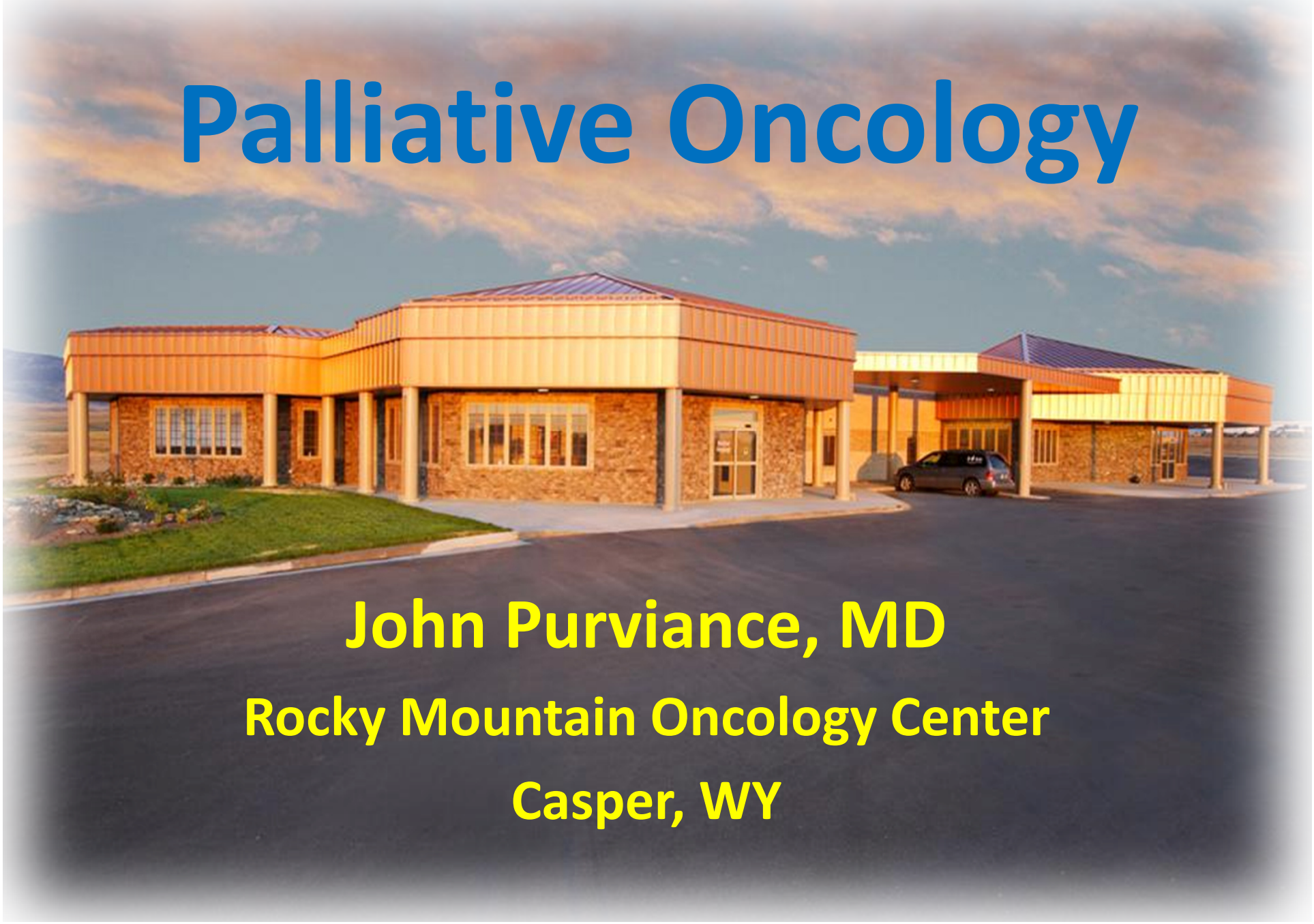
Palliative Oncology



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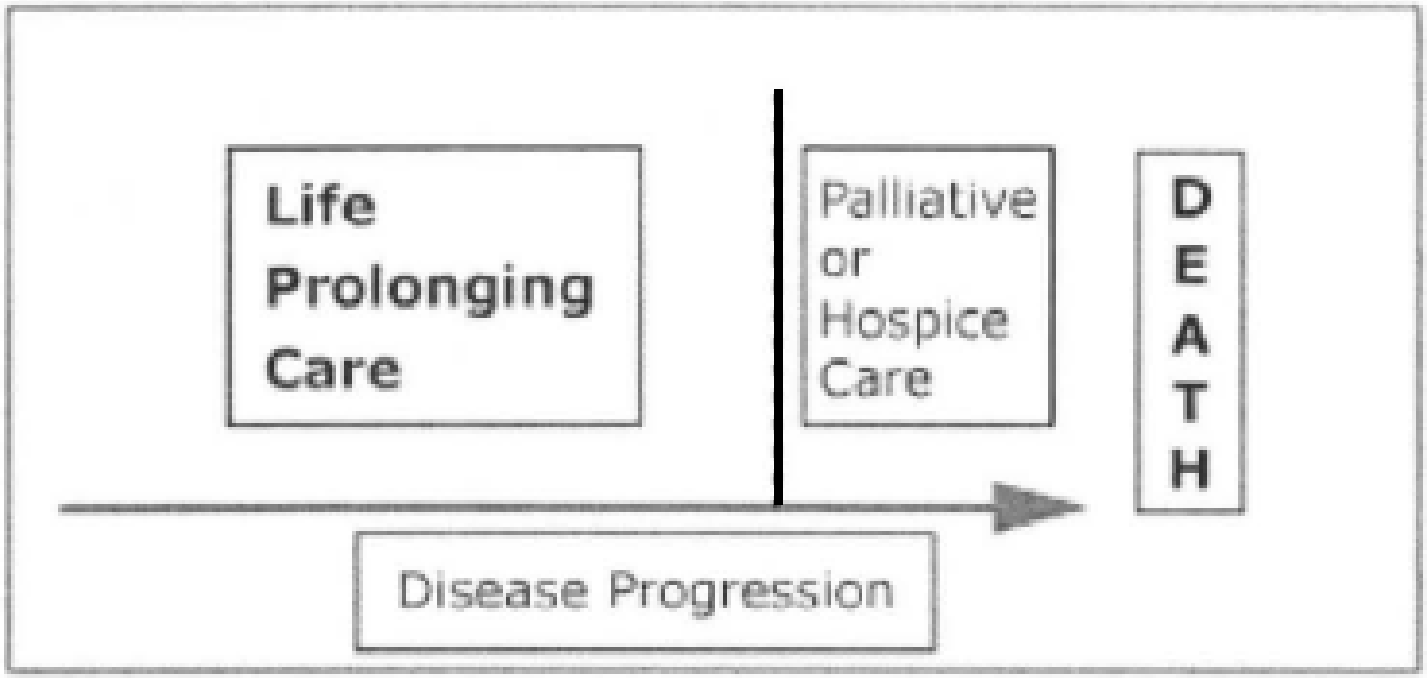
Overview

- Discuss fundamentals of palliative care
- Models of care
- Palliative care in oncology

Palliative Care

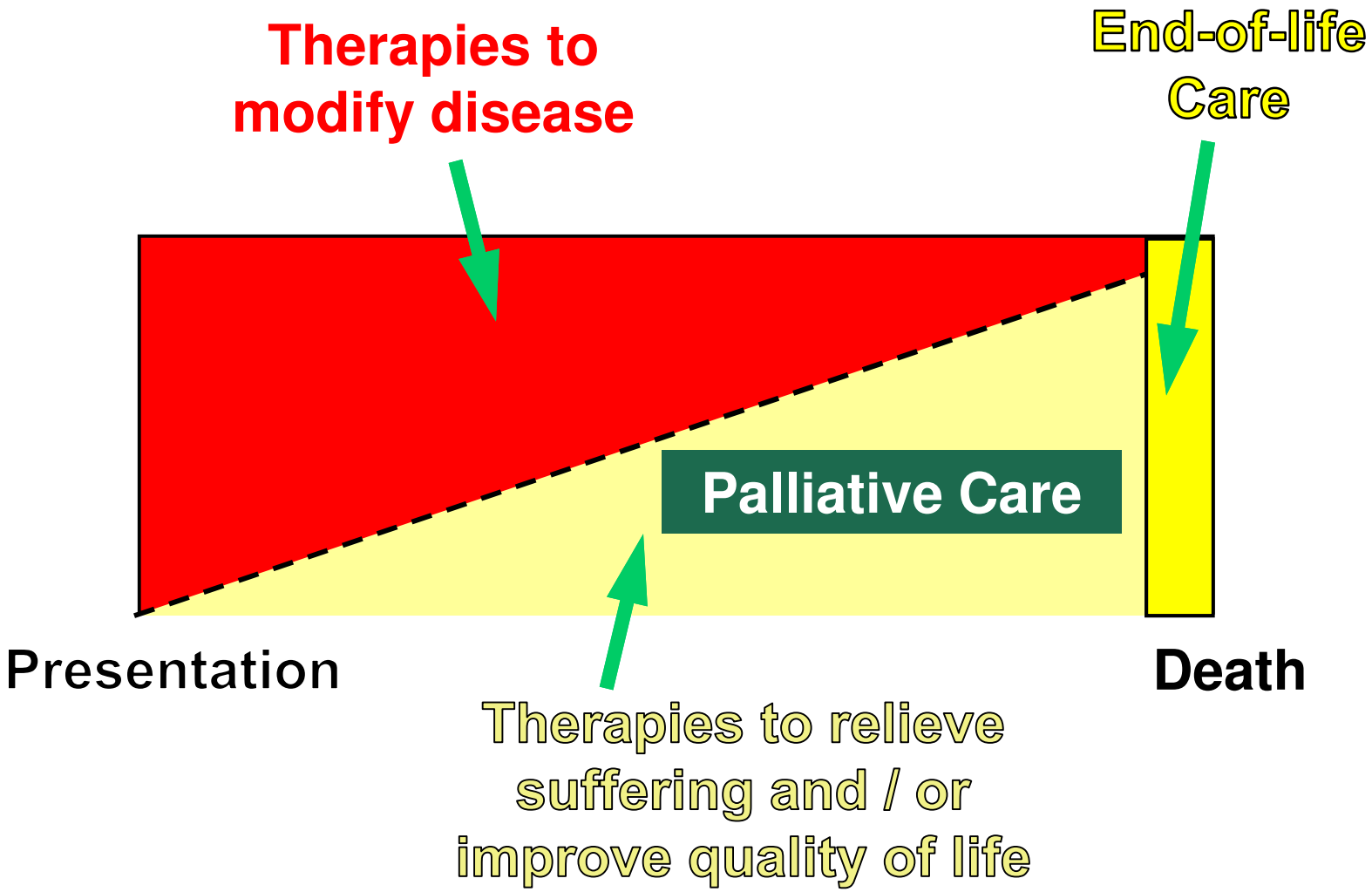
- Focuses on
  - preventing and relieving symptoms
  - Supporting best quality of life
  - Palliative measures should not add substantial toxicity that detract from these goals
- Medical care is historically dichotomous
  - Curative/disease-modifying Care
    - Intent to prolong life
  - Palliative Care
    - Historically synonymous with End-of-life Care

Dichotomous Model of Care

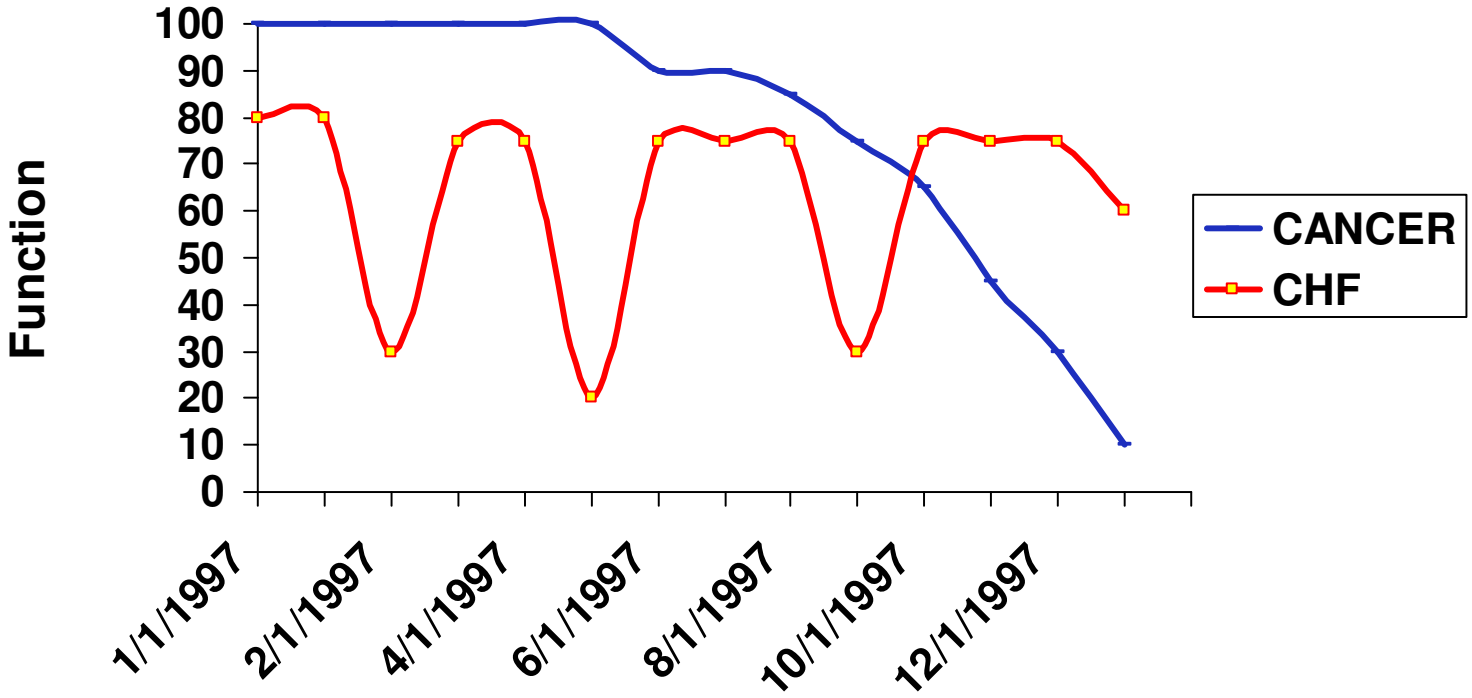


Palliative care is NOT synonymous with End of Life Care

Integrated Model of Care



Progression of Disease and functional status - Cancer vs CHF



Primary Tenets of Palliative Care

- Symptom Management
- Establishing Goals of Care
  - Patients values and preference
- Communication between patient/family and providers
- Psychosocial/spiritual support
- Practical support
- Coordination of care across sites of care
  - Hospital
  - PCP
  - Specialists

Palliative Care Services

- Symptom management
  - Pain, dyspnea, depression
- Achieving a sense of control
- Gaining realistic understanding of an illness
  - Pros and cons of treatment
- Relieving burden on family
- End of life planning

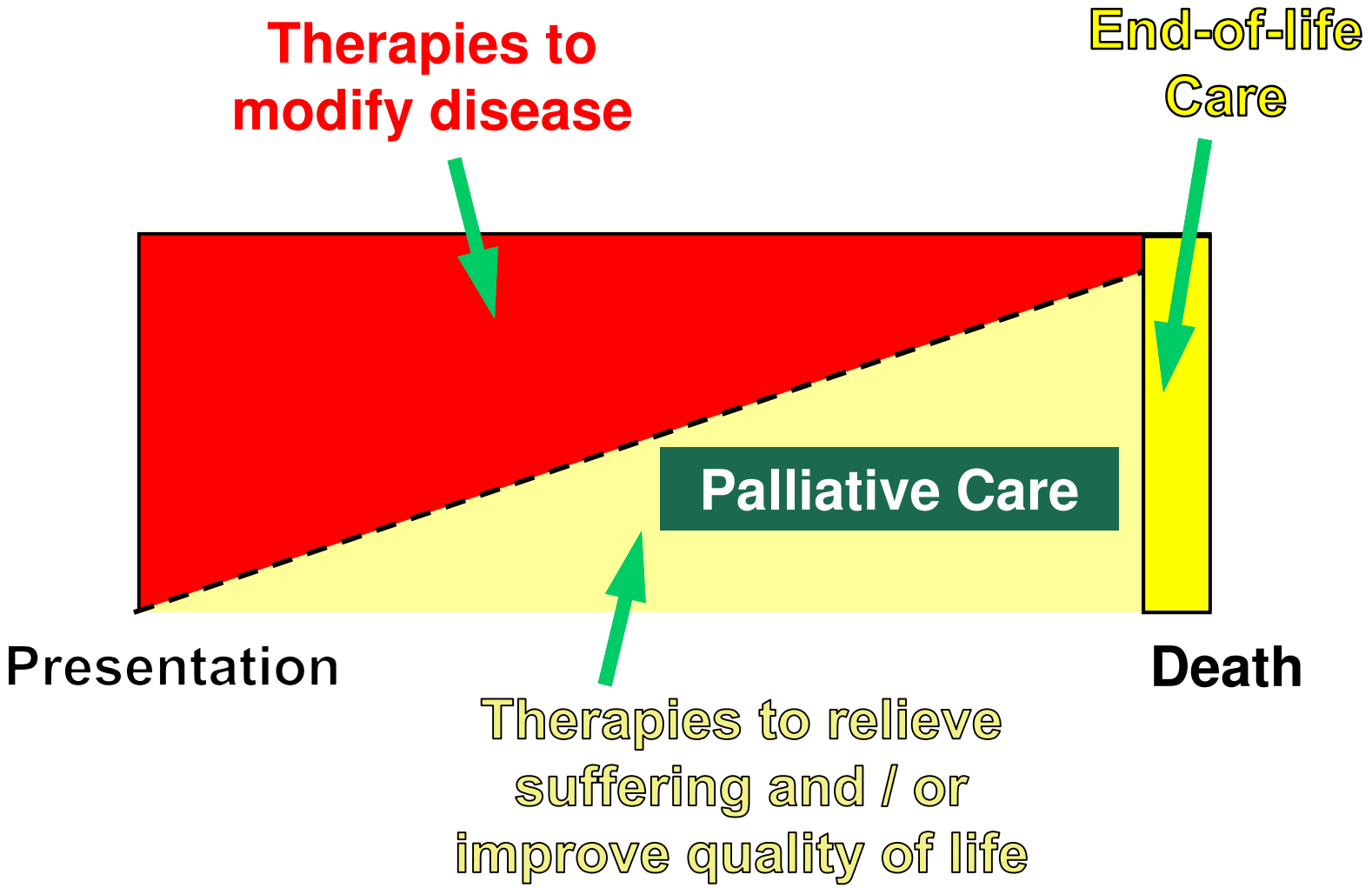
Models of care

- Inpatient palliative care services
- Outpatient palliative team (cancer center, Rehab facility)
- Hospice (inpatient/outpatient)

Ambulatory Palliative Care

- Provides palliative services in conjunction with life prolonging therapy
- Enables a more holistic approach to patient needs, but does not neglect medical needs or life-prolonging therapy
- Social worker, clinicians (MD, PA, RN etc), Chaplin, psychologists/therapists, volunteers

Outpatient Oncology Care



Hospice

- Provides similar palliative benefits with dedicated professionals around the clock
- For patients at the end of life when curative or life-prolonging therapies are no longer beneficial
- Patients must forego life prolonging therapies in order to focus on maximizing comfort and QoL
- Patients must be in the last weeks to months of life (≤ 6 months)

Hospice

- Hospice revolution in the 70's-80's brought a patient focus and humanity to medicine that was lacking
- Voice of reason stopping futile toxic treatments to allow dignity at End of Life
  - Perpetuated the wall in the dichotomous model
- Hospice Medicare Benefit in the US is based on the antiquated dichotomous model of healthcare
- Hospice services are reimbursed by Medicare Part A under a flat daily rate
- This per diem must cover all services

Hospice Debate

- From 2005-2009 Medicare hospice expenditures rose 70% to $8 billion
- For-profit Hospice > 52% of market share
- Management of the per diem allows hospice to be a highly profitable enterprise
- Hospice disallows “curative” treatments
  - strongly incented to avoid costly palliative services
    - Palliative RT “allowed”, but rarely done
    - De facto lumping of life-prolonging or costly palliative treatments with aggressive curative care
- In general hospice is incented to avoid most cancer patients until end of life

Hospice Bridge Models

- Step in the right direction for Hospice towards an integrated model
- Patients can receive some elements of hospice care while pursuing chemo/RT
- Patients do not enroll on per diem hospice reimbursement. Hospice can bill separately for palliative services
- Traditional Hospice will remain critical for poor PS patients and end of life

Palliative Care Improves Quality

- Relieves pain and other symptoms
- Supports re-evaluations of goals of care and difficult decision-making
- Improves quality of life, satisfaction for patients and their families
- Helps patients complete life-prolonging treatments

Temel et al, NEJM 2010

- Early palliative care in metastatic NSCLC
- Ambulatory palliative care setting fully integrated with an oncology team
  - Majority of patients received Chemo and RT
- Palliative care group had an improved QOL and Median Survival (11.6 mo vs 8.9)
- This study confirms the importance of palliative care.
  - Does not say that people in hospice live longer

Palliative Care in Oncology

- Cancer is set to surpass heart disease as the leading cause of death
- New chemotherapy and RT delivery are helping advanced cancer patients live longer
- Stage IV cancer as chronic disease
  - Palliative care is important to manage their functional decline and improve QoL.
- Palliative care should start at diagnosis, regardless of stage

Palliative Care Assessment in Oncology

- Estimate the trajectory of the patient's disease
  - Tumor Extent
    - Proper staging
      - Life expectancy can vary dramatically for a given stage
        - » Newer predictive tests
  - Performance Status
    - Karnofsky/ECOG
      - Based on amount of time patient is active in the day and the degree to which their disease makes them symptomatic
    - Strong predictor of life expectancy
  - Comorbidities
- Determine needs of patient
    - Symptoms
    - ADL's
    - Logistical
    - Spiritual

Assessing Needs of a Patient

- Identify Symptoms
  - pain
  - Dyspnea
  - Tumor bleeding
  - Depression
- Prevention of symptoms
  - Palliation of brain mets
  - Prevention of pathological fracture
  - Prevention of atelectasis/Post obstructive pneumonia

Life prolonging care in palliative setting

- Untreated stage IV cancer typically has 1-6mo life-expectancy
- Not all stage IV cancer is the same
  - Breast and colon are highly treatable with median survival in years.
  - Subtypes of Lung cancer and melanoma respond to modern chemo

Establishing Goals of care

- Communicating the nature of an illness
  - Curable versus incurable
  - Typical symptoms associated with a disease
  - The course or natural history of a disease
- Goals of treatment
  - Cure
  - Prolong survival
  - Maintain Quality of Life
  - Palliate symptoms
- Review the Pros and Cons of treatment

Patient perspective

- Strong desire to seek life prolonging treatment
- Antipathy towards healthcare system
  - Fears/ preconceptions of treatment related toxicity
- Understanding and acceptance of disease course
- Respect these perspectives and direct them towards a reasonable plan of care/ Goals

Psychosocial Support

- Include social workers, psychologists/therapists, chaplains, volunteers
- Bereavement support
- Spiritual support
- Attending to needs of caregivers/ family
- Respite care
- Treatment for depression, anxiety
- Practical support
  - Logistics (ADL's , transport)
  - Filing disability
  - End of life planning

Symptom Management

- Pain, dyspnea, anxiety and depression are highly prevalent in cancer patients
- Neurologic symptoms from brain involvement or nerve compression
  - Cord compression
  - MS changes
  - Seizures
  - Focal/generalized weakness

Assessment of Cancer Pain

- Pain characteristics
- Pain etiology
  - Establish a lesion or disorder that is causing the pain
- Psychiatric modifiers
- Determine treatments to modify tumor pathology or alleviate symptoms

Types of cancer Pain

- Nociceptive- bone and soft tissue
- Neuropathic- brain, cord, nerve roots/ plexus, peripheral
- Acute presentation
  - Tumor bleeding
  - Pathologic fracture
  - Obstruction/perforation
- Treatment related
  - Mucositis
  - Enteritis
  - Neuropathy

Palliation of Cancer Pain

- Pharmacologic
  - Narcotics
  - NSAIDS
  - Co analgesics
- Interventional
  - Nerve blocks
  - Pain pumps
  - Vertebroplasty/Kyphoplasty
- Radiotherapy
- Chemotherapy

Cancer Pain- Opiods

- Effective for all types of cancer pain
- First line for moderate to severe pain
- Multiple routes of administration (oral, iv, SQ, transdermal, rectal, intrathecal)
- Side effects a concern
  - Constipation
  - Nausea
  - Somnolence

Cancer Pain- CoAnalgesics

- Useful for mild to moderate pain
- Includes:
  - Tylenol
  - NSAIDS
  - Nerve stabilizers (Lyrica, Neurontin, Amytriptiline)
  - Steroids
- Often helpful for poor response to opioids
  - neuropathic pain

Radiotherapy as palliative treatment

- Effective at relieving tumor pain
  - Bone involvement
  - Soft tissue
  - Direct nerve involvement
- Tumor bleeding
- Post-obstructive pneumonia
  - Preventing atalectasis
- Tx and prevention of cord compression
- SVC syndrome

Whole Brain Radiotherapy

- Shown in randomized trials to double median survival and prevent neurologic death
  - Maintains cognitive function during end of life
  - Decreases seizure potential
- Short 10 fraction course delivered before chemo to limit toxicity

Radiosurgery for treatment of oligometastic Disease

- Oligo mets (1-5 lesions)
- Breast, Colon, Renal Cell, Sarcoma
  - Prolonged survival with ablative treatment of mets
- Radiosurgery achieves an ablative dose with high precision that limits toxicity
- Common sites of radiosurgery brain, lungs, spine and liver

Palliative Chemotherapy

- Symptom management with chemo can be highly effective
- Performance status biggest predictor of outcomes for traditional chemo
- Chemo consistently shown to prolong survival in stage IV disease
  - Additional
    - 3-4 months in lung
    - 1 year in colon
    - >1 year in breast
- Steroids and antiemetics reduce side effects of chemo

Molecularly-targeted Chemo can prolong survival

- Lack traditional side effects of chemo
- These treatments are changing the paradigm
  - Life prolonging Tx without the toxicity concerns
- B-RaF inhibitors for the treatment of melanoma
- EGFR directed therapy in Lung and Head and Neck Cancer
- VEGF inhibitors in Renal Cell Carcinoma

Patient M.H.

- 78 yo female presents to ER with severe vertigo, nausea
  - multiple brain mets
  - large lung lesion with adrenal mets
  - Lung biopsy confirms SCC, EGFR wild type
  - Pt admitted to hospital
  - Unable to ambulate or sit up secondary to severe nausea.
  - Whole brain RT x 10 while in hospital
  - Seen by med onc. Chemo option carbo taxol based on sensitivity. Not an ideal chemo candidate 2° PS
  - Disharged directly to hospice after RT with improved nausea/vertigo

Patient J.M.

- 63 yo man presented with hemoptysis in June 2010
  - CT shows large mediastinal mass with bilateral pulmonary nodules.
  - Biopsy performed
  - 10 fraction course of RT initiated to stop hemoptysis
  - Diagnosed with stage IV EGFR mutated pulmonary adeno
  - Started on Tarceva in July 2010
  - Good response on PET
  - July 2012 diagnosed with brain mets
  - 15 fraction course of WBRT

Palliative Oncology

- Highly individualized- determined by presentation and performance status
  - Prolonging survival and maintaining QOL
  - Palliating symptoms
  - End of life care/planning
- Preferably done via integrated model
  - Involve the oncology team
- With advanced presentations, disease modifying treatments (Radiotherapy) can be done quickly prior to transitioning to End of life care/ Hospice

Palliative Oncology

- Highly satisfying part of Oncology
- The vision of the Hospice Revolution inspires us to be better doctors
- Challenges the physician to communicate effectively
- Not formulaic/ one-size-fits-all
  - "Art of medicine"

Puppies and Babies