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Profile of patients in palliative care treated by physiotherapy in home care at an oncology hospital

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Abstract

Population aging and the increase in chronic non-communicable diseases, including cancer, have required the incorporation of Palliative Care (PC) into health care networks. Thus, the objective of this study was to describe the profile of patients in palliative care treated by physiotherapy in home care at an oncology reference hospital. This is a cross-sectional, quantitative, retrospective and descriptive study, analyzing 76 medical records of patients assisted by physiotherapy in the hospital's home care between August 2018 and August 2019. The majority of patients were female (n=51, 67.11%), of black race/color (n=46, 60.52%), aged between 60 and 80 years (n=36, 47, 37%). Breast (n=22, 28.95%), lung (n=11, 14.47%) and prostate (n=8, 10.53%) cancers were the most common and the majority showed disease progression. Finally, the main reason for physiotherapy monitoring was related to functionality and mobility. The characterization of patients who require physiotherapeutic care in home care at an oncology reference hospital is necessary for better care planning as such information can direct therapeutic possibilities, allowing greater effectiveness in treatment.

Keywords: Neoplasms. Palliative care. Home Care.

INTRODUCTION

The world population is going through a process of demographic transition and this movement occurs simultaneously with the change in the epidemiological profile of the population, in which there is an evident increase in the prevalence of chronic non-communicable diseases (NCDs)[1]. Among NCDs, cancer is considered the main public health problem in the world, being one of the main causes of death and, as a consequence, one of the main barriers to increasing life expectancy[2].

Estimates indicate that in Brazil in the 2023-2025 period, around 704 thousand new cases of cancer will occur each year, which reveals the magnitude of the problem. With population aging, the consequence of which is revealed by the substantial growth in the number of elderly people, which in turn results in an increase in the incidence of NCDs, has required the incorporation of Palliative Care (PC) into health care networks[1,2,3].

The World Health Organization (WHO) considers that PC can and should be offered as early as possible in the course of any potentially fatal chronic disease, defining it as assistance promoted by a multidisciplinary team, which aims to improve the quality of lives of patients and their families, in the pre-

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sence of problems associated with life-threatening illnesses, through prevention and relief of suffering through early detection and treatment of pain or other physical, psychological, social and spiritual problems, including the mourning period[4].

PC can be provided through three care models: hospital, outpatient and home. Each of them has its advantages and disadvantages, however, home care differs in that it allows the user to be welcomed into their own home, close to their family and without the obligation to adapt to the hospital routine[5].

Home Care (HC) was established by Ordinance No. 2,029 of August 24, 2011 and was redefined by Ordinance No. 825 of April 25, 2016, being defined as a set of actions that seek to prevent a health problem, its maintenance and recovery of the patient already affected by a disease or sequelae. It is a continuous activity, with specific and personalized supervision and action from the healthcare team. Aimed at patients with chronic diseases of moderate complexity who require assistance similar to that offered in a hospital environment. Its purpose is to promote inclusion, improve quality of life and preserve or restore the patient's health. To achieve these objectives, the team offers human resources, equipment, materials, medicines, taking into account the potentials and limitations of the patient and family, adapting them to the patient's health condition[6].

In this way, HC has been adopted in PC to reduce the demand for hospital care, continuing treatment, reducing the risk of hospital infection, restoring bonds and greater autonomy for patients and their families, promoting prevention and reducing suffering, enabling better quality of life[7].

Included in the multidisciplinary team that works in HC and in the care of patients in PC, physiotherapy has its activity recognized through Resolution No. 539, of September 27, 2021, which recognizes the activity of physiotherapists in PC, with the aim of improving the quality of life of patients without curative possibilities, reducing symptoms and promoting their functional independence[8].

In the context of home care, the physiotherapist's objective is to: adapt the patient's environment, prevent health problems, provide palliative care and care for patients unable to travel to the health unit. The session may consist of exercises/maneuvers on the patient, guidance and training of the caregiver for the maintenance or rehabilitation of the patient, aiming to improve the quality of life at home[9].

The present study aims to describe the profile of patients in palliative care treated by physiotherapy in home care at Cancer Hospital IV – HC IV.

METHODOLOGY

This is a cross-sectional, quantitative, retrospective and descriptive study analyzing the medical records of patients assisted by the physiotherapy service in home care at the Cancer Hospital IV (HC IV) of the José Alencar Gomes da Silva National Cancer Institute (INCA), from August 2018 to August 2019.

HC IV is INCA's Palliative Care unit, responsible for active and comprehensive care for adult patients referred from other units of the institute. Patients enrolled in this unit can be monitored through home care, a modality aimed at patients who have difficulty or are physically unable to travel to the unit and who require greater frequency of care and continuous monitoring at home. To achieve this, professionals are organized into teams, each serving a specific geographic region, favoring periodic monitoring, creating bonds and trust in continuing care. The multidisciplinary home visit team aims to carry out regular consultations at patients' homes within a distance

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of up to 60 km from HC IV, in places where the team can have easy and free access. The following regions are part of the municipality of Rio de Janeiro: Baixada (Caxias, Nova Iguaçu, São João de Meriti, Belford Roxo), North, West, Center-South and Niterói. The first visit will take place within a week of being referred to the sector. Doctors and nurses carry out regular visits. If they deem it necessary, they may request a visit from other professionals, such as a physiotherapist, psychologist, social worker or nutritionist.

The project was sent for analysis by the Research Ethics Committee of the National Cancer Institute – José Alencar Gomes da Silva and was approved under opinion number CAEE 46759721.0.0000.5274.

The inclusion criteria for this study were: medical records of patients over the age of 18, receiving palliative care at home care and monitored by the physiotherapy service. Incomplete medical records were excluded from the research, that is, with insufficient information to compose the database.

The data collected includes: gender, age group, educational level, race/color, marital status, caregiver and place of residence. Clinical diagnosis, presence of disease progression, reason for physiotherapeutic follow-up, performance status using the Karnofsky Performance Status Scale - KPS, presence of pain, fatigue, edema, lymphedema, dyspnea, use of orthoses in addition to the amount of visits carried out and the length of physiotherapeutic follow-up.

Excel 2010 software was adopted for data entry, as well as for creating tables. The description of the study population was presented in distribution of absolute frequencies (n) and percentages (%).

RESULTS

76 patients treated by physiotherapy in home care between August 2018 and August 2019 were identified through the Physiotherapy Service Care Control System - SISCASF.

Of the 76 medical records analyzed, the majority of patients were female (n=51, 67.11%), aged 61-79 years (n=36, 47.37%), had primary education (n=36 , 47.37%), of black race/color (black and brown) (n=46, 60.52%), married or single (n=27, 35.3%), with the caregiver being mostly children (a) (n=34, 44.74%), residing in the regions of Baixada Fluminense (n=24, 31.58%), north zone (n=17, 22.37%) and west zone (n=15, 19.74%) from the city of Rio de Janeiro, as shown in Table 1.

According to Table 2, it was shown that the main types of cancer were breast (n=22, 28.95%), lung (n=11, 14.47%), prostate (n=8, 10.53%), cervix (n=7, 9.21%), colon and rectum (n=4, 5.26%), melanoma (n=3, 3.95%) and others (n=16, 21 .05%), including oral cavity, central nervous system tumors and multiple myeloma. With the majority of patients experiencing disease progression (n=73, 96.05%).

Regarding the reason for physiotherapy follow-up, the main reason was changes related to functionality/mobility (n=71, 93.43%), pain (n=15,19,74%), bone metastasis (n=9,11,84 %) and fatigue (n=3, 3.95%). With 22 patients presenting more than one reason for follow-up, according to Table 3.

In relation to the information collected through the physiotherapeutic assessment form, most patients had KPS 40% (n=47, 61.84%), had pain (n=45, 59.21%), regarding fatigue 36 patients (47.37%) had complaints, 13 (17.11%) reported dyspnea, 26 (34.21%) had edema or lymphedema and 13 (17.11%) used some type of orthosis. Among those who used some type of ortho-

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sis, the models were of the high or low Putti vest type (n=6, 7.89% both). Regarding the number of home visits carried out by the physiotherapy, most patients received two to three visits (n=47, 61.84%) with a follow-up time of up to one month (n=31, 40.79%) and up to three months (n=20, 26.32%) according to Table 4.

Table 1 - Distribution of sociodemographic characteristics. Rio de Janeiro - RJ, 2019.

Variables	n	%
Sex		
Female	51	67.11%
Male	25	32.89%
Age group		
18-40 years old	5	6.58%
41-60 years old	23	30.26%
61-80 years old	36	47.37%
≥ 80 YEARS OLD	12	15.79%
Education level		
Elementary school	36	47.37%
High school	24	31.58%
College	9	11.84%
Illiterate	7	9.21%
Race/Color		
White	27	35.53%
Black	11	14.47%
Brown	35	46.05%
No classification	3	3.95%
Marital status		
Married	27	35.53%
Single	27	35.53%
Widowed	18	23.68%
Divorced	3	3.95%
No information	1	1.32%
Caretaker		
Spouse	18	23.68%
Children	34	44.74%
Other	24	31.58%
Region of residence		
Niterói-São Gonçalo	8	10.53%
Baixada	24	31.58%
West	15	19.74%
North	17	22.37%
Barra-Jacarepaguá	7	9.21%
Center-South	5	6.68%

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Table 2 - Distribution of clinical characteristics. Rio de Janeiro - RJ, 2019.

Clinical characteristics	n	%
Type of cancer		
Breast	22	28.95%
Lung	11	14.47%
Prostate	8	10.53%
Cervix	7	9.21%
Colon and rectum	4	5.26%
Melanoma	3	3.95%
Esophagus	1	1.32%
Stomach	1	1.32%
Larynx	1	1.32%
Lymphomas	1	1.32%
Ovary	1	1.32%
Others	16	21.05%
Disease progression		
Yes	73	96.05%
No	3	3.95%

Table 3 - Reason for physiotherapy follow-up. Rio de Janeiro-RJ, 2019.

Reason for follow-up	n	%
Functionality/Mobility	71	93.43%
Pain	15	19.74%
Bone metastasis	9	11.84%
Fatigue	3	3.95%

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Table 4 - Distribution of variables collected in the physiotherapeutic assessment. Rio de Janeiro-RJ, 2019.

Physiotherapeutic assessment	n	%
KPS		
30%	13	17.11%
40%	47	61.84%
50%	16	21.05%
Pain		
Yes	45	59.21%
No	31	40.79%
Fatigue		
Yes	36	47.37%
No	40	52.64%
Dyspnea		
Yes	13	17.11%
No	63	82.89%
Edema/ Lymphedema		
Yes	26	34.21%
No	50	65.79%
Uso de órtese		
Yes	13	17.11%
No	63	82.89%
Type of orthosis		
Lumbar vest	6	7.89%
Thoracolumbar brace	6	7.89%
Cervical collar and lumbar brace	1	1.32%
Does not use	63	82.89%
Number of visits		
One visit	14	18.32%
Two to three visits	47	61.84%
Over three visits	14	18.32%
No indication	1	1.32%
Follow-up time		
Up to one month	31	40.79%
1 to 3 months	20	26.32%
3 to 6 months	15	19.74%
6 months to 1 year	9	11.84%

KPS- Karnofsky Performance Status Scale

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DISCUSSION

In the present study, it was found that the profile of patients treated in home care at Cancer Hospital IV is predominantly women (n=51), aged 61-79 years (n=36), black (n=46) , living in the Baixada Fluminense region (n=24), with breast cancer (n=22) and lung cancer (n=11) as the most prevalent, referred to physiotherapy with the aim of improving functionality and pain (n=71 and n=15 respectively).

This result coincides with other studies[10,11], as there are high rates of detection of neoplasms typical of this gender, such as cervical and breast cancer, which stand out among the tumors that affect women around the world, especially in less developed regions. In developed countries, the incidence of cancer between genders is similar due to investments in prevention and health promotion[9,10].

The predominance of the age group found in the studied population corresponds to other studies, a fact possibly related to the high incidence of chronic-degenerative diseases in this portion of the population[12,13]. Advancing age is one of the factors that can influence the prognosis of the disease and the need for oncological PC[2,12].

Regarding educational level, the data found shows that the majority had primary education, a fact that makes it difficult to understand health guidelines. According to the Ministry of Health, the lower the level of education, the higher the incidence of chronic diseases. The results observed in a study where the majority had up to four years of study showed that this fact hinders the understanding of health guidelines, difficulty in accessing preventive programs, assistance with early diagnosis and immediate adequate treatment[14].

It is noteworthy that 60.52% of the participants included in the study were of black race/color (blacks 14.74% and browns 46.05%), which can be explained by the fact that 70% of users served in the Unified Health System Health being black. Regarding the place of residence, it was observed that 31.58% of the participants were from the Baixada Fluminense region, the metropolitan region of the city of Rio de Janeiro, where the majority of the working-class and poor population of the state of Rio de Janeiro is located. We observe a sum of inequalities when we find the combination of low education and black race, this was also demonstrated in the COVID-19 pandemic, in which this group of people in society suffered more from their illnesses or due to lack of access to the health network or due to the fact that institutional racism privileges non-black individuals for care, thus affirming social inequalities[15,16,17].

As for marital status, married and single are equal (35.53% both). Studies highlight the importance of the social situation, influencing the health situation of cancer patients, since the presence of a partner provides social support, reduces the effects of stress and helps maintain treatment and survival[16]. In our research, it was identified that the majority of caregivers are children (44.74%), that is, informal caregivers. It is common to see this type of caregiver, the family caregiver, who assumes care on an unpaid basis, taking responsibility for it spontaneously or out of obligation, solidarity, or a natural feeling of gratitude in the form of retribution. This role generally performs this role full-time, combining it with other daily activities such as environmental hygiene, preparing meals for the family, educating children, among other tasks, accumulating and performing different roles in the family context[15,16,17].

Regarding the most prevalent neoplasms, breast and prostate cancer appear as one of the most frequent in the studied population. Both occupy the first position in all Brazilian regions, without considering non-melanoma skin tumors. There are an estimated 73,610 new cases of breast cancer for Brazil, for

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each year of the 2023-2025 triennium, as for prostate cancer, an estimated 71,730 new cases of cancer[2]. Information found in a study highlights that among the main neoplasms that require palliative care in home care in men, prostate cancer was the most recurrent and, in women, breast cancer[18]. Lung cancer also had a high prevalence in our population. It is worth mentioning that, in the Brazilian population, this type of cancer ranks fourth among the most common cancers. Another type of cancer that stood out in the population was cervical cancer, which currently ranks sixth among the most common neoplasms in women, with an estimated 17,010 new cases for each year of the three-year period[2]. Some authors also emphasize that the high frequency of cervical cancer cases in palliative care is worrying, as it is a neoplasm that is easy to diagnose early and prevent in all basic care in the country[19].

Within HC IV's home care, the main reason for physiotherapeutic follow-up was to maintain functionality and mobility. The physiotherapist within palliative care has a well-defined role, drawing up a care plan and helping the patient to develop actively, adapting them to physical exhaustion and emotional, social and spiritual repercussions according to the course of the illness until death, for the purpose of maintaining, preserving, enhancing or restoring the integrity of organs, systems or function[20].

Another reason for physiotherapeutic follow-up was the presence of pain, a symptom present in 45 patients in the study, it is known that this is one of the most disturbing symptoms and is present in between 70% and 90% of patients in palliative care[21]. The lack of effectiveness in its control affects all aspects of the quality of life of these patients, making relief a prominent role[21,22]. Physiotherapy uses physical means, adaptation of orthoses and manual therapy, which minimize the symptomatic perception of pain. Among the therapeutic modalities we can mention kinesiotherapy, electrothermotherapy and orthoses (crutches, walkers, adapted chairs and vests)[22].

Fatigue, a symptom presented by 36 patients, may be directly related to a reduction in quality of life and functionality and interfere with the effectiveness of treatment in palliative care. When faced with this symptom, the physiotherapist can use energy conservation techniques to initially control fatigue, using resources such as ergonomics and biomechanics, organization of activities to reduce energy expenditure and use of orthoses when indicated[23]. Furthermore, the practice of physical activity is extremely consolidated in the literature in the management of fatigue. Its effects lead to a series of metabolic changes with anti-inflammatory effects that enhance tolerance to pharmacological treatments and minimize sarcopenia in terminal conditions[24].

In our study we found that the period of physiotherapeutic follow-up usually occurs between one and three months and with the patient receiving two to three physiotherapeutic visits. In a study on the recognition of the benefits of palliative oncology physiotherapy carried out through a questionnaire applied to oncology patients, they recognize that physiotherapeutic treatment can contribute to the improvement of their general clinical condition[22].

According to information collected from the HC IV HC service, the average length of stay for patients in home care is 44 days[26,27]. This fact demonstrates that there is still a limitation regarding the referral of patients to PC, since this referral carried out late is related to the short survival of patients in the HC service and the absence or short period of integrated, integral and comprehensive care from the individual can cause prolonged suffering and pain[28].

Among the limitations of the present study are the small number of participants, a fact that may be related to the short period of time analyzed and which may also have influenced the total number of consultations and physiotherapy follow-up time. Further-

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more, some data collected in the evaluation were not yet consolidated as a routine in the service. Therefore, it is suggested that more studies be carried out to evaluate this population in more depth in order to outline strategies to improve care.

CONCLUSION

The increase in NCDs and life expectancy has required the incorporation of PC into health care networks. This form of care can be provided through AD with the physiotherapist as an integral part of the multidisciplinary team. This professional's main demand is to maintain and/or restore patients' functionality and mobility, in addition to reducing symptoms and complaints such as pain and fatigue, providing a better quality of life. The characterization of patients who require physiotherapeutic care in home care at an oncology reference hospital is necessary for better care planning, as such information can direct therapeutic possibilities, allowing greater effectiveness in treatment.

CREdiT author statement

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