Optimizing Quality of Life for Metastatic Breast Cancer Patients

By Mark L. Fuerst
Reviewed by Joshua Strauss, MD, Fellow in Hematology/Oncology, Columbia University Medical Center, New York, New York

Take Note
- Although the importance of quality of life (QoL) is often emphasized in the management and treatment of metastatic breast cancer (MBC), only one-third of phase III clinical trials in MBC assess QoL.
- Recently diagnosed MBC patients have poor psychosocial adjustment and a high need for more information about their disease.

The contemporary approach to metastatic breast cancer (MBC) management consists of individualized treatment to best suit the patient's breast cancer characteristics and clinical history. The wealth of treatments available has heightened the complexity of tailored patient care and can result in better quality of life (QoL). Although there is no internationally accepted definition of health-related QoL, it is clearly multidimensional and should include physical, emotional, social and cognitive functioning in addition to disease symptoms.¹

Much attention has been given to QoL recently, and its measure has been incorporated as an endpoint into many clinical trials. However, a recent meta-analysis of 122 trials noted that still only one-third of phase III clinical trials in MBC assess QoL.² The authors call for greater emphasis on the evaluation of QoL with standard, validated tools in MBC clinical trials.

A major component of QoL assessment tools is psychological health. Psychological distress is common after a diagnosis of breast cancer, yet little is known about the psychosocial adjustment of patients with recently diagnosed MBC. A survey of 52 such patients found evidence of poor psychosocial adjustment and a great need for more information about their disease.³ Not surprisingly, their overall QoL appeared to be worse than that of the general population, with a subset of patients dealing with significant anxiety and depression.
The most reported unmet supportive care needs in patients with MBC are psychological support, counseling, and adequate information concerning things they could do to help themselves feel better. Patients also need more information about which staff members are available for communication, the status of their cancer, explanation of test results, the risks and benefits of treatment, and how to obtain access to counseling.

Psychological distress may also manifest as depression or anxiety, as noted above. About one-third of those with advanced cancer have mood disorders and one-quarter have minor depression. Antidepressants and anxiolytics can be effective, but patients should be monitored for potential drug interactions. Psychosocial support and cognitive behavioral therapy (CBT) may also be useful. In MBC the goal of treatment often is to control the disease for as long as possible while preserving the patient’s functional status and QoL. A major task for the clinician is palliating systems that interfere, such as the psychological symptoms described above, as well as pain, fatigue, insomnia, and lymphedema.

**Pain** The first steps in approaching pain include obtaining a careful history to assess its location and trusting the patient’s report of severity. Adjuvant analgesics are first-line therapy for neuropathic pain related to metastases or treatment. A common cause of chronic pain, bone metastases can also result in hypercalcemia, pathologic fracture, loss of mobility, and spinal cord compression. Pain caused by bone metastases may be addressed by nonsteroidal anti-inflammatory drugs, opioid and non-opioid analgesics, corticosteroids, adjuvant agents, interventional procedures, local radiation therapy, surgery, and systemic radiopharmaceuticals.

**Fatigue** In cancer patients with metastatic disease, tumor burden, pain, difficulty sleeping, anemia, poor nutrition, inactivity, and other comorbid conditions can all contribute to increased fatigue. Several pharmacologic approaches show potential to relieve cancer-related fatigue. The most rigorously designed clinical trials have been conducted with epoetin alfa and darbepoetin alfa. CNS stimulants also show promising results in open-label prospective studies. Nonpharmacologic management includes regular physical activity and psychosocial interventions.

**Insomnia** Poor satisfaction across all domains of QoL and higher rates of depression are associated with insomnia. Approaches that have been helpful for breast cancer patients include CBT, benzodiazepines, and benzodiazepine receptor agonists, as well as mindfulness meditation and yoga.

**Lymphedema** Women with lymphedema can experience functional impairment as well as decreased emotional well-being. Lymphedema may be treated with decongestive lymphatic therapy (including manual lymph drainage), compression garments, remedial exercises, and skin care. Some women may benefit from low-level laser therapy.
Optimal management of MBC must balance many factors, including a woman’s performance status, social support, symptoms, disease burden, prior therapies, and surrogates for tumor biology. A team approach provides close, frequent communication among caregivers, patients, and families. The goal of care should be to maintain the highest QoL while optimizing disease control.

Published: 06/29/2013

References:


