

Overview of main palliative care **interventions** delivered by **oncologists** and by **specialists** in palliative care

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What is Palliative Care?

What is a Palliative Care Intervention?

What is the Evidence?

Who should deliver Palliative Care?

What is the role of the Oncologist?

When to involve a specialist PC Team?

What shall I do tomorrow in my clinic?

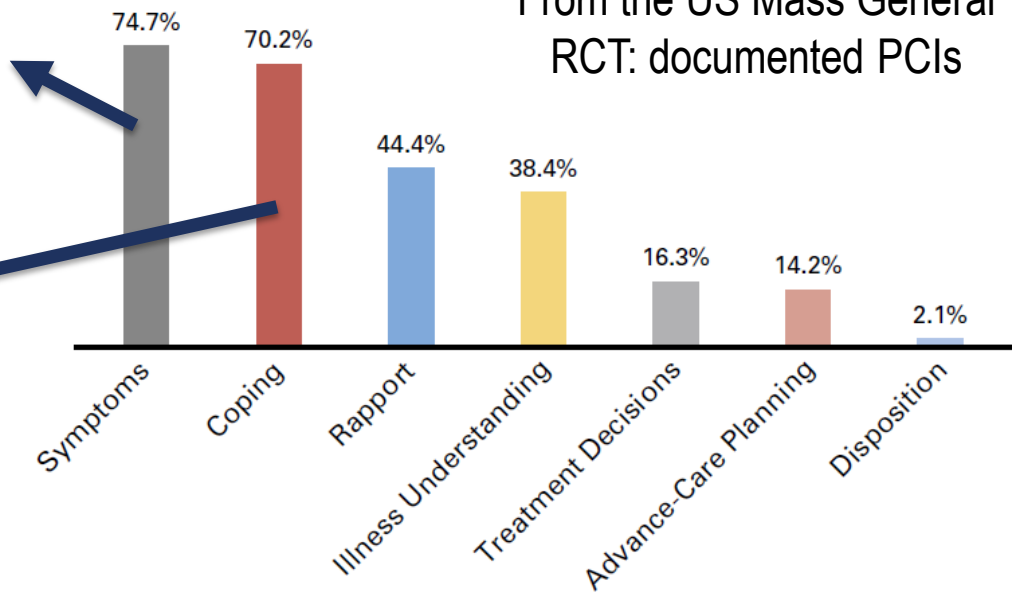
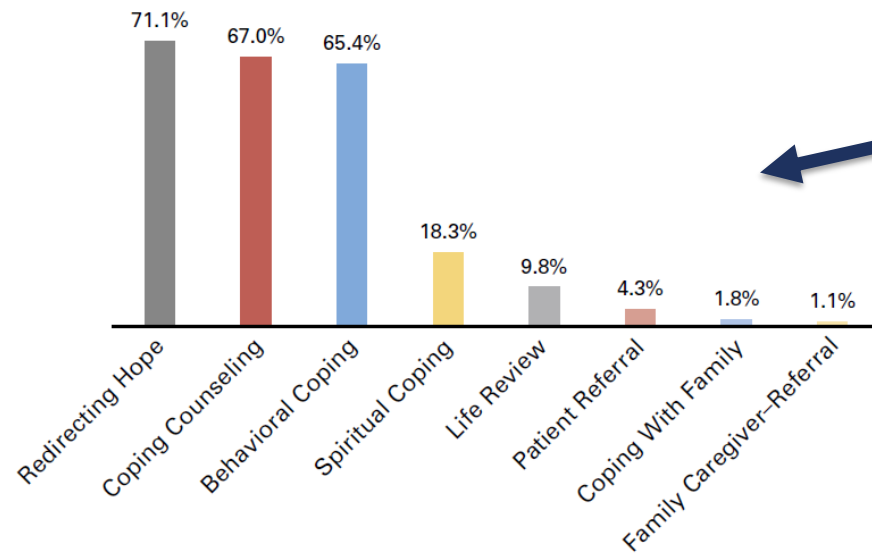
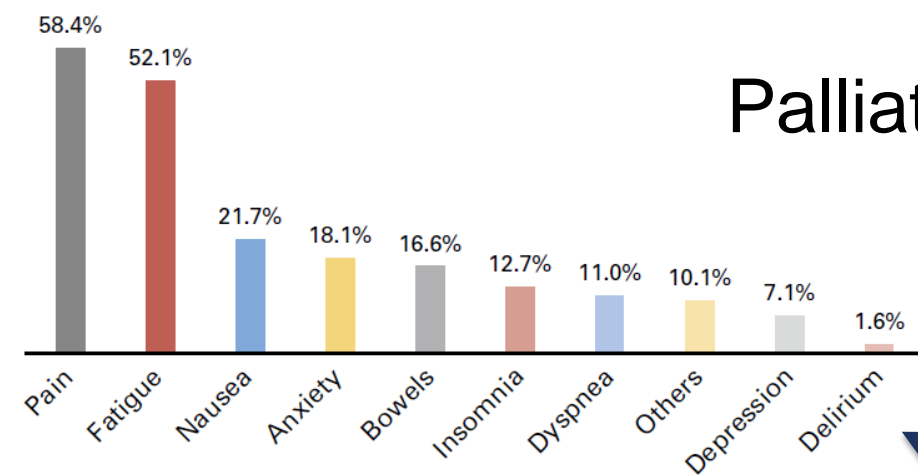
Palliative Care

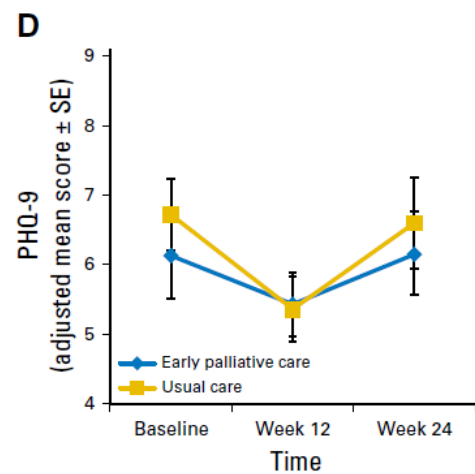
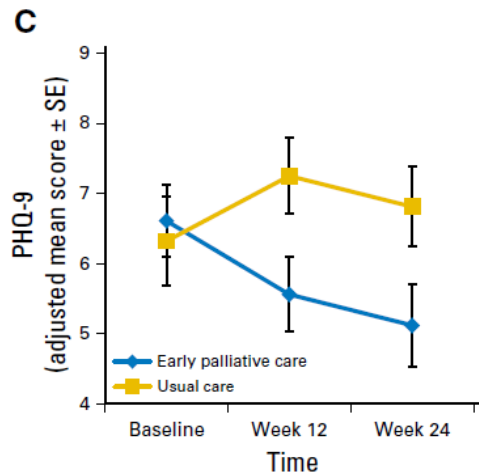
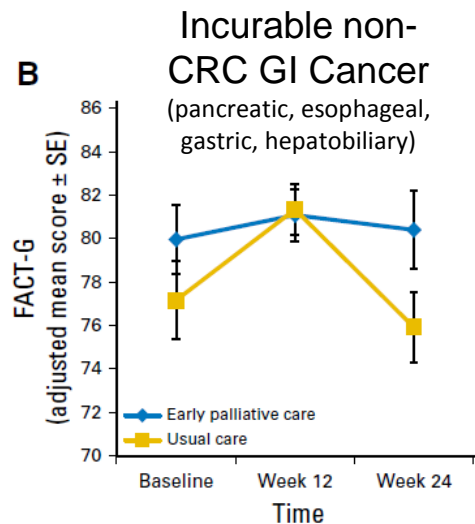
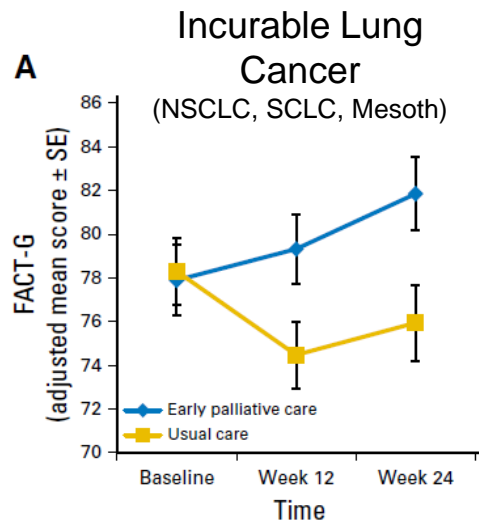
- provides **relief** from pain and other distressing **symptoms**;
- **affirms life** and regards **dying** as a **normal** process;
- intends neither to hasten or postpone death;
- integrates the **psychological & spiritual aspects** of patient care;
- offers a **support system** to help patients live as actively as possible until death;
- offers a support system to help **the family cope** during the patients illness and in their own bereavement;
- uses **a team approach** to address the needs of patients and their families, including bereavement counseling, if indicated;
- will enhance **quality of life**, and may also positively influence the course of illness;
- is applicable **early in the course of illness**, in conjunction with other therapies that are intended to prolong life, such as **chemotherapy** or **radiation** therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Palliative Care Interventions (PCIs)

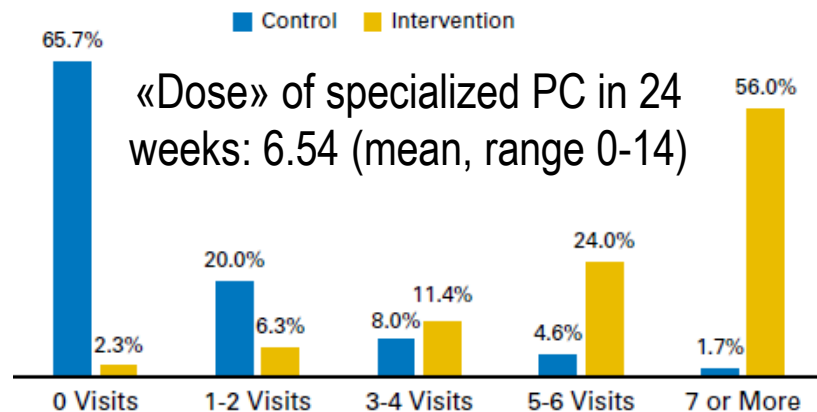
Definable interventions as part of the specialist Palliative Care «package»

From the US Mass General RCT: documented PCIs





Effects of specialized Palliative Care are different in incurable Lung and non-CRC GI Cancer Patients



«Dose» of specialized PC in 24 weeks: 6.54 (mean, range 0-14)

→ Once a month: recommended dose*

Temel J et al. JCO 2016; Dec 28

Ferrel BL et al. JCO 2017;35:96-112

Palliative Care Interventions

Pharmacological

Procedural (e.g. pleural pct)

Educational (e.g. prognosis)

Counselling (e.g. decisions)

Coaching, Empower (e.g. prompt list)

Psychological (e.g. behavioural)

Coordinative (e.g. HCP network)

...

**Complex: relevant
interactions between
interventions**

Simplified PCIs

- **Illness understanding**
(prognosis, mechanism, trajectory)
- **Symptomcontrol**
(bio-psycho-social-spiritual)
- **Decision processes**
(cancer-specific Tx, nutrition, ...)
- **Continuity of care Network**
(various HCP, home-out- inpat)
- **Care of family members**
(incl. premortal grief, coaching)
- **End of life preparation & care**
(family; double way, legacy, dying)
- **Spirituality**
(meaning, transcendence, ..)

Palliative Care Key Interventions based on & adapted by Magaya N et al from:
Temel NEJM 2010; Jacobsen J Pall Med 2011; Yoong JAMA Int Med 2013;
Zimmermann Lancet 2014; Bakitas JCO 2015; Dionne-Odom JCO 2015

Many HCPs believe patients and caregivers *should* be told the truth about the prognosis
→ *but* in practice avoid discussion / withhold info¹

- .no time (?)
- .fear of a negative impact on patient
- .uncertain prognosis
- .family requests
- .feel inadequate/
hopelessness

Illness & Prognosis Understanding Intervention

In daily practice: HCP learn and apply, empower patients

- Ask proactive patients about their illness understanding
„In your own words, what do you tell proxies what you have?“
- Truth telling about prognosis, expected trajectory ²
worst (5%) & best case (95%) scenarios: weeks, months, years
- Fair information to make decisions, use time left well
→ *normalization approach: „many patients want to know...“*

Question prompt list: patients can ask clinicians³

Communication skills training for oncologists important⁴

1: Hancock K et al. Palliat Med 2007;21:507-17 2: Epstein RM et al. JAMA Oncol 2016 Sep 9

3: Walczak A et al. Palliat Med 2013;27:779-88

4: Hillen MA et al. Ann Oncol 2014;25:896-901; Goelz T et al. JCO 2011;29:3402-7;
Tulsky JA et al. Ann Int Med 2011;155:593-601; Moore PM et al. Cochrane 2015

The Palliative Intervention Illness understanding improves Outcomes

Prognostic Understanding and Communication Outcomes

Measure	Usual Care	Early PC	P-value
Primary goal of cancer treatment is cure	34.5%	28.7%	0.29
Prefer to extend life as long as possible, even if meant more pain and discomfort	34.5%	33.6%	0.99
Knowing about prognosis is very/extremely helpful for:			
Making decision about treatment	89.8%	96.5%	0.043
Coping with the disease	83.6%	97.3%	<0.001
Discussed wishes about care if dying	14.5%	30.2%	0.004

Many symptoms are still poorly controlled

- .insufficient **access** to drugs (e.g., opioids)¹
- .no proactive **screening**
- . **non-specialized** setting²
- .**silent** symptoms (fatigue, depression) neglected

Monitoring incl. **coaching**³
or symptom **mgmt drugs**⁴
or **email alerts** to HCPs⁵
improve outcomes

1: Cherny N Ann Oncol 2013;S11:xi7-13

2: Greco MT JCO 2014;32:4149-54

3: Berry DL JCO 2014;32:199-205

4: Strasser F Ann Oncol 2016;27:324-32

5: Basch E JCO 2016;34:557-65

Symptom Control Intervention(s)

Manage symptoms & syndromes **multidimensional**
- physical, emotional, intellectual, social, spiritual

Define **Syndrome** and **risk factors**

- Pain: incident, neuropathic, cognitive, emotional⁶
- Cachexia: concurrent malnutrition, constipation⁷
- Depression: concurrent delirium, dementia

Management by **drugs, education, counseling**, etc.⁸

- always consider mechanism, ev. location
- always ask for impact of symptom on quality of life
- pharmacological management: Guidelines⁸

6: Nekolaichuk CL J Palliat Med 2013;16:516-23

7: Aapro M Ann Oncol 2014;25:1492-9

8: Sheinfeld Gorin S et al. *JCO* 2012; 30:539-547

Edmonton Symptom Assessment System Revised (ESAS-R)

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness (Tiredness = lack of energy)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness (Drowsiness = feeling sleepy)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression (Depression = feeling sad)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety (Anxiety = feeling nervous)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing (Wellbeing = how you feel overall)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No _____ Other Problem (for example constipation)	0	1	2	3	4	5	6	7	8	9	10	Worst Possible

Watanabe SM JPSM 2011;41:456-68

Completed in daily routine care

- . as paper or by computer
- . verbally
- . by a Scale Device

**Can be completed
by proxies, HCP**

Completed by (check one):

- ☐ Patient
- ☐ Family caregiver
- ☐ Health care professional caregiver
- ☐ Caregiver-assisted

www.palliative.org/NewPC/professionals/tools/esas

3728 pts & caregiver rated **26 concerning issues** of support related to their cancer¹
. 91% „**making decisions** about about care“
in top categories important & very important
. lung cancer rank **3/26**, breast cancer **4/26**

Syst Lit Rev 5 databases decision making²
37 articles (original research, western, adult)
Majority pts **want participate** in DM process
Most not achieve level of involvement:
. Decisions are delayed
. Alternative treatment options not discussed

Anticancer treatment close to end-of-life
«aggressive», if no spec. Pall Care unit³

1: Gralla RJ Supp Care Cancer 2011;19(S2);S160

2: Bélanger E Palliat Med 2011;242-61

3: Rochigneux P Ann Oncol 2016 Dec 19. pii: mdw654

Decision support Intervention

Preparing the decisional encounter⁴

- . Consider emotional burden of patient
- . Assess illness & prognosis understanding
- . Check individual meaning of hope
- . Relate symptoms to cancer disease
- . Address family emotional / logistic burden
- . Discuss preparation for End-of-Life
- . Ask for preferred decisional involvement

Decision⁴

- . Define specific goal, when & how measure
- . Inform about non-abandonment if no Tx
- . Prepare worst & best case scenarios
- . Empower pts to cope with & report toxicity

4: Ribi K [...] Strasser F; submitted

Continuity of care Network Intervention

Prepare with the multiprofessional team a **concrete care plan** for community-based patients

- what symptoms are expected, what drugs needed
- who will assess patient, who gives drugs, how?
- who cares for the patients' care needs?
- which phone numbers 1st – 2nd -3rd to call? 24/7

Care of family members Intervention

Discuss & acknowledge family members double role

- carer, advocate, „nurse“, coordinator,..
- own burden, grief work, prepare role after death

Preparing for End-of-life Intervention

Special Communication | LESS IS MORE

Communication About Serious Illness Care Goals A Review and Synthesis of Best Practices

Rachelle E. Bernacki, MD, MS; Susan D. Block, MD; for the American College of Physicians High Value Care Task Force

Evidence That Early Communication About Goals of Care and End-of-Life Preferences Improves Care

End-of-life conversations are associated with better quality of life, reduced use of life-sustaining treatments near death, earlier hospice referrals, and care that is more consistent with patient preferences.

Patients who received early palliative care showed significant improvements in quality of life and mood, and survived 25% longer.^b

Patients who engaged in advance care planning were more likely to have their wishes known and followed.

Preparation for the end of life is associated with improved bereavement outcomes for family.

Bernacki RE & Block SD. JAMA Intern Med 2014; 174:1994-2003

Intervention is (cost-) effective¹

- . Discuss living will, DNR, value-based diagnostic / therapeutic interventions
- . Solve legal and financial issues
- . Support concrete legacy work (dignity therapy², narratives, books)
- . Use of remaining life time & finish business: dreams, duties, people, etc.
- . Support pre-mortal grief work
- . Preferred place of death, funeral
- . Care in dying phase (awakeness, skin care, pastoral care, catheter, etc.)
- . Prepare family for after death roles

1: Zhang B Arch Int Med 2009;169:480-8

2: Chochinov HM Lancet Oncol 2011;12:753-6
Martinez M Palliat Med 2016 Aug 26

Evidence of Palliative Care: specialized teams

- **US Lung Cancer** (Temel, NEJM 2010) QoL, Depression, Survival
- **US Lung & non-crc GI** (Temel, JCO 2016) QOL Lung wk 12/24, GI wk24
Prognostic awareness
- **US Hemonc trspl.** (El-jawahri JCO 2016) Qol wk 2
- **Canadian** (Zimmermann, Lancet 2014) QoL, EOL burden
- **ENABLE I, II, III** (Bakitas, JCO 2015) QoL Pat & Caregiver, Survival
- **Japan** (Nakajima JPSM 2014) Communication, QOL
- **Denmark** (Groenvold, DanPact EAPC 2015) negativ (Intensity PC too low)
- **Italy** (Franciosi ESMO 2016) negative (contamination?)
- **US** (Ferrel, JPSM 2015) Family QoL, Survival
- **Japan** (Murakami BMC Pall 2015) Survival
- **England** (Higginson Lancet Resp 2015) Qol, Survival

*Early integrated Palliative Care
improves QoL of patients and
family members, prognostic
awareness & depression
and patient survival*

“Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, *intellectual*, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.”

Patients with advanced cancer: *Evidenced-based* (Evidence Quality, Recommendation level)

- | | | |
|--|---------------------|-----------------|
| - referred to interdisciplinary palliative care teams | <i>intermediate</i> | <i>strong</i> |
| - consultation available both inpatient and outpatient care | <i>intermediate</i> | <i>strong</i> |
| - early in the course of disease, alongside active treatment | <i>intermediate</i> | <i>moderate</i> |

Newly diagnosed pts, referral < 8 weeks: <i>In-formal consensus</i>	<i>intermediate</i>	<i>moderate</i>
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Cancer patients with high symptom burden: <i>Evidence-based</i> and/or unmet physical or psychosocial needs outpatient cancer care programs shall use dedicated resources	<i>intermediate</i>	<i>moderate</i>
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For family caregivers in outpatient setting: <i>Evidence-based</i> nurses, social workers, et al. caregiver-tailored PC support	<i>low</i>	<i>weak</i>
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Recommendation Type and Strenght

Type of Recommendation	Definition
Evidence based	There was sufficient evidence from published studies to inform a recommendation to guide clinical practice.
Formal consensus	The available evidence was deemed insufficient to inform a recommendation to guide clinical practice. Therefore, the Expert Panel used a formal consensus process to reach this recommendation, which is considered the best current guidance for practice. The Expert Panel may choose to provide a rating for the strength of the recommendation (ie, "strong," "moderate," or "weak"). The results of the formal consensus process are summarized in the guideline and reported in the Data Supplement.
Informal consensus	The available evidence was deemed insufficient to inform a recommendation to guide clinical practice. The recommendation is considered the best current guidance for practice, based on informal consensus of the Expert Panel. The Expert Panel agreed that a formal consensus process was not necessary for reasons described in the literature review and discussion. The Expert Panel may choose to provide a rating for the strength of the recommendation (ie, "strong," "moderate," or "weak").
No recommendation	There is insufficient evidence, confidence, or agreement to provide a recommendation to guide clinical practice at this time. The Expert Panel deemed the available evidence as insufficient and concluded it was unlikely that a formal consensus process would achieve the level of agreement needed for a recommendation.

Rating for Strength of Recommendation	Definition
Strong	There is high confidence that the recommendation reflects best practice. This is based on (1) strong evidence for a true net effect (eg, benefits exceed harms); (2) consistent results, with no or minor exceptions; (3) minor or no concerns about study quality; and/or (4) the extent of Expert Panelists' agreement. Other compelling considerations (discussed in the guideline's literature review and analyses) may also warrant a strong recommendation.
Moderate	There is moderate confidence that the recommendation reflects best practice. This is based on (1) good evidence for a true net effect (eg, benefits exceed harms); (2) consistent results, with minor and/or few exceptions; (3) minor and/or few concerns about study quality; and/or (4) the extent of Expert Panelists' agreement. Other compelling considerations (discussed in the guideline's literature review and analyses) may also warrant a moderate recommendation.
Weak	There is some confidence that the recommendation offers the best current guidance for practice. This is based on (1) limited evidence for a true net effect (eg, benefits exceed harms); (2) consistent results, but with important exceptions; (3) concerns about study quality; and/or (4) the extent of Expert Panelists' agreement. Other considerations (discussed in the guideline's literature review and analyses) may also warrant a weak recommendation.

Ferrrel BL et al. JCO 2017;35:96-112

Patients with advanced cancer should receive palliative care services, which *may* include referral to a palliative care provider

Essential components of palliative care may include:

- | | |
|--|------------------------|
| • Rapport and relationship building with patients and family caregivers | Family support |
| • <i>Symptom</i> , distress, and functional status management (eg, pain, dyspnea, fatigue, sleep disturbance, mood, nausea, or constipation) | Symptom Mgmt |
| • Exploration of understanding & education about <i>illness</i> and <i>prognosis</i> | Illness & Prognosis |
| • Clarification of [anticancer] treatment <i>goals</i> | Decision process |
| • Assessment and support of coping needs (eg, dignity therapy) | EOL-prepare, Spiritual |
| • Assistance with medical <i>decision</i> making | Decision process |
| • Coordination with other care providers | Continuity of care |
| • Provision of referrals to other care providers as indicated | Continuity of care |

→ interestingly, explicit end-of-life preparation not mentioned (US setting)

Who should deliver Palliative Care Interventions?

Role of Medical Oncologist

- Objectives**
- To be able to screen for, assess, prevent and manage symptoms of patients with cancer such as pain, fatigue, anorexia, anxiety, depression, breathlessness and nausea
 - To communicate effectively with patients and families about illness understanding and coping with it, prognosis, difficult decisions, end-of-life and its preparation
 - To recognise the role of cancer rehabilitation, including physical therapy and nutrition
 - To recognise the importance of culturally competent, multidisciplinary care including families
 - To understand how to integrate palliative interventions in routine multidisciplinary cancer care
 - To recognise the difference between burnout, compassion fatigue and depression
- Awareness**
- Appreciation of the role of palliative care interventions across the trajectory of illness for patients with cancer
 - Recognition of the effects of palliative care interventions integrated into decision-making for anticancer

- Recognition of the role of various professions involved in palliative, supportive and postcurative rehabilitation
 - Appreciation of synergistic competencies of different disciplines in care pathways of patients with cancer
 - Appreciation of the effectiveness of structured and compassionate communication with patients and families
 - Awareness of the impact of culture on cancer management
 - Awareness of the need for self-care by oncology professionals
- Knowledge**
- Familiarity with the role of multiple disciplines in the care of patients with advanced cancer
 - Familiarity with how to screen patients for common symptoms and syndromes in routine practice and how to use scales to evaluate their severity
 - Understanding of the main components of a comprehensive assessment of cancer symptoms and how to make a differential diagnosis
 - Understanding of the pharmacology and toxicity of medications used for the control of main symptoms
 - Familiarity with non-pharmacological interventions for symptom control such as counselling, nursing, physical or music therapy, including their indications, efficacy and side effects
 - Familiarity with an integrated competencies-based management approach to common symptoms in patients with a

A medical oncologist may need to train 3 months in a specialized palliative care unit during the 3 year Curriculum

- depression, breathlessness and nausea), including the use of scales
- Ability to demonstrate understanding of the pharmacology of medications used to treat main symptoms by appropriately prescribing and titrating opioids, adjuvant analgesics and other drugs
- Ability to demonstrate understanding of the toxicities of symptomatic medications by prescribing medications to prevent toxicities
- Ability to assess a patient with complex symptoms using cognitive assessment, symptom assessment scales and modular assessments for main syndromes
- Ability to discuss the role of anticancer therapies for the relief of cancer-related symptoms and to demonstrate how a patient can be prepared for the decisional encounter
- Ability to demonstrate a structured approach to making decisions for managing complications of metastatic/

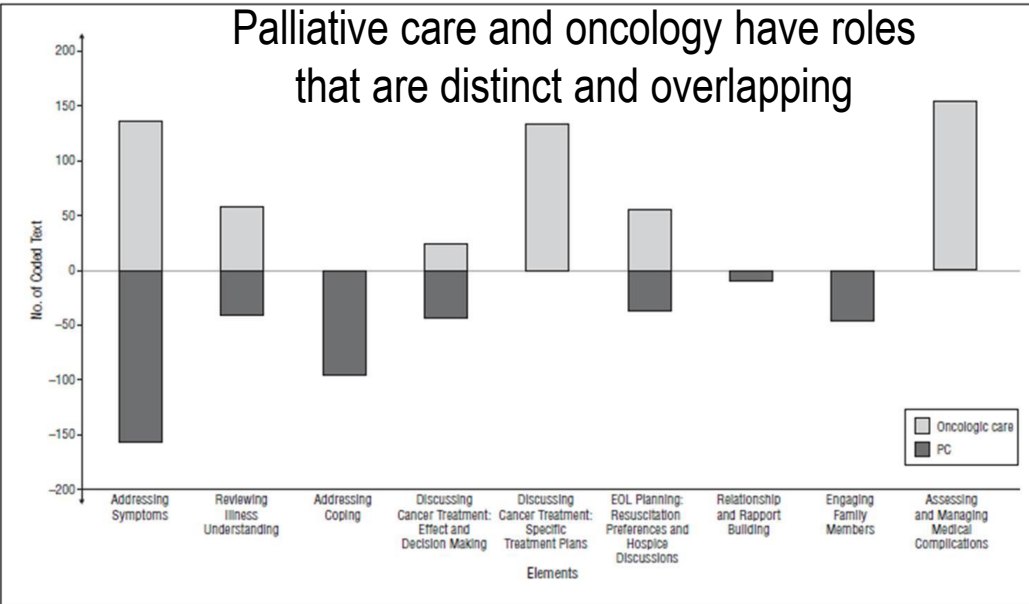
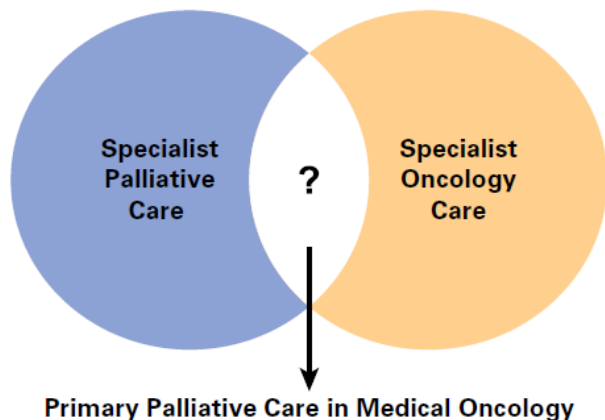


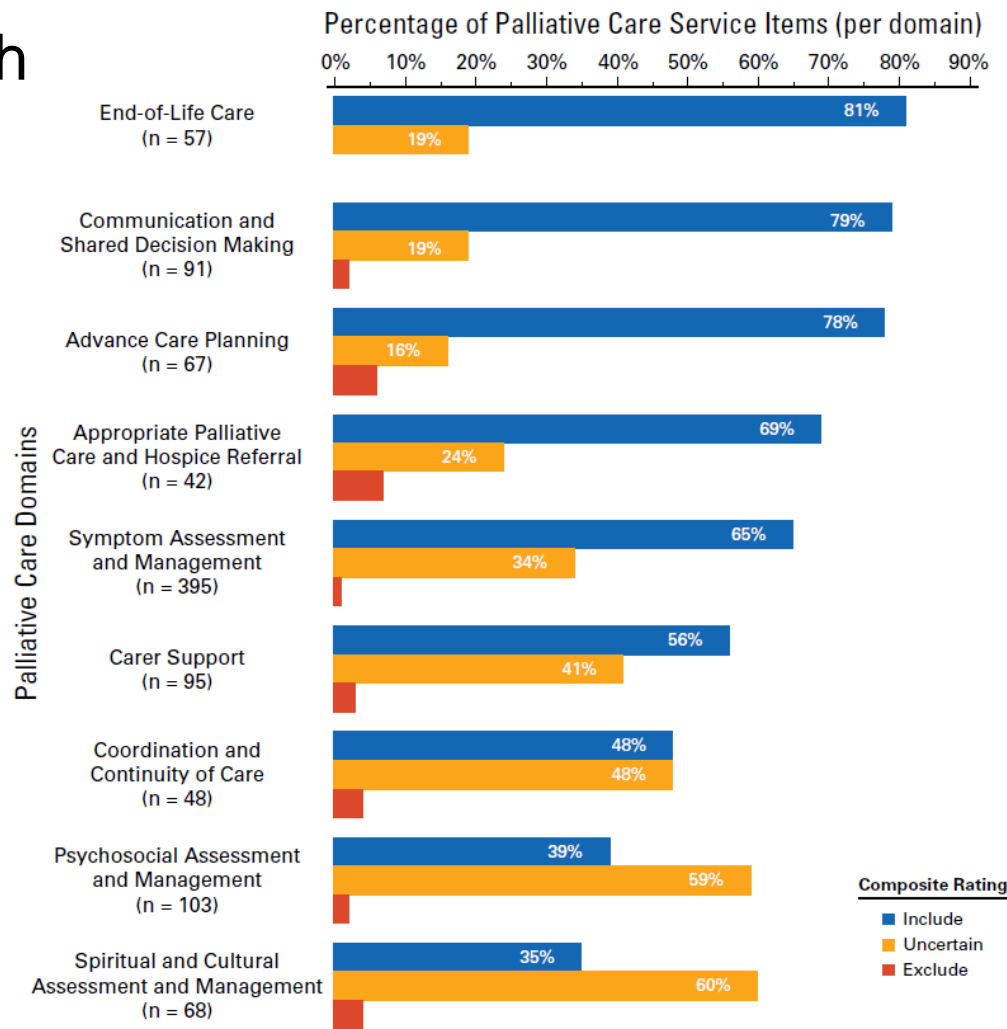
Figure 2. Elements of palliative care (PC) vs oncologic care visits at clinical turning points. EOL indicates end of life.

Oncologists shall deliver which topics of specialized PC?



966 PC service items as candidate elements of primary PC for pts with advanced cancer or high symptom burden. Modified Delphi by 31 experts: importance, feasibility, scope within medical oncology practice.

Bickel KE et al. JOP 2016;12:e828-38



Referral criteria for outpatient Palliative Care **Which Patients? When?** The 11 major criteria

Methods: 60 intl
Cancer PC experts
(26 North America,
19 Australia/ Asia,
11 Europe) rated 39
needs-based & 22
time-based criteria,
3 iterative rounds

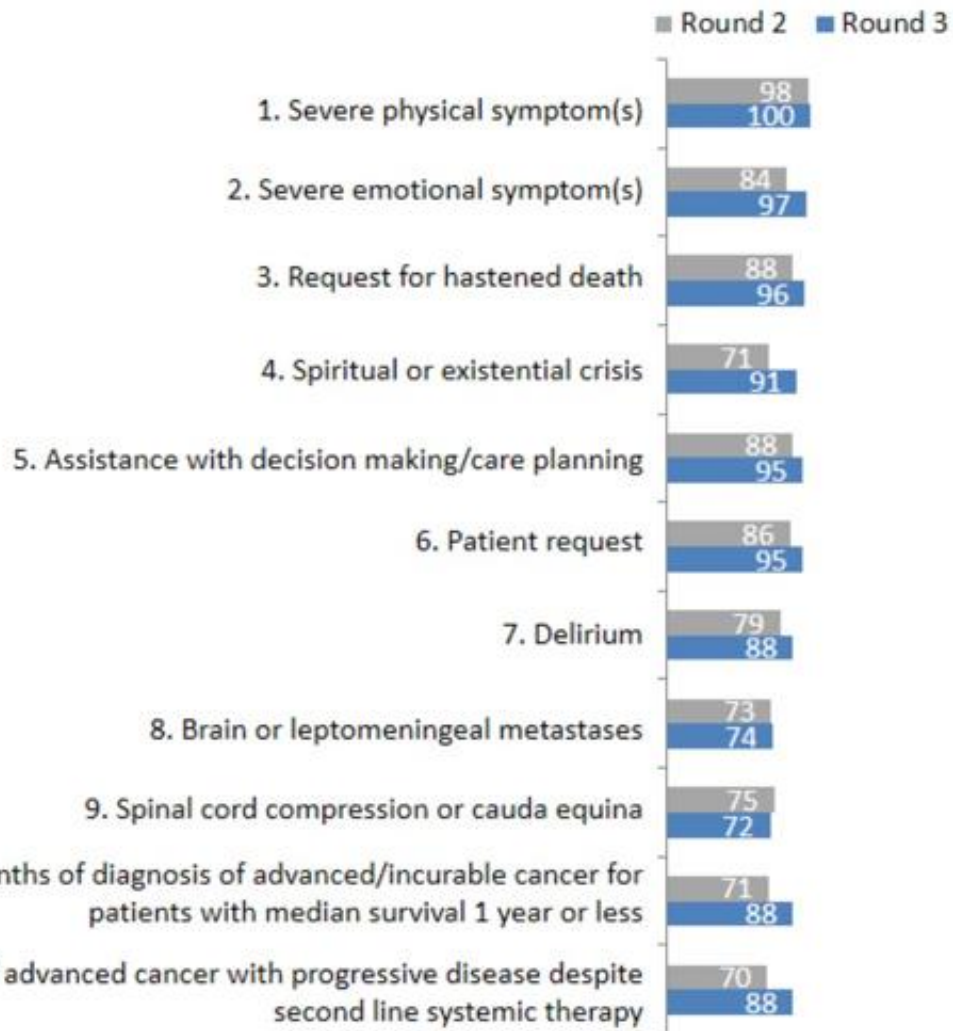
Hui D Lancet Oncol 2016;17:e552-e559

**Severe
distress**

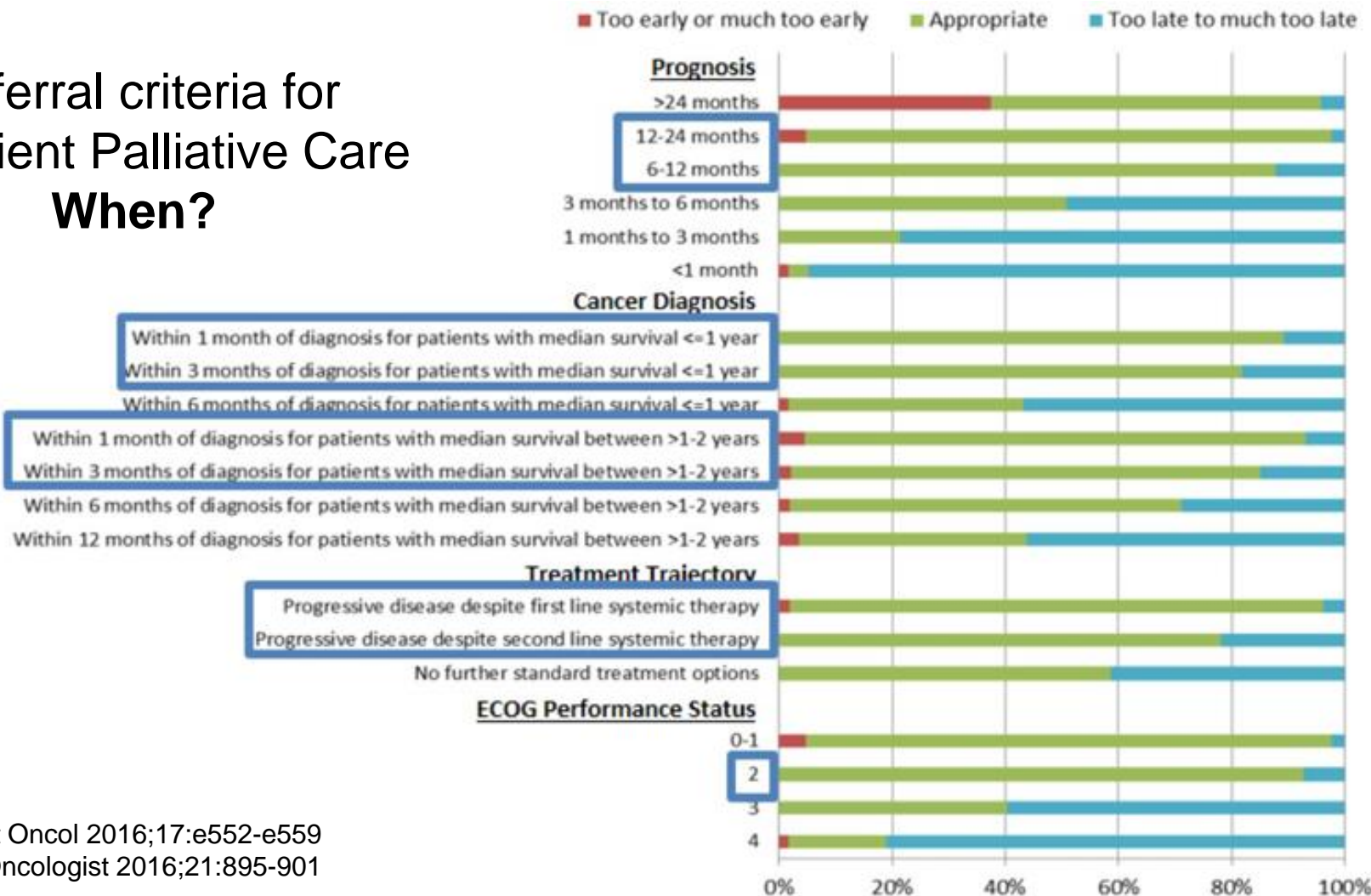
**Additional
support**

**Neurological
complications**

Timing



Referral criteria for outpatient Palliative Care When?



Practice change in my clinic fostering Palliative Care Interventions

- . Implement routine **screening** for main **symptoms** (e.g. ESAS)
- . Deliver and document in flow charts main **Palliative Interventions**
- . **Collaborate** with other health care professionals¹
- . **Rotate** three months in a specialized Palliative Care Service,
OR become a **double boarded** Palliative Oncologist²

1: Lamb BW Ann Surg Oncol 2011;18:2116–25; Taplin SH J Onc Pract
2015;11:239-47; Pannik S *JAMA Intern Med* 2015;175:1288-98

2: Hui D JCO 2015;33:2314-7