

**How do we provide the best
psychological care for patients with
thoracic malignancies?
The provision of early palliative care**

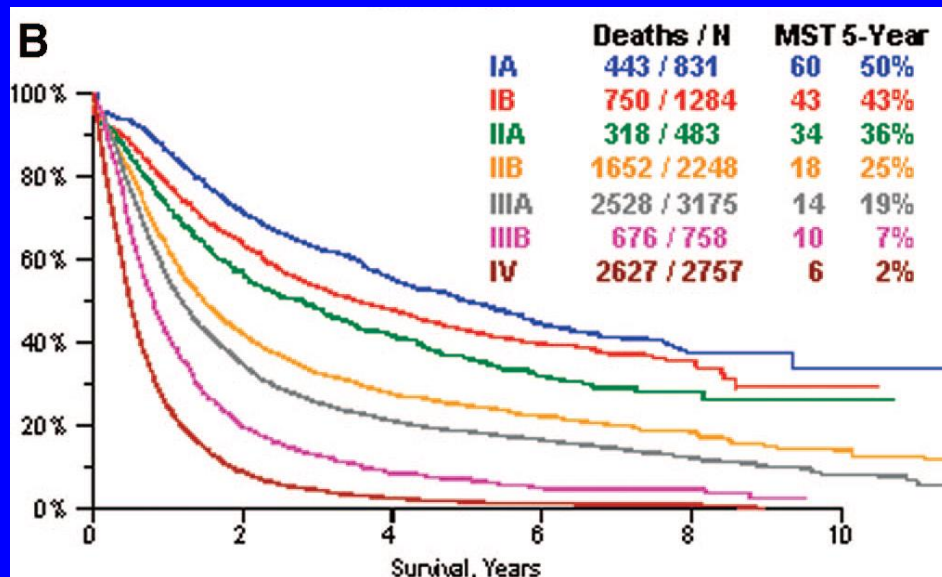
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Conflict of interest

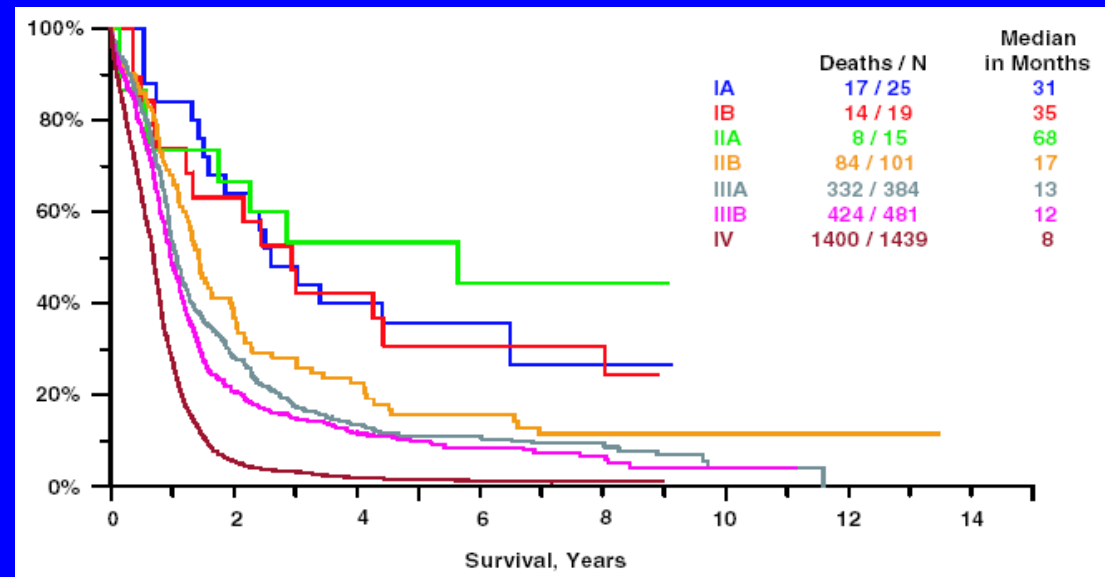
- I have no conflict of interest in relationship with this presentation

Why are we speaking about palliative care in thoracic malignancies?

- First, because of the poor prognosis
 - Advanced/metastatic disease
 - Limited activity of chemotherapy



NSCLC



SCLC

Chemotherapy: the first palliative care

NSCLC: MST 3-4m → 8-12m

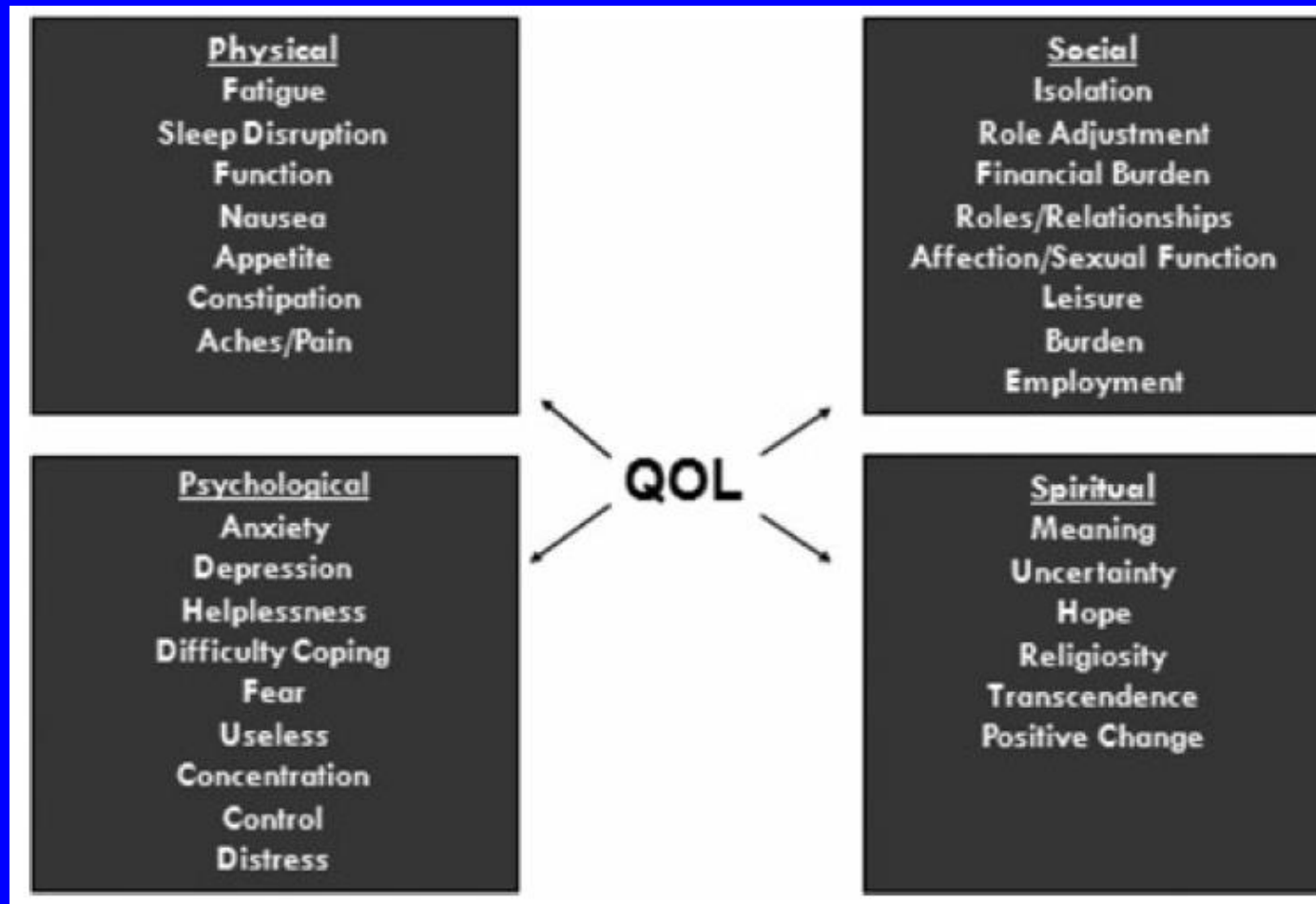
SCLC: MST 2-3m → 9-12m

Authors	N trials	N patients		p
Souquet et al	7	706	OR 0.51	S
Grilli et al	6	635	RR ↘ 24%	S
Marino et al	8	712	OR 0.44	S
NSCLC collaborative group	11	2334	HR 0.73	S
Sculier et al	6	557	RR 2.07	S
Baggstrom et al	5	1029		S
NSCLC collaborative group	16	2774	HR 0.77	S

If palliative care is considered, which dimensions have to be considered?

- Related to cancer
 - Physical component: breathlessness, pain ...
 - Psychological component: depression, anxiety ...
 - Social component: loss of work, lack of money...
 - Spiritual component
- Related to tobacco consumption
 - COPD, emphysema
 - Cardiovascular diseases
 - Other primary cancers

City of hope quality of life model



Periods	Symptoms (%)
<i>Pain</i>	
0–3 months (<i>n</i> = 490)	43.6
3–6 months (<i>n</i> = 286)	36.4
6–9 months (<i>n</i> = 171)	31
9–12 months (<i>n</i> = 128)	28.9
<i>Malnutrition</i>	
0–3 months (<i>n</i> = 490)	37
3–6 months (<i>n</i> = 286)	25.5
6–9 months (<i>n</i> = 171)	19.9
9–12 months (<i>n</i> = 128)	16.4
<i>Psychological disorders</i>	
0–3 months (<i>n</i> = 490)	25.3
3–6 months (<i>n</i> = 286)	16.8
6–9 months (<i>n</i> = 171)	8.8
9–12 months (<i>n</i> = 128)	7
<i>Social difficulties</i>	
0–3 months (<i>n</i> = 490)	10.8
3–6 months (<i>n</i> = 286)	9.4
6–9 months (<i>n</i> = 171)	8.8
9–12 months (<i>n</i> = 128)	6.3

<i>Terminal care</i>	
0–3 months (<i>n</i> = 490)	17.3
3–6 months (<i>n</i> = 286)	18.9
6–9 months (<i>n</i> = 171)	12.9
9–12 months (<i>n</i> = 128)	7.8
<i>Fatigue</i>	
0–3 months (<i>n</i> = 490)	36
3–6 months (<i>n</i> = 286)	31.1
6–9 months (<i>n</i> = 171)	27.5
9–12 months (<i>n</i> = 128)	23.4
<i>Other symptoms^a</i>	
0–3 months (<i>n</i> = 490)	60.1

Symptoms	Whole sample	Whites	Hispanics	Blacks
Severe pain	30%	33%***	50%***	49%***
Depressed mood	13%	14%**	26%**	11%**
Fatigue	50%	59%	64%	49%

Reyes-Gibby et al, Cancer 2012

Vergnenègre et al, Lung Cancer 2013

Psychological distress

Assessment of mood symptoms — no./total no. (%)		
HADS**		
Anxiety subscale	24/72 (33)	28/77 (36)
Depression subscale	18/72 (25)	17/77 (22)
PHQ-9 major depressive syndrome††	12/72 (17)	9/76 (12)

Temel et al, NEJM 2010: 733

Tobacco-related co-morbidities

Demographics and lung cancer characteristics, by presence of COPD, CHF, or number of comorbid illnesses (<i>n</i>)				
	Mean or % of population			
	COPD	CHF	Both COPD and CHF	Neither COPD nor CHF
Mean age	76	78	77	76
Male gender (%)	57	56	57	54
Black ethnicity (%)	6	8	8	7
Dual eligible (Medicaid) (%)	16	19	22	11
Metastatic disease at diagnosis (%)				
Any	40	38	38	44
Bone	10	8	8	11
Brain	7	5	4	9
Other distant	19	19	20	20
Total <i>n</i>	1276 (29%)	577 (13%)	337 (8%)	2931 (66%)

How integrating (early) palliative care?

- This is an approach
 - with multiple component
 - multidisciplinary
- Oncologist
- Internal medicine
- Pneumologist
- (Thoracic) surgeon
- Psychiatrist, psychologist
- Social worker

Is early palliative care adequate?

Why EARLY palliative care?

« The most significant barriers to providing appropriate and timely levels of palliative care to patients with advanced NSCLC are:

- (1) the existing standard-of-care practice of sequencing palliative care after cancer-directed therapies have failed;
- (2) a significant priority in the care of patients with advanced cancers;
- (3) most oncologists are ill prepared to adequately provide care for the physical and psychosocial symptoms that their patients typically suffer. »

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.

CONCLUSIONS

Among patients with metastatic non–small-cell lung cancer, early palliative care led to significant improvements in both quality of life and mood. As compared with patients receiving standard care, patients receiving early palliative care had less aggressive care at the end of life but longer survival. (Funded by an American Society of Clinical Oncology Career Development Award and philanthropic gifts; ClinicalTrials.gov number, NCT01038271.)

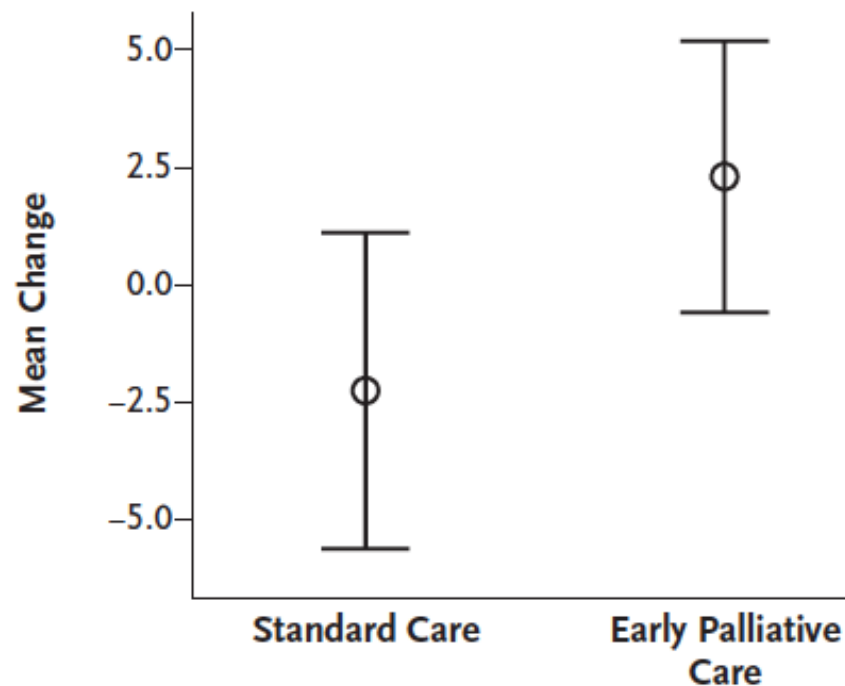
Table 1. Baseline Characteristics of the Study Participants.*

Variable		
Age — yr		
Female sex — no. (%)		
Race — no. (%)‡		
White		
Black		
Asian		
Hispanic or Latino ethnic group‡		
Marital status — no. (%)		
Married		
Single	9 (12)	9 (12)
Divorced or separated	12 (16)	12 (16)
Widowed	8 (11)	8 (10)
ECOG performance status — no. (%)¶		
0	30 (41)	26 (34)
1	35 (47)	46 (60)
2	9 (12)	5 (6)
Presence of brain metastases — no. (%)	19 (26)	24 (31)
Initial anticancer therapy — no. (%)		
Platinum-based combination chemotherapy	35 (47)	35 (45)
Single agent	3 (4)	9 (12)
Oral EGFR tyrosine kinase inhibitor	6 (8)	6 (8)
Radiotherapy	26 (35)	27 (35)
Chemoradiotherapy	3 (4)	0
No chemotherapy	1 (1)	0
Receipt of initial chemotherapy as part of a clinical trial — no. (%)	20 (27)	16 (21)
Never smoked or smoked ≤10 packs/yr — no./total no. (%)	16/73 (22)	18/76 (24)
Assessment of mood symptoms — no./total no. (%)		
HADS**		
Anxiety subscale	24/72 (33)	28/77 (36)
Depression subscale	18/72 (25)	17/77 (22)
PHQ-9 major depressive syndrome††	12/72 (17)	9/76 (12)

Table 2. Bivariate Analyses of Quality-of-Life Outcomes at 12 Weeks.*

Variable	Standard Care (N=47)	Early Palliative Care (N=60)	Difference between Early Care and Standard Care (95% CI)	P Value†	Effect Size‡
FACT-L score	91.5±15.8	98.0±15.1	6.5 (0.5–12.4)	0.03	0.42
LCS score	19.3±4.2	21.0±3.9	1.7 (0.1–3.2)	0.04	0.41
TOI score	53.0±11.5	59.0±11.6	6.0 (1.5–10.4)	0.009	0.52

C TOI



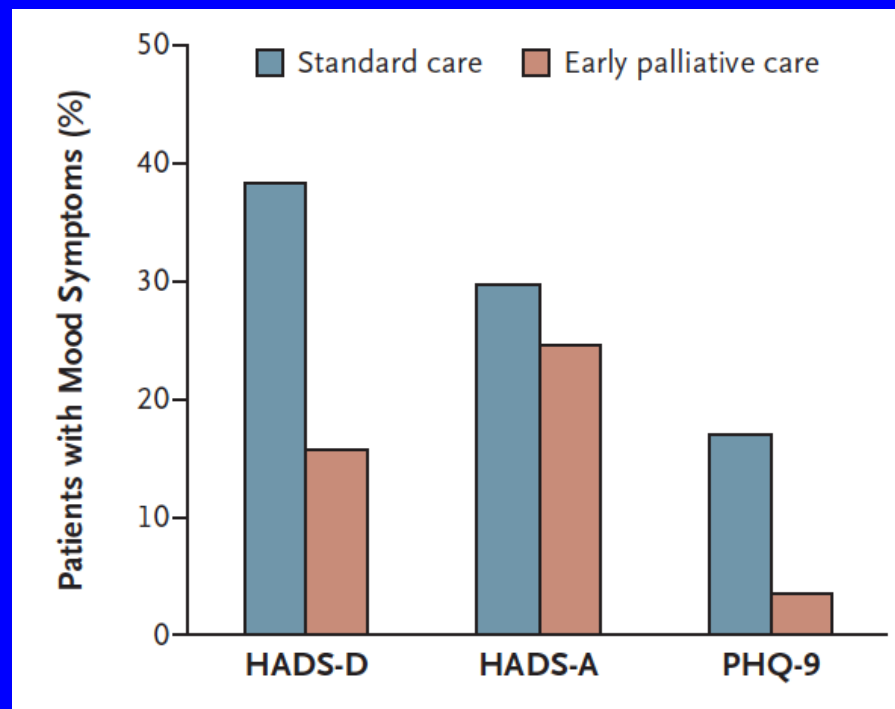


Figure 2. Twelve-Week Outcomes of Assessments of Mood.

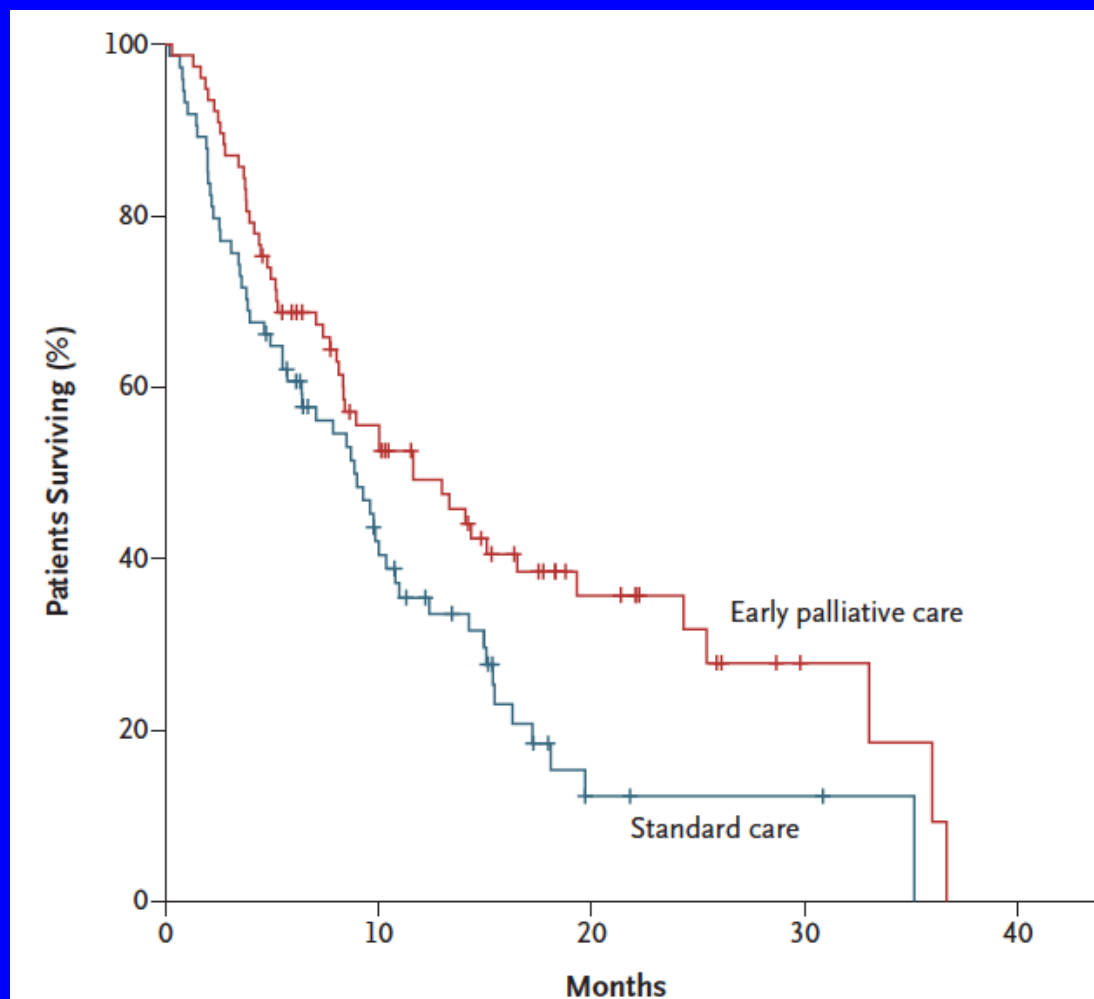


Figure 3. Kaplan-Meier Estimates of Survival According to Study Group.

Definitions of supportive care and palliative care

Supportive care

- All medical care given by a multidisciplinary team including physicians, nurses, social workers ... taking in charge symptoms. The aim is giving the best quality of life to patients and their family

www.nationalconsensusproject.org/guidelines.pdf

Palliative care

- 2011 WHO definition: Palliative care aim at improving the quality of life of patients and their family facing a potentially lethal disease by preventing and reducing suffering, early identified and carefully assessed, including treatment of pain and physical, psychological and spiritual problems.

www.who.int/cancer/palliative/definition/en

What is early palliative care in the Temel's trial?

- Member of the palliative care team
 - board-certified palliative care physicians
 - advanced-practice nurses
 - social workers
 - Chaplains
 - bereavement specialists
 - volunteers.

- Aims

1. Pain and symptom management
2. Psychosocial and spiritual support
3. Assistance with treatment decisions
4. Help in planning for future care
5. Bereavement support

Supplemental Table 1: Ambulatory Palliative Care Guidelines

Illness understanding/education

Inquire about illness and prognostic understanding

Offer clarification of treatment goals

Symptom management – Inquire about uncontrolled symptoms with a focus on:

Pain

Pulmonary symptoms (cough, dyspnea)

Fatigue and sleep disturbance

Mood (depression and anxiety)

Gastrointestinal (anorexia and weight loss, nausea and vomiting, constipation)

Decision-making

Inquire about mode of decision-making

Assist with treatment decision-making, if necessary

Coping with life threatening illness

Patient

Family/family caregivers

Referrals/Prescriptions

Identify care plan for future appointments

Indicate referrals to other care providers

Note new medications prescribed

Are specific interventions able to be implemented?

Multicentre randomised controlled trial of nursing intervention for breathlessness in patients with lung cancer

Mary Bredin, Jessica Corner, Meinir Krishnasamy, Hilary Plant, Chris Bailey, Roger A'Hern

Design Patients diagnosed with lung cancer participated in a multicentre randomised controlled trial where they either attended a nurse-led intervention offering intervention for their breathlessness or received best supportive care. The intervention consisted of a range of strategies including control, activity pacing, relaxation techniques and psychosocial support. Best supportive care consisted of receiving standard management and having access to available for breathlessness, and by a multidisciplinary team. Participants completed a range of questionnaires at baseline, 4 weeks

Table 2 Change between baseline and 8 weeks in intervention and control groups in scores					
Questionnaire	Intervention group		Control group		P value
	No of patients	Median (range) change	No of patients	Median (range) change	
Visual analogue scales:					
Distress caused by breathlessness	49	0 (−9-11)	51	10 (−7-11)	0.09
Breathlessness at worst	50	1 (−7.2-8.5)	52	4.8 (−6.2-8.5)	0.14
Breathlessness at best	50	1.3 (−7.1-8)	52	7.0 (−3.3-8)	0.03
WHO performance status	51	0 (−3-3)	52	2 (−1-3)	0.02
Hospital anxiety and depression:					
Anxiety	50	0 (−7-11)	52	9.5 (−6-11)	0.08
Depression	50	0.5 (−10-7)	52	6 (−7-7)	0.02
Rotterdam symptom checklist:					
Psychological symptoms	50	1 (−9-13)	52	9 (−8-13)	0.21
Physical symptoms	50	2.5 (−24-16)	52	14 (−11-16)	0.04
Activity:					
Items 38-44	47	2 (−12-15)	52	8.5 (−4-15)	0.1
Subitems R41, R43, R44	47	0 (−6-9)	52	5.5 (−3-9)	0.05
Quality of life (1 item)	47	1 (−4-4)	52	2 (−2-4)	0.25

Dyadic Psychosocial Intervention for Advanced Lung Cancer Patients and Their Family Caregivers: Results of a Randomized Pilot Trial

- (1) teaches skills to enhance patient and caregiver competence for self-care, coping with cancer, and managing symptoms at home;
- (2) supports patient/caregiver autonomy by providing a clear rationale for recommendations and a variety of options to encourage choice and elaboration;
- (3) seeks to improve interpersonal connections or the sense of relatedness by teaching patients and caregivers strategies for solving problems, effectively communicating, and mobilizing support/maintaining supportive relationships.

BACKGROUND: Advanced lung cancer (LC) patients and their families have reported low self-efficacy for self-care/caregiving and high rates of distress, yet few programs exist to address their supportive care needs during treatment. This pilot study examined the feasibility, acceptability, and preliminary efficacy of a 6-session, telephone-based dyadic psychosocial intervention that was developed for advanced LC patients and their caregivers. The program was grounded in self-determination theory (SDT), which emphasizes the importance of competence (self-efficacy), autonomy (sense of choice/volition), and relatedness (sense of belonging/connection) for psychological functioning. The primary outcomes were patient and caregiver psychological functioning (depression/anxiety) and caregiver burden. The secondary outcomes were the SDT constructs of competence, autonomy, and relatedness. **METHODS:** Thirty-nine advanced LC patients who were within 1 month of treatment initiation (baseline) and their caregivers (51% spouses/partners) completed surveys and were randomized to the intervention or usual medical care. Eight weeks after baseline, they completed follow-up surveys.

RESULTS: Significant improvements in patient self-efficacy ($P < .001$) and caregiver self-efficacy ($P < .001$) and homogeneity of self-efficacy ($P < .001$) were observed. Significant improvements in patient depression ($P < .001$) and caregiver depression ($P < .001$) and caregiver burden ($P < .001$) were observed. Significant improvements in patient anxiety ($P < .001$) and caregiver anxiety ($P < .001$) were observed. Significant improvements in patient relatedness ($P < .001$) and caregiver relatedness ($P < .001$) were observed. Significant improvements in patient competence ($P < .001$) and caregiver competence ($P < .001$) were observed. Significant improvements in patient autonomy ($P < .001$) and caregiver autonomy ($P < .001$) were observed. Significant improvements in patient motivation ($P < .001$) and caregiver motivation ($P < .001$) were observed. Significant improvements in patient self-efficacy ($P < .001$) and caregiver self-efficacy ($P < .001$) were observed. Significant improvements in patient depression ($P < .001$) and caregiver depression ($P < .001$) were observed. Significant improvements in patient anxiety ($P < .001$) and caregiver anxiety ($P < .001$) were observed. Significant improvements in patient relatedness ($P < .001$) and caregiver relatedness ($P < .001$) were observed. Significant improvements in patient competence ($P < .001$) and caregiver competence ($P < .001$) were observed. Significant improvements in patient autonomy ($P < .001$) and caregiver autonomy ($P < .001$) were observed. Significant improvements in patient motivation ($P < .001$) and caregiver motivation ($P < .001$) were observed.

Participants receiving the intervention evidenced significant improvements
($P < .0001$) in depression, anxiety, and caregiver burden in comparison with usual medical care

A tailored, supportive care intervention using systematic assessment designed for people with inoperable lung cancer: a randomised controlled trial

Objective: People with inoperable lung cancer experience higher levels of distress, more unmet needs and symptoms than other cancer patients. There is an urgent need to test innovative approaches to improve psychosocial and symptom outcomes in this group. This study tested the hypothesis that a tailored, multidisciplinary supportive care programme based on systematic needs assessment would reduce perceived unmet needs and distress and improve quality of life.

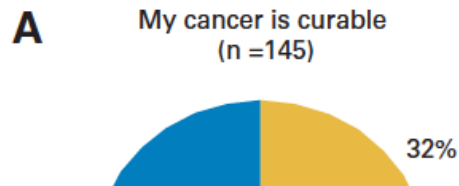
Methods: A randomised controlled trial design was used. The tailored intervention comprised two sessions at treatment commencement and completion. Sessions included a self-completed needs assessment, active listening, self-care education and communication of unmet psychosocial and symptom needs to the multidisciplinary team for management and referral. Outcomes were assessed with the Needs Assessment for Advanced Lung Cancer Patients, Hospital Anxiety and Depression Scale, Distress Thermometer and European Organization of Research and Treatment of Cancer Quality of Life Q-C30 V2.0.

Results: One hundred and eight patients with a diagnosis of inoperable lung or pleural cancer (including mesothelioma) were recruited from a specialist facility before the trial closed prematurely (original target 200). None of the primary contrasts of interest were significant (all $p > 0.10$), although change score analysis indicated a relative benefit from the intervention for unmet symptom needs at 8 and 12 weeks post-assessment (effect size = 0.55 and 0.40, respectively).

Conclusion: Although a novel approach, the hypothesis that the intervention would benefit perceived unmet needs, psychological morbidity, distress and health-related quality of life was not supported overall.

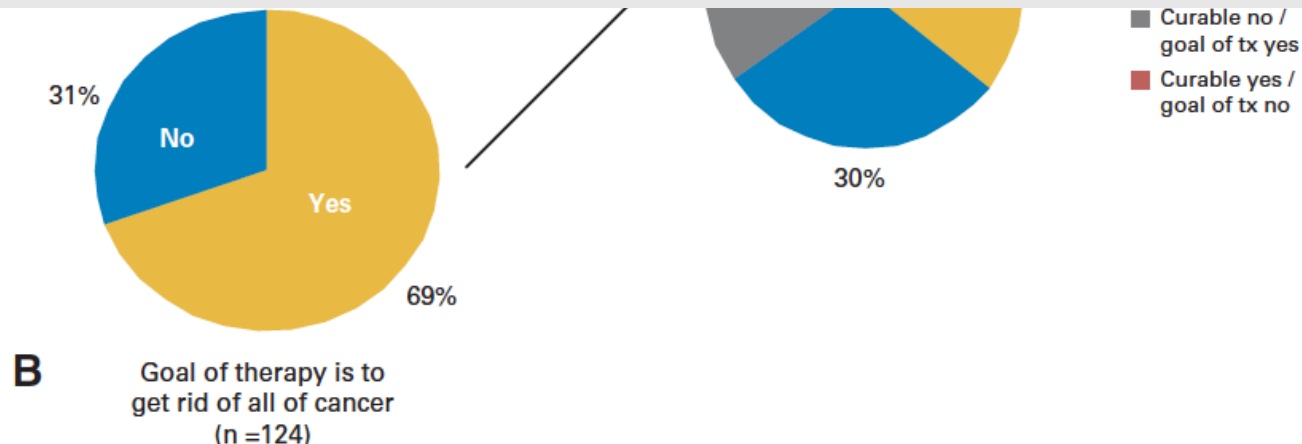
Is palliative care of importance?

Perception of cancer prognosis and use of chemotherapy at the end of life



C Concordance of perceptions of prognosis and goals of therapy

Variable	Standard Care		Early Palliative Care		P
	No.	%	No.	%	
Chemotherapy use					
Any within 60 days of death	47 of 67	70.1	32 of 61	52.5	.05
Any within 30 days of death	29 of 67	43.3	18 of 60	30.0	.14
Any within 14 days of death	16 of 67	23.9	8 of 59	13.6	.18



Is it applicable in routine practice?

Assessment of palliative care for advanced non-small-cell lung cancer in France: A prospective observational multicenter study (GFPC 0804 study)[☆]

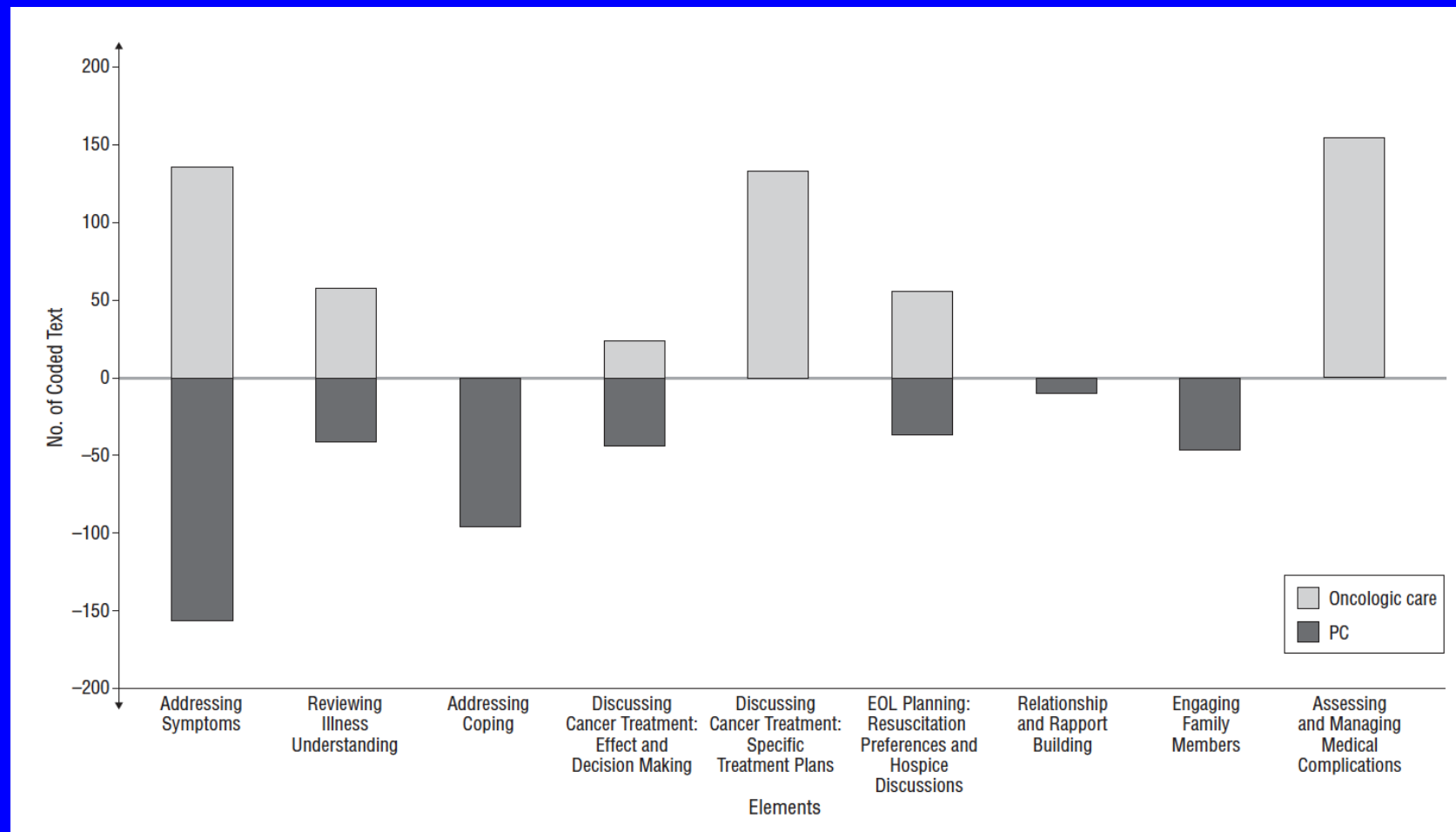
Results: 514 patients were enrolled by 39 centers (age: 62.3 ± 10.7 years, performance status: 0/1; 68.6% cases). At baseline, the most frequent symptoms concerned pain (43.6%), malnutrition (37%) and psychological disorders (25.3%). Specific interventions were infrequent for pain control and malnutrition, but were more numerous for psychological and social problems and terminal care. Median time between diagnosis and PC initiation was 35 [13–84] days, median PC duration was 4.2 [0.6–9.3] months. Median

Conclusions: This study showed that early PC initiation is not a standard for patients with advanced NSCLC

Multivariable analysis of PC initiation ≤ 3 months (0) vs > 3 months (1).

Items	OR	CI 95%	P
Performance status			0.0049
≤ 1	1		
≥ 2	0.53	[0.34–0.82]	
Admission in PC unit	2.85	[1.54–5.27]	0.0080
Recombinant human erythropoietin	2.05	[1.24–3.39]	0.0053
Parenteral nutrition	2.08	[1.20–3.61]	0.0092

Differential role for palliative and oncological care?



Conclusions

- Lung cancer is one of the first cause of death from cancer worldwide
- Palliative/supportive care have to be provided early in the course of the disease and integrated in the oncology care due the major symptoms burden associated with the disease
- It must include physical, psychological, spiritual and social interventions

Is it really « early palliative care » or an integrated approach of a complex disease?

