

Care of malignant disease in an urban practice

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SUMMARY. *The prevalence, incidence and care of malignant disease in an urban general practice were studied over a one-year period. Prevalence of malignant disease was 13.1 per 1000 patients, with an incidence of 1.9 per 1000 patients per year. The mortality rate over the year was 2.6 per 1000 patients per year.*

Patients with malignant disease generated twice as many primary care consultations as the average practice patient and home visiting was increased fourfold. This increased visiting was most apparent for terminal-care patients. Nevertheless, the increase in consultations did not fully reflect the amount of time, energy and emotional support given by the primary care team.

Introduction

THE incidence of malignant disease in the United Kingdom is between two and three per 1000 patients per year.¹ A general practitioner with a practice list of 2500 patients will only see between five and eight new cases each year. The prevalence of malignant disease in general practice is approximately 13–16 malignancies per 1000 patients.^{2,3}

Nevertheless, the impact of the disease on doctors, nurses and relatives can be considerable as a great deal of time and stress may be involved.^{4,5} This is in part due to the high mortality of 2.5 per 1000 patients per year. Several studies have shown that between 50 and 90 per cent of patients die in hospital,^{4,6} but this figure should decrease as community services improve.^{4,5}

The aims of this study were twofold: first to determine the incidence and prevalence of malignant disease in an urban general practice, and secondly to report some aspects of the care of the patients concerned.

Method

The practice staff consists of five partners, two vocational trainees, four practice attached community nurses and three health visitors. The practice operates in an urban area and had at the time of the study a list size of 13 700. Out-of-hours cover is shared between the doctors in the practice. The proportion of females on the practice list is in agreement with national figures² and 16 per cent of the practice list are over the age of 65 years. The practice shares a 27-bed general practitioner hospital with two other practices in the area.

In order to establish a point prevalence all cases of malignant disease within the practice (excluding skin basal cell carcinoma) were identified from the morbidity register on 1 April 1982. During the ensuing year all new malignancies were recorded, thus determining the incidence. The medical and nursing care of all patients with malignant disease was recorded throughout the year. This care was compared with the data on medical and nursing workloads which are produced annually within the practice. The ratio of resources devoted to cancer patients to resources devoted to the average practice patient was thereby estimated.

An attempt was made to distinguish between active and quiescent malignancies. A case was considered to be quiescent if at the end of the year of observation neither the general practitioner nor the hospital could provide any evidence of activity of the malignant process in the patient.

Results

At the beginning of the study 180 patients with malignant disease were identified in the practice of 13 700 patients, a point prevalence of 13.1 per 1000 patients. The prevalence of individual malignancies within the practice approximated to those of Pippiatt,³ with breast, cervical, bladder and colorectal cancers being the most prevalent (Table 1). During the year of the study 26 new cases were diagnosed. This represents an incidence of 1.9 per 1000 per year. The incidence of individual malignancies was similar to national figures,¹ the most common being bronchial, breast, colorectal and cervical cancers (Table 1). Overall prevalence and incidence are of the same order as expected from previous studies.¹⁻³

It can be seen from Table 2 that there are many long-term survivors of malignant disease within the practice. However, the outcome for certain malignancies is poor, those patients with bronchial, stomach and prostate cancers faring worst. Table 3 shows that in most cases some form of surgical treatment had been carried out, the exceptions being for bronchial, prostate and stomach cancers. These figures do not attempt to distinguish between palliative and definitive treatment.

Table 1. Prevalence and incidence of the eight most common malignancies per 1000 patients.

| Malignancy | Prevalence | Incidence |
|--------------|------------|-----------|
| Breast | 2.41 | 0.29 |
| Cervix | 1.97 | 0.22 |
| Bladder | 1.53 | 0 |
| Colon/rectum | 0.95 | 0.22 |
| Bronchus | 0.87 | 0.44 |
| Uterus | 0.87 | 0 |
| Prostate | 0.80 | 0 |
| Stomach | 0.58 | 0 |

Table 2. Survival of patients with malignant disease.

| Malignancy | Number of patients | Survival (years) | |
|--------------|--------------------|------------------|--------|
| | | Range | Median |
| Breast | 33 | <1–27 | 4.5 |
| Cervix | 27 | <1–32 | 7.0 |
| Bladder | 21 | <1–25 | 7.0 |
| Colon/rectum | 13 | 1–19 | 4.5 |
| Bronchus | 12 | <1–8 | 1.5 |
| Uterus | 12 | <1–24 | 12.0 |
| Prostate | 11 | <1–7 | 2.0 |
| Stomach | 8 | <1–3 | 0.5 |

Table 3. Treatment of patients with malignant disease.

| Malignancy | Percentage of patients receiving treatment | | | | No treatment |
|------------------------|--|---------------|---------------|-------|--------------|
| | Operation | Radio-therapy | Chemo-therapy | Other | |
| Breast (n=33) | 92 | 46 | 14 | 3 | |
| Cervix (n=27) | 93 | 33 | | | |
| Bladder (n=21) | 100 | | 14 | | |
| Colon/rectum (n=13) | 100 | | 6 | | |
| Bronchus (n=12) | 33 | 33 | 17 | | 33 |
| Uterus (n=12) | 92 | 38 | 17 | | |
| Prostate (n=11) | 64 | | 73 | 9 | |
| Stomach (n=8) | 75 | | | | 25 |

n = number of patients.

Thirty-six cancer patients died during the year, a mortality rate of 2.6 per 1000 patients per year. Mortality was highest for bronchial, breast, and stomach tumours. Of those who died, 13 (36 per cent) died at home and six (17 per cent) died in the general practitioner hospital. The remaining 17 (47 per cent) died in a consultant hospital.

Consultation rates for the practice in 1982 are shown in Table 4. For the purposes of this study, the total primary care workload was defined as all surgery attendances and home visits per patient by both doctors and nurses during the study year. The mean figure for patients with malignant disease is more than double the practice average (Table 4). The total primary care workload is consistent for all the common malignancies apart from carcinoma of the bronchus, in which the workload is trebled. This increase in consultation rate is seen only for patients with active disease (Figure 1). Terminally-ill patients need a greater amount of support for themselves and their relatives than other patients with active disease.

Malignant disease accounted for 2.0 per cent of surgery attendances, 6.3 per cent of home visits by general practitioners, 5.4 per cent of the workload of the district nurses and 3.5 per cent of the total practice workload during the year.

Discussion

Although malignant disease accounted for only 3.5 per cent of the total primary care workload in terms of numbers of consultations, the impact of the disease on our practice would

appear to be far greater. There are two main reasons for this. First, the increase in the number of consultations within the practice is principally through an increase in home visiting. There is little difference in surgery attendances between patients with malignant disease and the average value for the practice as whole, but there is a fourfold increase in home visiting of patients with malignant disease (Table 4). Home visiting in the practice as a whole accounts for 25 per cent of all consultations, but with malignant disease patients this figure rises to 52 per cent of consultations. Secondly, the high mortality rate of 2.6 per 1000 patients per year demands a greater amount of emotional support for both the patient and relatives. A community nurse in our practice expressed the feeling of many carers: 'If I have been attending a malignant case for some time and have watched him go downhill, I feel absolutely drained when he dies and I often feel I have not done enough.'

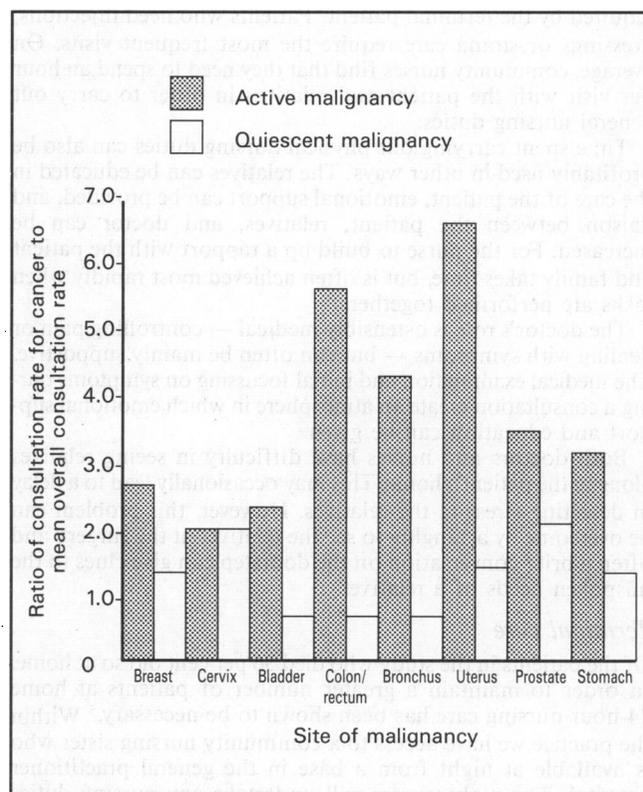


Figure 1. Comparison between consultation rates (surgery plus home visits) with general practitioners for patients with active malignancies and those with quiescent malignancies relative to the practice average. (Mean overall practice consultation rate = 3.5 consultations per patient per year.)

Table 4. Mean consultation rates given as numbers of consultations per patient per year.

| | General practitioner | | | | |
|--|----------------------|---------------------|-------------|------------------------|-----------------------------|
| | Total consultations | Surgery attendances | Home visits | Community nurse visits | Total primary care workload |
| All practice patients (n=13 700) | 3.5 | 2.6 | 0.9 | 0.7 | 4.2 |
| All patients with malignancies (n=206) | 7.3 | 3.5 | 3.8 | 2.5 | 9.8 |
| Patients who died (n=36) | 13.5 | 2.3 | 11.2 | 10.2 | 23.7 |

Those patients in this study with bronchogenic carcinoma illustrate these points well. They had a higher consultation rate with the primary care team than other patients with malignant disease; consulting three times as often as the practice average — 85 per cent of these consultations were home visits. We find that the young terminally ill need more emotional support; this is provided by regular visiting. The higher consultation rate was due to the poor survival rate of patients with this tumour (50 per cent of the patients with bronchogenic carcinoma died during the year) and the fact that many of these patients were younger than the mean age of patients with malignant disease.

The care of patients with a malignant disease is shared among the members of the primary care team from an early stage. The high rate of operative intervention for malignant disease ensures early contact with the community nurse for dressings. The amount of time spent nursing malignant cases varies considerably from patient to patient, depending upon the needs of the patient and the carer. Newly diagnosed patients may require few nursing visits, whereas six to eight visits per day may be required by the terminal patient. Patients who need injections, dressings or stoma care require the most frequent visits. On average, community nurses find that they need to spend an hour per visit with the patient and relatives in order to carry out general nursing duties.

Time spent carrying out physical nursing duties can also be profitably used in other ways. The relatives can be educated in the care of the patient, emotional support can be provided, and liaison between the patient, relatives, and doctor can be increased. For the nurse to build up a rapport with the patient and family takes time, but is often achieved most rapidly when tasks are performed together.

The doctor's role is ostensibly medical — controlling pain or dealing with symptoms — but can often be mainly supportive. The medical examination and initial focussing on symptoms during a consultation create an atmosphere in which emotional support and education can be given.

Both doctors and nurses have difficulty in seeing relatives alone in the patient's home. This may occasionally lead to a delay in detecting stress in the relatives. However, this problem can be overcome by arranging to see the relatives at the surgery and often a brief conversation on the doorstep can give clues to the unspoken needs of a relative.

Terminal care

Of the patients in the study who died 36 per cent did so at home. In order to maintain a greater number of patients at home 24-hour nursing care has been shown to be necessary.⁵ Within the practice we have access to a community nursing sister who is available at night from a base in the general practitioner hospital. The night nurses will undertake any nursing duties required of them such as dressings and injections. The service is limited because only one nurse is available for a large area with a population of 78 000. This night nurse is unable to stay with one patient for long periods of time but is able to visit as often as is necessary during the night.

The precipitating factor in a terminal patient's admission to hospital is often exhaustion of the relatives from lack of sleep. The Marie Curie Foundation funds a night-sitting service for the terminal patient. Nurses are employed by the Foundation and will attend any patient within hours of a request being made by the community nurse. With careful planning by the primary care team and the help of the Marie Curie nurses, we find that hospital admission owing to the exhaustion of relatives can be avoided.

Seventeen per cent of the patients in the study who died did so in the general practitioner hospital. This provides a more homelike local alternative to a general hospital for those patients who can no longer be managed at home. The reasons for admission to hospital fall into three categories.

1. *Lack of family support.* Some families are either unable, un-

willing, or afraid to attempt the nursing of a parent or spouse. If the patient is elderly, then the spouse may be physically incapable of coping. In an unhappy marriage the partner may not be willing to cope with the strain of nursing a patient at home.

In our experience relatives belong to one of three groups: those who will never complain and will cope even if no resources are provided, those who will cope with appropriate resources, and those who will not cope even with the maximum of community support. Knowledge of the family enables the primary care team to predict from an early stage in a terminal illness those patients who will later need hospital admission. This gives the opportunity to plan appropriately and to begin educating the family about the possible future need for hospitalization. Knowledge of the family also enables the primary care team to maximize the use of community resources and to ensure that as many needs as possible are being met among caring families. This should help to prevent the physical and mental exhaustion which is so common among caring relatives.

2. *Patients wishes.* A few patients request admission to hospital when they reach a terminal stage because they believe their family will not be able to cope.

3. *Pain control.* This is no longer a major factor as the provision of 24-hour nursing cover enables regular injections of analgesics.

Our experience would suggest that in the terminal stages of illness the greatest satisfaction for patient, family and primary care team is gained when the patient is cared for at home. Emotional support for the patient is best provided by loved ones in a familiar environment. Relatives gain personal satisfaction from looking after a terminally-ill patient. Their confidence is increased by adequate support from the primary care team. For the primary care team there is the knowledge of having satisfied the wishes and needs of the patient. It is also an opportunity to build up relationships with the other members of the family who may continue to be patients for many years.

This study reveals that although only 3.5 per cent of the practice workload is generated by patients with malignant disease, there is considerable personal involvement with these patients, particularly in terminal care. The provision of improved community services has enabled more patients to stay at home longer and to die at home, if they so wish. Efficient planning and use of resources by the general practitioner will be increasingly necessary as this trend continues, in order that the quality of life and care which the patient receives may also continue to improve.

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