Journal of Palliative Care & Medicine
ISSN: 2165-7386

Hamilton, J Palliat Care Med 2016, 6:3
DOI: 10.4172/2165-7386.1000257

Short Communication Open Access

Chemotherapy near the End-of-Life – A Review of the Literature

Hamilton IJ*

Researcher, Institute of Health and Wellbeing, University of Glasgow, UK

***Corresponding author:** Hamilton IJ, Researcher, Institute of Health and Wellbeing, University of Glasgow, Institute of Health and Wellbeing, 1 Lilybank Gardens, Glasgow, G12 8RZ, UK; Tel: 07799745900; E-mail: ijdhamilton@doctors.org.uk

Received date: Mar 29, 2016**; Accepted date:** Apr 25, 2016**; Published date:** Apr 28, 2016

Keywords Chemotherapy; End of life care; Palliative Care; Cancer care

Discussion

Chemotherapy near the end-of-life is controversial. The et al. [1] in a study of lung cancer patients found that initial optimism about recovery tended to vanish when the tumour recurred after chemotherapy and they suggested collusion was occurring between doctor and patient with the doctor not wanting to pronounce a "death sentence" and the patient not wanting to hear it. Matsuyoma et al. [2] in a literature review showed that patients were willing to undergo treatment which had little benefit but major toxicity and suggested that honest unbiased sources were needed to inform them of their prognosis, choices, consequences, typical outcomes and ways to make decisions. Harrington and Smith [3] commented that patients faced difficult decisions about near end-of-life chemotherapy which may prolong survival or reduce symptoms but prevents them from engaging in meaningful life review and preparation for death. Earle et al. [4] estimated that 20% of cancer patients were still receiving chemotherapy in the last 2 weeks of life and suggested aggressive treatment near the end-of-life was a quality-of-care issue. Buiting et al. [5] in a study of health care professionals found greater use of chemotherapy near the end of life could be explained by the doctor and patient mutually reinforcing an attitude of "not giving up" and the doctor interpreting quality of life in terms of "they would be taking away hope" by withholding treatment. Braga [6] in a case study poignantly asked "why are we not ceasing chemotherapy when it is useless, toxic, logistically complex and expensive".

Zdenowski et al. [7] reported wide variations in the use of chemotherapy in the last 30 days of life and Pacetti et al. [8] in a study of advanced cancer patients found 24 per cent of patients received their last chemotherapy regimen within one month of death. Wright et al. [9] demonstrated that chemotherapy in the last months of life was associated with an increased risk of undergoing cardiopulmonary resuscitation, mechanical ventilation or both and of dying in an intensive care unit and Prigerson et al. [10] stated that quality of death (QOD) for end-stage cancer was being harmed by near end-of-life chemotherapy. Fujisawa et al. [11] demonstrated anxiety, depression and poor psychological quality of life was associated with chemotherapy at the end of life and Wijnhoven et al. [12] showed that patients receiving chemotherapy during the incurable phase of cancer had more difficulty in accepting the incurable nature of their disease. Pirl et al. [13] stated that administering chemotherapy close to death was poor quality care and Mohammed et al. [14] suggested guidelines were required to ensure the appropriate use of palliative chemotherapy. Massa et al. [15] called for a reduction in the number of patients who start chemotherapy in the last 30 days of life but Schildmann et al. [16] advised caution highlighting ethical issues involved in limiting treatment at the end of life.

Luthy et al. [17] suggested a supportive care programme assessing risks and benefits of chemotherapy could help prevent aggressive care near death and Jang et al. [18] in a study of advanced pancreatic cancer patients demonstrated that consulting patients and providing more palliative care resulted in less aggressive treatment near death. Amano et al. [19] and Zakhour et al. [20] also showed that early palliative referral and end-of-life discussions with patients was associated with less aggressive end-of-life care.

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