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CONTENTS

Editorial
Rhiannon Lewis 1

Natural relief for persons receiving taxane chemotherapy - focus on the Polybalm® nail bed study
Professor Robert Thomas, Dr Sarah Smith and Dr Saul Berkovitz 2

Breathlessness in patients with life-limiting illness: The potential of aromatherapy
Carol Rose 7

Clinical aromatherapy spotlight: Acute procedural anxiety in cancer care
Rhiannon Lewis 19

A protective and healing skin cream improves quality of life in oncology and palliative care: an experiential report
Madeleine Kerkhof 32

Aromatic insights into palliative and end-of-life care in Japan
Interview with Tomomi Nakamura 39

Book reviews
Rhiannon Lewis, Gabriel Mojay 47

Rédaction/Publication:
Essential Oil Resource Consultants EURL
Chemin des Achaps
83840 La Martre
FRANCE
Tel/fax: (+33) 483 11 87 03

Rédactrice/Editor: Rhiannon Harris Lewis

Email: editor@ijca.net

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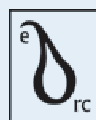

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Editorial

Over the past 25 years in the Western world, complementary therapies (CTs) have increasingly been used alongside conventional medical care for people with cancer, from diagnosis, through treatment, survivorship and into end-of-life care. In the UK alone, it is estimated that up to one third of all persons with cancer use CTs in a supportive role (Smithson et al, 2010). Aromatherapy, together with massage and reflexology, is one of the most popular CTs accessed in cancer and palliative care environments and is included in CT service provision in all the leading cancer hospitals in England, Wales, Northern Ireland and Scotland. Until recently, CT services had their own place in the National Institute of Clinical Excellence guidance manual on cancer services (2004); however, this section has sadly been removed from the latest guidance review, with the risk of negative consequences on continued service provision.

The main reasons that most patients with cancer choose CTs such as aromatherapy are to improve their experience of conventional care, to enhance personal well-being and to help manage symptoms linked with the disease or its treatment. Few patients are seeking active treatment options concerning their disease – they are simply seeking reassurance that the therapy is safe, appropriate and that it will serve to complement their ongoing medical care

From the patient's perspective, one of the biggest barriers to a positive experience of CT is perceived polarization between complementary therapies and conventional medicine (Smithson et al, 2010). This polarization can be experienced by patients at both a professional and institutional level and highlights the delicate and influential relationship the person has with their general practitioner, their oncologist and/or other key members of their medical team. If the person encounters a reluctance to talk about CTs from their doctor, receives mixed reactions or senses hostility towards CTs, it is likely they will be more anxious and/or less likely to access them as part of their supportive care.

Patient involvement, dialogue, clear communication and education are therefore, more than ever, essential for ensuring continued care provision. In the words of Lewith et al (2010) it is *"in our interest to create dialogue between conventional and complementary practitioners treating cancer and in particular for oncologists to allow the patient to play an important, active and informed role in managing their illness and survival."*

Through publication of rigorous and pertinent papers that clearly demonstrate the value of aromatherapy provision in cancer and palliative care, medical professionals are better informed as to the safe and positive contributions of essential oils for persons with cancer - whatever the stage of their journey with their disease. Hence choosing cancer and palliative care as the overall themes for this and the following issue of the IJCA.

Rhiannon Lewis

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Breathlessness in patients with life-limiting illness: The potential of aromatherapy

Carol Rose

Clinical Aromatherapist, RMT
The Aromary, Kerikeri, New Zealand
carol@thearomary.co.nz

Breathlessness is a common and debilitating symptom experienced by patients with chronic respiratory disease which increases over the course of life-limiting illness. The underlying causes are multi-factorial, involving a complex interplay of physical, psychological, spiritual and social factors (Corner et al, 1995). As such, successful management requires an array of interventions tailored to the patient's subjective experience. However, pharmacological approaches are not without unpleasant side-effects and non-pharmacological interventions have not been fully evaluated or routinely suggested.

Within aromatherapy, the direct interface between inhaled essential oils and the respiratory mucosa, offers rapid access and symptom-relief for several respiratory disorders. This has been well documented in the general population (Harris, 2007, Baudoux, 2007, Buckle, 2015). Combined with an aromatherapist's holistic approach to care, these recognised aromatherapy interventions offer plausible potential for symptom-relief in breathlessness management. This paper explores breathlessness in patients with life-limiting illness and considers how aromatic interventions can be adapted and integrated into clinical practice and influence future research initiatives.

Introduction

Cited as one of the core symptoms of four main life-limiting illnesses, breathlessness affects up to 70% of patients with advanced cancer, 95% with chronic obstructive pulmonary disease (COPD), 88% with heart failure (HF) and 85% with motor-neurone disease (MND) (Gysels and Higginson, 2011). Additionally, breathlessness affects patients with dementia, advanced age, HIV and is highly prevalent in patients receiving end-of-life care, particularly in the last 3-months of life (Kamal et al, 2011).

Traditional approaches to the assessment and management of breathlessness have predominantly revolved around its physiological measurement. However, Bausewein et al (2018) point out that in advanced stages of illness, these objective findings do not fully illustrate the distress experienced by patients. Consequently, the emphasis is to consider the patient's actual descriptions as exampled in these excerpts:

"*I feel as though I've permanently just run really fast to catch a bus*" (Taylor, 2007) "*I feel my breathing is more rapid*", "*I feel hunger for more air*", "*I feel I am suffocating*" (Kamal et al, 2011) whilst others report breathlessness as "*hard work*", "*frightening*", "*painful*" or a "*continuous fight*" (BPJ, 2012). These reveal far more about the true nature of the person's experience and the impact of breathlessness on their daily life.

Recently, the medical term, 'dyspnoea', often used interchangeably with 'breathlessness', has been regarded as limited in its focus to "*the clinical*