Rehabilitation of Cancer Disable

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Rehabilitation has become a necessary part of comprehensive care for cancer patients, because of the extent and variety of their treatment related and disease related disabilities.

The majority of cancer patients are in their years of greatest productivity, family, social and community responsibility and therefore are a group of great importance. Rehabilitation of the cancer patient has offered a great challenge in direct ratio to the increasing number of cured and controlled patients. Nearly 40 percent of today's new cancer patients will have a cure and 60% with persistent, recurrent or metastatic cancer will have increased survival periods and 15% of this latter group will still be alive 15 years after the first diagnosis.

Since the time of survival is increasing due to improved methods of control of the disease, both cured and controlled patients have frequent need for rehabilitation to improve the quality of survival for each individual, so that they will be able to live as independent and productive life, as possible at minimum level of dependency, regardless of life expectancy.

The first step in provision of rehabilitation care is the prompt recognition of the presence of existing disability and ideally the recognition of potential disability. Initial examination and evaluation of the patient and the provision of the first orders for rehabilitation care can be made at the bed side without waiting to reach a status of readiness for being moved to a rehabilitation service department.

Rehabilitation therapy started early can eliminate development of periods of hopelessness, frustration and despair in cancer patients.

BACK GROUND

Rehabilitation of disability resulting from cancer or its treatment has not been practised until recently. Cancer patients have not been considered eligible regardless of whether their condition was cured, controlled or advanced.

The diagnosis of cancer is associated with fear of the unknown and carries a stigma of dread and an out of proportion sense of finality. The diagnosis of other disease with lethal potential like coronary occlusion and stroke, is usually accepted with far less emotional reaction. Vast rehabilitation efforts are directed towards stroke and heart patients in comparison to cancer patients. This deep seated fear of cancer has prevented wide spread public understanding of the actual potential that exists for cure or long term survival and associated rehabilitation now possible.

Todays physicians are oriented towards acute disease, and consequently have little interest in disability or its rehabilitation. No cohesive interaction has been developed between various disciplines to assume a role in the comprehensive care of patients to ensure the quality of their survival.

Physicians must be aware of the need for rehabilitation and understand that a proper survival pattern for all patients can provide economic and human returns from the investment in rehabilitation efforts.

MEANING OF REHABILITATION

Rehabilitation involves treatment and training of the patient to the end that he may attain

his maximal potential for normal living physically, psychologically, socially and vocationally.

There are wide varieties of specific disability found in cancer patients. The problems may be regional related to the site of the disease, or generalized. Brain, spinal cord, or peripheral nerve involvement may cause muscular weakness, sensory loss or paralysis, and require specific care. Peripheral nerve involvement requires splinting or support for wrist or foot drop. Patients who may have developed hemiplegia and paraplegia need a standard care programme. Head and neck surgery frequently produce cosmetic problems. Mastectomy may be emotionally depleting and leave physical deficit. The patients undergoing thoracic surgery, need training and assistance in postoperative respiratory functions. Patients who undergo amputation need training and guidance for a suitable prosthesis. Other disabilities which need attention are joint contractures, osteoporosis, pathological fractures, urinary calculi, phlebothrombosis and pneumonia.

When disease or its treatment leave the patient with severe physical impairment, a resultant need is created for an adjustment to a new way of life. The sudden knowledge of catastrophic illness can find the individual psychologically ill, unprepared for any change in capacities and status. Simple survival becomes no longer the patient's only cause of anxiety. Attention turns to his or her residual physical limitations and unless specific rehabilitation assistance is immediately available, dependency, depression and fear may become source of deeper problems. Experience has indicated that rehabilitation should begin at the earliest possible opportunity, and be continued through out the entire convalescence, until maximum benefits can be achieved.

GOALS AND OBJECTIVES OF REHABILITATION

The initial goals of rehabilitation of cancer patients are elimination, reduction or alleviation of disability, while the ultimate goal is reestablishment of the patient as a functional individual in his or her environment.

The goals should be selected for each patient after initial evaluation at the onset of care in order to establish a programme that can provide realistic results. Individual goals depend on the certain factors relevant to the patient, and are as follows : —

(1) Preventive: when the disability can be predicted, and the appropriate prior training can reduce the severity of its effect. (2) Restorative: if the patient can be expected only to have minimum residual handicap and can return to a fully active life style and work. (3) Supportive: when the patient will have to tolerate ongoing disease or persistent disability but can make appropriate gains, towards control of problems, and improved day to day performances. (4) Palliative: if advanced disease and basic disability exist, that cannot be corrected, but where training can aid comfort, performance, and emotional support. This is also important if pain is to be reduced, for the correction of hygienic problems, treatment and prevention of decubitus ulcers, and maintenance of whatever independent function, the patient can assure for remaining period of his life.

Other factors to be considered for the programme include age of the patient, type and stage of the disease, other unrelated disabilities present, physical control, social and vocational back ground and basic education. Patient's home circumstances and surroundings must also be considered.

The treating physician should provide initial assessment on which appropriate rehabilitation programme can be based. Planning can then be started early for patient's rehabilitation needs, or referring the patient to the rehabilitation area is likely to be more effective, the sooner such rehabilitation efforts are started.

This early approach is important because bed rest alone allows nearly 3% per day loss of combined muscle power and endurance, and can carry a patient beyond an independent ability to get out of bed. This is also complicated by emotional disability that can result from prolonged inactivity of any kind. The immobilized patient should have a suitable physical and occupational therapy bed programme, prescribed and instructed.

To meet the goals, the following objectives should be considered.

(a) General objectives

1. To provide rehabilitation care for the greatest variety of needs, so as to minimize disability, dependency, emotional stress, and the complications of illness or treatment. 2. To contribute to discharge planning and future purpose of individual patient, as needed.

(b) Specific objectives (According to individual Goal)

1. To provide preventive measures so as to improve function and reduce morbidity and disability. 2. To provide restorative measures for patients with potential cure of cancer, whose residual disability can be appropriately controlled, or eliminated. 3. To provide supportive measures for patients who must continue with cancer, but can expect relative control or remission for appreciable time, and in whom disability, emotional stress or discomfort can be lessened by rehabilitation care. 4. To provide palliative measures for patients whose disease is advanced and relentlessly progressive, but whose disability, discomfort, and stress can be mitigated by rehabilitation.

The psychological problems faced by patients, are sometimes as devastating as the physical consequences of disability, therefore attention should be given to psychosocial as well as physical and vocational rehabilitation. Prompt rehabilitation attention can reduce the disability and the time needed for recovery of the patient's handicap.

CONCLUSION

(1) Disability from cancer or its treatment can be considered by the same criteria as are used for non-cancer disabilities.

(2) It is essential to establish early recognition of patient's existing and potential disability and of rehabilitation needs and to stimulate prompt referral for rehabilitation care.

(3) Rehabilitation therapy started early can reduce the disability and time needed for recovery of patient's handicap.

(4) Each patient should be considered on individual basis, with evaluation of the medical findings, the prognosis, and maximum eventual gain to the patient, his family, and the community, then comprehensive medical care be provided to patient, for improvement in his quality of survival.

(5) Realistic goals are necessary for rehabilitation of the cancer patient. The patients should be assisted in reaching improved performance levels. Even in instances where the patients life expectancy is limited, efforts towards maintaining function at maximum potential may produce results that transcend an economic return.

(6) The physician should commence intensive medical care and early rehabilitation of the handicapped in acute hospital setting, incorporating rehabilitation services into ongoing hospital programme, is therefore part of comprehensive care for all cancer disabled patients.

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