ABSTRACT

Objetivo: evaluar evidencias científicas disponibles en los artículos sobre cómo se está desarrollando el cuidado paliativo en oncología en el contexto mundial. Método: estudio de revisión, para lo cual se percorrieron las siguientes etapas: identificación del tema, de la pregunta e del objetivo de la revisión, establecimiento de criterios de inclusión y exclusión, selección de los estudios, y de las evidencias a serem extraídas de los artículos, análisis y discusión de los resultados. A selección foi na base Medical Literature Analysis and Retrieval System Online (MEDLINE), com descritores “cancer” and “cuidados paliativos”. Resultados: totalizando 113 artigos, evidenciou-se que el cuidado paliativo en oncología es desenvolvido nas situaciones de cáncer avanzado, predominantemente no fim da vida e no proceso de morrer e morte. Conclusão: el cuidado paliativo em oncología é desenvolvido nas situações de câncer avançado, predominantemente no fim da vida e no processo de morrer e morte. Conclusión: é imprescindible que la filosofía de cuidado paliativo sea incorporada por las instituciones, academia e servicios de salud, por medio de la formación y de la educación permanente de los profesionales, para atender a las personas que tienen enfermedad avanzada y su familia. Descriptores: Neoplasias; Cáncer; Cuidados Paliativos; Asistencia Paliativa.

RESUMEN

Objetivo: evaluar las evidencias disponibles en los artículos sobre cómo está siendo desarrollado el cuidado paliativo en el contexto de la oncología en escenario mundial. Método: estudio de revisión de literatura, en las bases de datos de la Medical Literature Analysis and Retrieval System Online (MEDLINE). Resultados: totalizó 113 artículos se evidenció que el cuidado paliativo en oncología es desarrollado en las situaciones de cáncer avanzado, predominantemente, en el fin de la vida y en el proceso de morir y muerte. Conclusión: los cuidados paliativos se constituyen hoy en una importante cuestión de salud pública. Imprescindible que la filosofía de cuidado paliativo sea incorporada por las instituciones, academia e servicios de salud, por medio de la formación y de la educación permanente de los profesionales, para atender a las personas que tienen enfermedad avanzada y su familia. Descriptores: Neoplasias; Cáncer; Cuidados Paliativos; Asistencia Paliativa.
INTRODUCTION

In 2011, the National Cancer Institute (NCI) - Instituto Nacional de Cáncer (INCA) released estimates of cancer incidence for 2012, which will be valid also for 2013. They point to the occurrence of approximately 518,510 new cases of cancer. Without cases of nonmelanoma skin cancer, it is estimated a total of 385,000 new cases. The most incidents are the nonmelanoma skin cancers, prostate, lung, colorectal and stomach for males, and non-melanoma skin cancers, breast, cervix, colon and rectum, and thyroid gland in females.¹ ²

Despite the technological advances in curative therapies against malignant disease, this may have a negative prognosis, with recurrences and eventually impossible to cure. The therapeutic range for healing at the time of advanced cancer generates demands for particular and individual health care for these people. In 1990, the World Health Organization has called these practices comfort of palliative care, which are active and total care of patients whose disease no longer responds to curative treatment.¹ They highlight the principles of attention to psychological, social and spiritual needs of patients and their families.

In health, palliative care arise in several countries, including Brazil, as the basic condition to redeem the respect and dignity for whom have advanced disease.⁴ There are numerous challenges regarding the inclusion of palliative care programs in oncology, such as the deployment of institutional actions and qualification of human resources. However, there is progress with regard to public policy, for example, the National Oncological Care, which includes palliative care.

Given this specialized care, they highlight the importance of the multidisciplinary team monitoring the health of the person who has cancer, with skills to: assess their conditions, develop an individualized plan of care and monitor the results of treatment. They envision to integrate objectivity (technical) and subjectivity (support) for both person or to his family. Such care should be developed to meet the needs emerging from the period of transition from curative to palliative care to the dying process and death.⁵

From the principles that guide palliative care, it is necessary to implement changes in routines and technical standards. And to include attention to the emotional feelings that involve both the patient and his family, and the health team. For such changes to take effect, it is necessary that the practitioner understands the reason for doing the same procedure otherwise, considering the needs and preferences of each of choices for defining ducts. Thus, it is vital that healthcare staff develop competence on the philosophy of palliative care, to meet the needs and peculiarities of physical, psychosocial and emotional patient and his family.⁶

There is a gap in the training of health professionals in regard to preparation for dealing with difficult situations arising from disease progression, recurrence, the impossibility of healing and losses. Thus, it is necessary to develop skills of the multidisciplinary team that stays with the patient and family in palliative care.⁷

Thus, palliative care becomes a challenge for professionals in how to care and understand the illness and the inability to cure, to provide support and relief of suffering experienced by patients who have advanced malignant disease and his family.

Given this issue, they emphasized the research question: How has palliative care cancer developed in the world? The objective was to evaluate the available evidence in the papers about how it is being developed palliative care cancer on the world stage.

METHODOLOGY

This is a review study. For the survey, we covered the following steps: identification of the subject, the research question and defining the purpose of the review, establishment of criteria for inclusion and exclusion, selection of studies to be analyzed, establishment of information to be extracted from selected articles, analysis and discussion of results.⁸

We established the following inclusion criteria: research articles on the topic of palliative care in oncology, available in full online, in Portuguese, English or Spanish. Inclusion criteria: research articles on the topic of palliative care in oncology quantitative approach, available in full online, in Portuguese, English or Spanish. And as exclusion criteria: Articles without abstracts in the database or incomplete.

It was not predetermined initial time frame, dated from 1996 - the first article identified, covering articles published until 2011. The literature search was performed in the Virtual Health Library (VHL) - Biblioteca Virtual de Saúde (BVS) - in the database Medical Literature Analysis and Retrieval.
System Online (MEDLINE). To gather data we used the descriptors (DeCs): “cancer” and “palliative care”. Data collection occurred in March 2012.

Found 586 studies. The selection of studies was developed by reading the titles and abstracts, totaling 113 full articles, which were analyzed.

To perform the analysis of this production was an elaborate form of analysis, made by item number, corresponding to the reference, and results. The articles were identified by the letter A, “article”, followed by a number (A1, A2, A3, successively).

It was developed thematic content analysis of nine studies with categorization theory: when is being developed palliative care in oncology, by whom and for whom this care is being developed, where and how it is accomplished.

### RESULTS

Among the 113 articles in the issue of palliative care cancer, with respect to the year of publication, the following ranges were determined for analysis of production: 1996-1999 (7.07%), 2000-2003 (16.81%), 2004-2007 (32.74%), 2008-2011 (43.36%), which showed an increase significant publications (Figure 1).

According to the knowledge area, pointed to Medicine (69.91%), followed by Nursing (21.23%). About the merits of the productions, there was a concentration in the United States (50.44%), England (11.50%) and China (8.84%).

Brazil does not appear in the rankings. Regarding the research design: non-experimental (53.98%), quasi-experimental (26.54%), experimental (19.46%) (Table 1).
The theoretical category showed that when palliative care are developed in cancer advanced (A1-12-107, 91,103,106, 110,113), the transition from curative care to palliative (A13-15) at the end of life (A1-3, 14-28, 30-50, 68, 102, 105, 108 -109, 112) and the face of death (A17, 43,51-55, 104,111).

As referred to by whom, being developed that care team multidisciplinary, being a nurse, doctor, and sometimes psychologists (A13, 16,23,26,41,44,46,56, 58,91,102,103,105-109,111), doctors (A3-4, 8,15,24-25, 33,38,59-62, 68), the nursing staff (A7, 43,48,63-64, 113), the volunteer caregivers (A43, 50,110); relatives (, 14,17,22,25,43,50,65 A2-66), researchers (A24, 67,112) and friends (A65).

To whom this care is being developed: for patients, from infants to the elderly (A1-30,32,34-35, 37-41, 44-53, 55-56, 58-64, 66-89, 91,102-113 ) and caregivers (,16,42,46,48,58,60,91 A4-92).

Where the palliation is performed in oncology pointed hospice private or public (A5, 7-8, 13-16, 18, 20-21, 25, 28, 30, 32-33, 35, 38, 40-41, 43, 45-48, 51-52, 54-55, 56-57, 60-62, 64, 67-71, 74, 77, 82-88, 92-95); clinics (A16, 43), hospitals (A17, 28, 34, 39, 49, 55, 61, 68, 72, 80, 91, 96, 101-103, 105-109, 111) and address (A11, 17, 23, 30, 32, 40, 47, 50, 60, 61,63, 75, 78, 80, 89, 104, 110, 112-113).

How it is performed as indicated palliative hospitalizations (A5 0.17 to 18, 23, 52, 59, 78, 89); procedures (A1, 6-10, 15, 19, 23-24, 26, 28, 30-31, 36, 40, 48-49, 53-54, 56, 58-59, 61, 65, 79,81, 83-84, 86-88, 93, 95-99;); therapies (A6, 12, 27, 59, 70, 76, 100); interventions support (A1-4, 6,13, 15, 17, 19, 22, 25-26, 30-31, 44-45, 50, 56, 59, 60-62, 65, 68-69, 75, 77, 87, 91-94, 98 - 100, 102 -103), institutional and management issues (A2, 7, 22, 42, 46, 48, 64, 74, 96-97).

In regard to hospitalizations, it was shown a prolonged hospital stay(A5, 18,52); admissions to home health services (A61, 80,91) and interventions forreduction in hospitalizations (A17).

With respect to procedures, include: supportive care (A6-10, 19, 23-24, 26, 30-31, 36, 40, 48-49, 53-54, 56, 58, 60-61, 63, 67-68, 81, 83, 85-86, 88-90, 91, 95, 97-101, 104, 106109, 111, 113), the reduction of invasive procedures (A15, 28,60,103); weight control regularly (A57), the nutritional state (A1), the discussion of resuscitation versus noresuscitation (A19 from 0.97 to 98).

The therapies include complementary medicine (A6, 12,27,61,72,74,98); experimental therapies (A6) and palliative chemotherapy (A6).

They are interventions to support the communication of the transition from curative to palliative care and patient's prognosis (A59, 63); interventions to better quality of life (A1-2,13,15,17,57,85,89,97-98,102,105,107,109), the reduction of stress (A26), the investment minimize the stress related to deprivation (A4, 17,22,31); dialogue, listening and counseling(A13 ,19,45,58-59, 73,90), psychosocial support (A6, 30,60,66,91,96,98), the family care(A3 ,13,25,60,89-91 ,100-101), educational activities (A92), the
environmental comfort (A96), the discussions of end of life (A15), and the choice for the location of death (A30, 44,50,67,75,108).

With respect to institutional issues, proves that the planning of care(A2, 46,48,72,95) and team training (A7, 62). Management issues contemplated the investment policies and palliative care (A22, 42.94).

**DISCUSSION**

About the productions, we highlight the differences between countries and the deficit still detected in Brazil, which can be understood from political differences, epidemiological, technological and investment in research. However, there is a global movement and national level in support of palliative care to meet the new paradigm of care, which explains the increase in scientific production.

The productions do not indicate when to implement palliative care. However, when there is no successful treatment and the person is diagnosed as out of therapeutic possibilities of cure, the transition from clinical follow-up to the palliative care should be gradual. It is essential to clear communication and also a relationship of trust, considering the emotional and respecting the patient and his family.¹ The goal is to add quality of life for days and not days to life.¹¹

With regard to by whom this care is being developed, there was a multidisciplinary team. However, there are still situations in which professionals work in isolation. Sometimes palliative care is regulated by the institution. It can also be developed by the family and caregivers volunteers. To meet the principles of palliative care, according to the WHO, it should be developed by a link between the multidisciplinary team, family and patient.¹

The approach of the complexity of palliative care acknowledges the commitment required from the health team in order to meet the demands of patient care and your family. In order to contemplate the possibilities in the face of uncertainty, diversity and unpredictability of the situation of advanced malignant disease that no longer responds to curative treatment by the instability of the clinical and the proximity of death.¹²

When family members become involved in patient care, they offer emotional support, physical comfort and monitoring of their health situation, noting their clinical signs that may require immediate care.¹³ Thus, it appears vulnerable to fatigue and stress before death and lack of emotional support and practical care.¹⁴ The family is present at diagnosis, treatment, especially in home care.

About to whom this care is being developed, it became clear that it contemplates the patients, from infants to the elderly, and caregivers.

Cancer in children and adolescents until the 1980s was considered a fatal disease, but with advances in technology and health care, it is now a potentially curable disease when it has access to early diagnosis and treatment occurs in centers specialized. These factors have increased the survival of children and adolescents with cancer, but even with progress in recent decades, approximately 25% of them fail to achieve a cure.¹⁵-¹⁶ Among the adult population, cancer is considered the second leading cause of death.¹⁷ There is a significant increase in mortality from 30 years-old, especially in the geriatric population, in which the highest concentrations.¹⁸

As for the family caregiver caring, attentive to the fact that when the family live with the patient in palliative care, their daily lives have changed by the demands of him. They are submitted to feelings such as helplessness because of the patient's situation, distress when the symptoms start and fear of death.

For most families in the same situation to receive such support, it becomes necessary to train a larger number of specialized teams to provide care in palliative care. The urgency for the expansion of this type of service is justified by the fact that caregivers feel often unprepared to deal with a terminal illness, requiring much support in relation to the practice of nursing as an emotional support.¹⁴ This care to the caregiver can be developed individually and / or group, promoting the encounter between the pairs to share experiences and challenges in coping with this situation.

The need is highlighted, including monitoring of these families after the process of dying and death, when they are vulnerable to the daily absence of the loved who died.

About where the actions are developed, they were highlighted the public and private services from hospice, clinics, hospitals, and the actual residence of the person and / or family.

Generally, palliative care are offered through programs inserted or not in hospitals. Programs linked to hospitals, mostly, are not normalized, i.e., are linked to the individual.
The number of programs in palliative care has grown, the programs included in hospitals are still few. When not placed in a hospital, the palliative care programs can develop in hospices, nursing homes, care homes, hospices, clinics and at home (home care).19

Finally, with regard to how palliative care is carried out, care and support issues, and institutional management.

The issues include the welfare prolonged hospitalizations, invasive procedures and supportive, and palliative therapies. For these patients, a variety of symptoms is possible. They can be caused by the disease itself, complications and sequelae of treatment, or due to disease or treatment related. Thus, health professionals should be alert to the presence of these symptoms and their treatment as well as conducting periodic reviews, for a change in priority may occur from one day to another. Important to consider the change of body image is directly reflected in the welfare and often, this is the main concern of patients with advanced stage disease and usually is accompanied by anxiety, depression and adjustment disorders.20-22

Concerning support in palliative care teams need to promote a caring environment that fosters the expression of feelings, dialogue, conflict resolution pending in the relations of the patient, the care of their own desires and tasks of the end of life. Health professionals have a significant role at this stage, whether the patient is for the family, providing quality to the process of dying and death. This requires specialized training for the management of end of life in terms of physical, emotional, spiritual, cultural and bioethical issues.23-25

In regard to the institutional issues, on the one hand palliative care is assuming increasing importance in the world, on the other hand there are gaps in education, training and continuing education. Given the moral necessity to organize a suitable model of care to people with advanced and terminal diseases, providing a dignified dying process, it is necessary that the discipline of palliative care integrates the curricula of graduate programs in health.26-27

Regarding the management, palliative care programs, regardless of being placed in hospitals or not, must follow guidelines that enable the achievement of objectives for the relief of suffering and promoting quality of life of people with advanced disease and their families. These guidelines can be grouped into six areas: physical, psychological, social, spiritual, cultural and structural.19, 26-27

**CONCLUSION**

The results showed that palliative care in oncology is developed in cases of advanced cancer, predominantly in later life and in the process of dying and death. It is being developed by a multiprofessional team, sometimes regulated by the institution by the family and volunteer caregivers. The remedial actions include patients, from infants to the elderly, and caregivers. As scenarios there are the private or public hospices, clinics, hospitals and homes. The actions indicated care and support issues, and institutional management.

So, currently, palliative care affirms life and face death in the daily care; not extend or postpone death, but provide relief of pain and other symptoms, offering support to patients and their families in the process of dying and death so worthy. Thus, palliative care is now constitute a major public health issue, especially when it comes to palliative care cancer, on the epidemiology highlighted.

It is essential that the philosophy of palliative care is incorporated institutions, academia and health services. For palliative care are in place and implemented effectively, are necessary training and continuing education of health professionals to meet people who have advanced disease and their families, whether in public or private hospitals, specialized services or home.

It is indicated that the need for further scientific investigations that analyze the specifics involving the public policies of different countries, given its epidemiological evolution, technological and scientific. Besides deepening the specialty of oncology health of children, adolescents, adults and senior citizens.

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