Palliative Care
Oral Abstracts Discussion

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Abstracts to Discuss

- Howard Chan et al
- Abs 369 O
- Early Palliative Care trial in Non Small Cell Lung Cancer

→ No impact on survival and Aggressiveness at the end of life

- Darshit A Thaker et al
- Abs 370 O
- Palliative Prognostic Index (PPI) calculations in a palliative care unit

→ Palliative scores have to be defined in different settings

Timing of palliative care referral and its impact on receiving aggressive end of life care in patients with metastatic non-small lung cancer (NSCLC) in Southwest Sydney

AuthorS: HOWARD Chan, Peey-SeI Kok, Clement chao, Joseph descallar, Victoria Bray, Annette tognela, po Yee Yip

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WESTERN SYDNEY UNIVERSITY
NSW GOVERNMENT Health South Western Sydney Local Health District
UNSW THE UNIVERSITY OF NEW SOUTH WALES
Ingham Institute Applied Medical Research

EARLY PALLIATIVE CARE

VOLUME 25 · NUMBER 17 · JUNE 10 2007

JOURNAL OF CLINICAL ONCOLOGY

ORIGINAL REPORT

Start of thoughts NSCLC

Phase II Study: Integrated Palliative Care in Newly Diagnosed Advanced Non–Small-Cell Lung Cancer Patients

Jennifer S. Temel, Vicki A. Jackson, J. Andrew Billings, Constance Dahlin, Susan D. Block, Mary K. Buss, Patricia Ostler, Panos Fidias, Alona Muzikansky, Joseph A. Greer, William F. Pirl, and Thomas J. Lynch

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

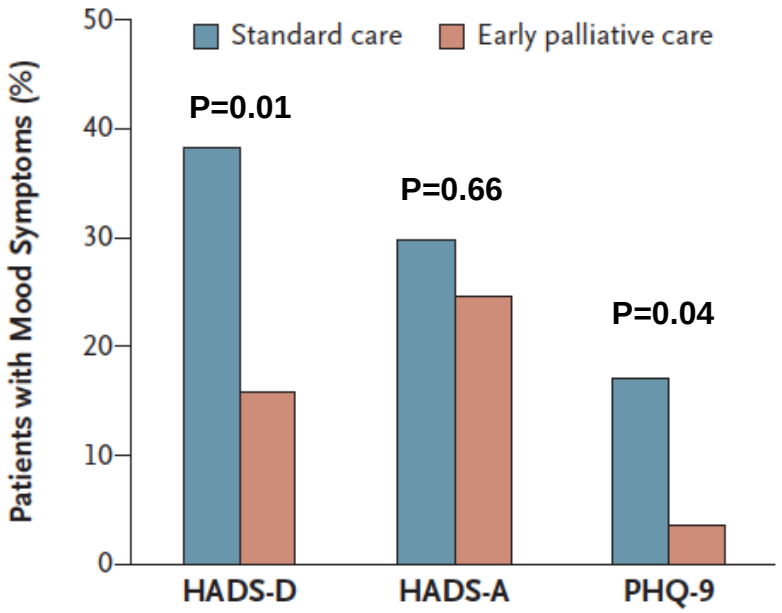
The Message ASCO 2010 → NEJM 2010 NSCLC

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.

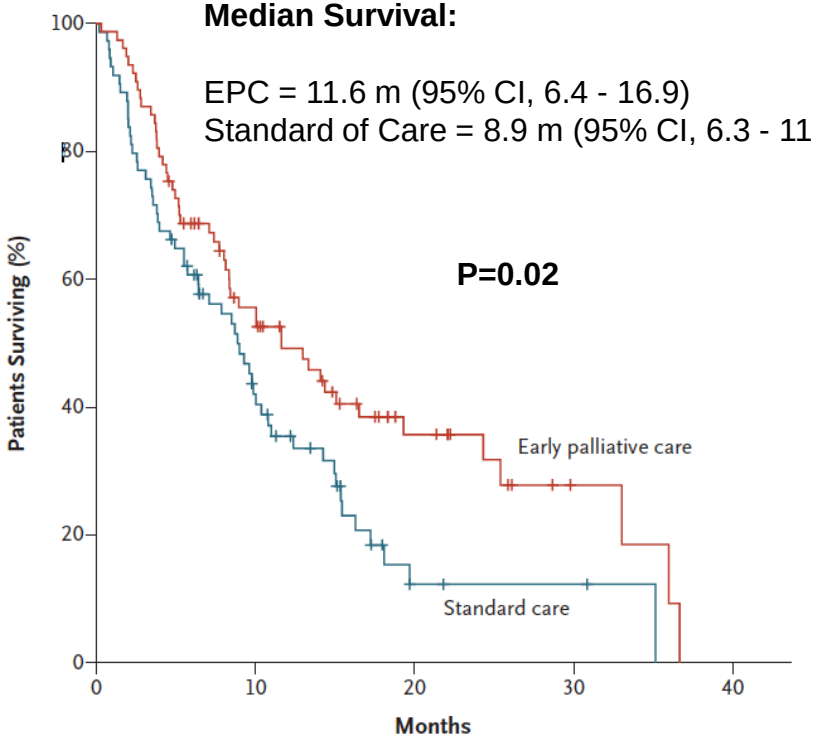
Temel J et al. N Engl J Med 2010;363:733-42.

Early Palliative Care NSCLC



Median Survival:

EPC = 11.6 m (95% CI, 6.4 - 16.9)
Standard of Care = 8.9 m (95% CI, 6.3 - 11.4)



Temel J et al. N Engl J Med 2010;363:733-42.

CHAN's Study : Early Palliative Care in NSCLC

Aims

- To examine the timing of PC referral for patients with metastatic NSCLC.
- To assess impact on overall survival and aggressiveness of end of life care in Southwest Sydney Local Health District in Australia.

Methods

- Retrospectively reviewed pre- (1/1/2008- 31/12/2009) and post-Temel study (1/1/2011-31/12/2012).
- Early referral to PC = within 8 weeks of diagnosis.

Results: Baseline Characteristics

- **94% of the 262 patients were referred to palliative care**

Characteristics	Early* n= 154 (%)	Late^ n= 93 (%)	
ECOG performance status			Better ECOG
0-1	64 (46)	78 (84)	←
≥2	90 (54)	15 (16)	
Received systemic treatment	41 (30)	61(68)	←
			More Treated

*** Early: PC referral made within 8 weeks of diagnosis of metastatic NSCLC**
^ Late: PC referral made beyond 8 weeks of diagnosis of metastatic NSCLC

	Early	Late
Median OS	3.1 months	9.8 months
HR = 0.39 (95% CI: 0.3-0.51); p<0.0001		

Temel's Study Impact on referral

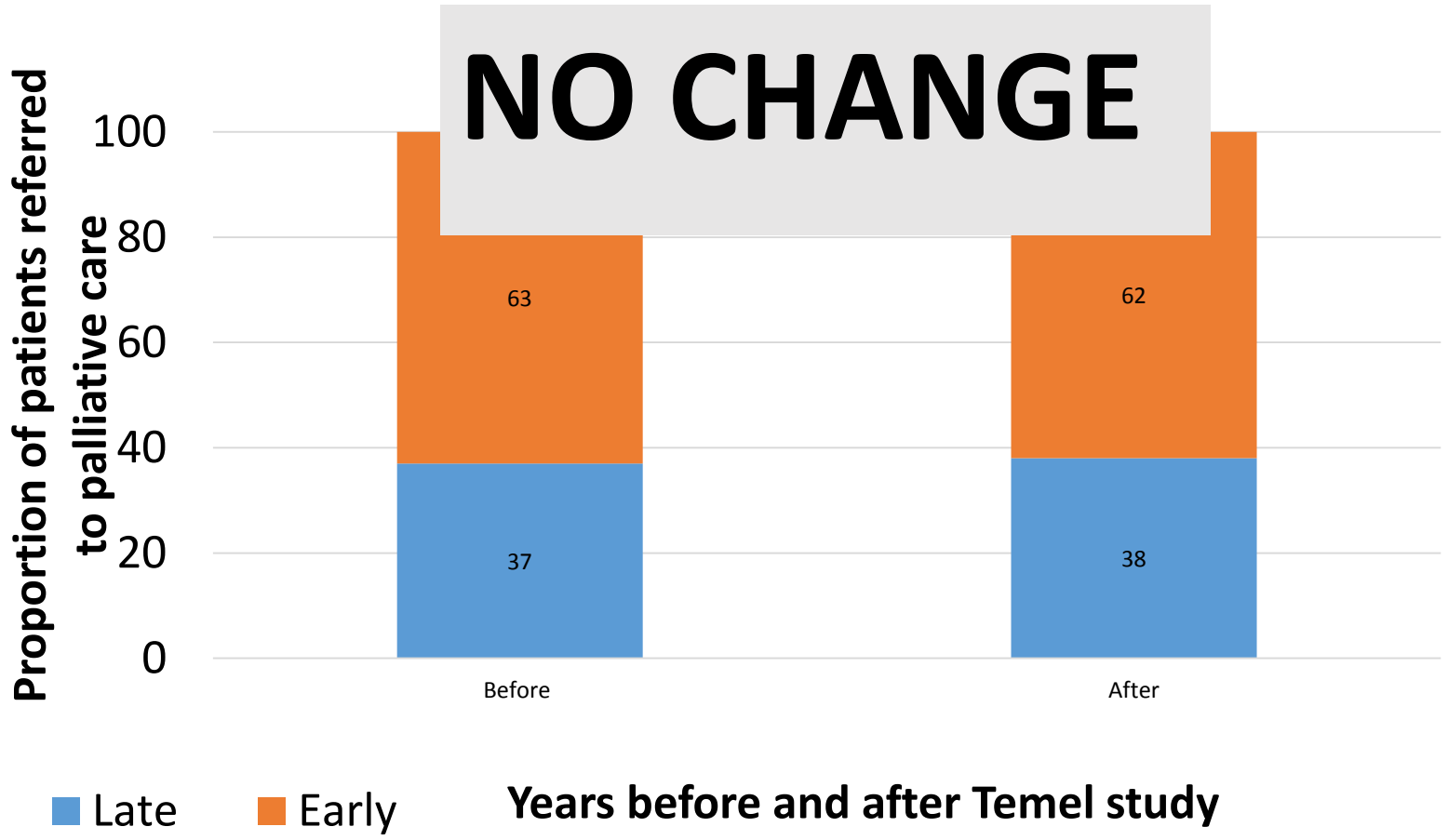


Table 2. Services utilised

Services	Early n=154 (%)	Late n=93 (%)
MDT Discussion	102 (66)	67(72)
No. of hospital admission		
0-2	99 (64)	46 (49)
≥3	55 (36)	47 (51)
Duration of stay in acute hospital		
<30 days	86 (56)	52 (56)
≥30 days	68 (44)	41 (44)
Hospice admission	71 (46)	52 (56)
Duration of stay in hospice		
Mean	29	16
Range	1-69	1-100

RESULTS: Aggressiveness of end of life care

Indicator (Occurred within last 30 days of life)	n (%)		
	Early	Late	Total
More than one acute hospital admission	23 (15)	18 (20)	41 (17)
Length of stay more than 14 days	53 (34)	25 (27)	78 (31)
More than one ED presentation	22 (		
ED presentation in death admission	91 (		
Chemotherapy in last 14 days of life	1 (		
Intensive care admission	1 (<1)	0 (0)	1 (<1)
<3 days in hospice	11 (7)	9 (10)	20 (8)

NO DIFFERENCES

Early Palliative Care RCT

Table 1. Randomized Trials of Early Specialty Palliative Care Interventions in Patients with Cancer.

Trial	Population	Intervention	Results
Brumley et al.[6]	298 homebound patients with a prognosis of <1 yr to live and a recent hospital or ED visit; included 138 patients with cancer	Usual care + in-home multidisciplinary PC (frequency of visits based on individual needs of patients) vs. usual care	Patients assigned to PC had lower rates of ED visits (P=0.01) and hospital admissions (P<0.001) and lower medical costs (difference in mean cost, $7,552; P=0.004) and were more likely to die at home (P<0.001). There was no significant between-group difference in hospice enrollment.
Gade et al.[9]	517 patients with ≥1 life-limiting diagnosis and their physician "would not be surprised" if the patient died ≤1 yr; included 159 patients with cancer	Usual care + inpatient multidisciplinary PC consultation vs. usual care	Patients receiving PC reported more satisfaction with care (P<0.001), had fewer ICU stays on hospital readmission (P=0.04), and had a 6-mo net cost savings of $4,855 per patient (P=0.001). There were no significant between-group differences in hospice use, completion of advanced directives, symptoms and quality of life, or survival.
Bakitas et al.[10]	322 patients with a life-limiting cancer and a prognosis of approximately 1 yr to live	Usual care + phone-based PC administered by advanced-practice nurse in 4 structured sessions and at least monthly follow-up vs. usual care	Patients assigned to PC reported better quality of life (P=0.02) and mood (P=0.02). There were no significant between-group differences in symptom burden or intensity of service (hospital and ICU days or number of ED visits).
Temel et al.[11]	151 patients within 8 wk after diagnosis of metastatic lung cancer	Usual care + outpatient PC (provided by physician or advanced-practice nurse) at least monthly and PC consultation if patient hospitalized vs. usual care	Patients receiving early PC had better quality of life (P=0.03), lower rates of depression (P=0.01), less aggressive end-of-life care (P=0.05), and longer median survival (P=0.02).
Zimmermann et al.[12]	442 patients with metastatic cancer and a physician-provided prognosis of 6 mo to 2 yr to live	Usual care + early ambulatory PC at least monthly vs. usual care with routine PC	Patients receiving early PC reported greater satisfaction with care (P<0.001), better quality of life (P=0.008), and less severe symptoms (P=0.05) at 4 mo.

Ravi B. Parikh et al. N Engl J Med 369;24, 2013

Oncologists' Perspectives on Concurrent Palliative Care in an NCI-designated Comprehensive Cancer Center

- 35 medical Oncologists questionnaire post Enable II study
  → Views on the complementary role of palliative care
  - Refer early and often
  - Palliative care as consultants or co-manager
  - Palliative care shares the load

  To conclude, Enable II facilitated palliative care integration

Bakitas M et al. Palliat Support Care 2013

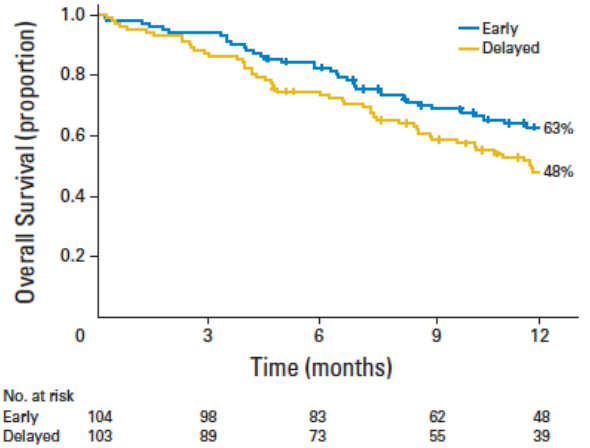
VOLUME 33 · NUMBER 13 · MAY 1 2015

JOURNAL OF CLINICAL ONCOLOGY ORIGINAL REPORT

- 207 **advanced cancer** pts
- Failed in:
  - QOL : p=0.34
  - CT last 14 days p=0.27
  - ICU last days p= 0.49
- Survival improvement
  - P=0.038

Early Versus Delayed Initiation of Concurrent Palliative Oncology Care: Patient Outcomes in the ENABLE III Randomized Controlled Trial

Marie A. Bakitas, Tor D. Tosteson, Zhigang Li, Kathleen D. Lyons, Jay G. Hull, Zhongze Li, J. Nicholas Dionne-Odom, Jennifer Frost, Konstantin H. Dragnev, Mark T. Hegel, Andres Azuero, and Tim A. Ahles



Early palliative care for patients with advanced cancer: a cluster-randomised controlled trial

Camilla Zimmermann, Nadia Swami, Monika Krzyzanowska, Breffni Hannon, Natasha Leighl, Amit Oza, Malcolm Moore, Anne Rydall, Gary Rodin, Ian Tannock, Allan Donner, Christopher Lo

- 461 **advanced cancer** pts
- Failed at 3 months:
  - FACIT-Sp: p=0.07
  - ESAS p=0.33
- Failed at 4 months:
  - FACIT-Sp, ESAS, QUAL-E, FARMCARE-P16

Zimmermann C. Lancet 2014; 383: 1721–30

Temel J. Ann Palliat Med 2015;4(3):99-121

- « We need an evidence-based definition of “early” palliative care to determine the optimal timing to intervene ».
- Define what models of care are effective
- Define the best models of care for variable populations
  - Inpatient *vs.* home care
  - Disease types
- Determine the economic impact of palliative care including all medical and non-medical factors

CHAN'S STUDY CONCLUSION

- 94% of NSCLC patients received palliative care.
- No Impact of Temel's Study (but high rate of PC referral /EPC defined as 8 w post dg)
- Early referral not associated with an improvement in overall survival (but bad ECOG)
- Aggressive end of life care occurred at low frequency.
- Lowest rate of hospitalisation
- Increase in length of stay

Needs to define population, cost, prognostic factors for early referral

THE UNIVERSITY OF QUEENSLAND
AUSTRALIA

Queensland Government
Queensland Health

Determining the value of routine Palliative Prognostic Index (PPI) calculations in a palliative care unit

D.A. Thaker, A. Veltre, A. Smith, C. Orth, B. Stafford;
Palliative Care Unit, Redcliffe Hospital, Brisbane, QLD, AU

Dr. Darshit A Thaker

Medical Oncologist & Pall. Med. Physician

QLD Health, Australia

Senior Lecturer, University of Queensland

SINGAPORE 2015 ESMO ASIA 18-21 DECEMBER SINGAPORE

Background

- Prognosis Assessment of terminally ill patients.
  - Why:
    - desire of full disclosure and honesty about prognosis
    - Treatment and care management decision
    - Family information / Patient's end of life anticipation
  - When:
    - Palliative Care Unit admission
    - Degradation
    - Weekly / Daily
  - How:
    - Scores ? → Palliative Prognostic Index (Morita T. Palliative Medicine 2001)

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JOURNAL OF CLINICAL ONCOLOGY

ORIGINAL REPORT

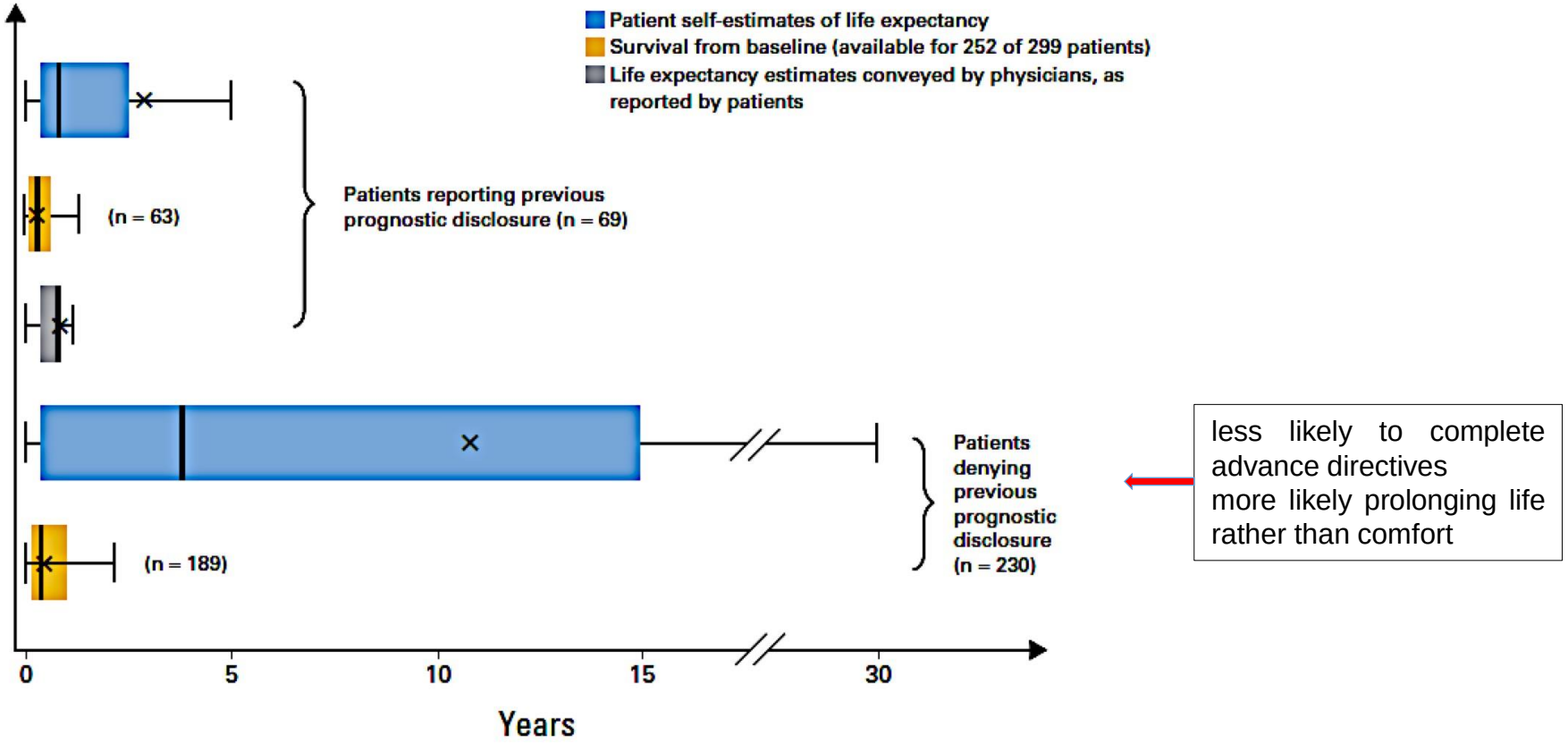
Outcomes of Prognostic Disclosure: Associations With Prognostic Understanding, Distress, and Relationship With Physician Among Patients With Advanced Cancer

Andrea C. Enzinger, Baohui Zhang, Deborah Schrag, and Holly G. Prigerson

- 590 patients with advanced cancer (median survival, 5.4 months)
  - 71% wanted to be told their life expectancy
  - 17.6% recalled a prognostic disclosure by their physician
- 299 willing life expectancy estimation
  - 66.3%, patients reporting prognostic disclosure by physician ($p<0.001$)
  - Life expectancy self estimates shorter ($p<0.001$)

Enzinger Andrea JCO 2015

Patients' self-estimates of life expectancy versus actual patient survival (n 299)



less likely to complete advance directives
more likely prolonging life rather than comfort

Each 1-year increase in the length of a patients' LE self-estimate:

- DNR order decreased by 2.5-fold (OR, 0.439; 95% CI, 0.296 to 0.630),
- Preferring life-prolonging over comfort-oriented care increased by 1.5-fold (OR, 1.493; 95% CI, 1.091to 1.939).

Palliative Prognostic Index

Factor	Partial score
PPS 10–20%	4
PPS 30–50%	2.5
PPS >50%	0
Delirium	4
Dyspnoea at rest	3.5
Oral intake mouthfuls or less	2.5
Oral intake reduced but more than mouthfuls	1
Oral intake normal	0
Oedema	1

Score > 6 → 3 week survival
prediction sensitivity 80% specificity 85%.

Methods

- 106 patients admitted over a three months period in 16 bedded palliative care unit.
- Three categories: All patients / Cancer / Non-cancer
- Further subgroups based on the PPI score on admission:

➢Group 1: PPI < 4

➢Group 2: PPI of > 4 but ≤ 6

➢Group 3: PPI of > 6.

- PPI score reassessed and recorded each week.
- Outcome of each patient was recorded.

Results: Score / Median Survival

Patients	All Patients (n=106)		Cancer Patients (n=76)		Non Cancer Patients (n=30)	
	n	Median Survival (days)	n	Median Survival (days)	n	Median Survival (days)
Group 1 (PPI<4)	29	32	27	52	3	50
Group 2 (PPI 4-6)	15	14	15	15	0	
Group 3 (PPI>6)	62	4.5	34	5	27	4

Sensitivity / Specificity → Survival < 3 weeks

	All Patients (n=106)				Cancer Patients				Non Cancer Patients			
	n	Median Survival (days)	Se (CI 95%)	Sp (CI 95%)	n	Median Survival (days)	Se (CI 95%)	Sp (CI 95%)	n	Median Survival (days)	Se (CI 95%)	Sp (CI 95%)
Group 3 (PPI>6)	62	4.5	77% (66-86)	70% (50-86)	34	5	69% (55-80)	72% (50-89)	27	4	96% (80-100)	60% (15-95)

- Cancer patients with lower PPI (< 4) on admission = average survival > 6 w.
- Weekly PPI use = prognosis changes prediction
- Non cancer-patients referred too late to palliative unit

In-patients → Out-patients

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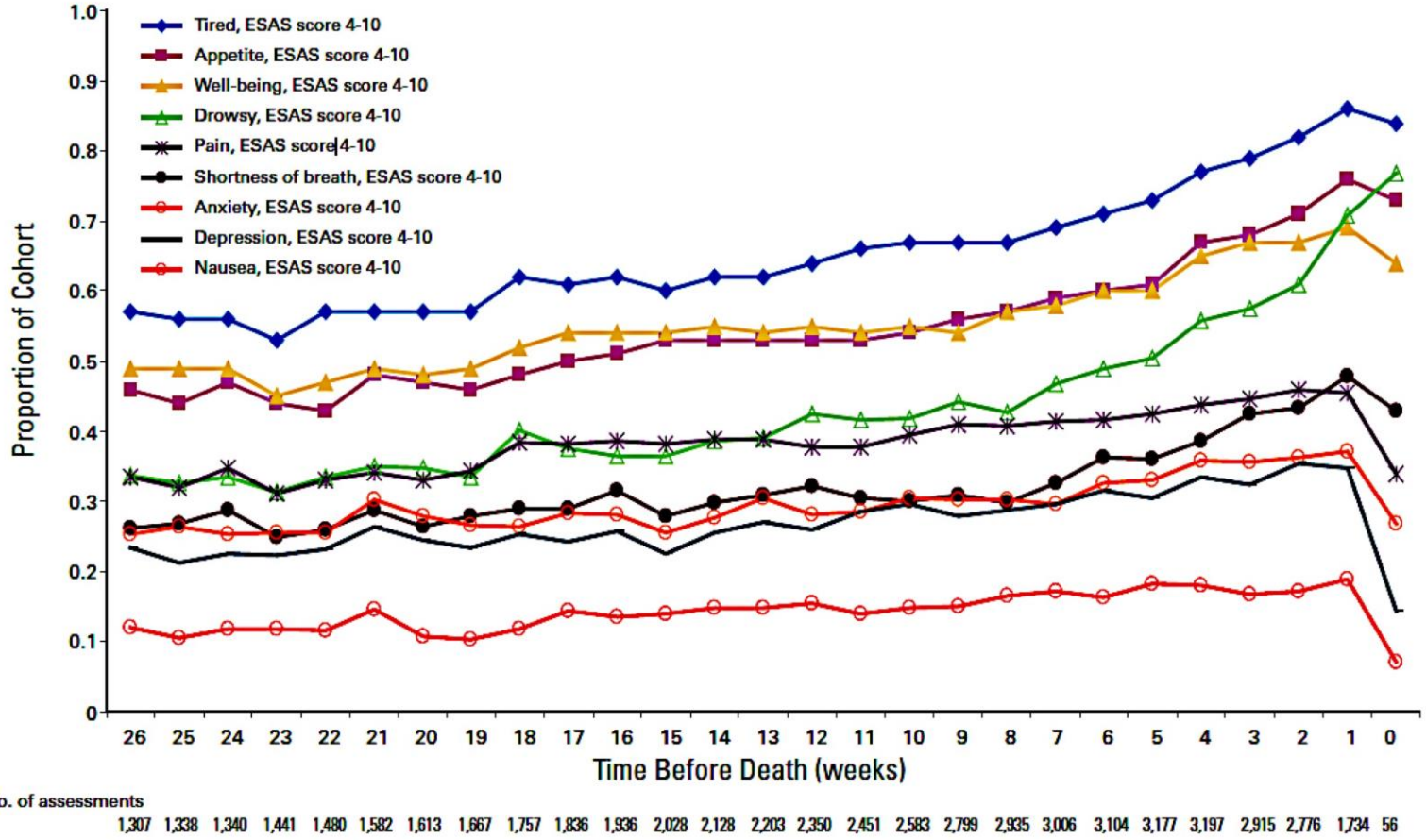
JOURNAL OF CLINICAL ONCOLOGY ORIGINAL REPORT

Trajectory of Performance Status and Symptom Scores for Patients With Cancer During the Last Six Months of Life

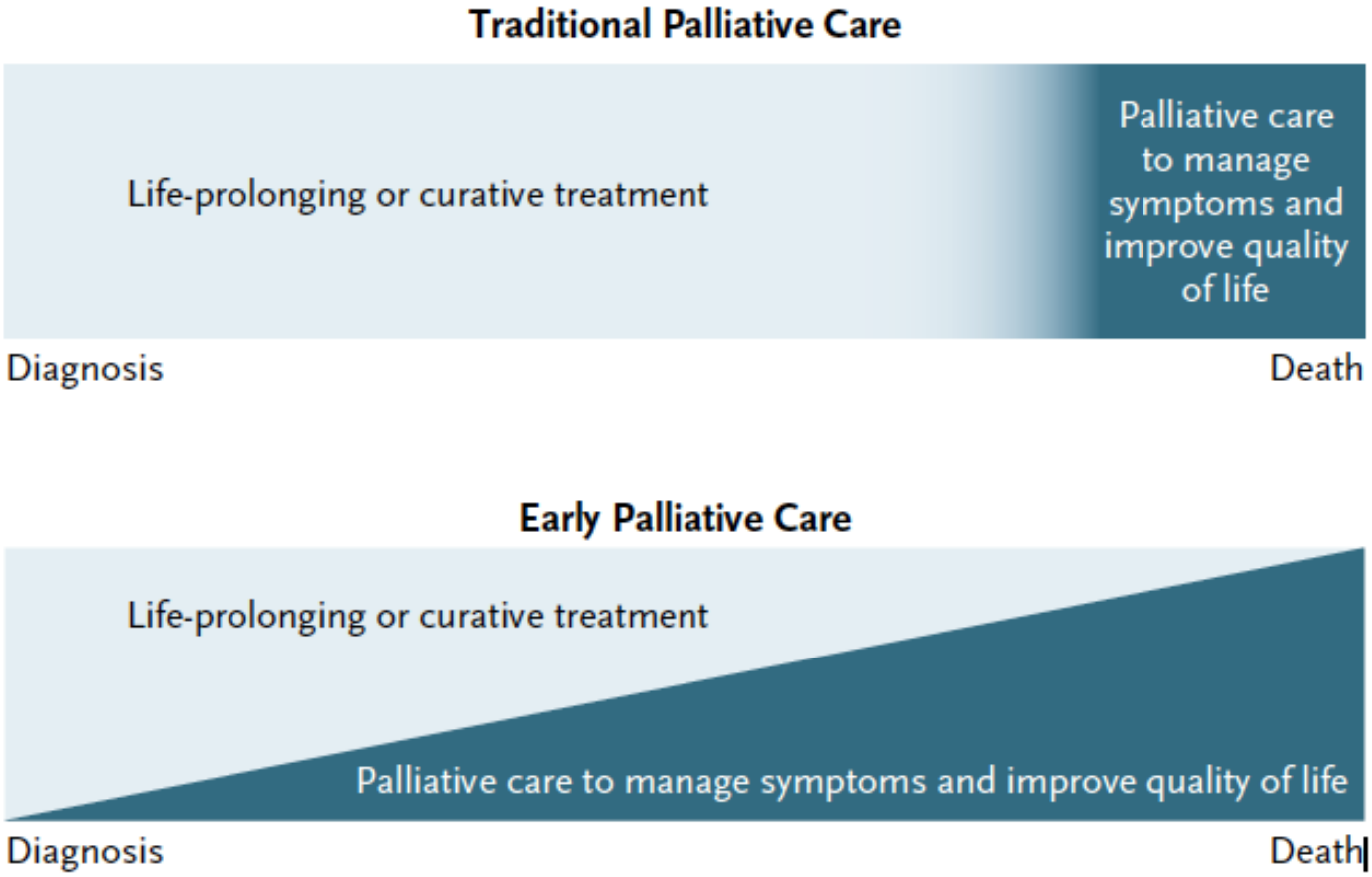
Hsien Seow, Lisa Barbera, Rinku Sutradhar, Doris Howell, Deborah Dudgeon, Clare Atzema, Ying Liu, Amna Husain, Jonathan Sussman, and Craig Earle



Hsien Seow, JCO 2011

CONCLUSION

- Two interesting randomized studies in palliative course of patients
- Early Palliative Care is a way to change practice and collaborations
- Studies are yet needed to define:
  - Costs impact of palliative care / early palliative care
  - Impact on aggressive end of life care
  - Patients who may benefit Early Palliative Care
  - Symptoms burden during / after treatment and at the end of life
  - Out-patients vs In-patients programs
- Prognostic factors has to be determined (PPI – PPS – ESAS …)



NEXT CHALLENGE: EARLY GLOBAL CARE

Improving palliative care for cancer: summary and recommendations. Washington, DC: Institute of Medicine, 2003

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