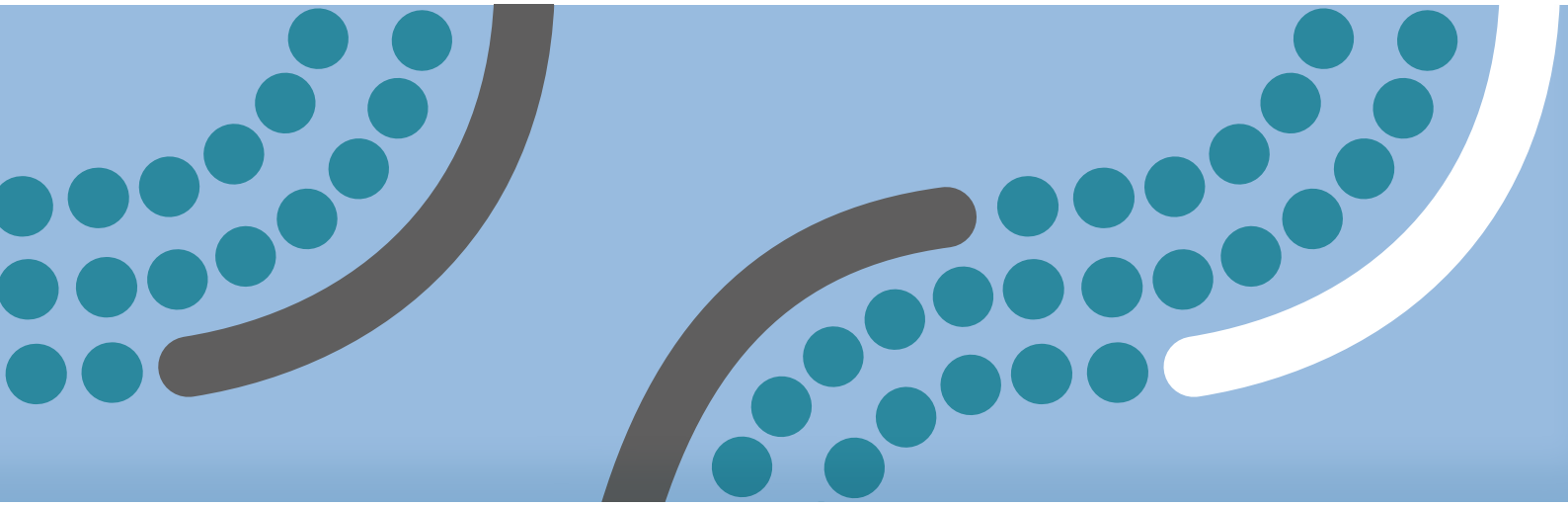
RACGP | *OP16 Oncology and palliative care contextual unit*



Rationale

Cancer is increasing in prevalence as one of the major disease burdens in Australia, and is currently the country's leading cause of death among people aged 45–64. Cancer causes more premature deaths and overall disease burden than cardiovascular disease (this includes all types of cancer, other than basal cell and squamous cell carcinoma of the skin) and is responsible for 16–19% of the total burden of disease, as measured by death and disability adjusted life years.[1] Cancer accounts for approximately three of every 10 deaths (29%) in Australia and, although survival rates are improving, cancer accounts for nearly 40,000 deaths per year. While the number of deaths from cancer continues to rise, there is a decrease in the age-standardised death rates in Australia.[2]

This relatively increased prevalence of cancer is due variously to ageing of the population, reductions in mortality from other chronic diseases due to improved diagnosis and treatment, and improved early diagnosis and detection of at-risk individuals through effective population health screening and improved diagnostic technologies.[1]

The most prevalent types of cancer contributing to these mortality statistics are lung, breast, prostate, bowel and pancreatic cancers.[1] The rate of general practice cancer-related services is also increasing (3.2 of every 100 general practice encounters).[3] Skin cancers, including basal and squamous cell carcinomas and melanomas, are the most common cancers managed by general practitioners (GPs) (1.2 of every 100 general practice encounters).[4] About 434,000 people are diagnosed with non-melanocytic skin cancers each year. About two-thirds of the Australian population will develop at least one non-melanocytic skin cancer in their lifetime, and one in two men and one in three women will develop a major cancer before the age of 85 years.[1]

Provision of evidence-based quality care across the spectrum of cancer and degenerative disease prevention, identification, management and, if cure is not possible, palliative care requires a strong foundation in the core skills of general practice. Palliative care is the active holistic care of patients whose disease is not responsive to curative treatment. It requires a holistic, patient-centred, multidisciplinary approach, with the GP playing a central and increasing role, especially in the management of domiciliary care. Palliative care provision is broader than end-of-life provision of care to patients with cancer. Other commonly encountered palliative conditions may include neurological degenerative diseases (eg motor neurone disease, end stage dementia), organ failure (eg chronic obstructive pulmonary disease, congestive cardiac failure, hepatic failure), frailty, and HIV/AIDS.[5]

The community sector is increasingly caring for people at home rather than in hospital, and GPs often coordinate sometimes fragmented and competing community services and advocate on behalf of patients, their families and carers for community-based palliative care.[6] In 2002, of the approximate 134,000 deaths that occurred in Australia, about 64,000 (almost 50%) of patients would have been cared for by a GP several times during their last 12 months of life.[5,7]

More than 50% of individuals who die an easily predictable death from a diagnosed terminal illness want to be cared for at home. However, only about 16% are able to exercise this option, as most patients now die in hospital. Only 20% of people die in hospices and 10% in nursing homes.[7]

Like other doctors, GPs are largely trained to work with curative or life-prolonging models of health and many have identified that they require further education in the skills that underpin the practice of palliative care, such as communication skills, symptom control and management skills, and self-care skills for dealing with 'death and dying'.[6]

Every GP should develop the skills to appropriately screen for and identify those at risk of cancer and degenerative diseases in order to, ideally, prevent the development of disease. If disease does develop, GPs should aim to meet the care needs of every individual patient, including palliative care needs, using evidence-based practice, as well as consider the needs of the patient's family and carers.

GPs should draw on the core skills of general practice to provide holistic, patient-centred care and coordinate multidisciplinary teams to enable high-quality, comprehensive healthcare during the typically stressful time for individuals following a cancer diagnosis. GPs also have an important role in providing continuity of care following surgical intervention, during and after chemotherapy and/or radiotherapy, and in screening for recurrence as appropriate. GPs require skills in identifying and managing common oncological and palliative symptoms, and have a vital role in providing care at the end of life in a setting of the individual's choice, maintaining the dignity of the individual and optimising the chances of them receiving the care they wish for at this time.

Related contextual units

CO16 Care of older people

PM16 Pain management

References

1. Australian Institute of Health and Welfare. Cancer in Australia: An overview 2014. Cat. no. CAN 88. Canberra: AIHW, 2014. Available at www.aihw.gov.au/publication-detail/?id=60129550047 [Accessed 11 November 2015].
2. Australian Institute of Health and Welfare. Australian cancer incidence and mortality (ACIM) books. Canberra: AIHW, 2016. Available at www.aihw.gov.au/acim-books [Accessed 7 April 2016].
3. Britt H MG, Charles J, Henderson J, et al. General practice activity in Australia 2013–14. General practice series no. 36. Sydney: Sydney University Press, 2014. Available at http://ses.library.usyd.edu.au/handle/2123/11882 [Accessed 11 November 2015].
4. Australian Institute of Health and Welfare, Cancer Australia. Non-melanoma skin cancer: General practice consultations, hospitalisation and mortality. Cancer series no. 43. Canberra: AIHW, 2008. Available at www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442454591 [Accessed 27 April 2016].
5. Palliative Care Australia. A guide to palliative care service development: A population-based approach. Canberra: PCA, 2005.
6. Australia and New Zealand Society of Palliative Medicine. Palliative care curriculum for undergraduates (PCC4U). Kelvin Grove, Qld: Queensland University of Technology, 2016. Available at www.pcc4u.org [Accessed 27 April 2016].
7. Commonwealth of Australia. Supporting Australians to live well at the end of life: National Palliative Care Strategy 2010. Canberra: Commonwealth of Australia, 2010. Available at www.health.gov.au/internet/main/publishing.nsf/Content/EF57056BDB047E2FCA257BF000206168/$File/NationalPalliativeCareStrategy.pdf [Accessed 27 April 2016].

Useful oncology and palliative care resources and tools

Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP. SPIKES – A six-step protocol for delivering bad news: Application to the patient with cancer. The Oncologist 2016;21(4), http://theoncologist.alphamedpress.org/content/5/4/302.full

Australian Government Department of Health, *Population based screening framework*, www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/population-based-screening-framework

Cancer Council Australia, Clinical practice guidelines PSA testing and early management of test-detected prostate cancer – updated prostate cancer screening resource, http://wiki.cancer.org.au/australia/Guidelines:PSA_Testing?_ga=1.189949227.1841081490.1445088280

Australian Government Department of Health, Future changes to cervical screening, www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/future-changes-cervical

CareSearch, Palliative care knowledge network, www.caresearch.com.au/Caresearch/Default.aspx

Therapeutic Guidelines, Palliative care, https://tgldcdp.tg.org.au/topicTeaser?guidelinePage=Palliative+Care&etgAccess=true

Glossary

End-of-life care

May include effectively conveying bad news, assisting in development of realistic expectations and maintenance of hope, managing grief processes for families and carers that progress beyond the patient's death into their bereavement phase and dealing with 'unfinished business', and effectively managing symptoms to alleviate distress and to comply with wishes of the individual and their family and carers.

Common oncological symptoms

Can include:

- pain (nociceptive, visceral, neuropathic and complex)
- nausea and vomiting
- constipation
- anorexia
- hiccoughs
- fatigue, weakness and lethargy
- delirium and confusion
- dyspnoea
- depression and anxiety
- existential distress
- malignant effusions
- peripheral lymphedema.

Oncological emergencies

Can include:

- neutropaenic sepsis
- hypercalcaemia
- superior vena cava (SVC) compression
- spinal cord compression
- delirium and confusion caused by cerebral metastases.