An Overview of patients admitted to Cancer Home, Varthalaivilan, Tellipallai.

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Introduction

Terminal care of patients with any incurable disease, and in particular cancer, is as important as medical care of any other patient. The alleviation of the suffering of the patient, till his / her demise and the relief of burden on the family members and their cost of management are potent reasons for establishment and functioning of terminal care homes.

The incidence of cancer in the Northern Province is five times that in the South[1]. The Radiotherapy Unit housed in District Hospital, Tellipallai, has not started functioning for want of a Radiotherapist, and many patients are reluctant to go to Maharagama Cancer Institute, owing to travel, financial and language problems. Especially in our Province, therefore, a Cancer Home is very essential.

The Cancer Home established by our Society to care for 25 to 30 patients, started functioning on 27th of January, last year (1989). An overview of patients admitted during the 11 months from 27th January, is presented.

Materials and Methods

62 patients are available for review. Some were found to be curable and were referred to Jaffna General Hospital and if Radiotherapy was necessary, to Maharagama Cancer Institute (if the patient was willing). Daily states were recorded (by Registerd Medical Practitioner) on a Monitors exercise Book with annexed Drug Chart and Symptoms and Signs Chart and necessary drugs

prescribed (by R. M. P). The symptoms and signs chart was filled by the Visiting Surgeon (author), on his weekly visit, with review of the patients and necessary action taken.

Results.

Diagnosis (Table I)

Table I

Cancer of		No. Living.	No. dead.	Total	
Cheek	Oral Cavity	11	3	14	31 (50%)
Tongue		7	2	9	
Palate		3	1	4	
Alveolus		1	1	2	
Floor of Mouth		1	1	2	
Breast		6	1	7	
Oesophagus (Gullet)		2	1	3	
Larynx		3	0	3	
Cervix		2	1	3	
Hodgkins		2	0	2	
Pyriform Fossa		2	0	2	

One each of the balance cases were: Cancer of liver, Uterus, Kidney, Epiglottis, Bladder, Tibia (Shin bone), Face, Forearm and a case of secondary from unknown source. In one the diagnosis was not known and was referred for investigation and treatment.

It will be seen that 50% of cases (31) were of cancer in oral cavity, the cheek (14) and tongue (9) forming the majority. There is no doubt that Betel Chewing (table IV) and / or Cigar Smoking (table V) were responsible for these cases and were therefore preventible. Betel chewing and/or cigar smoking could have contributed to the causation of cancer of pyriform fossa (2) larynx (3) epiglottis (1) and Oesophagus (1) too. Though Oesophagus is the second commonest region affected in our Province only three had come to the Home. This may probably be due to their getting "cured" or dying too soon.

Number Alive and dead

44 are living and 18, dead, 4 in Cancer Home and 14 in their own home, having left earlier.

AGE (Table II)

Table II

Age Group in Years	No of patients		
	Living	Dead	Total
0 to 10	1	0	1
11 to 20	1	0	1
21 to 30	1	0	1
31 to 40	4	0	4
41 to 50	9	6	15
51 to 60	10	4	14
over 60	18	8	26
	44	18	62

55 (88.9%) were over 40 years of age, 26 of them (41-9%) being over 60. One was an 8 year old with Osteosarcoma of Tibia. One a 22 yr old with Hodgkins from the age of 9 years, and one 30 Year old with cancer of Breast.

SEX (Table III)

Table III

Sex	Living	Dead	Total
Male	25	7	32
Female	9	11	30

Sex was equally represented

Civil status 59 were married

No of children Information was rccorded in only 20. 4 had 1 or 2 children, 3 had 3 to 5, 12 more than 5 and one none.

Breast feeding Recording was poor, are hence not analysed.

Betel chewing Table iv

Table iv

Number of chews / day	No. of patients	No. of yrs	No.of pts
1 to 3	13	less than 5	4
over 3	27	6 to 10	6
		over 10	30

40 (60%) chewed betel, all except two using tobacco. All used lime and arecanut. Many patients (27 out of 40) had more than 3 chews per day and 30 out of 40 chewed for more than 10 years: some of them even 20 to 30 years. Most of them kept the chew in the cheek for more than 10 to 15 minutes but very few only swallowed it.

Smoking (Cigar) (Table V)

Table V

No. of Cigars	No. of Patients	No. of Years	No. of Patients
1 to 2	10	Less than 5	3
3 to 5	5	6 to 10	3
Over 5	7	Over 10	16

22 (35.4%) smoked cigars, 12 of them smoking more than 3, a day. 16 of them were smoking for more than 10 years, 3 of them between 6 to 10 years and 3 below 5 years.

7 smoked cigarettes (2 cigars too) and 2 beedi for more than 10 years.

Alcohol 13 took alcohol, 11 of them for more than 10 years

Period of Presentation After Treatment (Table VI)

Table VI

Period	Number of Patients
Less than a month	5
1 to 6 months	14
7 to 12 months	6
1 to 3 years	9
4 to 6 years	9
Over 6 years	5

25 out of 48 presented at the Cancer Home within an year of treatment (5 of them within a month), 9 within 1 to 3 years, 9 within 4 to 6 years and 5 after 6 years. In 3 the period after treatment was not known. 11 were curable cases and were referred for treatment to appropriate institution.

Symptoms and Signs (Table VII)

Table VII

Symptoms & Signs	No. of Living Patients	No. dead	Total
Pain	33	14	47
Depresion	11	8	19
Difficulty in-Swallowing	10	6	16
Insomnia	7	8	15
Weight Loss	5	5	10
Weakness	6	1	7
Sore Mouth	4	3	7
Anaemia	4	2	6
Anxiety	3	3	6
Cough	4	0	4
Swelling (thigh, arm)	1	1	2
Leucorrhoea	1	1	2

In addition to above, Hoarseness, Constipation, Vomiting, Pruritus, Groin Ulcer, Urinary Incontinence, Frequency of Micturition, Cervical fistula and dyspnoea were observed in one patient each.

Pain was present in 47 (75.9%) patients. Depression, Difficulty in swallowing, insomnia, weakness, weight loss, sore mouth were other predominant sympoms. Difficulty in swallowing was usually due to trismns (difficulty in opening mouth) and/or pain. Sore mouth was due to ulceration and vitamin deficiency.

Many had more than two or three symptoms.

Duration of Stay

The average duration of stay was 37 days. Excluding those referred for cure and those who left on their own or died within 10 days, the average duration was 52 days. Two patients (who expired) stayed 7 months and 8½ months. Six patients stayed 171*, 141, 135, 115*, 106* and 104 days. (*expired)

Management

The aims of management have been spelt out by many authors:

i. "Terminal Care is a facet of oncology concerned with the control of Symptoms instead of with the control of the tumour"[2].

ii. "We should aim for the relief that enables a patient not only to die peacefully but also to LIVE until he dies[3] ——————"

iii "The concept of palliation is directed especially towards the wellbeing and comfort of the patient but included also must be the family and society[4]".

We have made every effort to relieve suffering (Table VII) both physical and mental. Staff who participated comprised Resident R. M. P. Nurses (3), Male (2), and Female (2) Attendants, Cooks (2), Labourers, Male (2) Female (4), Sanitory Labourers (2) an Administrative Officer and Visiting Surgeon.

Selected patients were sent to G. H. Jaffna for adjuvant and / or palliative cytotoxic therapy, returning to Cancer Home, after each course. Some not treated earlier were sent to appropriate instiution for treatment aimed at cure. We could not undertake the psychological treatment of the family owing to the existing situation but they were obviously relieved of the burden of management of the patient (not likely to be efficient) and the cost that would be incurred.

Counselling and spiritual therapy are important aspects of the Bristol Programme, practiced by the Bristol Cancer Help Centre[5] Counselling was undertaken to a limited extent by the author. Spiritual therapy was attempted (one class in meditation was given by Swami Siththananda) but the continued response by the patients was poor. It would be necessary for a "Guru" to visit at least every other day for beneficial effect and we hope to arrange this once the situation improves. Saibaba devotees conduct 'Bajanas' fairly frequently. Priests of other denominations, visit too. Occupational therapy was not instituted.

Symptomatic relief was achieved by use of analgesics, antidepressants, tranquillizers, hypnotics, antibiotics, vitamin & mineral preparations, local dressings and other measures. Appropriate patients were given palliative hormonal therapy. Solid, semisolid and liquid food was given depending on the patient's ability to swallow. Some had to be fed by the

feeding cup and one by Naso-gastric tube. Items in diet were varied day by day, a chart being kept in the kitchen. Jeevakaram, Fruits, tea, milk were also served. Meal donations in memory of their beloved were made by members of the public. Saibaba devotees, in rotation, prepared varied puddings, taken to the Home at visits by the author.

A lounge with Radio and Television and a Room with story books and journals are other facilities available for the patients. The building was so designed to site 2 toilets for four rooms within a yard of the room. Bed pans and urinals are used for those too weak to go to the toilet.

Relief of most symptoms was obtained after a variable period and drugs could be omitted but except for pain due to infection which subsided with antibiotics, analgesics had to be continued indefinitely in most patients.

Overall, the Cancer Home has served to relieve the suffering of many patients and relieved the burden on their families. However, those seeking relief have been few. Though we could accommodate 25 to 30 patients, there has been on an average only 9 to 10 at any one moment. It is hoped that this article would serve as an incentive for those suffering in their own home, to seek our services and benefit thereby. Patients from any part of the Island are welcome.

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An Appeal

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