

Yoga as a Treatment for Toxicities Caused by Cancer

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Abstract

Low-intensity yoga, specifically gentle hatha and restorative, has been shown to be safe, effective and feasible for treating sleep disruption, fatigue related to cancer, cognitive impairment, psychosocial distress and musculoskeletal symptoms in cancer patients receiving chemotherapy and radiation as well as in cancer survivors, according to 24 phase II and one phase III clinical trials. If a patient is suffering from these toxicities, doctors should think about prescribing yoga by referring them to trained yoga practitioners. To confirm these findings and investigate additional yoga types, doses and delivery methods for treating cancer-related toxicities in patients and survivors, further definitive phase III clinical trials are required.

Keywords: Yoga • Sleep disorder • Cancer-related fatigue • Cognitive impairment • Psychological distress • Musculoskeletal symptoms

Introduction

Stress can have a wide range of physiologic effects, such as shortening of telomeres, an increase in inflammatory cytokines and a decrease in cell-mediated immunity, all of which are linked to an increased risk of cancer and worse outcomes related to cancer. Despite the fact that pressure may not straightforwardly cause disease, it can advance disease development and movement through neuroendocrine pathways (e.g., thoughtful sensory system, hypothalamic-pituitary-adrenal pivot) that increment irritation, advance angiogenesis, diminish anoikis and decline the viability of chemotherapy. By reducing stress and disrupting its effects on cancer biology, biobehavioral interventions like yoga have the potential to improve cancer outcomes [1].

Description

The reviews all came to the same conclusion: there is moderate to good evidence that, at least for the time being, yoga improves the mental health of early-stage breast cancer patients and survivors. While functional well-being effect sizes were small, psychosocial outcomes (such as emotional distress, anxiety and depression and global quality of life) had moderate to large effect sizes. In approximately half of the studies that were evaluated, fatigue decreased. The authors of this paper conducted only one RCT to evaluate pain, which improved in that study. Serious side effects were not reported in any of the studies. Better control conditions, more physiological measures, longer-term follow-up and a wider range of cancer populations, including those with advanced cancer, should all be included in larger, more rigorous trials, according to each of the available systematic reviews. The absence of RCTs involving people with advanced cancer is a significant gap in the literature on yoga for breast cancer. As of late, we directed a pilot review to test an original 8-week Careful Yoga intercession intended to address the malignant growth related torment, exhaustion and close to home misery experienced by ladies with MBC [2]. The feasibility and effects on these symptoms of this intervention, which was previously published under the name "Yoga of Awareness," were

both shown to be promising. The MBC pilot study, on the other hand, lacked a control group, had a very small sample size (N = 13) and did not address mediators that might explain the effects of the treatment.

One of the three reviewers (RH, JT and LNB) used a spreadsheet to extract the study's characteristics. Information for the estimation of impact sizes for exhaustion or essentialness from the initial time point after the finish of the time of the mediation under evaluation in the particular review were separated by one commentator (RH) and constrained by a subsequent commentator (JT). When the data made it possible to calculate the mean and standard deviation of the changes, change values were extracted. Post-treatment mean and standard deviation values were extracted if change values were unavailable or could not be calculated. Using p values, confidence intervals (CIs), or extracting data from figures were some of the methods utilized to estimate the SD in the event that it was absent. Means were estimated using the median and SDs were calculated by dividing the IQR if only the median and IQR were presented [3]. By reversing the signs for the means, the effect sizes were changed so that higher values always indicated more fatigue. In the event of insufficient data or inaccurate reporting, the corresponding authors were contacted. In the event that in a given report exhaustion was surveyed by more than one poll, we chose the survey introduced as essential result or as the primary outcome for exhaustion.

The practice of applying physical force to muscles, tendons and connective tissues to promote relaxation, alleviate tension, alleviate pain and improve circulation is known as therapeutic massage therapy. The most common treatment for cancer is Swedish massage. It utilizes five kinds of strokes (floating, massaging, tapping, grating and vibration). Myofascial release, the craniosacral technique, ayurvedic massage, tuina, shiatsu, reflexology and deep tissue massage are some of the other common methods. The various techniques differ in their use of pressure, theoretical framework, education credentials and regulatory setting. The majority of massage therapy for cancer patients studies that were not randomized had small sample sizes. One large observational study (N=1290) showed that massage reduced pain scores by approximately 50% from baseline, with outpatients achieving an improvement of approximately 10% greater than inpatients. When the benefits were reexamined 48 hours later, they remained [4].

It is unlikely that we introduced significant bias during the literature search given that we searched the most important medical databases, trial registries and conference proceedings without regard to language restrictions. By not including one study whose outcome measure was unclear and three conference abstracts with insufficient data, we may have introduced bias. We might have lost additional evidence as a result. Additionally, the authors of four studies provided missing data upon request. Even though sensitivity analyses did not significantly change the review findings by excluding studies for which missing data were replaced, including data that were not peer reviewed may have introduced bias. In yoga studies, it is generally considered impossible to blind participants and, particularly, staff. We didn't do a sensitivity analysis

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because we didn't blind the participants or the staff, which could have led to bias. Due to the lack of a suitable sham or placebo procedure for yoga interventions, it is currently impossible to distinguish between specific and nonspecific effects [5].

Conclusion

The Outcome Expectations for Exercise Scale, which has nine items and asks participants to rate their agreement with the potential benefits of physical activity on a 5-point Likert-type scale, with 1 representing no expectations and 5 representing the highest expectations for exercise, will be used to examine treatment expectations. This measurement has previously been shown to be reliable and valid.

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Conflict of Interest

No conflict of interest.

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