Overview

• Discuss fundamentals of palliative care
• Models of care
• Palliative care in oncology
• **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
Palliative care is NOT synonymous with End of Life Care
Integrated Model of Care

 Therapies to modify disease

 Presentation

 Therapies to relieve suffering and/or improve quality of life

 Palliative Care

 End-of-life Care

 Death
Progression of Disease and functional status - Cancer vs CHF

Function

CANCER

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

- Therapies to modify disease
- Palliative Care
- Therapies to relieve suffering and/or improve quality of life
- End-of-life Care

Presentation → Death
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- Opioids

• 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, Amytriptyline)
  - 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 atelectasis
• 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 oligometastatic 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
  - Discharged 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