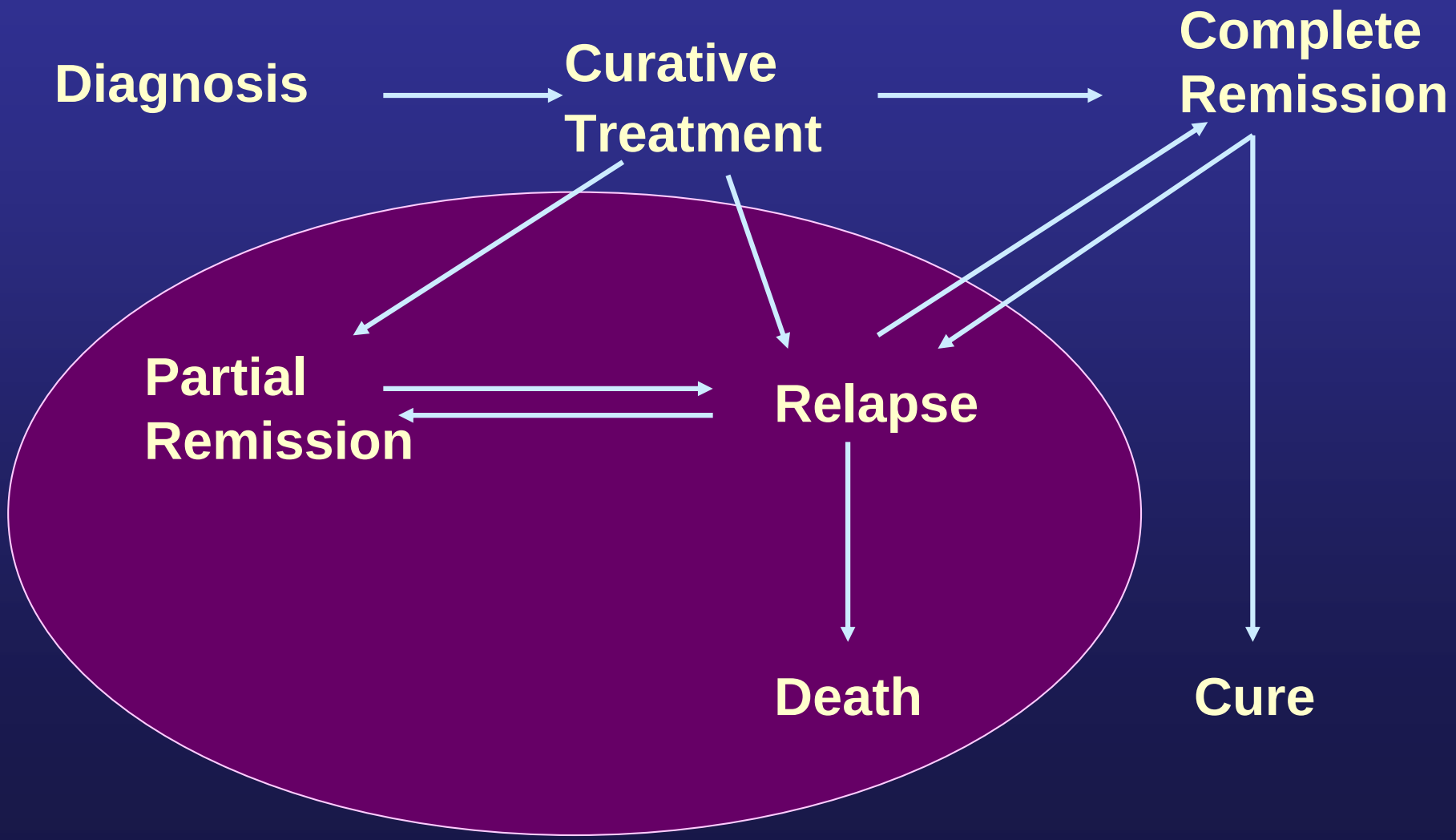
The Interface of Oncology and Palliative Care in Research

Nathan I Cherny
Director, Cancer Pain and Palliative Care Service
Dept of Cancer Medicine
Shaare Zedek Medical Center

The Cancer Experience



Palliative Care issues in Oncology

- Communication
- Goal setting
- Palliative anti tumor therapies
- Common physical complications of advanced cancer
- Complications of cancer treatments
- Coping
- Terminating active therapies
- Transfer to palliative care
- Interdisciplinary care issues

Common Vs Distinct Issues

- Communication
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Palliative Anti Tumor Therapies

Palliative anti tumor therapies

- Chemotherapy, RT and targeted therapies can palliate.
- The issues are:
  - Patient selection
    - Are there factors that make the likelihood of benefit so small as to render the trial of therapy as futile
  - What is clinically significant benefit?
  - When does the evidence suggest that harm outweighs potential benefit?
  - Is there psychological value in a trial of therapy?

Non Small Cell Lung Cancer

- 4 meta analyses have demonstrated superiority palliative of Chemo over BSC alone.
- Age alone not predictive

Impact ECOG Performance Status

0 or 1	best candidates for chemotherapy and can achieve both prolongation of survival and improvement in quality of life.
2	improve symptoms, no overall survival benefit.
3 or 4	do not benefit from chemotherapy.

How much, how long?

- **230 patients with advanced NSCLC.**
- **Randomised**
  - carbo/Pac 4x => Paclitaxel at progression
  - carbo/Pac until radiographical progression.
- **Results**
  - **ORR, median and 1-year survival rates were similar**
  - **>4 cycles ➔ much more toxicity**

Socinski MA, Schell MJ, Peterman A, et al. Phase III trial comparing a defined duration of therapy versus continuous therapy followed by second-line therapy in advanced-stage IIIB/IV non-small-cell lung cancer. J Clin Oncol 2002;20:1335.

How much, how long?

- Initial trial 2 cycles
- Patients with clear response or stable disease
  ➔ 2 additional cycles
- Then
  - follow patients carefully and allow a treatment break
  - Restart 2nd line treatment at progression if PS allows

Controversies in Palliative Chemotherapy

- Many! Many unanswered questions!
- Ovarian cancer
  - Role of >3 sequential trials of chemotherapy
- Beast Cancer
  - Relative role of sequential single agent therapies vs more toxic combinations
- Soft tissue Sarcoma
  - Treatment=>modest survival advantage BUT very toxic

Diseases with dramatic changes in palliation and survival

- Metastatic Ca Colon
  - 5FU 9mth
  - FOLFIRI/FOLFOX 15-20 mth
  - FOLFIRI/FOLFOX+ targetted therapy 20-24 mth
- GIST
  - Imatininib
- Breast Cancer
  - Median survival increased from 12➔ >20mths

Palliative RT

- Benefit well established for brain and bone metastases.

- Research issues
  - Duration/dose of therapy
  - Single fraction therapies for bone metastases
  - Palliation in other settings
    - Bleeding control
    - Dysphagia
    - Dyspnea control
    - Nerve compression other than spinal cord compression

Other Palliative Interventions

Palliative and Supportive Approaches to Relieve or Prevent the Adverse Effects of Therapy

- Issues of recent Research
  - Treatment related diarrhea
  - Anti emesis
  - Anti emetic-induced constipation
  - Treatment related fatigue
  - Treatment related cognitive dysfunction
  - Cardioprotection (anthracyclines, herceptin)
  - Nephroprotection (platinum)

Other common palliative interventions

- Impending fractures
  - Patient selection
  - Relative role with RT
- Biliary obstruction
  - Drainage: extent of benefit
  - Patient selection issues
- Pleuradesis
  - Technique
  - Patient selection
  - Alternative approaches
- Ureteric obstruction
  - Stents vs nephrostomy
  - Patient selection
  - benefit
- SVC compression
  - RT vs Stent
  - Patient selection issues
- Esophageal Obstruction
  - Laster vs stent vs photoRX
  - Patient selection

Communication

Communication

- Vigorously addressed by both oncology and PC researchers
- Issues
  - Disclosure
  - Prognostication
  - Decision making
  - Candor
  - Working with Children
  - Impaired adults

Specific Communication Issues

Oncologists

- Aims of ChemoRx/RT
- Benefits of Rx
- Cost of ChemoRx
- Futility
- Endpoints
- Stopping chemotherapy
- Introduction of PC
- Transfer to PC

Palliative Care

- Aims of PC
- Integration with Oncology
- Refractory symptoms
- Hope
- Limits of care
- Desire for death
- Exploring spirituality

Examples of Communication Research

Advanced breast cancer patients' perceptions of decision making for palliative chemotherapy.

J Clin Oncol 2006;24(7):1090-8.

The content and amount of information given by medical oncologists when telling patients with advanced cancer what their treatment options are. palliative chemotherapy and watchful-waiting.

Eur J Cancer 2004;40(2):225-35.

Patient participation in medical consultations: why some patients are more involved than others.

Med Care 2005;43(10):960-9.

Perspectives of elderly veterans regarding communication with medical providers about end-of-life care.

J Palliat Med 2005;8(3):534-44.

Israeli Survey: Communication issues in Advanced and Incurable Cancer

When it is clear that chemotherapy is not working and that the likelihood of benefit of further therapies is small, do you….

	Occasionally	Often
Tell the pt that the chemo is not working and suggest PC only	27	71
Explain and offer a range of options including PC, chemoRx and experimental Rx	33	65
Explain the situation and ask how the Pt and his family are coping and what their major concerns are.	38	57
Suggest consideration of an experimental treatment (if one is available)	64	33
Say that here is nothing more that you can do and suggest a PC referral	71	17
Avoid a confrontation that may undermine hope and suggest another course of chemotherapy	55	9

- A 45year old man is referred with metastatic Ca Pancreas with multiple liver metastases. He presents with his young wife to discuss treatment options. In discussing treatment options would you..

	Maybe	Yes
Explain that chemotherapy may make him feel better	17	83
Ensure that the Pt+wife understood the nature and extent of the disease	21	77
Explain that the major aim of Rx is palliation and that this can be achieved =/- chemoRx	46	46
Ensure that the patient not give up and tell him that you will help him get well	36	33
Explain that his life expectancy is unlikely to be different with or without chemotherapy	55	18

No Consensus

	Agree+	Disagree+
It is important to convey hope for recovery, irrespective of the situation	61	24
Most family concerns about disclosure of information to the patient are exaggerated	47	20
The more patients know about a bad prognosis, the worse they cope	22	44
Patients who know too much about their disease are difficult to work with.	22	65
When the outlook is poor, family members should be asked if the patient should be told	25	65

The Interface between PC and Oncology

Attitudes of medical oncologists toward palliative care for patients with advanced and incurable cancer.

Cherny NI, Catane R.

Cancer 2003;98(11):2502-10.

AIMS

- **to evaluate**
  - the degree to which ESMO oncologists are involved in the management of advanced cancer
  - the degree with which they collaborate with PC clinicians
  - their personal involvement in PC
  - their attitudes to PC

Survey tool

- Demographics
  - age
  - sex
  - experience
  - place of work
  - involvement in advanced cancer

Survey tool 2

- Collaboration with PC
  - 7 items
- Practice of PC
  - 16 items
- Attitudes
  - 24 items
- 895 respondents

Demographics 1

- N=895
- European 82.4%
- Sex: F 194 (21.7%) M 701 (78.3%)
- Median age: 45-49
- Median experience: 15-19 years

Proportion of my practice involved with advanced (incurable) cancer

None	4	0.4%
A small proportion	78	8.7%
A substantial proportion	615	68.8%
Most of my practice	197	22.0%

PC Collaboration

	often
A social worker	47.9
A home hospice (palliative care) team	37.8
A palliative care medical specialist	35.1
A psychologist	33.3
A palliative care nurse specialist	31.7
An inpatient hospice	26.4
A psychiatrist	14.9

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Attitudes: >75% agree

	Agree + Strongly agree
All adv.ca patients should receive concurrent PC even if receiving anti tumor treatment	92.0
I derive satisfaction from managing the physical symptoms of my patients.	89.3
All cancer centers should have a PC service.	89.1
MOs should coordinate the care of cancer patients at all stages of disease including end of life care.	88.4
MOs should be expert in the management of the physical and psychological symptoms of advanced cancer.	88.1
I am usually successful in managing my patient's pain	86.9
I read journals and papers related to the palliative care of advanced cancer	83.6
I own a textbook of palliative care	76.0

Attitudes: >66% disagree

	Disagree + Strongly Disagree
Palliative care begins where medical oncology ends.	84.3
Dying patients do not belong in the oncology ward	73.5
I deal with palliation in the non-dying patients (“symptoms management”), but not with the palliation of the dying patient (“end of life care”)	70.4
Managing patients with advanced cancer and dying patients depresses me.	68.2
Palliative care specialists “steal” patients who would otherwise benefit form medical oncology	68.0
I would rather have someone else look after my dying patients.	66.0

Attitudes: No Consensus

	Agree +	Disagree +
I received good training in PC during my oncology fellowship (residency)	52.8	42.0
I feel emotionally burned out by having to deal with too many deaths.	33.8	55.6
Most MOs I know are expert in the management of the physical and psychological symptoms of advanced cancer.	37.5	41.8
A palliative care specialist is the best person to coordinate the palliative care of patients with advanced cancer.	36.3	39.4
Palliative care (or Hospice) physicians don't have enough understanding of oncology to counsel patients with advanced cancer regarding their treatment options.	35.2	39.2

Conclusions

- There is manifest and enormous overlap in
  - the clinical responsibilities
  - goals care
  - research issues

Better research cooperation

=> Better care

=> Better clinical cooperation

=> Better mutual understanding