Symptom prevalence and functional status among patients with advanced cancers of the head and neck.

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Background:

Little is known about quality of life and functional status of patients with terminally ill head and neck cancers. In general, patients with incurable HNC have one or more following specific symptoms: 1) functional symptoms associated with eating, speaking, and breathing caused by the anatomical location of the tumor (e.g., dysphagia and dyspnea); 2) late toxicity and comorbidity from previous treatment (e.g., aphonia and xerostomia); 3) complications from medical devices (e.g., feeding tube and tracheostomy cannula); and 4) symptoms caused by a fungating tumor (e.g., cosmetic change, malodor, and bleeding). These symptoms substantially reduce quality of life (QOL) as well as physical functioning.

Methods:

We conducted a prospective, observational study to examine quality of life and functional status in terminally ill head and neck cancer patients. EORTC QLQ C15-PAL was used to assess QOL. QOL score and Clinician reported outcome were assessed every week.

Results:

Of the 29 patients meeting inclusion criteria, 27 were observed until death.(1-18 weeks)

Patient n=27	
Sex	
Male	19
Female	8
Age(y)	65.3 (36-81)
Site of cancer diagnosis	
Oral	10
Paranasal	2
Nasopharynx	1
Oropharynx	3
Hypopharynx	3
Larynx	3
Thyroid	3
Salivary gland	2

QOL score

The General Health QOL score from EORTC QLQ-C15-PAL did not change significantly between baseline and week 3. In addition, secondary endpoints (Dyspnea, Pain, Insomnia, Fatigue, Appetite loss, Nausea and vomiting, Constipation, Physical functioning, Emotional functioning) evaluated with the EORTC PAL-15 did not differ significantly.

Feeding and medication route

Oral Cancer
n=10

Non-oral cancer
N=17

Twenty-four patients(88.9%) received opioids and other medicine(tranquilizer, antidepressant). Most drugs were administered with the same route as nutrition.
There are more drug options for patients who can absorb from the intestine.

Seventeen patients (63.0%) could speak and nine patients (33.3%) could have oral intake upon study entry.

Twenty-two patients (81.5%) received enteral nutrition. Eight patients fed through a percutaneous gastrostomy(PEG) tube. Patients with oral cancer tend to receive a benefit with PEG.

Thirteen patients (48.1%) required dressing changes for fungating tumors. No patient had hemorrhagic shock.

Discussion:

The EORTC QLQ-C15-PAL, did not change significantly between baseline and 3 weeks in a patient population with poor prognosis. This may suggest that in patients with HNC, QOL does not decline substantially in the last month of life. Eating is one of the most important factors influencing on QOL. We hypothesized that QOL differs among patients receiving nutrition through different routes. However, we did not find a significant difference in EORTC QLQ-C15-PAL between PEG-fed and nasogastric tube-fed patients. Although artificial nutrition in terminally ill cancer patients is controversial, patients with a PEG tube were able to receive nutrition and medications.
Fungating tumors are commonly found in terminally ill HNC patients. It is associated several QOL-deteriorating symptoms such as malodor, exudate, hemorrhage, pain, mass effect, esthetic distress, pruritus, and crusting. Hemorrhage from the neck is a frightening event that makes patients and their family members imagine death, regardless of whether the bleeding is massive or not. Fatal hemorrhage has not been observed in this study.

Conclusion:

We observed how patients with HNC live during the last month of life in an acute hospital setting. Our data suggests that route of nutrition intake may play a role in QOL.