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Letter to Editor

Supportive Care is No More Equivalent to Withdrawal of Care

Georges El Hachem*

Department of Medical Oncology, Institut Jules Bordet, Brussels, Belgium

***Corresponding Author:** Georges El Hachem, Department of Medical Oncology, Institut Jules Bordet, Brussels, Belgium.

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In 2018, cancer remains a fatal, life-threatening and incurable disease in around 50% of the cases despite all the progress in the systemic and targeted therapies. In this perspective and knowing that the patients are facing more and new newer side effects, the practice of "supportive care" is more justifying its place. As it is called, its main goal is to support the patients all over the evolution of their disease in order to improve their quality of life. The concept of supportive care is not a withdrawal of care highlighting that the supportive measures shouldn't be initiated at the terminal phase once there are no more suggested therapeutic options. For a successful supportive care, clinicians (surgeons, internists, oncologists) who are responsible for the antineoplastic care should collaborate with the palliative team whose main objectives are to help and assist the patients to understand their situations, thus better tolerating their treatments.

In Oncology, there are 2 main types of diseases: the curable malignancies and non-curable ones. When the antineoplastic treatment is administered at a curative intent, supportive care still has a major role: a better management of the toxicities so that the patients can successfully achieve their treatments. It can be a nutritional support (especially in cases of concomitant chemo radiation therapy in head and neck cancers and upper gastro-intestinal tract malignancies), social support (transportation, assistance at home, adequate care for other family members and children), psychological and emotional supports. Besides, it can also be given as a medical support: growth factors to overcome myelotoxicity, anti-emetics, management of other chemotherapy side effects and surgical rehabilitation. However, when the disease is advanced or metastatic, the goal of the oncologic treatment becomes the prolongation of the survival without affecting the quality of life. In this situation, the supportive care fulfills a broad spectrum of activities, managing the symptoms related to the tumoral growth, as well as the resulting side effects.

Furthermore, the patients in this group will be more dependent, less autonomic, sarcopenic with many complaints and comorbidities. The palliative team is experienced in assessing these symptoms, communicating with the clinicians and actively working on the quality and consequently the quantity of the patients' life. Once they are in the terminal phase of their disease, antineoplastic treatments will become futile and the only benefit would be how to assume a best supportive and palliative care. The patients are more fragile and more symptomatic requiring a special and adapted comfort whether it is symptomatic, medical or psychological. So, the palliative team will act accordingly and will answer all the demands of the patients and their families. They will be accompanied and won't feel anymore abandoned.

Supportive care should be installed early in the disease. The patients are introduced earlier to the palliative team and are better surrounded. Many publications proved the benefit of the early installation of the supportive care. JS. Temel., *et al*. in 2010, Colombet., *et al*. in 2012 and Z Obermeyer., *et al.* in 2014 showed that the earlier introduction of the palliative care in patients suffering from a metastatic disease improved the quality of life, decreased the costs of medical care with a decrease in the number of the hospitalization and surprisingly, an increase in the survival.

In conclusion, cancers are one of the heaviest pathologies in which the adequate management of the symptoms may change the outcome. Supportive care should be anticipated and offered for all the patients. It must be discussed during every consultation, as it is done for the anti-cancer therapies. The oncologist shouldn't hesitate to prescribe, recommend, re-evaluate and adjust the palliative care as one of the patient's vitals.

Conflict of Interest

No conflicts of interest.

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