

Chairman's introduction

Despite remarkable progress in the curative treatment approaches for several types of neoplastic diseases that were formerly considered to be lethal, the real prognostic outcome of a large number of patients with advanced adult solid tumours remains poor, especially for older patients. Besides scientific activities to find new 'curative' treatments for many inoperable and/or disseminated cancer types, the development of adequate and comprehensive strategies for supportive and palliative care to relieve or at least to minimise suffering in these 'incurable' patient groups, remains a vital part of modern quality-of-life-oriented oncological practice.

Although cancer patients with advanced or even terminal disease are usually suffering from more than one burdening problem out of a broad range of nasty symptoms, effective analgesia remains one of the cornerstones of optimal symptom control. Nathan I. Cherny in his well documented and exhaustive review of the pharmacological management of cancer pain makes it very clear, that optimal pain control in oncology is much more complicated than adjusting daily morphine doses according to the patient's growing demand in progressive disease. Optimal pain control in many tumour patients — not only those with very advanced stages — requires expert experience and imagination to deal with the patient's real needs, which includes the attentive use of the large selection of analgesic adjuvant drugs from muscle relaxants to antidepressants and sedatives, to keep the patient's quality of life as high as possible even in terminal disease. Interdisciplinary pain consulting services and units of excellence within cancer centres and their referral areas are called for, paying attention to the historically very different medical systems and structures available. How can we address our cancer patient's many other symptomatic needs at a global, comprehensive level, if we are not able to adequately control their pain? For many cancer patients, "pain is more than just pain": it is the somatic equivalent or surrogate marker of disease progression and approaching death! Successful pain control, therefore, may also help us to solve or even prevent other somatic and/or psychological symptoms and problems, which are often much more difficult to treat, such as depression, dyspnoea, cough etc. — sometimes called the 'orphan topics' of supportive and

palliative cancer care, because neither academia nor industry are interested in dealing with these 'unrewarding' aspects of care due to the lack of promising pharmacological or technical approaches.

Radiotherapy — besides its role in the curative treatment of lymphomas and selected solid tumours — plays a major part in palliation and symptom control in patients with advanced cancer, especially these with metastatic bone pain, neurological deficits and visceral obstructions. Ole S. Nielsen in his well balanced and nicely documented contribution about the present status of palliative radiotherapy advocates the more extensive use of single-dose analgesic radiotherapy. This certainly would greatly contribute to many cancer patients' quality of life, rendering frequent, repetitive visits to hospitals or even hospital stays for 1–2 weeks unnecessary. Careful patient selection seems to be vital for this approach, but does not substitute for comprehensive additional symptom control besides pain. With many of these cancer patients presenting with more than one problem, it is essential to deal with all of them and to discuss their relative value with the patients directly. Not infrequently, there is a certain transposition of problems to other symptoms as pain is controlled over time, and it is of paramount importance that the 'pain expert' (especially if his educational and practical background is that of a technical anaesthesiologist and not a medical oncologist) remains aware of all the other real or potential sources of trouble for our mostly polymorbid patients.

No session or survey about supportive and palliative care in cancer patients would be complete without portraying the extremely important role of nursing in this domain. The final contribution by Jessica Corner in this chapter highlights the many aspects of palliative nursing care in cancer drawing on the vast background of experience available in the United Kingdom where this field has been developed since the early 1980's. Nurses have from the very beginning played a key role in the delivery of palliative care in many ways: in home care, in nursing homes and regular hospital wards, as well as in specialised palliative care units in larger hospitals and cancer centres. While the doctor's involvement in the care of very advanced tumour patients with disappearing 'curative' medical approaches is traditionally de-

creasing, the caring involvement of oncology nurses and other health care professionals such as physical therapists, spiritual counsellors etc. has increased. Nursing in supportive and palliative care encompasses a wide range of activities and responsibilities. Nurses have prioritised emotional approaches and supportive care elements in their education and daily work much more than physicians in the past, giving rise to potential interprofessional conflicts of interest and responsibility, depending on the hierarchical structure of certain country's medical system.

But this process is changing, as supportive and palliative care have become an educational priority for physicians at major clinical oncology meetings such as the American Society for Clinical Oncologists meeting (ASCO) in the United States or the European Cancer Conference (ECCO) and European Society for Medical Oncologists meeting (ESMO) in Europe. Furthermore, since worldwide societies and journals about Supportive Care and Palliative Care in Cancer are gaining influence in modern, quality-of-life-oriented clinical oncology. It is particularly reassuring to see, that nurses, physicians and psycho-oncologists engaged in supportive

and palliative care in cancer patients are also increasingly starting interprofessional research activities into the prevention and management of difficult symptoms of advanced cancer and hopefully the 'orphan topics' of supportive care mentioned above as well. As specialised annual, repetitive courses in supportive and palliative care increasingly highlight the importance of this area at an interdisciplinary or even interprofessional level for nurses, physicians and psychologists together — for example, by the German-speaking programme of the European School of Oncology — it is hoped that this approach and consecutive common research endeavours will finally benefit more and more cancer patients who are in their advanced and terminal disease stages. Seeing the patient's needs and being ready and willing to help is fine, but may not be professional and efficient enough. Let's close this editorial with a citation by one of the great proponents of palliative care, Robert Twycross from Oxford in the UK: "Patients need a helping hand, but it helps if this helping hand is connected to a thinking brain!"

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