

Prostate Cancer Treatment cannot be Enhanced without including Comprehensive Cancer Rehabilitation

Sir,

I read the editorial, "Prostate Brachytherapy: Advancing Prostate Cancer Treatment in the Region",¹ by Pervez and Alrashidi with interest. I commend the authors for their comprehensive overview of prostate brachytherapy and its potential to improve prostate cancer (PCa) treatment in our region. Their work highlights the critical need for advanced and accessible treatment options in the face of rising PCa incidence.

While the editorial provides valuable insights into the technical aspects and benefits of brachytherapy, I believe it is crucial to address a significant aspect of PCa care that was not discussed: The integration of cancer rehabilitation services. I would like to suggest that the discussion of PCa management remains incomplete without the early integration of cancer rehabilitation services. While technological advancements such as brachytherapy are undoubtedly important and life-saving, addressing the physical, functional, and psychosocial consequences of PCa and its treatment are equally vital for holistic patient care.

Cancer rehabilitation is a specialised and rapidly upcoming field in the realm of Physical Medicine and Rehabilitation (PMR) that aims to optimise patients' quality of life (QOL) by addressing the impairments, activity limitations, and participation restrictions that can arise from cancer and its treatment.² In the context of PCa, rehabilitation can play a pivotal role in managing urinary incontinence, erectile dysfunction, fatigue, pain, and psychological distress – all of which can significantly impact a patient's well-being and overall outcome. The management of PCa is incomplete without the early integration of cancer rehabilitation services. Zopf *et al.* in a 15-month supervised exercise programme demonstrated significant improvement in physical fitness, urinary incontinence, physical role, emotional and social functioning, and reduced treatment-related side effects (dyspnoea, urinary, and bowel symptoms) in PCa patients.³ A meta-analysis found that preoperative pelvic floor muscle exercise can improve postoperative urinary incontinence in the short-term at 3 months, after radical prostatectomy.⁴ A comprehensive systematic review by Santa Mina *et al.* concluded that prehabilitation and rehabilitation interventions across various domains (including exercise, psychosocial support, and symptom management) consistently showed benefits in functional outcomes and QOL for PCa patients.⁵

The integration of cancer rehabilitation services alongside PCa management is not just beneficial; it is essential for optimal patient outcomes. An early integration of rehabilitation can potentially reduce both direct and indirect healthcare costs by preventing complications and reducing hospital readmissions, as shown by Silver *et al.* in their review of cancer rehabilitation models.⁶

However, significant challenges hinder the implementation of comprehensive cancer rehabilitation services in Pakistan. Despite growing evidences and recommendations for better integration of rehabilitation into oncology care, rehabilitation services in oncology are relatively underutilised.⁷ Other challenges include:

1. **Lack of resources:** Limited funding and inadequate infrastructure for rehabilitation services in many healthcare facilities.
2. **Knowledge gap:** Insufficient awareness among oncologists and patients about the benefits of cancer rehabilitation.
3. **Lack of referrals:** Absence of standardised referral pathways from oncology to rehabilitation services.
4. **Shortage of trained professionals:** Limited number of rehabilitation specialists with expertise in cancer care.
5. **Geographical disparities:** Uneven distribution of rehabilitation services, particularly in rural areas.
6. **Financial constraints:** High out-of-pocket expenses for patients seeking rehabilitation services.
7. **Lack of research:** Limited local data on the effectiveness of rehabilitation interventions in our population.

To address these challenges and improve PCa care in our region, healthcare policymakers, oncologists, and rehabilitation specialists need to take collaborative action. Some suggestions are as follows:

1. Develop and implement national guidelines for integrating rehabilitation services in cancer care pathways.
2. Increase funding for cancer rehabilitation research and service development.
3. Enhance education and training programmes for healthcare professionals (particularly oncologists in training) in cancer rehabilitation.
4. Establish multidisciplinary teams that include PMR (Physical Medicine Rehabilitation) specialists in cancer treatment centres.

5. Create public awareness campaigns about the importance of cancer rehabilitation.

In conclusion, while I appreciate the authors for their valuable contribution to advancing PCa treatment through brachytherapy, I urge our medical community to recognise that optimal care extends beyond the primary treatment. By integrating comprehensive rehabilitation services, we can significantly enhance the QOL and functional outcomes for PCa survivors in our region. I hope that this letter will spark a broader discussion on the critical role of rehabilitation in PCa care and lead to tangible improvements in our healthcare systems.

COMPETING INTEREST:

The author declared no conflict of interest.

AUTHORS' CONTRIBUTION:

FAR: Design of the work, acquisition, analysis and interpretation of the data, drafting of the manuscript, clinical analysis, revision, and approval of the final draft.

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AUTHOR'S REPLY

Dear Author,

Thank you for your commendation of our editorial on the pressing need for prostate brachytherapy in our region. We appreciate your positive feedback on the technical details provided about the brachytherapy procedures.

We whole-heartedly agree with your emphasis on the early integration of rehabilitation services to provide holistic patient care. Your insights into the multiple factors affecting patient rehabilitation and the measures to improve their QOL are invaluable.

You have highlighted the challenges in providing early rehabilitation services in Pakistan and have proposed some practical remedies to address these issues. We believe this is an important subject and are in complete agreement with your suggestions on the role of early rehabilitation services in cancer treatment, including prostate brachytherapy. Your identification of the challenges and your proposed efforts to resolve them are critical steps toward improving patient care.

While most cancer treatments do carry a risk of side effects, we would like to bring to your attention the relatively lower rates of certain treatment-related side effects associated with brachytherapy compared to other treatment options.¹ For instance, urinary incontinence, which you mentioned in your letter, is more common following radical prostatectomy than brachytherapy, as referenced in your letter.

In conclusion, we fully support your suggestions for the early integration of rehabilitation services to enhance the long-term QOL for patients. We appreciate your thoughtful contribution to this crucial aspect of cancer care.

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