

OBJECTIVES:

To discuss common lung cancer symptoms including prevalence, assessment, etiology, and recommended interventions.

DATA SOURCES:

Research studies and systematic reviews.

CONCLUSION:

A mandate in care of persons with lung cancer is to deliver supportive care concurrently with life-prolonging care or as the main focus of care. Most are diagnosed with advanced disease that impairs health with both physical and psychological symptoms.

IMPLICATIONS FOR NURSING**PRACTICE:**

Early assessment and comprehensive management of symptoms are main components of improving quality of life and functional status for those living with lung cancer.

KEYWORDS:

Lung cancer, palliative care, fatigue, dyspnea, cough, pain, cachexia, anorexia, psychosocial distress

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SUPPORTIVE CARE IN LUNG CANCER

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EARLY assessment and comprehensive management of both disease and treatment-related symptoms are main components of improving quality of life (QOL) and functional status for those living with lung cancer. Lung cancer, with an estimated 160,390 deaths in 2007, remains the leading cause of cancer death among US men and women.¹ This is due in part to the fact that there is no routine screening recommended for lung cancer and, as a result, many tumors are discovered at a late stage of disease. A diagnosis that includes regional or distant spread of disease can produce significant physical and psychological symptoms. Hence, the mandate in the care of persons with lung cancer is to deliver supportive or palliative care concurrently with life-prolonging care or, in some cases, as the main focus of care.² In addition, the number of symptoms to be managed and therefore the intensity of supportive care required may change as a person moves through the trajectory of their illness.

Common symptoms reported by newly diagnosed lung cancer patients include fatigue, pain, anorexia, coughing, and insomnia. However, pain, dyspnea, and anorexia are ranked by patients with advanced lung cancer as the most common and most intense.³ Several researchers have attempted to characterize symptom clusters in lung cancer. Symptom clusters refer to concurrent, related symptoms that may have a synergistic or collective effect on patient outcomes. Depression and fatigue were found in cluster in a group of persons with lung cancer of mixed stages.⁴ Chan et al⁵ found a cluster of breathlessness, fatigue, and anxiety in a small sample of advanced lung cancer patients undergoing palliative radiotherapy to various sites. Gift et al⁶ found, through secondary analysis of a large data set, that nausea, fatigue, weakness, appetite loss, weight loss, altered taste, and vomiting clustered together in a group of newly diagnosed lung cancer patients with both early and late stage disease. A common antecedent related to the cluster was treatment with chemotherapy. This group also reported that the severity of the symptoms in this cluster declined over time, perhaps because of the completion of chemotherapy.⁷ It is logical to assume that certain symptom clusters may be timed with respect to therapy. Despite the current therapy, or lack thereof, persons with lung cancer experience multiple concurrent symptoms

that require attention. This discussion is limited to six common symptoms experienced by persons with lung cancer and offers evidence-based practice recommendations.

FATIGUE

One of the most severe and debilitating symptoms for patients undergoing cancer treatment and at the end of life is fatigue.^{8,9} Seventy-five percent to 100% of patients undergoing chemotherapy report fatigue. Cancer-related fatigue has been found to strongly affect QOL.^{9,10} In 171 outpatients with advanced lung cancer, Tanaka et al¹¹ found that fatigue affected at least one activity of daily living in more than half the patients (52%). Walking and work were reported as the two physical activities impacted the most.

Cancer-related fatigue is a distressing, persistent, and subjective sense of tiredness or exhaustion related to cancer or to treatment for cancer that is not proportional to recent activity and interferes with functioning.¹² Regular screening for fatigue is recommended. A simple numerical 0-to-10 scale can be used on initial visit and at regular intervals to capture and quantify current fatigue and documentation over time can indicate improvement or decline.¹² Patient input is essential when assessing for fatigue. It is crucial to acknowledge fatigue to be as important as other symptoms that affect QOL.¹³ Clinical assessment for fatigue should include consideration of:

1. Hemoglobin/hematocrit: regular screening of hemoglobin/hematocrit to detect for anemia (hemoglobin \leq 12 g/dL).
2. Physical appearance: Does the patient look tired? Do they look rested? How is their color?
3. Shortness of breath: Often associated with fatigue. Depending on the level of anemia, patients may be short of breath with activities of daily living.
4. Quality of sleep: Is there a change in sleep habits? Do they nap during the day? Do they go to bed the same time each night and get up the same time each day? Is the quality of sleep the same? Do they wake up feeling refreshed?
5. Pain: A complete pain assessment is needed as fatigue may be a consequence of pain.¹⁴
6. Psychosocial issues: Are they experiencing increased stress? Do they have money concerns or concerns about the disease and its treatment?

Two lung cancer-specific assessment tools with demonstrated reliability and validity that assess the impact of fatigue are (1) The Functional Assessment of Cancer Therapy—Lung Cancer (FACT-L) and (2) The Lung Cancer Symptom Scale (LCSS). FACT-L is a 44-item self-report that measures physical and functional well-being with assessment of lung-specific symptoms.¹⁵ The LCSS is a site-specific measure of QOL with nine visual analogue scales that evaluate six major symptoms associated with lung cancer and the effect on symptomatic distress, function, and global QOL.¹⁶ One general tool to measure the severity of fatigue is The Brief Fatigue Inventory (BFI). The BFI allows rapid assessment with nine questions that evaluate fatigue using a scale of 0 to 10, with 0 being “No fatigue” to 10 being “As bad as you can imagine.” Six of the nine questions ask how much fatigue interferes with various activities of daily living.¹⁷

Non-Pharmacologic Interventions

Exercise is one intervention to manage fatigue supported by strong evidence from well-designed studies.⁸ The National Comprehensive Cancer Network (NCCN) guidelines for the management of cancer-related fatigue recommend that all patients, whether actively on treatment or in follow-up, should be encouraged to participate in regular physical activity.¹² The type of exercise, frequency, intensity, and duration should be tailored to the patient’s needs. For example, patients with skeletal muscle weakness may need strength training, whereas those who have maintained their lean body mass may benefit from aerobic exercise.¹⁸

Energy conservation is defined as the deliberate, planned management of an individual’s personal energy resources so that valued activities and goals can be maintained.¹⁹ Energy conservation and activity management as an intervention aims to balance patient activities and rest by prioritizing and planning their day.²⁰ This may include scheduling household chores or using friends or family to assist with activities such as shopping, cooking or cleaning.

Sleep hygiene practices that include avoiding long or late-afternoon naps, going to bed only when sleepy, using the bedroom and bed for sleep and sexual activities only, going to bed and getting up at regular times, and avoiding stimulating activity and caffeine, may be helpful to patients. Using

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