NSW Health Sydney Local Health District · Concord Cancer Centre · The University of Sydney

HOW TO INTEGRATE PALLIATIVE CARE IN ONCOLOGY

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GREETINGS!

Oncologists from Mars, Palliative Care specialists from Venus

MODERN MEDICINE

- There has been a real exponential increase in the technology and advancements in Medicine
  - Wealth of information and knowledge, readily available

CANCER CARE: CHANGES IN LAST TWO DECADES

- Cure is possible in some cancers
- Significant improvement in treatment options
  - Staging/surgery/chemotherapy/radiotherapy etc.
- Improved survival: breast cancer, lymphoma
- Improved time to progression/metastatic disease
- Targeted therapies
- Combination therapies
- Reduction in side effects and improved tolerability
- Improved supportive care

CANCER CARE: WHAT ARE THE CONSEQUENCES?

- Patients are having more lines of treatment
- More patients are having chemotherapy at the end of life
- The trajectory of disease is changing
  - More complications from the cancer
  - Complications from the treatment
- Society's expectation
  - Cure
  - Prolongation of life
  - Treatment means better care

MODERN MEDICINE

- With this advancement in cancer care and medical technology………
- We have lost the ART of caring
- We needed a paradigm shift
- “Palliative care”: old but new
- Words
  - Compassionate care
  - Patient centred care
  - Holistic care
  - Recognition of Suffering
  - Ethical basis to care

THE GOALS OF PALLIATIVE CARE

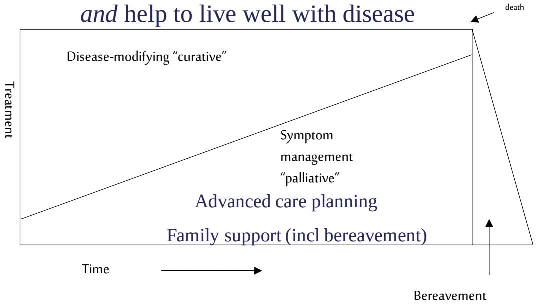
- Quality of life
- Pain and Symptom control
- Compassionate care
- Holistic care (psychosocial/ spiritual)
- Patient, carers and family
- Context and place of care and death
- Bereavement

TRANSITION OF CANCER CARE

- What if he had not been referred to palliative care early?
  - Died receiving futile treatments and possibly chemotherapy
  - Significant symptoms
  - Preparation for family and patient
- Opportunity for palliative care concepts in the community
- Advanced Care Planning (ACP) with goals setting
- Improved quality of life as much as quantity

- What happens the next time if he has biliary obstruction?
- Would we treat with antibiotics?
- Would we resuscitate this man?
- Need for advanced care planning early on

Better concept: Most patients need both disease-modifying treatments *and* help to live well with disease



death

Treatment

Disease-modifying “curative”

Symptom management “palliative”

Advanced care planning

Family support (incl bereavement)

Time

Bereavement

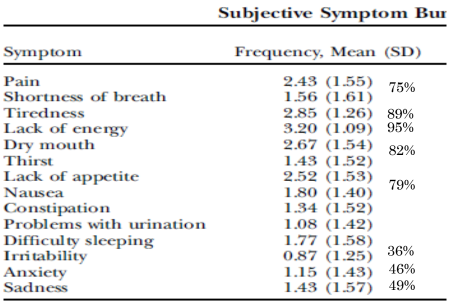
WHAT DID WE LEARN?
UNDERSTANDING THE PATIENT

- Early on, it was expected and good Cancer Care to investigate and treat ‘invasively’
- We improved survival but also quality of life
- As the disease progresses, the same outcomes may not be achieved
  - Not about prolonging life
  - BUT to improve quality of life with impeccable symptom control and support
- Diagnose dying
- Not prolonging dying
- **Shared care helped us to achieve this balance**

WHAT DO PATIENTS WANT?

SYMPTOM BURDEN AND DISTRESS

- There is a high level of symptoms in patients with cancer
- This impacts on their quality of life
- Does it have a negative consequence if we don't identify and manage them?



Subjective Symptom Bur

Symptom	Frequency, Mean (SD)	
Pain	2.43 (1.55)	75%
Shortness of breath	1.56 (1.61)	
Tiredness	2.85 (1.26)	89%
Lack of energy	3.20 (1.09)	95%
Dry mouth	2.67 (1.54)	82%
Thirst	1.43 (1.52)	
Lack of appetite	2.52 (1.53)	79%
Nausea	1.80 (1.40)	
Constipation	1.34 (1.52)	
Problems with urination	1.08 (1.42)	
Difficulty sleeping	1.77 (1.58)	
Irritability	0.87 (1.25)	36%
Anxiety	1.15 (1.43)	46%
Sadness	1.43 (1.57)	49%

All patients suffered from at least one symptom frequently and almost constantly with an average of 6 symptoms. *Oechsle 2014 JPSM*

FINDINGS: *OECHSLE 2014 JPSM*

- Perceived sense of dignity was strongly associated with symptom burden
  - The intensity of symptoms (highest)
  - Symptom distress
  - Frequency of symptoms
  - Perceived treatment requirements
- Symptoms with psychological symptoms especially anxiety and sadness
  - Highest correlations with symptom distress, existential distress, peace of mid and social support
- Perceived sense of dignity and psychological well being are closely related

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OUR DUTY OF CARE

- To identify these symptoms and the distress it causes our patients
- To treat or manage these symptoms
- Some symptoms are easier to control (Pain, breathlessness, nausea, vomiting, bowels)
- Some are harder (anorexia, tiredness, fatigue, anxiety)
- Need a combination of pharmacological and non-pharmacological
  - Communication
  - Validation
  - Support

DOES PALLIATIVE CARE MAKE A DIFFERENCE?

Original Article

Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer

Jennifer S. Temel, M.D., Joseph A. Greer, Ph.D., Alona Muzikansky, M.A., Emily R. Gallagher, R.N., Sonal Admane, M.B., B.S., M.P.H., Vicki A. Jackson, M.D., M.P.H., Constance M. Dahlin, A.P.N., Craig D. Blinderman, M.D., Juliet Jacobsen, M.D., William F. Pirl, M.D., M.P.H., J. Andrew Billings, M.D., and Thomas J. Lynch, M.D.

N Engl J Med
Volume 363(8):733-742
August 19, 2010

The NEW ENGLAND JOURNAL of MEDICINE

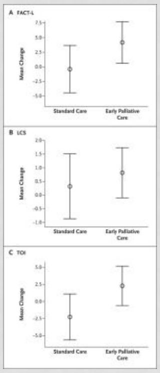
METHOD

- **Non blinded, randomized, controlled trial of early palliative care integrated with standard oncologic care, as compared with standard oncologic care alone**
- **The study was performed at Massachusetts General Hospital in Boston**
- **Eligible patients were enrolled within 8 weeks after diagnosis**
- **151 patients enrolled in the study**

MEASURES USED

- Assessment of **Cancer Therapy–Lung (FACT-L) scale**
  - multiple dimensions of the quality of life (physical, functional, emotional, and social well-being)
- **Lung cancer subscale (LCS)** of the FACT-L scale
  - seven symptoms specific to lung cancer
- The **primary outcome** of the study was the change from baseline to 12 weeks in the score on the Trial Outcome Index **(TOI)**
  - sum of the scores on the LCS and the physical well-being and functional well-being subscales of the FACT-L scale
- **Mood** was assessed with the use of both
  - Hospital Anxiety and Depression Scale (HADS)
  - Patient Health Questionnaire 9 (PHQ-9)

Mean Change in Quality-of-Life Scores from Baseline to 12 Weeks in the Two Study Groups



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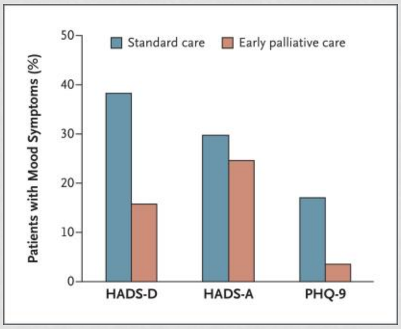
Twelve-Week Outcomes of Assessments of Mood



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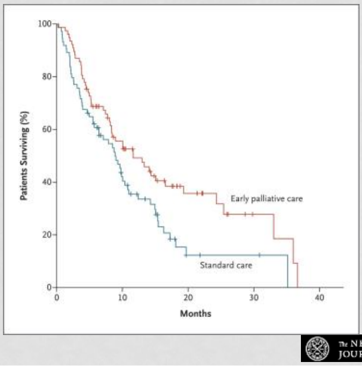
Kaplan–Meier Estimates of Survival According to Study Group



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CONCLUSION

- "Early integration of palliative care for patients with metastatic non–small-cell lung cancer is a clinically meaningful and feasible care model that has **effects on survival and quality of life** that are similar to the effects of first-line chemotherapy in such patients"
- those who were assigned to early palliative care
  - **had improved mood**
  - **more frequent documentation of resuscitation preferences**
  - **Less aggressive end-of-life care**

EARLY PALLIATIVE CARE FOR PATIENTS WITH ADVANCED CANCER:
A CLUSTER-RANDOMISED CONTROLLED TRIAL.
CAMILLA ZIMMERMANN, THE LANCET, 2014

- Outpatient medical oncology
- Diagnosed with various cancers
- Received standard cancer care or early palliative care referral
- 461 patients evaluated
- Quality of life measures (FACT and QUALE), symptom assessment and satisfaction

PRIMARY OUTCOMES

- Quality of life (Functional Assessment of Chronic Illness Therapy-Spiritual Well Being [FACIT-Sp]
- Quality of life at the End of Life [QUAL-E]
- Symptom Severity (Edmonton Symptom Assessment System [ESAS])
- Satisfaction with care (FAMCARE-P16)
- Problems with medical interactions (Cancer Rehabilitation Evaluation System Medical Interaction Subscale [CARES-MIS]

Secondary outcomes: changes in above

RESULTS

- At 3 months, there was a non-significant difference in change score for FACIT-SP between intervention and control groups
- a significant difference in QUAL-E and FAMCARE-P16
- But no difference in ESAS
- At 4 months, there were significant differences in change scores for all outcomes except CARES-MIS.
- All differences favoured the intervention group
  - Early referral to palliative care

FINDINGS: SATISFACTION WITH CARE (FAMCARE-P16)

- Satisfaction of patients with their care improved significantly at both endpoints in the early palliative care intervention group, whereas it deteriorated in the control group

CONCLUSION

- Although the difference in quality of life was non-significant at the primary endpoint, this trial shows promising findings that support early palliative care for patients with advanced cancer

AS AN ONCOLOGIST
WHAT IS YOUR ADDED RESPONSIBILITY?

ADVANCED CARE PLANNING (ACP)

- Conversation about how a person wishes to be treated under circumstances in which they are not able to speak for themselves.
  - Assists patients to make autonomous decisions
  - To prevent them from having inappropriate treatments but also appropriate end of life care when needed
  - Takes into account their values, goals and priorities
- Patients often want the doctor to initiate this conversation
- Needs to occur early
- The 'conversation' is very important
- The tool (Advanced Care Directive: ACD) allows documentation of the wishes

ONCOLOGISTS MUST LEARN HOW TO PROGNOSTICATE

WITHDRAWAL OF CHEMOTHERAPY IN ADVANCED DISEASE

- Blurring of boundaries between active and palliative interventions
  - Molecular targeted agents
  - Not as easy as in the past of 'disease progression'
- Generally considered continuing treatment in the last 30 days of life as futile
- Oncologist find it difficult to determine time to stop chemotherapy
- No guidelines to assist decision making
- But a sense of patients values, goals and burden of treatment must be taken into account

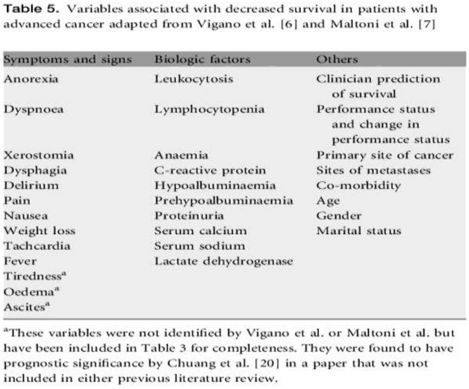

Table 5. Variables associated with decreased survival in patients with advanced cancer adapted from Vigano et al. [6] and Maltoni et al. [7]

Symptoms and signs	Biologic factors	Others
Anorexia	Leukocytosis	Clinician prediction of survival
Dyspnoea	Lymphocytopenia	Performance status and change in performance status
Xerostomia	Anaemia	Primary site of cancer
Dysphagia	C-reactive protein	Sites of metastases
Delirium	Hypoalbuminaemia	Co-morbidity
Pain	Prehypoalbuminaemia	Age
Nausea	Proteinuria	Gender
Weight loss	Serum calcium	Marital status
Tachcardia	Serum sodium	
Fever	Lactate dehydrogenase	
Tiredness[a]		
Oedema[a]		
Ascites[a]		

[a] These variables were not identified by Vigano et al. or Maltoni et al. but have been included in Table 3 for completeness. They were found to have prognostic significance by Chuang et al. [20] in a paper that was not included in either previous literature review.

IF THREE OR MORE OF THE FOLLOWING SYMPTOMS ARE PRESENT IS LIKELY THE PATIENT IS ENTERING THE TERMINAL PHASE.

- Experiencing rapid day to day deterioration that is not reversible
- Requiring more frequent interventions
- Becoming semi-conscious, with lapses into unconsciousness
- Refusing or unable to take food, fluids or oral medicines
- Irreversible weight loss
- An acute event has occurred, requiring revision of treatment goals
- Profound weakness
- Changes in breathing patterns

DIAGNOSING DYING

- Allows appropriate conversations with patient/family
- Withdrawing and withholding inappropriate interventions
  - Including NFR (Not for Resuscitation)
- Commencing appropriate end of life measures
- Availability of extra support and communication
- Dying at home may be possible

CARING FOR PATIENTS AT THE END OF LIFE

- Holistic care plan
  - Physical
  - Psychosocial
  - Spiritual
- Commencing appropriate end of life measures
  - Medications (prn, route, access to)
  - Mouth/ bowel / pressure / supportive care
- Conversations around feeding/fluids
- May require a multidisciplinary team
  - (nurses, social worker, OT, physio, psychologist)

INTEGRATION OF PALLIATIVE CARE INTO ONCOLOGY

- Cancer centres
- Concepts of shared care
- Multidisciplinary (Oncologist/pal care/surgeons/rad onc)
  - Meetings
  - Clinics
  - Research
- Interdisciplinary teams
  - Doctors/nurses/social workers/ psychologist etc
- Evidence based practice for treatment and supportive care
- Palliative care must be part of cancer care
- Opioid and other drug availability
- Education and academic future combined initiatives

NOT HIDING BEHIND IGNORANCE

- Cancer care needs to change
- Shared care between Oncologists and Palliative Care Specialists but
  - Oncologist need to be as responsible for symptom control, advanced care planning and end of life care
- Don't use culture as an excuse
- Literature from the EAST also shows patients want to know and be part of conversations
- Palliative care is everyone's business

In the past:
Oncologists from Mars,
Palliative Care specialists
from Venus

But on Earth today:

Let's work together for
the best of the patient.

Integrated,
Multidisciplinary,
Collaborate Cancer Care

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