

ESMO 2019 Palliative Care Observer Fellowship  
October 2019

Fellow: Oumou Kimso

Home Institute: Treichville University Hospital

Host Institute : Institut de Cancérologie de l'Ouest

Mentor : Julia Quintin



## Introduction

Cancer diagnosis in Niger and in Cote d'Ivoire is usually done at a locally advanced or metastatic stage (75% are stage 3 and 4) (1). With low-income levels and only 10% of patients having insurance coverage (in Cote d'Ivoire and even less in Niger) (2), many cannot afford chemotherapy, radiotherapy is sometimes unavailable and supportive care quickly becomes the sole mean of care for cancer patients.

When I graduated from medical school, I worked for 16 months as a general practitioner at the only Hematology-Oncology ward at the National Hospital of Niamey, in Niger. The ward had 18 beds in which we hospitalized not only patients with solid tumors, hematologic cancers, sickle cell anemia, and most of the patients undergoing chemotherapy in the country. These were very difficult and limited working conditions. With very few resources, our daily battles were against pain, anemia, infection, malnourishment, depression, etc. When I started residency in Cote d'Ivoire, though a developing country, the medical facilities were considerably better equipped compared to those in Niger. Appropriate imaging for better staging, growth factors, and even immunohistochemistry (for breast cancer) were available. I could see that curability and tumor control were possible, and the fight against febrile neutropenia, anemia could be won, or at least, options existed. Yet again, palliative care still represented a good percentage of our workload.

With only a few doctors treating cancers in many African countries; five internist and 5 medical oncologists in training for the case of Niger, unless substantial efforts are made in health care in general and in oncology in particular, palliative care will remain the only medical option physicians will have to offer patients. As a future oncologist, I needed a solid background in palliative care to be able to give patients the best care possible. I needed to be able to:

- Assess and manage pain and other symptoms
- Have a holistic approach to palliative care
- Learn communication skills to exchange with patients and their families
- Develop skills that I could implement in my country

This palliative care observational fellowship was the first step in guiding me toward these goals. It not only showed me how palliative care is issued in Europe but see the advances and different options available for patients. Seeing if these options could one day be replicated in the developing world context and hopefully, extend into a palliative care training program. Finally, I hoped that this training would enable me to build a network of dedicated people willing to help and support cancer care in Niger.

I was very excited to know that this opportunity would be a possibility through the ESMO Palliative Care Award and was looking forward to this exceptional experience when the Institute de Cancérologie de L'Ouest accepted to be my host institution.

#### Description of time in the host institute

The four-week observational fellowship took place at the Palliative Care Unit of the Institut de Cancerology de l'Ouest (which is part of Unicancer). It is located on two sites, Angers and St Herbain Nantes. The center has a multidisciplinary approach to treating cancer patients, with a three-part mission to treat, do research, and teach. It has become a pole of regional and national excellence due to its numerous research, innovative technics, and the will of its team to achieve the highest level of quality of care. I was able to get first-hand experience working with their team of dedicated doctors in the palliative care department of the ICO of Nantes.

#### Description

The palliative care unit was comprised of 10 hospitalization beds on the fourth floor of the center, a consultation sections on the first floor, and 18 beds on the third floor of the west wing of CHU Laennec. The supportive care unit was included in the consultation section with three outpatient rooms (two beds and one chair).

#### The staff and Activities

The palliative care team was a multidisciplinary group of individuals, through which their individual backgrounds gave patients a holistic approach to care and support.

Dr. Quintin, the head of the department worked out a schedule that would have me rotate with the different pain doctors and see how they managed pain in their own particular way. From the oncologist and palliative care specialist's point of view to the anesthesiologist dealing with secular pain. I also witnessed how an internist and osteopathic physician (Dr. Kerroualt) approached pain management.

During consultations with Dr. Quintin, I saw how she dealt with patients' concerns, not just on a medical/cancer basis, but also on a social and psychological level. With her, we saw metastatic patients that were on specific treatment and some that had symptomatic care. She showed me how the patients' comfort and quality of life was the most important focus point. The patients had an active role in the decisions taken for them. Quality of life primed over the efficacy of treatment. Invasive treatments were always weighed against the risks.

Once a week we rounded on hospitalized palliative care patients that were there for acute problems. We adjusted their pain medication and coordinated their transfer to the appropriate structures after their release: a return to residency with or without medical assistance or a retirement facility.

We also saw outpatients who needed pain reevaluations and/or treatment adjustments that were in the hospital for chemotherapy and other treatments. The focus was on getting everything the patient needed during their hospital visit and limiting the number of visits they made to the hospital. This was the case when patients were seen at the day clinic for UEA (ambulatory evaluation unit), where they were seen by at least three health care providers of which at least one physician. These sessions showed me how the center worked as a team for the patient's convenience. Pain nurses strategically organized sessions. They collected information, concerns pertaining to the patient, and related them to the palliative care doctor and oncologist. It was also during these visits that intrathecal pumps were filled, Ketamine and Botox injection done, and Qutenza (capsaicin) patches placed.

Seeing all the options available for manage pain was wonderful. I was particularly impressed by the Qutenza used to treat neuropathic pain. Capsaicin is a derivative of paprika, which is readily available and inexpensive in West Africa. It would be great if we could reproduce a paste made by pharmacists (the industrialized patches would be too expensive for our patients; two Qutenza patches cost around 400 euros). It would not only be cheaper, but the patients would also get a chance to get relief from their pain and open up our options for managing neurological pain which was very limited when neuroleptics failed. Its action, when effective, lasts up to three months limiting the intake and cost of medicine.

I was also able to see other options for pain management through the algo and spine tumor boards.

The multidisciplinary approach to care was furthermore seen during the staff meeting I attended with Dr. Kerroualt at the surgical and west wing. It included psychologists, doctors, and nurses. Understanding the patients' interactions with the staff and their families gave a better understanding of the patient's environment. Nurses picked up subtleties that doctors might have missed. During these sessions, the staff expressed the emotional and technical difficulties they faced while caring for patients. The group met once a week for these sessions.

Consultations with the onco-nutritionists were also very interesting; he showed me the different evaluation tools used for nutrition and see all the different food supplements available for patients. I could see the benefits of these supplements for the patients' health and the fact that they were covered by the health care plan. Patients could benefit from the nutrients they needed as long as they needed it. A luxury that even the most privileged in my country cannot afford.

The day spent with the intervention imaging team was very insightful, allowing me to see how cementoplasty was performed and see how such a small amount of cement can provide such rapid and effective relief.

As a whole, it was an enlightening month at the ICO, where I got to see all the possibilities that were available for patients' care in a palliative care setting. To see how patients were cared for and supported by this team of incredible and devoted caregivers, all trying to strive to give the best possible care for their patients. It was a formidable experience, but it gave me the proof that without socialized health cover, cancer care would be incomplete in my country.

### [Acknowledgment](#)

I would like to thank the ESMO Palliative Care Comity for making this fellowship possible; I would particularly want to thank Nicola Latino, for her availability and efficiently in helping me every step of the way.

Julia Quintin for opening up the doors of ICO for me and for sharing her knowledge and experience with me.

All the palliative care doctors particularly Dr. Eva Kerroualt and the pain nurses for their time and kindness.

## References

1. Islami F, Lortet-Tieulent J, Okello C, Adoubi I. Tumor size and stage of breast cancer in Côte d'Ivoire and the Republic of Congo - Results from population-based cancer registries. *Breast*. 2015 Dec;24(6):713-7
2. Health financing profile: côte d'Ivoire: USAID. Peer-to-Peer Learning Workshop held in Accra, Ghana (February 2016)