Rehabilitation of Cancer Patients
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Background
As treatments for various forms of cancer improve in effectiveness, the spectrum of disease and disability experience in cancer patients is changing. Twenty years ago, very many cancer patients did not survive the acute phase of their disease treatment. Now, the five-year survival of many cancer patients, even with metastatic disease, is as good as (or better than) the survival rates of many of the “benign” conditions that we see in our rehabilitation units. Cancer is the new chronic disease of this century.

Yet many patients with cancer are not admitted to rehabilitation units for therapy programs to deal with their disabilities, because many clinicians still think of cancer as being rapidly fatal, with hopeless outlook.

Lehmann et al (1978) first reported attempting rehabilitation programs for patients with cancer-related disability. We report on the outcomes of a six-year pilot inpatient Cancer Rehabilitation program commenced in mid-1997 at Braeside Hospital, for first episodes of rehabilitation care.

Method
143 patients with cancer-related disability were admitted to the Rehabilitation Unit at Braeside Hospital. Two died during their stay in our unit. 31 patients suffered interruptions to their rehabilitation program and were transferred back to acute care. Nine transfers were planned (for radiotherapy, chemotherapy or further surgery), and 22 were unplanned (18 with sepsis; one episode each of DVT, NOF, bowel obstruction and acute renal failure). All but eleven patients returned to Braeside, and thus 132 patients completed their rehabilitation program. Complete FIM data are available on 118 patient care episodes.

FIM was used as the primary measure of rehabilitation outcome, as it is the anchor of the classification system used in NSW for description of workload of inpatient rehabilitation services.

Results
27 patients had spinal compression, 37 had intracranial tumours, 16 had pathological fractures and 38 had general debility from haematological or GI tumours, or from the effects of treating these. Age range was from 19 to 94 years, with median age of 70 years. Only three patients failed to improve their FIM scores during rehabilitation. 101 of the 118 patients returned home, while five required low-level (hostel) nursing care, and 12 were placed in higher-level (nursing home) care at discharge from Braeside.

All the cancer-disability patients were matched with general rehabilitation control patients having benign diagnoses, treated at Braeside during the same period. Matches were for patient gender, and as closely as possible for age, lesion location and ethnicity. Comparison of the two groups showed no significant differences with FIM progress, residential outcomes or lengths of stay in the rehabilitation unit.
Discussion

In recent years, several papers have shown that the outcomes of inpatient rehabilitation of cancer patients are comparable with patients having benign disease, in a number of conditions. Some of these papers are based on control comparison studies, although other control matching has not generally been as tight as we describe in our series. Previous studies have not matched for ethnicity, which is likely to be an important factor influencing the decision to care for a given patient at home, after discharge.

Conclusions

We conclude that inpatient rehabilitation for patients with cancer-related disability is just as effective as for those with non-cancer-related disability. Cancer is a complex, common and increasingly chronic cause of disability in developed and industrialised nations. Cancer patients with residual disabilities deserve the best rehabilitation management of their functional limitations, to give them the best possible quality of life.

Reference