

Overview: Supportive care in breast cancer

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As survival after breast cancer increases, the focus of research and practice is increasingly turning to supportive care. This Forum is focussed on breast cancer in women.

Breast cancer is a traumatic diagnosis for any woman. Women have to engage in complex decision-making concerning multiple options for surgery, radiotherapy, chemotherapy and hormone therapy, taking into account genetic and fertility issues, as well as perceived benefits and risks.¹ They will face short and long-term side effects, potentially including hair loss, fatigue, cognitive decline, loss of fertility, menopausal symptoms and anxiety/depression. Despite ever-improving survival statistics, women experience fear of recurrence that can be ongoing even long after treatment and in the good prognostic context of early stage disease.² Women with advanced cancer face existential issues, ongoing treatment, as well as a range of symptoms and side effects.

Unsurprisingly, the need for information and support in this population is high.³ Thus this issue of *Cancer Forum*, very appropriately, focuses on the supportive care needs of women with breast cancer, complementing the medical/surgical focus in the previous issue, and mirroring one of the themes (breast cancer) of the Clinical Oncology Society of Australia meeting of 2016.

In the pages to follow, current models of supportive and decisional support are described, as well as the prevalence and severity of specific symptoms and side effects, and evidence-based interventions for these.

Claudia Rutherford and Nicholas Zdenkowski discuss the nature, benefits and challenges of shared decision-making (SDM), a model of decision making which is integral to patient centred care.⁴ While SDM is now strongly endorsed by most policy statements and frameworks, its implementation into routine care is variable. The authors identify the key decision-points in breast cancer, as well as resources that can be used to facilitate SDM. These include decision-aids, question prompt lists, patient navigators, decision coaches and online risk calculators, as well as training for clinicians in communication strategies that enhance SDM.

Janine Porter-Steele and colleagues provide an overview of models of supportive care in breast cancer, including shared care with GPs, specialist breast cancer nurses, peer support and e-health.⁵ They emphasise the importance of supportive care spanning the disease trajectory, including follow-up care and extending into survivorship.

Laura Kirsten and Kim Hobbs discuss models of supportive care specifically for women with advanced cancer.⁶ They highlight the multiple needs of this population, and the importance of screening for and managing distress through a stepped-care model. Information and general support will be required for all, but referral to specialist psycho-oncology services is needed to address more complex needs. A growing evidence base supports specialist interventions to reduce distress, address existential concerns and facilitate end-of-life adjustment and planning. These authors note the importance of maintaining an adequate workforce of psycho-oncology specialists to deliver these interventions.

Rebecca Tay and colleagues discuss sexual dysfunction after breast cancer arising from body image disturbances due to disfigurement or loss of the breast(s), menopausal symptoms and general fatigue.⁷ They provide guidance in taking a sexual history, using the PLISSIT (an acronym based on permission, limited information, specific suggestions and intensive therapy) model to guide sexual discussion and intervention, encouraging communication between women and their partners, and making referrals if necessary to specialist staff. Recent evidence on interventions to improve vaginal

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dryness or atrophy is presented, including fractional microblative CO₂ laser to improve microcirculation below the level of the mucosa.

Infertility after breast cancer is a major issue for women, discussed by Michelle Peate and colleagues.⁸ Issues covered include the risk of infertility, fertility measurement after cancer, the impact of future pregnancy on prognosis, birth outcome, contraception, the psychosocial impact of infertility and pregnancy and assisted reproduction after breast cancer. They emphasise the importance of discussing fertility issues with women before they make their treatment decisions, so that they can consider options that might decrease their risk of infertility.

Joanne Shaw and Fran Boyle discuss the sometimes under-rated chemotherapy side effect of alopecia.⁹ They discuss its impact on self-image, its role in marking women and men as cancer patients, and how it is a constant reminder of cancer. Pre-emptive shaving, wigs and head coverings can help women, but more recent attempts to limit hair loss through scalp cooling offer promise of at least reduced impact. Innovative Australian research on scalp-cooling is presented in this chapter.

Cognitive dysfunction after cancer, predominantly breast cancer, is explored by Victoria Bray and colleagues, including the growing evidence base that the so-called 'chemo-brain' is a real phenomenon, whether caused by cancer treatments or the cancer itself.¹⁰ Interventions to help women better manage or reduce cognitive dysfunction are described, though many interventions still under evaluation.

Lisa Beatty and David Kissane tackle the mental health outcomes after breast cancer, in particular anxiety and depression.¹¹ Levels of anxiety and depression are significantly higher in the cancer population than in the general population, and if left untreated, can add significantly to the burden of breast cancer, reduce adherence to medication and increase health costs. This article provides an overview of pharmacological and psychological treatments for anxiety and depression, including new and emerging therapies.

The special needs of patients in rural and regional areas, including indigenous patients, are discussed by William Fox and colleagues.¹² The tyranny of distance, as well as challenges in accessing expert care, can increase the burden of breast cancer on this population. The role of breast care nurses, aboriginal health workers, telemedicine and innovative IT solutions are presented.

Finally, Afaf Girgis and colleagues raise the banner for an often under-served group of people greatly affected by breast cancer – the caregivers.¹³ They note that distress can be as high or higher in this group as in the patients themselves. A number of individual, group and couple-based therapies have been shown to reduce distress and improve quality of life in caregivers, and by extension, in patients.

While this is not an exhaustive coverage of the supportive care needs of women with breast cancer, it is hoped that it will provide health care practitioners with an update on current knowledge and interventions to improve the supportive care of women with breast cancer, reducing suffering and improving quality of life.

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