Expanding Paradigms in Oncology Rehabilitation

By Leslie J. Waltke, PT

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Can you imagine being diagnosed with cancer? Can you then further imagine that after being treated—when you are weak, fatigued, limited and scared, and you just want to get your life back—being told that you should no longer do the things you enjoy? No lifting, no sports, no carrying, no flying, no hot tubs, no gardening. This is what the rehabilitation profession has been doing to cancer patients and survivors for decades (although we are by no means the only guilty party).

Thankfully, as a profession, for the most part we have erased that paradigm. But despite work by the Oncology Section of the American Physical Therapy Association and by pioneering oncology physical therapists throughout the country, cancer and rehabilitation are still not an automatic association in health care. As an unfortunate result, most cancer patients and survivors are going grossly undertreated for their musculoskeletal, cardiopulmonary and functional deficits common with oncological medical management. For the sake of the 12 million cancer survivors in this country and for the 1.5 million people who are diagnosed each year, year after year, our work on changing and expanding paradigms in cancer rehabilitation deserves and demands the full attention of our profession.

With most PT schools providing only minimal curriculum attention to cancer, it falls on the shoulders of clinical physical therapists to educate ourselves, our students and our medical teams on the critical role of physical therapy in oncology. But before we can do this effectively, physical therapists need to expand their own understanding of the true, fully comprehensive role of cancer rehabilitation.

Paradigm Expansion 1

The primary role of cancer rehabilitation is not to treat lymphedema. The primary role for oncology physical therapists is to treat the plethora of musculoskeletal, cardiopulmonary and functional deficits associated with cancer surgery, reconstruction, chemotherapy, radiation and hormonal and biological therapies.

For most people, their first thought after hearing the words “cancer rehabilitation” is “lymphedema.” Though it is true that a small percentage of cancer patients will develop lymphedema, if we do not evolve our thinking, the upward of 75 to 90 percent of patients who develop pain and fatigue will continue to go undertreated or completely untreated by rehabilitation. Like any post-operative orthopedic evaluation, our assessment and treatment plans need to address pain, strength, range of motion and function. Additionally, by addressing tissue mobility, strength and limb mobility, research tells us that patients with lymphedema symptoms will improve and that we will decrease the incidence of lymphedema for those at risk for the condition.

Paradigm Expansion 2

Cancer rehabilitation is not one post-operative visit with a physical therapist. The true scope of practice for a cancer rehabilitation therapist assesses and treats the physical and functional problems of cancer patients from diagnosis on into survivorship. Most medical centers do offer a one-time post-operative physical therapy visit with range of motion and lymphedema teaching. However, like most orthopedic surgeries, people post-cancer surgery are most likely going to exhibit musculoskeletal symptoms for weeks or months.

Our profession would be unlikely to advocate a one-time post-operative visit for knee or shoulder surgery, Parkinson’s disease or a CVA, so why are we doing this for cancer surgeries? A majority of oncological medical management plans will include more treatment beyond just surgery, including chemotherapy and radiation. Both chemotherapy and radiation will cause additional musculoskeletal, cardiopulmonary and functional problems. How can we address, minimize or prevent these expected issues if we are no longer seeing the patient?
Paradigm Expansion 3

Cancer rehabilitation is not just for post-surgical range of motion. Again going back to what should be a comprehensive traditional post-operative assessment, we are often forgetting to address muscle weakness with our cancer patients. Additionally, with tissue removal common with oncology surgeries, we also need to add tissue length and mobility assessment and treatment to our paradigms.

Only giving range of motion exercises to our patients without assessing them from a manual therapy tissue perspective is doing them a great disservice. And if we know that a patient will begin chemotherapy and/or radiation after surgery, it is our job to immediately address the well-documented impending cardiopulmonary and functional issues. Not only is it safe for people undergoing chemotherapy and radiation to exercise, it is imperative that they do. Regardless of the type of cancer being treated, a patient undergoing chemotherapy and/or radiation's first post-operative physical therapy appointment should include a walking program and a strengthening program for the core and large muscle groups of the lower extremities. This will minimize loss and maximize function, which is the responsibility of the physical therapist on the medical oncology team. We need to expand our paradigm thinking from treating “post-op” to treating from diagnosis to survivorship.

Paradigm Expansion 4

Cancer rehabilitation is not just for people with breast cancer. There are many referral biases in oncology physical therapy. We tend to be referred the very young, the very old and those with certain types of cancer, mainly breast. However, since we are not treating disease, but the effects of surgery, chemotherapy and radiation, we need to encourage medical oncologists to refer based on treatment, not on type of disease. A person with fatigue, pain, fibrosis or function-changing neuropathy needs to be evaluated and treated by an oncology physical therapist whether they have lung cancer, fallopian tube cancer or lymphoma.

Paradigm Expansion 5

Patients should not be referred only when there is a problem. Best practice for cancer rehabilitation includes assessment and treatment as indicated shortly after diagnosis and following that patient throughout his or her cancer medical management into survivorship. With many cancer-related musculoskeletal and cardiopulmonary problems being treatable or preventable with rehabilitation, survivorship is too late to begin to address these issues.

We as a profession need to expand our paradigm to be more comfortable with one- to six-month follow-up appointments. My patient is doing well now, but I know that in three to six months he or she probably won't be.

Cancer rehabilitation is not a fad. Trends in cancer incidence and survivorship, including an aging population, are driving an increased need for cancer rehabilitation that will grow for decades to come. With one in three women and one in two men developing cancer in their lifetime, most physical therapists, regardless of area of specialty, will treat patients with a history of cancer. If we hope to help cancer patients and survivors live well and fully, we need to add to the APTA's Vision 2020 our expanded paradigm of "Oncology PT Vision 2020." There will be an estimated 20 million cancer survivors in 2020. Are you ready?

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