

Magic Word “Palliative:” An End to Cure but No End to Care

Sir,

Although palliative care is beneficial for people at the end of their lives, it is also relevant for people diagnosed with an incurable illness, when they are still healthy. Palliative care is about life, quality of life (QOL), and allowing people to make informed choices about the way they want to live the rest of their life. Palliative care is more than just treating pain and symptoms as suffering goes beyond pain. “There is nothing more that we can do for you” is one of the most searing phrases a patient can hear. But, if we see a patient as a living, thinking, and feeling human being, there is always something that can be done and palliative care will do all, it can not only help you to die peacefully but also help you to live until you die. To cure sometime, to heal often, and to comfort always are the salient features of palliative care. In India, our medical teaching is such that we keep concentrating on curative care and are not taught about comfort care. The concept of palliative care is as important as curative care.

Here, I am discussing one such case of advanced breast cancer in which palliative care compassionately and effectively easing her suffering, thereby making her life not only tolerable but also often worth living.

It is all about a 50-year-old married but nulliparous lady without any medical risk factors or addiction. She was a diagnosed case of carcinoma of the left breast for which she underwent modified radical mastectomy followed by six cycles of adjuvant chemotherapy and tamoxifen. She was advised adjuvant radiotherapy but could not receive it due to financial and logistic issues.

After a 1½ year of disease-free period, she presented to us with a histologically proven recurrence at the chest wall in the form of a large 5 cm × 5 cm ulcer with contralateral axillary lymph node of size around 3 cm × 3 cm and massive pleural effusion on the left side with suspicious lung metastasis. At the time of presentation, she had complained of pain at the local site with Visual Analog Scale score 3–4, severe breathlessness which is increasing on lying-down position, and unable to sleep for the last 10 days. Her Karnofsky Performance Status (KPS) was 60. Before presenting to our institute, she had consulted multiple physicians for these distressing symptoms, but the answer was “there is nothing more that we can do for you,” “wasting of money and time as there is not much to do,” and “take her back at home.”

Being a palliative physician, I quietly submitted to the patient that my first aim is to provide you symptomatic relief so that you can lie down comfortably, have proper sleep, and then only I will see further what can I do for you. With the aim of providing comfort, we have admitted the patient and started on paracetamol 1 g thrice a day with metrogyl

dressings. Pleural fluid aspiration was done immediately to relieve her dyspnea followed by chest tube drainage. The very next morning, she was a lady with a great relief and comfort. She was able to lie down and had comfortable sleep overnight after prolonged sleep deprivation because of breathlessness and pain. However, now, she was worried about her household activities which earlier she used to do. Therefore, pleurodesis (NOT with talc but with betadine which is very cheap) was done to prevent recurrent pleural effusion.

Now I have to decide, can we do something to reduce disease burden with no added side effects to further improve her QOL. As I already know, it was a metastatic disease in the form of contralateral axillary lymph node and pleural effusion. As I learned and imbibed the words “palliative” and “care,” I am no more only oncologist, taking care of financial and emotional aspect is another important aspect for further treatment plan. In view of this, instead of choosing series of costly investigations (positron-emission tomography-computed tomography [CT], CT-thorax, CT-abdomen, magnetic resonance imaging brain, and bone scan) to prove more metastatic sites, ultrasound abdomen and serum alkaline phosphate level were done to know about her liver condition and bone metastasis which revealed normal study. Multiple counseling sessions with her and her brother (caretaker of the patient) were done about the metastatic disease and getting cure is not possible, but still I want to give a trial of chemotherapy with low-dose single agent of weekly schedule so that, if there is any toxicity or no response or both, I can stop it immediately. Along with chemotherapy, dressing and analgesics was continued.

On follow-up after 4 weeks, she was pain free, stopped analgesics herself, able to do her household work, and able to climb upstairs without any assistance. After 6 weeks, she has gained confidence and asked herself for more chemotherapy as she had not developed any discomfort in the form of nausea, vomiting, diarrhea, and neutropenia. In fact, not only the patient and her brother but also I and my colleagues get confidence in such palliative doses and schedule of chemotherapy. Now, we have started her on 3-weekly schedules as a part of palliative care. I have not converted chemotherapy into doublet or triplet regimen as I can only provide her symptomatic relief and no cure, so I do not want to add any toxicity, supportive therapy, and expenses.

After 6 months, I am actually surprised that she has started gaining weight (5 kg in the last 3 months; normal ultrasound abdomen and chest radiograph to reconfirm that this weight gain is not because of pleural effusion or ascites), her KPS is 90, no breathlessness, no pain, no analgesics, no dressing as

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fungating ulcer had converted into scab without any discharge, and able to do not only her households but also her daily outside work.

Hence, it is a story of only about 6 months, but I just want to share these 6 months of happiness, symptom free, a much-improved QOL, and no added toxicity. I feel without having an approach of palliative care I am not able to do it, may be as oncologist I am able to achieve the same or better response in disease but with the cost of toxicities, decreasing QOL, more stay in hospital than home, much more money, and even decreasing QOL of his brother.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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