Early Palliative Care
for people with advanced cancer

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When should palliative care begin?

What is early palliative care?

- **Palliative care** is an "approach that **improves** the **quality of life** of patients and their families facing the problems associated with **life-threatening illness**, through the **prevention** and **relief** of **suffering** by means of **early identification** and **impeccable assessment** and **treatment** of pain and other problems, **physical, psychosocial** and **spiritual**" (WHO 2013).
- "**early**" when it is administered within eight weeks of diagnosis of advanced cancer (Ferrell 2017).

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August 2010 – a new era?

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer

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ABSTRACT

BACKGROUND

Patients with metastatic non–small-cell lung cancer have a substantial symptom burden and may receive aggressive care at the end of life. We examined the effect of introducing palliative care early after diagnosis on patient-reported outcomes and end-of-life care among ambulatory patients with newly diagnosed disease.

METHODS

We randomly assigned patients with newly diagnosed metastatic non–small-cell lung cancer to receive either early palliative care integrated with standard oncologic care or standard oncologic care alone. Quality of life and mood were assessed at baseline and at 12 weeks with the use of the Functional Assessment of Cancer Therapy–Lung (FACT-L) scale and the Hospital Anxiety and Depression Scale, respectively. The primary outcome was the change in the quality of life at 12 weeks. Data on end-of-life care were collected from electronic medical records.

From Massachusetts General Hospital, Boston (J.S.T., J.A.G., A.M., E.R.G., V.A.J., C.M.D., J.J., W.F.P., J.A.B.); the State University of New York, Buffalo (S.A.); Adult Palliative Medicine, Department of Anesthesiology, Columbia University Medical Center, New York (C.D.B.); and Yale University, New Haven, CT (T.J.L.). Address reprint requests to Dr. Temel at Massachusetts General Hospital, 55 Fruit St., Yawkey 7B, Boston, MA 02114, or at jtemel@partners.org.

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The evidence for early palliative care

- Temel et al 2010

Population	• 151 people with advanced lung ca • New diagnosis (within 8 weeks), incurable disease, ECOG 0-2
Intervention	• See pall care Dr/nurse ≥1 a month until death • Psychosocial support, symptom control, goals of care, decision-making, coordination
Comparator	• Usual care • Includes palliative care on request

Outcome: Improved quality of life, longer survival, lower depression, better symptom control, less chemotherapy last 2 weeks, better documentation of resus status

The evidence for early palliative care

Temel et al 2010

Survival benefit for people randomised to early palliative care

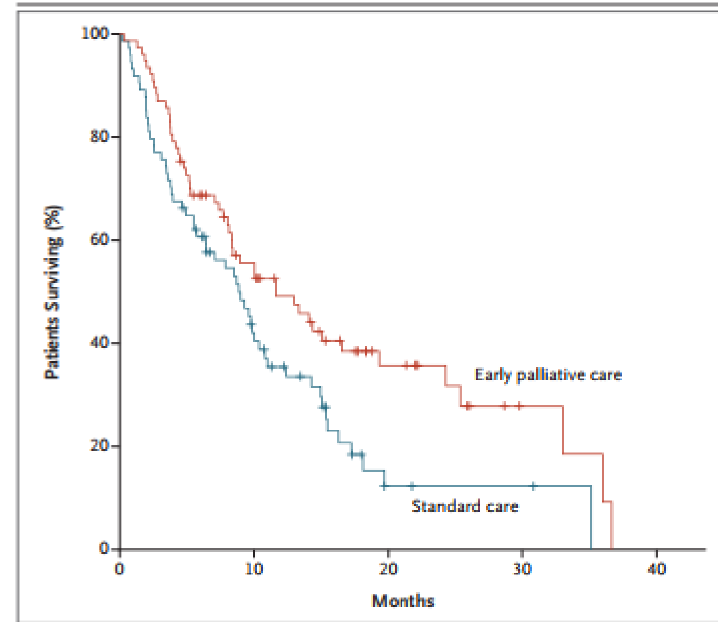

Figure 3. Kaplan–Meier Estimates of Survival According to Study Group.
Survival was calculated from the time of enrollment to the time of death, if it occurred during the study period, or to the time of censoring of data on December 1, 2009. Median estimates of survival were as follows: 9.8 months (95% confidence interval [CI], 7.9 to 11.7) in the entire sample (151 patients), 11.6 months (95% CI, 6.4 to 16.9) in the group assigned to early palliative care (77 patients), and 8.9 months (95% CI, 6.3 to 11.4) in the standard care group (74 patients) ($P=0.02$ with the use of the log-rank test). After adjustment for age, sex, and baseline Eastern Cooperative Oncology Group performance status, the group assignment remained a significant predictor of survival (hazard ratio for death in the standard care group, 1.70; 95% CI, 1.14 to 2.54; $P=0.01$). Tick marks indicate censoring of data.

The evidence for early palliative care

- Maltoni et al 2016

Population	• 186 people with advanced/metastatic pancreatic cancer • New diagnosis (< 8 weeks), ECOG 0-2, prognosis >2months, candidate for chemo
Intervention	• Systematic symptom assessment with SPC • See pall care Dr/nurse every 2-4 wks until death • Interventions and other referrals as appropriate
Comparator	• Usual oncological care • Includes palliative care on request

Outcome: improved quality of life and symptoms; less chemo; no significant difference in survival or depression.

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Early palliative care – in practice

- Discussion of two scenarios

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The evidence for early palliative care

- Tattersall et al 2014

Population	• 120 people with incurable metastatic cancer (or relapsed after previous treatment) • New diagnosis, Prognosis <12 months
Intervention	• See pall care nurse consultant in outpatients • Explain palliative care services, advice re symptom control • Offer: review by pall care Dr, monthly phone call
Comparator	• Usual care • Includes palliative care on request

Outcome: no significant difference in QOL, **shorter survival** (7m vs 11.7m), higher proportion with **worse pain** and **appetite**, no significant difference in chemo use

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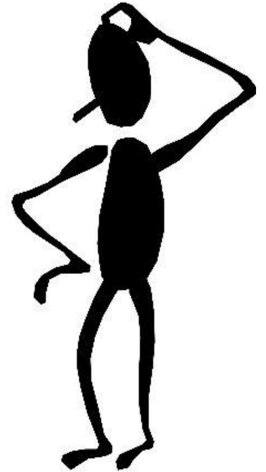
The evidence for early palliative care

- Haun MW, Estel S, Rücker G, Friederich H, Villalobos M, Thomas M, Hartmann M
- **Cochrane systematic review June 2017**
- 16999 abstracts considered
- 7 studies included
  - 5 prospective RCTs
  - 2 cluster RCTs
- "**Small improvements** in **quality of life** and **symptom intensity**. Effects on **survival** and/or on **depressive** symptoms remain **uncertain**..."
  - Small effect size, low certainty



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The evidence for early palliative care

	Quality of life	Survival	Depression	Symptom intensity	Caregiver burden	Health care use	Place of death
Bakitas 2009							
Bakitas 2015							
Maltoni 2016							
Tattersall 2014							
Temel 2010							
McCorkle 2015							
Zimmerman 2014							

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The evidence for early palliative care

- Bakitas 2009

Population	• 322 people with adv ca (GI/lung/genito-u/ breast) • New diagnosis (<8-12 wks), prognosis <12 months
Intervention	• Education - nurse, phone calls; manual • If distress >3/10 encouraged to ring onc/pall care
Comparator	• Usual oncological care • Includes palliative care on request

Outcome: improved quality of life, longer survival (14m vs 8.5m median), **lower depression** and other **symptoms**

No significant difference in caregiver burden, health care use

The evidence for early palliative care

- Bakitas 2015

Population	• 207 people with advanced/relapsed cancer – breast, lung, brain, GI, genito-u, haematological • New diagnosis/recurrence/progression (<60 d) Prognosis <2 years
Intervention	• Telehealth concurrent palliative care • Weekly phone coaching sessions (6 wks) with nurse; monthly phone follow up
Comparator	• Usual oncological care • Includes palliative care on request

Outcome: no significant difference in **quality of life**, depression or other symptoms, caregiver burden, admission; **longer survival** (18.3 vs 11.8m),

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The evidence for early palliative care

- McCorkle 2015 - cluster RCT (four clinics)

Population	• 146 adults with late stage/relapsed cancer • New diagnosis (within 100 days)with additional treatment recommended
Intervention	• Std. symptom management, complex care procedures, family education, clarifying illness experience, coordinating care, responding to family (5 clinic visits, 5 phone calls over 10 wks)
Comparator	• Usual care • Includes palliative care on request

Gynae and lung clinic – intervention; H&N and GI clinic – control

Outcome: no significant difference in QOL, depression or symptom intensity

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The evidence for early palliative care

- Zimmerman 2014 - cluster RCT

Population	• 461 people with adv ca (lung/GI/genitou/ breast/gynae) - Stage IV disease or Stage III and with poor prognosis (at discretion of oncologist) • Prognosis 6-24 months, ECOG 0-2
Intervention	• Physical / psychological /social / spiritual needs • Pall care Dr+nurse - routine monthly OP visits • Structured assessment of needs
Comparator	• Usual care • Includes palliative care on request

Outcome: no significant difference in quality of life, symptom intensity, caregiver QOL, chemo use

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The evidence for early palliative care

- …and 10 other studies awaiting classification and 20 other studies ongoing

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The evidence for early palliative care

- Temel 2017

Population	• 350 people with lung /upper GI ca • New diagnosis, incurable
Intervention	• Palliative care clinician at least once a month until death
Comparator	• Usual care • Includes palliative care on request

Outcome: improvement in QOL , lower depression at week 24.

Twice as likely to **discuss their wishes** with their oncologist if they were dying

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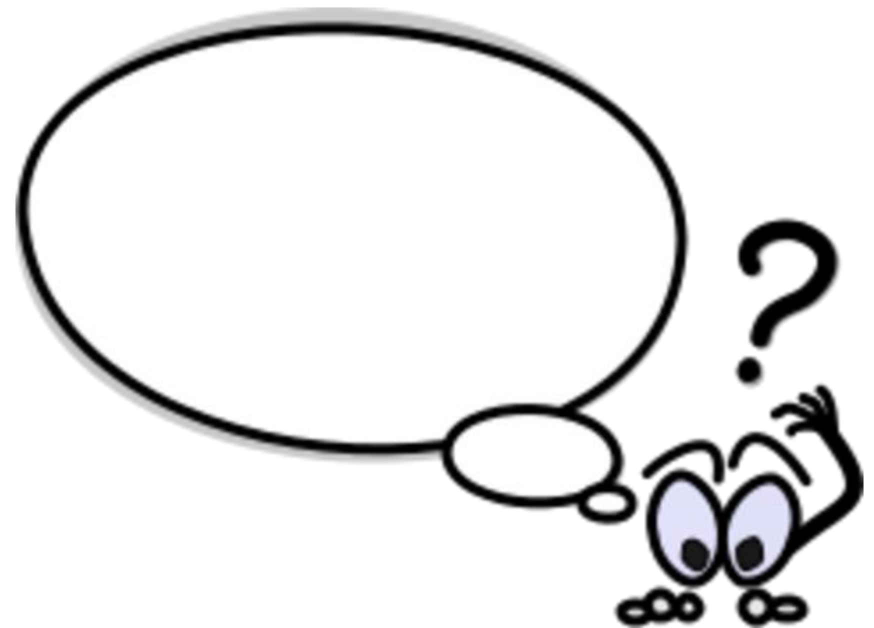
So where does this leave us?

- Benefits of early palliative care for some patient groups
- if done properly… *BUT*
- Potential for harm if done inadequately?

- Lots of ongoing studies



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Implementing early palliative care

- Recommended by ASCO 2016

  American Society of Clinical Oncology:
- **“Inpatients and outpatients with advanced cancer should receive dedicated palliative care services early in the disease course, concurrent with active treatment”**

- Ferrell, Temel, Temin et al. J Clin Oncol 2017, 35(1) 96-113.

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Implementing early palliative care (UK)

- Enhanced Supportive Care
- Several UK units have implemented
- Models vary widely e.g.
  - Rebranding of palliative care
  - Bridge between oncology and SPC
  - All patients or those with specific needs?

What’s in a name?

Palliative Care….

…Enhanced Supportive Care

Which do you prefer?

Which is easier to understand?

“Does it matter what you call it?”

- R. Maciasz et al 2013 Supportive Care in Cancer.
- A randomized trial of language used to describe palliative care services.
- 2x2 randomized factorial telephone survey
- 169 people with advanced cancer
- “supportive care” or “palliative care”
- Person-centred vs traditional model
- Rated 0-10 on Likert-like scale

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"Does it matter what you call it?"

- **Supportive care**:
- Better understanding (7.7 vs 6.8)
- More favourable impression (8.4 vs 7.3)
- Higher future perceived need (8.6. vs 7.7)
- $p<0.05$ for each finding

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In summary…

- Everyone who needs it should have access to supportive and palliative care
- Some will benefit from specialist palliative care
- **Done properly, palliative care can**:
  - enhance quality of life and symptom control
  - may improve survival in some patient groups
  - improve understanding of prognosis
  - reduce use of chemo in last two weeks of life
- An emerging field…

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Thank you

- Any questions?

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