Assessment of quality of life, pain and effectiveness of treatment in palliative care patients

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Abstract

Purpose: Evaluation of quality of life, appraisal of pain quality and intensity, assessment of treatment and care effectiveness in palliative care patients treated at the in-patient Palliative Care Department in Częstochowa Province Hospital.

Material and methods: The study was performed in 50 randomly chosen patients at the in-patient Palliative Care Department in Częstochowa Province Hospital. The studied group comprised 22 women and 28 men. The trial lasted since October 2003 till April 2004 and this was longitudinal study. At the first assessment patients filled Modified Sheet Pain Assessment, Support Team Assessment Schedule (STAS) and Rotterdam Symptom Checklist (RSCL). At the second, third and fourth appraisal patients filled RSCL and STAS.

Results: In patients surveyed by STAS at the second assessment 52% of patients achieved very high scores (poor effectiveness of treatment and care), 32% high scores – unsatisfactory treatment and care, 15% average results (average treatment and care). Results of RSCL indicate for decrease in physical activity and global quality of life of terminal patients. At the fourth assessment after 4 weeks of the treatment nearly 80% patients assessed their physical state as low.

Conclusions: The results indicate that patients have poor performance status, no effective treatment is provided, psychological state is significantly impaired, and patients were forced to resign from social life because of cancer progression.

Key words: pain, quality of life, satisfaction from care, terminal phase of the disease.

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Introduction

The value of research concerning quality of life in medical sciences particularly in oncology and palliative medicine is increasing [1]. The main goal of palliative care is to achieve possibly the highest patients' quality of life thus quality of life assessment is mandatory [2]. Quality of life is always very subjective and to significant extent it depends on the psychological state, personality and value system. The holistic approach to the patient covering all dimensions of life is a difficult challenge for hospice-palliative care teams [3].

Aim of the study. Evaluation of quality of life, pain quality and intensity, effectiveness of treatment and care in patients treated at the in-patient Palliative Care Department in Częstochowa Province Hospital.

Material and methods

The study was performed in 50 randomly chosen patients at the in-patient Palliative Care Department in Częstochowa Province Hospital. Twenty-two women and 28 men were enrolled. The trial lasted since October 2003 till April 2004 and this was longitudinal study. First assessment (on the day of patients' admission to The Palliative Care Department) was performed in 50 patients, the second evaluation (seven days after the first assessment) was done in 46 patients, in the third assessment (after two weeks) 45 patients were evaluated, in the fourth measurement (4 weeks since the first assessment) only

Table 1. **Assessment of effectiveness of treatment and care – first evaluation (STAS)**

Assessment of effectiveness of treatment and care (symptom control, social aspects, spiritual dimension, communication)	Women		Men		Overall	
	n	%	n	%	n	%
Low (0-5 points)	0	0	1	2	1	2
Average (6-13 points)	2	4	5	10	7	14
High (14-17 points)	3	6	7	14	10	20
Very high (18-32 points)	17	34	15	30	32	64
Sum	22	44	28	56	50	100

Table 2. **Correlation of somatic dimension and global quality of life (RSCL – first assessment)**

Somatic dimension / Global Quality of life	Low 57-84	Average 49-56	High 32-48	Very high 0-31	Sum
0 Very poor	3	0	0	0	3
1 Poor	4	1	0	0	5
2 Rather poor	2	27	0	0	29
3 Average	0	8	0	0	8
4 Rather good	0	0	3	0	3
5 Good	0	0	2	0	2
6 Very good	0	0	0	0	0
Sum	9	36	5	0	50

29 patients were appraised. At the first assessment patients filled Modified Sheet Pain Assessment, STAS (Support Team Assessment Schedule) [4] and Rotterdam Symptom Checklist (RSCL) [5]. At the second, third and fourth appraisal patients filled RSCL and STAS. Szatanik elaborated Modified Sheet Pain Assessment, which is a tool designed for chronic pain assessment [6]. The items in this questionnaire can be divided for two categories: sensory and emotional. This questionnaire allows also for pain intensity evaluation. STAS covers broadly patient's situation from symptom control through social and spiritual aspects to assessment of communication quality between staff and patient, between patient and family and also between members of the team. Patients' problems and needs are assessed by 5-point scale. RSCL is a simple tool for quality of life measurement. It consists of four scales: physical symptoms scale, psychological symptoms scale, activity level and global quality of life. The majority of items are expressed in 4 point Likert scale (for symptoms and activity level). The global quality of life is assessed by 7 point Likert scale.

Results

According to STAS on the day of admission to The Palliative Care Department 64% patients had very high scores, which means that previous treatment and care was ineffective – symptom control, social aspects, spiritual dimension, and communication (*Tab. 1*). In the second assessment 52% patients had very high scores, 33% high scores – unsatisfactory care and treatment, 15% average results of care and treatment. In the third assessment 49% patients achieved very high results, which indicate poor effectiveness of treatment and care, 40% high results – unsatisfactory, 11% average results of care and treatment. According to the fourth assessment 62% achieved very high results, 31% high scores, and 7% average results.

In the first assessment of global quality of life by RSCL 58% patients evaluated as rather poor, 16% as average, 10% as poor, 6% as very poor, 6% as rather good, 4% as good. In the second assessment 59% evaluated global quality of life as poor, 28% as rather poor, 13% as very poor. In the third assessment 58% appraised their global quality of life as poor, 25% as rather poor, 18% as very poor. In the fourth assessment 55% evaluated their global quality of life as very poor, 38% as poor, 7% as rather poor. Among patients surveyed by RSCL no patient assessed global quality of life as very high.

Physical state as high was assessed in the first, second and third assessment by 10%, 9% and 11% patients respectively. Physical state as average was assessed in the first, second, third and fourth assessment by 72%, 76%, 51%, and 21% patients respectively. Physical state as low was assessed in the first, second, third and fourth assessment by 18%, 15%, 38%, and 79% patients respectively. The mentioned results of RSCL prove decreasing physical state of terminal patients. At the fourth assessment after 4 weeks of the treatment at the in-patient Palliative Care Department, 79% patients assessed their physical state as low.

Among patients surveyed by RSCL no patient assessed psychological state as very high. The result high has decreased over the study period: at first assessment – 12% of patients, at the second – 9%, at the third – 2%, at the fourth – 0%. Average psychological state was chosen by 80%, 78%, 78%, and 55% of patients in the first, second, third and fourth assessment respectively. The low evaluation of psychological state was present in 8% at first, 13% at second, 20% at third, and 45% patients at fourth assessment. To summarise the mentioned data it should be noted that patients in terminal phase of cancer assess their psychological state as average or low.

In patients surveyed by The Modified Sheet Pain Assessment 22% had strong pain, 18% moderate, 14% very strong, 14% pain as bad as one can imagine, 12% mild; 20% of patients did not report pain. Pain quality was assessed by 35% as pressing or squeezing in the sensory category; the same percentage of patients had troublesome and annoying pain in emotional category.

The analysis of dependency between somatic and global quality of life on the base of the first assessment (RSCL) is submitted in *Tab. 2*. The more somatic symptoms (57-84 points) reported by patients, the worse global quality of life. The analysis of dependency between pain intensity and global quality of life in terminal patients (Modified Sheet Pain Assessment, RSCL – first assessment, *Tab. 3*). The more severe pain reported by patient, global quality of life decreases.

Table 3. **Correlation of pain and global quality of life in terminal patients (Modified Sheet Pain Assessment, RSCL – first assessment)**

Self assessment of pain / Global Quality of life	No pain 0	Mild pain 1-20	Moderate pain 21-40	Strong pain 61-80	Very strong pain 61-80	Pain as bad as one can imagine 81-100	Sum
0 Very poor	0	0	0	0	0	3	3
1 Poor	0	0	0	2	0	3	5
2 Rather poor	0	3	9	9	7	1	29
3 Average	5	3	0	0	0	0	8
4 Rather good	3	0	0	0	0	0	3
5 Good	2	0	0	0	0	0	2
6 Very good	0	0	0	0	0	0	0
Sum	10	6	9	11	7	7	50

Discussion

Quality of life assessment comprises physical activity, somatic, psychological, social, and spiritual dimension [7]. In terminal cancer patients performance status, and the ability for self-service significantly influence quality of life. In our study physical status (assessed by RSCL) of surveyed patients at the first three assessments was usually average (72%, 76%, and 51%) and low (80%) at the forth appraisal. Palliative care patients usually are not mobile, spending most of the time in bed, especially when they are approaching death. Family and medical staff usually gives the support for these patients [8]. Appropriate treatment of physical symptoms, e.g. loss of appetite, fatigue, weakness, nausea and vomiting, breathlessness, insomnia etc. is aimed at quality of life improvement [9]. In this study the somatic state of patients during the trial deteriorated, symptoms were present with increased intensity, only sometimes were eliminated or palliated because symptomatic treatment was quite often ineffective. In the fourth assessment, patients assessed their physical state as low (80%) or average (20%). In order achieve good quality of life, it is necessary to relief pain effectively [10]. On admission 80% of patients reported pain, in spite of analgesics' administration, only 20% of patients were free of pain. Nearly 70% of patients suffered from moderate, strong, very strong or the worst imaginable pain. This clearly indicates for inappropriate treatment before patients' admission in spite of observed huge progress in pharmacotherapy of cancer pain in Poland [11]. It would be interesting to explore results of pain treatment during stay at the in-patient unit. In our study 40% of patients suffered from mild depression, 30% from moderate depression, 4% from severe depression and 26% had no depressive symptoms. Moreover we observed also high level of anxiety [12]. This is understandable taking into account poor patient prognosis, inadequate treatment of somatic symptoms and probably insufficient social support from the staff (there is no psychologist in the department).

To sum up we can conclude that majority of patients in our study had poor physical and psychological state, and many patients resigned from social life due to cancer progression. The symptomatic treatment and psychosocial support was in many patients ineffective. These problems reported by patients will serve to improve the quality of care and symptomatic treatment at the unit.

Conclusions

Physical status (assessed by RSCL) of surveyed patients at the first three assessments was usually average (72%, 76%, and 51% respectively) and low (80%) at the forth appraisal. The somatic state of patients during the study deteriorated, symptoms were present with increased intensity, only sometimes were eliminated or palliated because symptomatic treatment was ineffective. On admission most of patients reported pain, in spite of analgesics' administration, only 20% of patients were free of pain. In the assessment of psychological status 40% of patients suffered from mild, 30% from moderate, 4% from severe depression and 26% had no depressive symptoms. Patients had poor physical and psychological state, and many were forced to resign from social life because of cancer progression.

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