Physiotherapeutic Care to the Patient in Oncological Palliative Care in Pandemic Times by COVID-19: Recommendations of a Reference Unit

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Atendimento Fisioterapêutico ao Paciente em Cuidados Paliativos Oncológicos em Tempos de Pandemia por Covid-19: Recomendações de uma Unidade de Referência

Atención Fisioterapéutica al Paciente en Atención Paliativa Oncológica en Tiempos Pandémicos por Covid-19: Recomendaciones de una Unidad de Referencia

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INTRODUCTION

The coronavirus disease 2019 – COVID 19 is a highly contagious viral infection of inflammatory character, where most of the patients presents the mild (40%) or moderate (40%) form of the disease, approximately 15% present the severest form requiring oxygen support and 5% of the cases develop to critical condition with complications as respiratory failure, acute respiratory failure, sepsis, septic shock, thromboembolism and/or multiple organ failure. Still, mental and neurologic alterations as delirium, encephalopathy, agitation, stroke, meningoencephalitis, compromise of smell or taste, anxiety, depression and sleeping disorders[1] may ensue.

The severest form of the disease can affect healthy individuals of any age but occurs predominantly in adults in advanced age and with risk factors as smoking, obesity, *diabetes mellitus*, systemic arterial hypertension, heart diseases, chronic pulmonary diseases, lung cancer and staging IV[2] metastatic diseases.

Whereas the dissemination of COVID-19 and knowing the patients with advanced cancer belong to the risk group for this infection[3], it is necessary to reorganize the follow up flow of this group and elaborate strategies to maintain control of the symptoms, regardless of the rules of isolation and restriction of social circulation because of the pandemic[4].

The patients with advanced cancer in palliative care diagnosed with COVID-19 can benefit of the physiotherapy follow up for approach and control of the complications that interfere in their functionality.

Physiotherapy is part of the multidisciplinary team and through its techniques and resources has the purpose of minimizing the physical-functional repercussions of the disease, protecting the autonomy, independence and quality of life[4]. According to the Professional Code of Ethics[5], the physiotherapist provides care to the human being individually and collectively, participating of the promotion of health and palliative care always having in mind the quality of life without any discrimination whatsoever.

According to the functional status and necessity to control the symptoms, the physiotherapeutic care provided occurs in outpatient, home care (HC) or during hospitalization (H). According to the Brazilian Health Regulatory Agency (ANVISA)[6] technical note because of the pandemic, it is necessary to follow new recommendations to contain the transmission and dissemination of the novel coronavirus during any medical approach. In the current scenario, the National Academy of Palliative Care (NAPC)[4] recommends to the services to change the conventional care to contingency resources.

The approach suggested by NAPC is the substitution of in-person consultations by tele-consultation or tele-monitoring, mainly in outpatient follow up and home care, to minimize the exposure to virus contamination. This recommendation is also upheld by the Federal Council of Physiotherapy and Occupational Therapy

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(COFFITO) in the Directive number 516, March 20, 2020[7] that describes the permission to non in-person consultation in the modalities of tele-consultation, tele-advise and tele-monitoring and ensure the physiotherapist autonomy and independence to determine in-person or remote follow up for the patient based in scientific evidences of benefits.

In every modality of care with in-person professional evaluation (hospitalization, outpatient or home care), the approach of the patient must follow the safety measures recommended by the Hospital Infection Control Committee (HICC) of the unit, using rationally the required Personal Protective Equipment – PPE and adopting precaution measures of infection dissemination in the environment.

One of the principles of palliative care is to ensure the quality of the care and comfort until the end of the life, this philosophy prevents avoidable suffering and therapeutic obstinacy[8]. The patients referred to exclusive palliative care are guided about the principles of this approach and sign an Informed Consent Form containing conventions about do not-intubate (DNI) and do not resuscitate order (DNR), in addition to receiving orientations, as, for example, that the unit has no Intensive Care Unit (ICU) and they will not be submitted to invasive mechanic ventilation (IVM) and will receive management measures for signs and symptoms of basal-related disease and current complications.

RECOMMENDATIONS FOR PHYSIOTHERAPEUTIC SYMPTOMS MANAGEMENT

Dyspnea

Like advanced cancer, dyspnea is one of the symptoms of severity demanding care and hospitalization of patients with COVID-19[3].

Considering non-invasive ventilation (NIV) is an option for dyspnea management in patients in palliative care[9], in the specificity of COVID-19, the current experience with hypoxemic heart failure demonstrates high rate of failure in utilizing the technique. Based in the literature review, the recommendation is that NIV should not be first line ventilatory strategy. Whether performed, must be done with strict use of PPE, proper equipment and interface because of aerosol release, viral dissemination and great risk of contamination[10].

In cases of complaints of dyspnea that has no indication for NIV, strategies for comfort and management of this symptom are recommended as: maintenance of ventilated and calm environment, open windows, cooling the patient face with cold compresses, comfortable clothes, preferentially postural correction with elevated headboard and techniques of relaxation[4].

According to Thomas et al.[10],

> The respiratory infection associated to COVID-19 infection is mostly associated to dry and non-productive cough; lower respiratory tract involvement usually involves pneumonitis rather than exudative consolidation. In these cases, respiratory physiotherapy interventions are not indicated[10].

For more complex clinical cases where exudative consolidation with mucosa hypersecretion with difficulty to mobilize secretions, referral of respiratory physiotherapy is indicated on a case-by-case specificity evaluation.

Fatigue

It is a symptom of great prevalence either in COVID-19 (44% to 70%)[11] or advanced cancer (>75%), impacting the functionality directly[12]. In intense fatigue cases, propose management of home activities with techniques for saving energy as: adaptation of the environment to facilitate the tasks, substitute tasks of orthostatic position to seated position, ask family and caretaker for help, organize the activities with different levels of demand progressing from low to high energetic expenditure according to the patient tolerance and facilitate the access to materials and devices to be used[13].

Physiotherapy interventions to recover during hospitalization can be considered in cases of significant functional restraints. These must be discussed with the multidisciplinary team after the evaluation of the clinical and physical status of the patient, who must present stable respiratory and hemodynamic function[10]. Early mobilization must be encouraged, functional incentive of activities in the room, as seating outside the bed and performing activities of daily living (ADL) are basic and essential recommendations to start the functional recovery.

Other symptoms related to advanced cancer

Further to dyspnea and fatigue, other signs and symptoms can be approached by physiotherapy as pain, bone metastasis and its complications, venolymphatic changes, among other[14]. These clinical conditions should not be neglected in the moment of hospitalization but need to be discussed with the team to define the proper moment of approach, pondering the exposure of the professionals, the relation cost-benefit of the care provided and criteria of clinical stability of the patient.

The patients who were discharged from hospital must be monitored through tele-consultation or tele-monitoring. Through this contact, it is estimated the condition of the patient at home for functionality-related

symptoms control. From then on, a planning treatment must be designed with guidelines to patients, family and caretakers. It can also be considered the necessity of video-call or in-person evaluation in cases the professional concludes it is mandatory. If the follow up process at the unit is home care, it is recommended the use of leaflets with orientations about exercises, use of orthosis and other physiotherapeutic resources that can be handed over to the family by a team member or sent electronically.

CONCLUSION

The physiotherapist role in palliative care is focused to the process of recovery of the patients, mainly in relation to functionality. Considering that the ideal physiotherapeutic approach needs to be conducted in-person, it is paramount the need of social distancing and adaptation of the consultation to the patient in the COVID-19 pandemic scenario. Thus, aware that the oncologic patient in palliative care is in frank process of physical, emotional, spiritual losses that impact directly in the quality of life, the continuation of the treatment cannot be neglected to ensure the respect to its dignity.

CONTRIBUTIONS

All the authors contributed equally for the conception and planning of the study, gathering, analysis and interpretation of the data, drafting and critical review and approved the final version to be published.

DECLARATION OF CONFLICT OF INTERESTS

There is no conflict of interests to declare.

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