pain relief drug was liquid morphine (58.43%). 65.75% of those who accessed care were resident outside Ibadan and financial constraint was the most reported psychosocial issue (24.16%). At the time of this review, 65 (36.5%) have gone back to their respective home base from where they were referred, 102 (57.3%) were reported dead while 11 (6.2%) were still in the care of the palliative care team.

Conclusion: Pain is a major symptom at presentation for the majority of those that accessed the palliative care services. Most of those who accessed these services were resident outside Ibadan indicating additional travel cost to receive treatment. There is a need to adopt a palliative care model suitable for resource poor environment that would be available to the patients near their homes to avoid long distance travel to access palliative care services and reduce the cost of treatment on the long run.

Keywords: Palliative care; Initial experience; Evaluation

Introduction

The occurrence of cancers in Africans was once believed to be rare due to the high prevalence of communicable diseases. Parkin et al. reported that in indegenous African population, 650,000 people of the estimated 965million are diagnosed of cancer annually [1]. WHO reported that worldwide 12.5% of all deaths are attributable to cancer and if the trend continues, it is estimated that by 2020, 16million new cases will be diagnosed per annum out of which 70% will be in the developing countries [2]. The relative frequencies of breast cancer among other female cancers, from Cancer Registries in Nigeria were 35.3% in Ibadan, 28.2% in Ife-Ijesha, 44.5% in Enugu, 17% in Eruwa, 37.5% in Lagos, 20.5% in Zaria and 29.8% in Calabar [3,4]. Breast cancer is the commonest cancer among women in Nigeria and the incidence is increasing [5]. Cervical cancer on the other hand is the second most common cancer among women worldwide, with an estimated 529,409 new cases and 274,883 deaths in 2008 with about 86% of the cases occurring in developing countries [6]. It is one of the few preventable cancers since it has a clear pre-cancer stage [7]. Despite the preventable nature of this cancer, it is still a major public health problem found mostly among poor communities with limited facilities for screening [8]. In Nigeria as in most other developing countries, most breast and cervical cancer patients present late in hospital with little hope of cure [5,9,10] and hence in need of palliative care services.

The University College Hospital, Ibadan is a foremost cancer referral centre in Nigeria and the first to have structured palliative care services. The palliative care service was commenced in 2007 as a collaborative effort between the hospital and the Centre for Palliative Care Nigeria (CPCN) which is a non-profit making organization. The centre itself though a daycare hospice and palliative unit also offers palliative services or hospital consultation for patients on admission as well as offer home based care for patients that cannot come to the hospital for whatever reason.

The palliative care team most of whom had trainning both in

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Hospice Africa Uganda and United Kingdom consists of doctors, trained nurses, social workers, pharmacist, physiotherapist, psycho-oncologist, and occupational therapists. The aim of palliative care is to ensure the highest quality of life for patients and their families. This care aims to relieve suffering and improve quality of life through a holistic patient care that addresses the physical, mental, spiritual and psychosocial needs [11-13]. The purpose of this study is to present a review of patients with advanced cervical and breast cancer who received palliative care in the University College Hospital hospice palliative care unit within 30 months of commencement of the hospice. These groups of cancer patients were studied because they formed the bulk of patients accessing the palliative care services on outpatient basis.

Material and Method

This was a retrospective review of all patients with advanced uterine cervical and breast cancer that accessed palliative care in our daycare hospice centre from June 2008 to December 2010. Services at the centre are strictly outpatient services but from time to time palliative services are extended to patients on the ward who require them. Hence participants for this study are strictly outpatients who accessed palliative care. Information retrieved from patients treatment notes included age, state of origin, place of domicile, source of referral, stage of disease at referral, pain and other presenting symptoms, pain score at presentation, analgesics, and other treatment received by patient, HIV status, level of satisfaction, outcome and psychosocial/spiritual issues. The pain score was done using Visual Analogue Scale (VAS). The data extracted were presented in a simple descriptive analysis.

Results

In the period under review, 178 patients with advanced uterine cervical (80) and breast (98) cancers accessed the newly introduced palliative care services alongside other treatment. The age range for the two groups of patients was 17 to 96 years; mean age was 55 years and 54 years for cervical and breast cancer respectively. Table 1 showed details of age distribution among the patients. 55% of breast cancer patients and 66% of cervical cancer patients were seen on outpatient basis while residing at the Alanu house, a charity home provided by a philanthropic group to accomodate patients referred from far distance. 25 of the patients domicile in Ibadan were on home based care. Almost all the patients had pain as one of their symptoms at presentation to the palliative care team. Table 3 showed source of patients accessing palliative care service; 100 (56.2%) of them were patients referred to the hospital from different parts of the country. All the patients were glad to have been introduced to palliative care service of the hospital, 83 (46.6%) of the patients however regretted non availability of similar service at their home base for continuum of care. The palliative care was seen by all the patients as a "new" treatment approach which was acceptable without any reservation. At the time of this review, 65 (36.5%) had gone back to their respective home base from where they were referred with symptoms well controlled, 102 (57.3%) were reported dead while 11 (6.2%) were still in the care of the palliative care team. Median follow was 6 months.

Table 1 shows that majority of patients (48.88%) that accessed the palliative care services were in the 41-60 age range. Table 2 indicates that 65.73% (% in Alanu house + % outside Ibadan) of those who accessed palliative care services did not live in Ibadan. Table 3 shows that 93.82% of those that accessed palliative care services presented with pain at first visit followed by vomiting (26.40%) and nausea (23.03%). Table 4 shows that over 80% of those that accessed palliative care services had pain scores of between 4-10, indicating moderate to severe pain. Table 5 shows that 57.3% of breast cancer and 69% of cervical cancer cases had 0-3 VSA which represent mild pain while on morphine. Table 6 indicates that majority of those that accessed palliative care services were on liquid morphine, followed by laxative (Bisacodyl) and NSAID (Diclofenac, Ibuprofen). Table 7 shows that psycho-social/spiritual issues data were not recorded for over 50% of those that accessed palliative care services. However, majority for those recorded had financial constraints (24.16%), depression (13.48%) and lack of family support (11.24%).

Age (Years)	Ca Cervix		Ca Breast		Total participants	
	N	%	N	%	N	%
<20	1	1.25	-	-	1	0.56
21-40	6	7.50	38	38.76	44	24.72
41-60	38	47.0	49	50.00	87	48.88
61-80	28	35.0	11		39	21.91
>80	7	8.75	_	_	7	3.93
TOTAL	80	100.00	98	100.00	178	100

Table 1: Age of patients.

Place of Domicile	Ca Breast		Ca Cervix		Total Participants	
	N	%	N	%	N	%
Alanu House (for patients resident outside Ibadan)	54	55.10	53	66.25	107	60.11
Ibadan Metropolis	39	39.7	17	21.25	56	31.46
Outside Ibadan	4	4.08	6	7.50	10	5.62
Not Recorded	1	1.02	4	5.00	5	2.81
Total	98	100.00	80	100.00	178	100.00

Table 2: Domicile while accessing palliative care service.

Breast Cancer	N	Cervical Cancer	N	Total
Pain	96	Pain	71	167 (93.82%)
Vomiting	27	Vomiting	20	47 (26.40%)
Nausea	24	Nausea	17	41 (23.03%)
Weight loss	25	Weight loss	6	31 (17.42%)
Cough	7	Anorexia	7	14 (7.87%)
Dyspnea	7	Fatigue	6	13 (7.30%)
Fatigue	6	Nil symptoms	2	8 (4.49%)
Lymphedema	13	Lymphedema	4	17 (9.55%)

Table 3: Presenting Symptoms.

Pain Score	Ca Breast		Ca Cervix		Total Participants	
	N	%	N	%	N	%
0-3 (Little/No pain)	3	3.02	7	8.75	10	5.62
4-6 (Moderate pain)	58	59.18	20	25.00	78	43.82
7-10 (Severe pain)	35	35.74	42	52.50	77	43.26
Not recorded	2	2.06	11	13.75	13	7.30
Total	98	100	80	100	178	100

Table 4: Pain score at presentation using visual analogue scale (VAS).

Breast Cancer			Cervical Cancer		
Pain score VSA	N	%	Pain score	N	%
0-3	55	57.3	0-3	49	69
4-6	21	21.8	4-6	15	21.2
7-10	20	20.9	7-10	7	9.8
Total	96			71	

Table 5: Pain Score after medication with morphine.

Drugs	CA Breast	CA Cervix	Total
Liquid Morphine	55	49	104 (58.43%)
Dihydrocodein (DF118) Tramadol	26	12	38 (21.35%)
Nsaid (Diclofenac, Ibuprofen)	34	15	49 (27.53%)
Acetaminophine	4	12	16 (8.99%)
Antidepresants	-	3	3 (1.69%)
Laxative (Bisacodyl)	38	42	80 (44.94%)

Table 6: Analgesics and adjuvant drugs used in pain relief.

Issues	CA Breast	CA Cervix	Total
Financial Constraint	18 (18.37%)	25 (31.25%)	43 (24.16%)
Depression	13 (13.27%)	11(13.75%)	24 (13.48%)
No Family Support	7 (7.14%)	13 (16.25%)	20 (11.24%)
Not Documented	60 (61.22%)	31 (38.75%)	91 (51.12%)
Total	98 (100.00%)	80 (100.00%)	178 (100.00%)

Table 7: Psycho-social/spiritual issues.

Discussion

Cancer of the breast has been reported over the years as the commonest female malignancy closely followed by cancer of the uterine cervix [14]. In this environment just like any other developing countries over 70% present in late stages when cure could not be achieved with radical treatment, palliative care remains the only option left to alleviate the sufferings from pain and distressing symptoms.

This study reports that 93.82% of those that accessed palliative care services presented with pain at first visit with over 80% of those that accessed the care having pain scores of between 4-10, indicating moderate to severe pain levels. Using the Visual Analogue Scale (VAS) the pain was moderate (4-6) in 60% and severe (7-10) in 36% of the breast cancer patients while for cervix cancer patients, moderate pain was experienced by 28% and severe pain by 59%. Researchers have consistently reported that 60 to 90 percent of patients with advanced cancer experience moderate to severe pain, irrespective of age, gender and whether ambulatory or hospitalized [15,16]. Therefore, effective pain management is the hallmark of a good palliative service.

Many of the patients 55(57.3%) in breast and 49(69%) in cervix had their pains effectively controlled with liquid morphine with an average VAS of 1-3. Liqiud morphine is a cheap medication when they are provided by the hospital. However, there are challenges experienced with the regular supply of this drug. This makes it necessary for patients to source for the drug from outside the hospital pharmacy at prices almost ten times the hospital cost. This often poses a serious challenge to many of many indigent patients who are unable to afford the cost. Availability of liquid morphine is the main stay of palliative services, for many of our patients to have effective pains relief they should have access to the drug. Federal Ministry of Health (FMoH) is the sole importer of powered morphine used in preparation of the liquid morphine in Nigeria. The country has witnessed non availability of powered morphine for close to two years, making access to the drug almost an impossibility. The major barriers to palliative care in Nigeria like other low and middle income countries are scarce resources, lack of national policies or low priority for pain relief. Issue of addiction or diversion of drug is not yet seen in our enviroment, but in western world like in the United States of America the problem of prescribed drug abuse, addiction, medication errors and diversion etc, with doctors facing litigations and different jail terms have been reported [17,18].

Other medications given to these patients in the absence of morphine were Non Steroidal Anti Inflammatory Drugs (NSAID), weak opioids like Dihydrocodeine and Antidepressant, these are relatively cheaper but often do not achieve adequate pain relief like morphine. Other distressing symptoms were vomiting, nausea and weight loss, these are usually interrelated since appetite will be compromised in the presence of nausea and vomiting with resultant weight loss. Center for Palliative care Nigeria (CPCN) in collaboration with Palliative care team of the UCH conducts regular home visits thus relieving the patients of cost of visit to the hospice while having access to their health care providers.

With regards to psycho-social/spiritual issues reported by those that accessed palliative care services, 24.16% indicated financial constraints, depression (13.48%) and lack of family support (11.24%). Most cancer patients in developed countries are able to cope with the financial burden of cancer treatment due to their embrace of the health insurance schemes. Such schemes though recently developing in Nigeria are not yet deeply entrenched. Most patients finance their treatment from personal fund since the National Health Insurance does not cover cancer treatment or palliative care services, hence the financial burden of cancer on the patients and their caregivers remain enormous. Before now, the strong family support system often experienced in most African families help to cushion the burden of illness. This strong benefit of extended family system in Africa is being lost to westernization; many now focus on their nuclear family while neglecting the distant relations. In Uganda palliative is far more established and their hospices are free standing being maintained on donations from overseas, hence patients have access to practicaly free palliative care services. The leading center in Uganda is Hospice Africa Uganda founded in 1993 by Dr. Anne merriman, this center is in the fore front of palliative care services and education in Africa. In Nigeria most of our palliative efforts are in the government hospitals hence faced with a lot of challenges from bureaucracy, the challenge is heightened when the management of such government hospitals are not convinced of relevance of palliative care. Merriman remarked in one of her publications that free standing hospices are essential to bring in the ethos and spirit of hospitality so essential to palliative care [19].

This initial evaluation of palliative care experience in our environment gives much needed insight to problems, challenges and area of need assessment in the nascent palliative care service in Nigeria and by extension in other Africa countries. Palliative care services are urgently needed in all parts of the country in view of huge burden of cancer in our enviroment. Cconsidering the level of poverty and the ugly trend of diminishing extended family support amongst our community, home based and rural mobile palliative care would be more appropriate for initial take off in order to increase accessibility to the people in their local communities, without needing to travel long distance to tertiary hospital based palliative care services.. In this study only 56 (31.4%) were from Ibadam metropolis while majority (68. 6%) were from outside Ibadan. Patients that had gone back to their places of abode outside Ibadan may not have continued with palliative care since there are very few centers in Nigeria with such facilities. Accommodation was a huge challenge for the generality of the patients, with poor sleeping and eating conditions for already ill patients, this may not be too far from what is obtained in other poor African countries, further supporting the need for palliative care service that is close to the people. CPCN in collaboration with Hospice and Palliative care Association of Nigeria (HPCAN) are intensifying efforts in inceasing awareness of palliative care in Nigeria through workshops, conferences and training programmes, by this more teaching hospitals are now having palliative care units, more stand alone palliative care bodies are coming up, hopefully through this, palliative care services will soon get closer to the people in their homes. It is hoped that States

and Local governments will embrace palliative care to furher spread the services to more local communities.

Conclusion

Pain is a major symptom at presentation for the majority of those that accessed the palliative care services. Most of those who accessed these services were resident outside Ibadan indicating additional travel cost to receive treatment. There is a need to adopt a palliative care model suitable for resource poor environment that would be available to the patients near their homes to avoid long distance travel to access palliative care services and reduce the cost of treatment on the long run. Liquid morphine which is the main stay drug of palliative care should be more available and accessible.

Limitation of the Study

A major limitation of this study is the lack of complete documentation of data for the psycho-social/spiritual issue experienced by patients at presentation. Few data obtained on the number of patients on laxatives suggests a problem of documentation and or omission of the drug in some patients on opioid medication in our practice all patients on opioids are routinely placed on laxatives to prevent costipation which sometimes could be very distressing. Proper documentation must be taken very seriously to avert future problems that may arise from documentation omission or error. This is however, a retrospective study and it is hoped that these limitations will be addressed in subsequent publications.

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