Influence of Oncological Disease on Patientęs Life Quality

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Original Article

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Abstract:

At present, despite of many prevention programs, the incidence of cancer still increases in Slovakia. Breast cancer is the most frequent cancer diseases. The number of new diagnostic patients has increased tangentially. This is the reason, why we have decided to find out about women with this diagnosis and their psychosocial problems after surgery. General healthcare about women with cancer disease contains therapeutic, preventive, and nursing care. It is necessary to focus our attention also on social relationships and quality of life during and after surgery. In the treatment of these women, it is important to know that their psychical reactions depend on: premorbid per-

sonality; level of education; social relationship; value orientation; previous experiences with medical stuff; information about their diseases. Psychological support of women is important in every phases of diseases. Postoperative phase is the most important, because this is the moment when women lost their expression of femininity and the physicians and nurses are the first who can help them. Emphasis put on satisfaction of psychological and social needs help women in their treatment process and aims to mitigate more quickly with this change and fight with disease.

Introduction

At present, despite many prevention programs, the incidence of cancer still increases in Slovakia. It is especially important for women after surgery to take care of social relationships and quality of life during and after treatment. Oncological disease interferes for the whole woman. It doesn´t interfere only in her physical health, but also in the psychical and social areas of her life. This is the reason why it so important that oncological treatment must be oriented toward whole women (1).

Psychosocial support

In the treatment of oncological patients, it is important to know that their psychical reactions depend on their: premorbid personality; level of education; social relationship; value orientation; previous experiences with medical stuff and information about their diseases. Psychological support of women is important in every phases of disease. The postoperative phase is the most important, because this is the moment when women lost their expression of femininity. The needs of women after surgery and after determination end diagnosis are changed. Priorities of women in postoperative phase are complicated and they prefer:

- encouragement, support, and safety
- toleration, respect, and adequate help
- positive news from surroundings
- respect to new daily mode and to other changes in the reason of disease
- compassion
- understanding, especially to transient emotional lability
- naturalness in communication: conformity between face expression and word contents
- need of touching is higher– it is very individual, some women don´t like touching

The role of communication

Communication is an important means by which to find the way to a patient, especially to a patient with cancer. To communicate withwomen it is important: to avoid underestimation(2); to avoid superiority;to avoid self-righteousness;to be age appropriate. Psychical trauma and disruption of self-assurance are more pronounced in women whose social background is inadequate. Their complex oncological treatment is complicated and protracted. Results show that women who were in social isolation had higher risk of mortality. When the women are standing face to face to their own mortality and must handle requirements for getting her grounding again as before surgery, she must reconsider her priorities and values in life (3).

Women talk with physician about these psychosocial problems:

- different kinds of worries
- fear about the future
- helplessness and confusion
- confrontation with their own death mortality
- hopeless and loss of faith
- loss of activities
- social isolation
- threat of social identity and own value *(4)*

Strategies for solutions

Physicians are those, who must show a right way to patients, encourage and motivate them to a better way of life. They must suggest possible strategies for managing these problems for example:

- active managing
- planning of other activities
- acceptance of disease and change of body look
- religiosity and spirituality
- using of emotional support
- self-relaxation

- sense of humor
- emotional ventilation *(5)*

These strategies influence the entire quality of women´s life. Women are influenced by their personality, age, abilities of daily activities, satisfaction of daily things, degree of suffering connected with annoying symptoms or distress. Evaluation of life quality has an important role in daily decision making. Levels of evaluation of life quality in which change of life quality is in progress are:

- physical contentment: can be disturbed with pain and other accompanying symptoms of disease, discomfort by using *epithesis,* that is according to the Harper Collins English Dictionary 12th Ed. 2014 is surgery or an orthopedic modification to a deformed extremity.
- psychical contentment: can be negative influenced by pain, fear of surgery and risk of death, restriction in connection with hospitalization, fear of the family or household, possible economic consequences of incapacity for work.
- relationship to myself: insufficient acceptation of anatomical and physiological changes.
- relationships to other people: women shy away from the other people because of problems and fear of unpleasant situations.
- relationships in family: can be disturbed because of load and claims which relate to nursing of ill member of family *(6)*

Discussion

The concept "quality of life" was for the first time used at the beginning of 20th century regarding of material support for the lower social class. Then we saw this term in post-war USA (President Johnson) when it described the situation in which a many times normal economic increase is not serving the higher satisfaction of people, but it increases only their requirements. From the 1970s this term is used for differentiating people´s needs, differentiatiingof own life feeling from material security.

At this time, the term is used in scientific social-economic studies. People´s life cannot be described only with objective parameters (especially economics), but it is necessary to include concrete social coherences and relations. Economic aspects are the most important at a concrete level, later this economic status is not in direct proportion with quality of life. On a basic level, we can understand the term "quality of life" as the consequences, which are working together. We can divide these factors in two basic forms: objective and subjective:

1) subjective factors come out from human emotionality
2) objective factors are characterized as a fulfilment of social status, material conditions and physical health *(7,8)*

In a healthcare system, the assessment of life quality comesfrom aWHO definition of health: health is not only absence of disease, but also physical, mental, and social contentment. Quality of life from a medical view is not only the health condition, but how this condition influences an individual, his/her possibilities, desires and fulfilment of life aims ***(8)***.

Today, the quality of life is the one of the most important parameters in approach to patients. Physicians are interested about patients; how the concrete treatment process influences the quality of life. In medicine, monitoring of life quality shifts into psychosomatic and physical health. It is implemented new term "health related quality of life". In praxis, it means, that clinically verifiable parameters of treatment processes are evaluated: also information's about physical, mental condition and its subjective perception of processes (perception of pain, fatigue, anxiety etc.) ***(9)***.

From this point of view, results for monitoring of life quality in medicine (especially in oncological patients) is importantand the parameters of how the treatments aggravate this quality of life. So, it is important to evaluate treatment processes only from clinical results, but also its influence for quality of life. Measurement of life quality is important information for physicians which they don´t have from clinical practice.

There are many specific approaches for analyzing the quality of life. They are oriented about disease or its phase. The importance of research in life quality formation of oncological patients has been documented by the *European Organization for Research and Treatment of Cancer*. It is necessary to say that there are many problemsin measurement of life quality. It is exceedingly difficult to decid how this quality life must be and represented as a standard. The effort to measure quality of life in respect to what choice of treatment is the right step. Against the past when

only objective results of treatment were mentioned, in last years are psychosocial aspects of health loss are mentioned. Especially for oncology patients must be the monitored influence of disease and treatment on physical and mental condition; on its social, family and work life. Every treatment process is evaluated not only from quantitative aspect (how long?), but also from qualitative aspect. To know, how the patient survived is an important factor in present oncology. In relation to health and disease, we can talk about health related quality of life. The quality of life gives some degree how disease and treatment (consequences of treatment) allow to live a life which is satisfactory***(10)***. This way understanding of life quality is identified by two characteristics:

1. Multidimensionality– quality of life describes some spheres:
   – physical disorders (pain, fatigue)
   – functional ability (ability to do ordinary activities)
   – psychological- social (mood, depression, anxiety)
   – social (relationships in family, social status, financial situation)
   – existential and spiritual (sense of life, hope, forgiveness)
2. Subjectivity – expressed reality from a different view as same things by different people.

In modern medicine, the correct practice is expressed by evidence of its effectiveness ***(11)***. The most valid are comparative studies systematically evaluating the influence of oncological treatment not only from quantity, but also quality done for the first time in 1948 by American oncologist, Professor David A. Karnofsky. Karnofsky used a scale from 0% to 100% for assessment of the entiire functional ability- performance status. Performance status of 100% meant full health; personal status of 0% meant death. Functional ability of a patient was evaluated by a physician. At the beginning of the 1980, another shift in evaluation of oncological treatment influence was noted by Professor Walter O. Spitzer. Spitzer´s index of quality was multidimensional, but physician evaluated all effects, too. Many studies prove, that patient´s evaluation of their situation is diametrically different from physician's. Patients with the same performance status can be different in the degree of influence of their social function.

Today, especially,questionnaires are used in clinical studies. Despite this, they can be used in practice as ,"a leash", for structural talk with patients. but we must not to forget that quality of life is subjective and the information from a group of questionnaires cannot be applicd for easchindividual patient ***(12)***.

Patients with advanced breast cancer had lower quality of life because of changed body image. Many authors mentioned that side effects of treatment influenced quality of life depending on individual circumstances, type of cancer and its treatment ***(13).*** One from many programs is called OSCAR. This one can improve patients´ quality of life with an advanced degree of cancer and with a bad prognosis. Its role is to increase medical literacy and have participation on planning the therapy with continuous support care ***(14)***. Today, there are many approaches for development and evaluation of navigation programs for cancer patients. One of them is project called ONKOLOTSE from the Saxon Cancer Society. It includes certificated nurses, psychologists, and social workers who are in contact with cancer patients about 20 times per year. Evaluation of this project is oriented tothe number of hospitalizations and psychical stress. Nurses from non-profit organization *Group Health* contact patients every week by phone and meet with them personally at least one time per this period. The aim of nurses is to develop strategies, which are oriented on difficulties and quality of patient life ***(15)***. Program OSCAR was developed for patients with the aim to offer one-year regular support in the matters of the cancer. It is a useful supplement for existing structures such as social services offered by hospitals which solve actual needs after discharge from hospital. Improvement of continuity and building the patient´s competences is important for cancer patients in the fragmental healthcare system. Further, there are necessary appropriate medical structures and contractual frameworks to ensure a low threshold approach to palliative care and counseling support. Experiences collected in OSCAR should bring results for other chronic somatic diseases which relate to serious physical and mental problems in patients and their relatives (***14***).

Conclusion

The treatment of pain caused by cancer is a critical question in medical care for patients. All medical workers must ensure that all the patients get early and adequate education and care. It is necessary to develop measures for useful managing of symptoms and for improving quality of life. Fundamental problems are management of symptoms and need of usingstrategies which help patients to have a better feeling of control over the disease and its treatment.

Women with breast cancer need help in psychical and social areas. It is exceedingly difficult to cope with disease when women don´t have the proper background; suffer from fear; inattention to surroundings. Also, diagnosis of cancer has influences on quality of marital, partner and family relations. Results show that optimism helpspatients better get through diseases. General evaluation of global quality of life cannot substitute for more concrete evaluation of working domains and symptoms.

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