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Review

Supportive care during treatment for breast cancer: Resource allocations in low- and middle-income countries. A Breast Health Global Initiative 2013 consensus statement☆

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ABSTRACT

Breast cancer patients may have unmet supportive care needs during treatment, including symptom management of treatment-related toxicities, and educational, psychosocial, and spiritual needs. Delivery of supportive care is often a low priority in low- and middle-income settings, and is also dependent on resources available.

This consensus statement describes twelve key recommendations for supportive care during treatment in low- and middle-income countries, identified by an expert international panel as part of the 5th Breast Health Global Initiative (BHGI) Global Summit for Supportive Care, which was held in October 2012, in Vienna, Austria. Panel recommendations are presented in a 4-tier resource-stratified table to illustrate how health systems can provide supportive care services during treatment to breast cancer patients, starting at a basic level of resource allocation and incrementally adding program resources as they become available. These recommendations include: health professional and patient and family education; management of treatment related toxicities, management of treatment-related symptoms of fatigue, insomnia and non-specific pain, and management of psychosocial and spiritual issues related to breast cancer treatment.

Establishing supportive care during breast cancer treatment will help ensure that breast cancer patients receive comprehensive care that can help 1) improve adherence to treatment recommendations, 2) manage treatment-related toxicities and other treatment related symptoms, and 3) address the psychosocial and spiritual aspects of breast cancer and breast cancer treatments.

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Supportive care during treatment for breast cancer

Breast cancer patients receiving therapy require supportive care for the prevention and management of physical and psychosocial adverse effects of cancer and its treatments[1–3]. Studies in high-income countries (HICs) and low- and middle-income countries (LMICs) have shown that cancer patients and their families may have unmet physical and psychosocial supportive care needs during treatment[4–7]. Supportive care is often a low priority in LMICs [3]. Integrating supportive care measures into existing breast cancer treatment programs is an important part of a multidisciplinary and interdisciplinary approach to cancer care, which requires both health professional education and patient awareness of supportive care services. Breast cancer treatments have acute as well as delayed side-effects; the frequency and severity differ according to the type of therapy as well as patient characteristics such as age, performance status and co-morbidities. Many treatments have shared side-effects of nausea, fatigue, insomnia, and/or pain, as well as specific toxicities that affect one or more body systems (musculoskeletal, gastrointestinal, nervous system, skin/hair/nail, or hematological toxicities). Treatments can also affect women's health issues (e.g., reproductive health, fertility and sexual health). Psychosocial complications of cancer and cancer treatment (e.g., emotional distress, depression, anxiety, and/or social disruptions) can affect patient outcomes and quality of life. Failure to address supportive care during cancer treatment can lead to decreased compliance and worsened outcomes, thereby diminishing the value of therapeutic interventions.

Defining "during treatment"

"During treatment" is defined, for the purposes of this consensus statement, as the time period from initiation of treatment to approximately 6 months following the completion of the treatment, to allow us to distinguish short-term vs. long-term treatment-related issues. The term refers to surgery and adjuvant/neoadjuvant systemic therapies and radiation therapy. Long-term treatment-related side-effects (i.e., persistent and late-effects) are addressed in the BHGI companion consensus statement, *Supportive Care after Curative Treatment (Survivorship)*[8]. Metastatic breast cancer and palliative care are addressed in the BHGI companion consensus statement, *Supportive and Palliative Care for Metastatic Breast Cancer*[9].

BHGI Global Summit and Expert Panel consensus process

All three Breast Health Global Initiative (BHGI) supportive care consensus statements provide recommendations for breast cancer supportive care program implementation in low- and middle-resource settings. Methods developed by the BHGI for the structured creation of evidence-based, 4-tier resource-stratified guidelines and consensus statements (see Table 1) have been previously described[10,11]. A systematic literature review was performed in preparation for the 5th BHGI Global Summit, which was held in association with the International Atomic Energy Association (IAEA) in Vienna, Austria, on October 2, 2012. Supportive care was chosen as the theme for the global summit, as it emphasizes often-overlooked aspects of medical care that are not always considered directly related to curative intent. The Supportive Care during Treatment Consensus Panel presented on key topics and then performed consensus analysis through facilitated expert panel discussion to draft the core resource-stratified table matrices, which are the primary outcome of the panel examination and deliberation. Companion consensus statements for supportive care after curative treatment[8], and supportive and palliative care for metastatic breast cancer[9], were developed in parallel during this 2012 Global Summit. Supportive care is an under-researched area of medicine, especially in LMICs. Systematic reviews and meta-analyses are often not available for select topics, or include only studies from HICs. When studies from LMICs are available on a topic, they are provided as additional references.

Table 1
Resource allocation levels: basic, limited, enhanced, and maximal.

Resource Allocation Level*	Description
Basic	Core resources or fundamental services absolutely necessary for any breast health care system to function; basic-level services are typically applied in a single clinical interaction.
Limited	Second-tier resources or services that are intended to produce major improvements in outcome, and are attainable with limited financial means and modest infrastructure; limited-level services may involve single or multiple clinical interactions.
Enhanced	Third-tier resources or services that are optional but important; enhanced-level resources should produce further improvements in outcome and increase the number and quality of therapeutic options and patient choice.
Maximal	High-level resources or services that may be used in some high-income countries, and/or may be recommended by breast care guidelines that do not adapt to resource constraints. They should be considered lower priority than those resources or services listed in the basic, limited, or enhanced categories on the basis of extreme cost and/or impracticality for broad use in resource-limited environments; to be useful, maximal-level resources typically depend on the existence and functionality of all lower-level resources.

*The table stratification scheme implies incrementally increasing resource allocation at the basic, limited, and enhanced levels. Maximal-level resources should not be targeted for implementation in LMICs, even though they may be used in some higher-resource settings.

Key resources needed for supportive care during treatment programs

This section describes the twelve key resource allocation categories identified by the expert international panel for supportive care during treatment. A resource-stratified recommendation follows each description of a key resource category, and is also presented in one of three tables. The resource-stratified tables illustrate how a health system can provide supportive care services during treatment to breast cancer patients, starting at a basic level of resource allocation, and incrementally adding program resources. The section, Special concerns and emerging issues in LMICs, highlights key issues from the panel deliberations. If a topic is covered in more detail in another companion consensus statement, a link and reference is provided.

Health systems (Table 3)

Health professional education/training (Table 3, row 1)

Description: The term "health professional" was chosen by the consensus panel to acknowledge the range in medical and other professionals who provide supportive care services in LMICs. When