1. GENERAL PRINCIPLES

- Cancer rehabilitation aims to “improve the patient’s quality of life by maximising their ability to function, to promote their independence & to help them to adapt to their condition.”
- Cancer rehabilitation may help improve psychological well-being and physical functioning.
- There are recognised ‘symptom clusters’ which occur in patients with lung cancer i.e. Pain - Psychological distress
  - Dyspnoea - Fatigue
- The rehabilitation needs of lung cancer patients may include a number of different symptoms / issues. (see Table 1 and Figure 1)
- Patients with lung cancer may have rehabilitation needs at different phases of their disease trajectory. Four cancer rehabilitation stages have been identified:
  - Preventative: reducing the impact of expected disabilities and learning to cope with any disabilities that do occur
  - Restorative: returning the patient to their pre-illness level of functioning
  - Supportive: in the context of continual disease. Aim to limit functional loss and provide support
  - Palliative: in the context of further loss of function, provide support and put in place measures that eliminate or reduce further complications

<table>
<thead>
<tr>
<th>Table 1 Rehabilitation Needs of Patients with Lung Cancer</th>
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<tbody>
<tr>
<td>Anorexia and cachexia</td>
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<td>Anxiety / stress</td>
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<tr>
<td>Communication difficulties</td>
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<td>Difficulties with work and leisure activities</td>
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<td>Dysphagia</td>
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<td>Dyspnoea</td>
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<td>Fatigue</td>
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<td>Impaired mobility</td>
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<td>Need for specific equipment</td>
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<td>Pain</td>
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<td>Reduction in independence for activities of daily living</td>
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Patients are at risk of developing or experiencing the following clinical indicators and should be assessed for referral to rehabilitation pathway interventions at all stages in the cancer care pathway as described below:

Consider level of intervention required:
- Information support
- General rehabilitation services
- Specialist oncology/palliative rehabilitation
- Ensure patient has contact details for timely access to rehabilitation services (see local cancer services directory-rehabilitation services)

Rehabilitation is not solely the responsibility of allied health professionals (AHP). All health and social care professionals may need to play a part. Allied health professionals not only help cancer patients recover from the physical changes of their illness but also help them function in everyday activities and adapt to their new needs.

Key professionals providing cancer rehabilitation include:
Physiotherapists
Occupational therapists
Dieticians
Speech and language therapists
Lymphoedema therapists

Other professionals who may contribute to the rehabilitation process include: 7
Podiatrists
Psychosexual counsellors
Stoma therapist
Therapy radiographers
Appliance officers
Oral health specialists

2. GUIDELINES

The rehabilitation needs of lung cancer patients should be reviewed at the different stages of their illness. 5 [Level 4] This will include:
- Diagnosis
- Treatment
- Post treatment
- Monitoring and survivorship
- Palliative care
- In last hours to days of life

Holistic assessment tools can help in the assessment of rehabilitation needs e.g. distress thermometer, SPARC. 6, 8 [Level 4]

A key worker for each patient should be identified to provide continuity of care throughout the patient pathway. 9 [Level 4]

There is evidence which supports the role of rehabilitation for lung cancer patients in several areas. (see sections below)

2.1 Cancer-related fatigue

Exercise interventions have been shown to have some benefit in the management of cancer-related fatigue during and post cancer therapy. No studies have specifically been conducted with lung cancer patients. Initial studies looking into the role of a pre- and post-surgical exercise program for lung cancer patients show promising results and further randomised controlled trials are required. 10,11,12,13
Exercise is a simple low-risk intervention and should be considered to help patients suffering from cancer-related fatigue both during and after treatment. [Level 1+]

Non-pharmacological therapies combining exercise and psychosocial interventions also show potential for improvement in functioning, e.g. cognitive-behavioural techniques.

2.2 Breathlessness

Non-pharmacological interventions and pulmonary rehabilitation have been shown to improve patients’ management of their breathlessness and functional ability although some of the trials have been conducted with COPD patients. [Level 1+]

A referral for more intensive non-pharmacological and psychological intervention should be considered for lung cancer patients to help improve both their dyspnoea and functioning level. [Level 1+]

Simple measures like the use of walking aids and breathing re-training should be considered to help lung cancer patients manage their breathlessness. [Level 2+]

2.3 Anorexia /cachexia

The role of multimodal strategies to address food intake and metabolic change remains controversial. There have been some studies demonstrating an improvement in function and quality of life but more research is required.

2.4 Pain

Successful pain management can be achieved through the co-ordinated efforts of team members e.g. input from an occupational therapist can help modify pain perceptions & lifestyles for individual patients.

There is evidence to support the use of acupuncture in the management of nausea / vomiting and breathlessness but not currently for pain. There is some evidence of the effectiveness of massage interventions on pain and psychological well-being. Although the evidence for acupuncture and massage is limited, these can still be beneficial interventions for some lung cancer patients. [Level 4]

Relaxation therapy should be considered as an intervention to help with psychological symptoms and somatic symptoms such as pain. [Level 1-]
3. **STANDARDS**

1. All lung cancer patients approaching the end of life should have their rehabilitation needs assessed, ideally using a holistic assessment tool e.g. distress thermometer, SPARC \(^6,8\) [Grade D]

2. Lung cancer patients approaching the end of life should have access to rehabilitation services according to need and in a timely manner. Routine referrals should be seen within two weeks. Urgent referrals should be seen within 48 hours e.g. high risk of falls; to prevent an acute admission; patient in last hours or days of life.\(^6\) [Grade D]

3. A cancer rehabilitation team should consist of, but not be limited to, the following five key Allied Health Professionals (AHPs) highlighted within the National Cancer Action Team Rehabilitation Care Pathway – physiotherapist, occupational therapist, speech and language therapist, dietician, and lymphoedema specialist.\(^6\) [Grade D]

4. There should be clear referral pathways for general rehabilitation services and specialist AHP services (who can deliver rehabilitation interventions).\(^6\) [Grade D]

4. **REFERENCES**


5. CONTRIBUTORS

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<th>Date of Guideline Production</th>
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<tbody>
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<tr>
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