

What else is new in cancer care?

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Following on from last issue's feature on cancer care Jane Hobden looks at spinal cord compression and breathless lung cancer patients

Physiotherapists are playing an increasingly important role in helping to minimise the damage caused by spinal cord compression. The condition occurs when the primary cancer spreads to the spine, leading to pressure on the spinal cord through collapsed vertebrae and soft tissue pressure.

'If we recognise symptoms early, and treat within 48 hours, it is very possible to maintain the patient's mobility,' says Lena Richards, a senior physio at Manchester's Christie Hospital. 'But if it isn't recognised, the damage is irreversible, leading to permanent disability and loss of function.'

Physios working in an outpatient setting need to be able pick up some of the 'red flags' signalling the condition and take a proper medical history. Lena advises: 'If a woman who had a mastectomy 10 years previously presents in outpatients with constant and worsening back pain, loss of movement, heavy, stiff legs, and lack of co-ordination, then she needs to be referred immediately for MRI scanning.'

Treating spinal cord compression involves radiotherapy, surgery and chemotherapy, with the physio helping to strengthen muscles after treatment to maximise the patient's ability to function independently. At Christie Hospital, they are about to pilot a care pathway for spinal cord compression which aims to standardise care, says Lena. And with awareness of the condition growing, a request that the National Institute for Clinical Excellence (NICE) develop national guidelines is being supported by the Association for Chartered Physiotherapists in Oncology and Palliative Care (ACPOPC).

The Velindre Hospital in Cardiff has just produced a care standard for spinal cord compression. As part of the process, a retrospective audit was carried out. Helen Tyler, clinical lead physio at the hospital, explains: 'Before the new care pathway was introduced, patients were being left lying flat far too long after their treatment - for an average of seven days. The thinking was that this would limit pressure from the tumour on the spinal cord.' The result was high complication rates for chest infections and deep vein thromboses (DVTs), as well as depression.

A new approach is now taken: starting from day one, patients are gradually elevated to sitting position, a few degrees at a time. 'The key is to monitor very closely the pain and sensation in the legs,' says Mrs Tyler. 'If there is no change, then we progress to sitting; if there is a change, then we move them down again.' When the new care pathway was audited, the complication rates went down for chest infections and DVTs, with mortality rates plummeting from 34 per cent to 7.9 per cent. Five days after treatment, patients are discharged and referred to the district general hospital for further rehabilitation.

Breathlessness in lung cancer patients

February 2005 saw the launch of NICE guidelines for lung cancer. A key proposal was that all lung cancer patients should have access to a breathlessness clinic using the non-pharmacological approach. Caroline Belchamber, a senior I physio at Poole Hospital, was part of the guideline

development group. From 2000 until 2003, she also ran the first breathlessness clinic in Lewis Manning House, a palliative daycare centre in Dorset. A study carried out at the clinic showed significant improvements in patients, with those experiencing regular bouts of breathlessness falling from 73 per cent to 27 per cent four weeks later.

Oncology physios are the best people to lead breathlessness clinics, Mrs Belchamber feels. 'We have a wealth of knowledge in dealing with respiratory conditions throughout our profession, including on-call experience prior to specialising in oncology and palliative care.' Musculoskeletal experience is also useful when working with lung cancer patients, she points out.

Senior physio Judy Williams has been running the clinic at Lewis Manning House for two years. The topics that she covers include breathing techniques, exercise, relaxation techniques and learning how to pace activities. Patients are seen individually, but are encouraged to bring carers and family members to foster a sense of support.

Seeing a patient as soon as possible after they develop lung cancer can also make a big difference to their ability to manage the disease as it progresses, Mrs Williams explains. Timely action can help to reduce their shortness of breath and increase their exercise tolerance. 'Patients make clear progress: one of my patients is now able to walk the dog, another goes to the gym and another can now do the shopping.'

Two key challenges now, both she and Caroline Belchamber believe, are getting the physio voice heard through the cancer networks, where nurses often have a much higher profile, and ensuring that physios play a full role in the new breathlessness clinics. 'We are ideally placed to carry out this work, and we need to promote a high profile role for physiotherapy in this field.'

Pease, Harris and Finlay [2004], 'Development and audit of a care pathway for the management of patients with suspected malignant spinal cord compression.' *Physiotherapy* Vol 90, No 1, pp27-34

Hately J and others [2003], 'Breathlessness clinics within specialist palliative care settings can improve the quality of life and functional capacity of patients with lung cancer.' *Palliative Medicine*, Vol 17, No 5, pp410-417

www.nice.org.uk/c5024quickrefguide - quick reference for the NICE guidelines on lung cancer

A breath of fresh air - a free CD-rom for health professionals, plus free patient information booklets (three in series). Both resources available from the Macmillan Practice Development Unit, tel 02380 596885; email nam-mpdu@soton.ac.uk

The relevant clinical interest group is the Association of Chartered Physiotherapists in Oncology and Palliative Care www.acpopc.org.uk