

Treatment of Late Stage Cancers — the Palliative Care Approach

Dominic F Glorioso Jr DO FACOI
Palliative Care Consultant
VNA Hospice Medical Director

Financial Disclosure:

Dominic F Glorioso Jr DO FACOI



None



Treatment of Late Stage Cancers the Palliative Care Approach

- Discuss the problems with the current treatment paradigm
- Look into some specific problems with lung and pancreatic cancer
- Illustrate what Palliative Care has to offer
- Explore ways that Oncology and Palliative Care can work together

“Can I win this game?”





Disease-Centered Approach

- Primary goal is to cure.
- The disease is the focal point.
- Symptoms are treated as clues to diagnosis.
- Primary value is placed on measurable data
- Therapy is medically indicated if it eradicates or slows the progression of disease.
- The patient is viewed as a collection of parts, with little need to know the whole person.



Chemotherapy for metastatic solid tumors

- Palliative chemotherapy is increasingly given near death.
- More than 20% of patients receiving Medicare who had metastatic cancer started a new chemotherapy treatment regimen in the 2 weeks before death
- In 2008, a medical director of a large insurance company reported that 16% of its cancer patients receive chemotherapy within 14 days of death

JAMA. 2008;299(22):2667-2678



Chemotherapy for metastatic solid tumors

- Patients are unlikely to benefit from chemotherapy when they have already been failed by the standard regimens, have poor performance status, and otherwise have a poor prognosis
- Survival was significantly longer for hospice patients with lung cancer and pancreatic cancer, marginally longer for colon cancer, but no different with breast or prostate cancer



Chemotherapy for metastatic solid tumors

- Improve disease-free or over-all survival
- Relieve symptoms
- Improve quality of life
- Rarely if ever cure



Death and Dying in America

- Substantial shortcomings in care of seriously ill hospitalized adults
- Clinicians lack knowledge and skill in effective pain and symptom management
- Communication barriers
- Frequent use of aggressive curative treatments in advanced disease



The SUPPORT Study

- \$28 million study, 5 Medical Centers, 10 years
- 4301 patients observed to determine terminally-ill patients base-line experiences during the dying process
- Less than 50% of physicians knew whether their patients wanted CPR or not
- 50% of patients who died in the hospital, the family reported that the patient had moderate to severe pain at least half of their stay

Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments



Death and Dying in America

Disparity between the way people die / the way they want to die

- Most prefer to be cared for at home
- Majority interested in a program such as hospice

Cancer doctors dodge the death talk

- Most cancer doctors do not discuss end-of-life care, a new study shows
- Those who had end-of-life talks are less likely to be on breathing machines
- About 7 percent of all patients in the study developed depression
- Sometimes doctors have trouble accepting that the end is near, one doctor says



What Do Patients with Serious Illnesses Want?

- Avoid a premature death
- Pain and symptom control
- Avoid inappropriate prolongation of the dying process
- Achieve a sense of understanding and control
- Relieve burdens on family
- Strengthen relationships with loved ones

Singer et al. *JAMA* 1999;281(2):163-168.

**Why is it a struggle for
patients to get what
they want?**





What do patients know about their disease?

- Oncologists only have discussions of prognosis 39% of the time.
- Oncologists only have a discussion about impending death 37% of the time. (Wright A, et al. JAMA 2008)
- Pts overestimate their chance of cure; those who are over-optimistic do NOT live longer but die worse.
- 1/3 of Patients confuse palliative with curative.
- Oncologists overestimate prognosis 30-40% to 5:1.



Why is that?

- Pts do not want to discuss advance directives with their oncologist...rather discuss with new admitting doctor.
- We change our “shared decision making status” in between chemotherapies, as goals change.
- We get burnt out on discussions. (Frank, Arthur. *At the Will of the Body*. 2002)
- It is easier on doctors to conceal the truth.

The dying patient perspective is different, Matsuyama R, Reddy S, Smith T. JCO 2006



Are all Oncologists the same?

(Oncologists) who embraced a broader perspective on the physician role, encompassing both biomedical as well as psychosocial aspects of care, tended to describe a clearer method of communication about EOL care, and reported a sense of empowerment to positively influence patient and family coping with and acceptance of the dying process.

A Qualitative Study of Oncologists' Approaches to End-of-Life Care
JOURNAL OF PALLIATIVE MEDICINE Volume 11, Number 6, 2008



Are all Oncologists the same?

In contrast, participants who described primarily a biomedical role reported a more distant relationship with the patient and family, a sense of failure at not being able to alter the course of the disease, an absence of collegial support, and they did not describe a clear method of communication.

A Qualitative Study of Oncologists' Approaches to End-of-Life Care
JOURNAL OF PALLIATIVE MEDICINE Volume 11, Number 6, 2008



What Is Palliative Care?

It may be combined with therapies aimed at reducing or curing the illness, or it may be the total focus of care. Care is delivered through the collaboration efforts of an interdisciplinary team including the individual, family and others involved in the provision of care. Where possible, the palliative care should be available in the setting of personal choice.”

Balfour Mount MD, McGill University, Director of the Royal Victorian Hospital, Palliative Care Center

What Is Palliative Care?

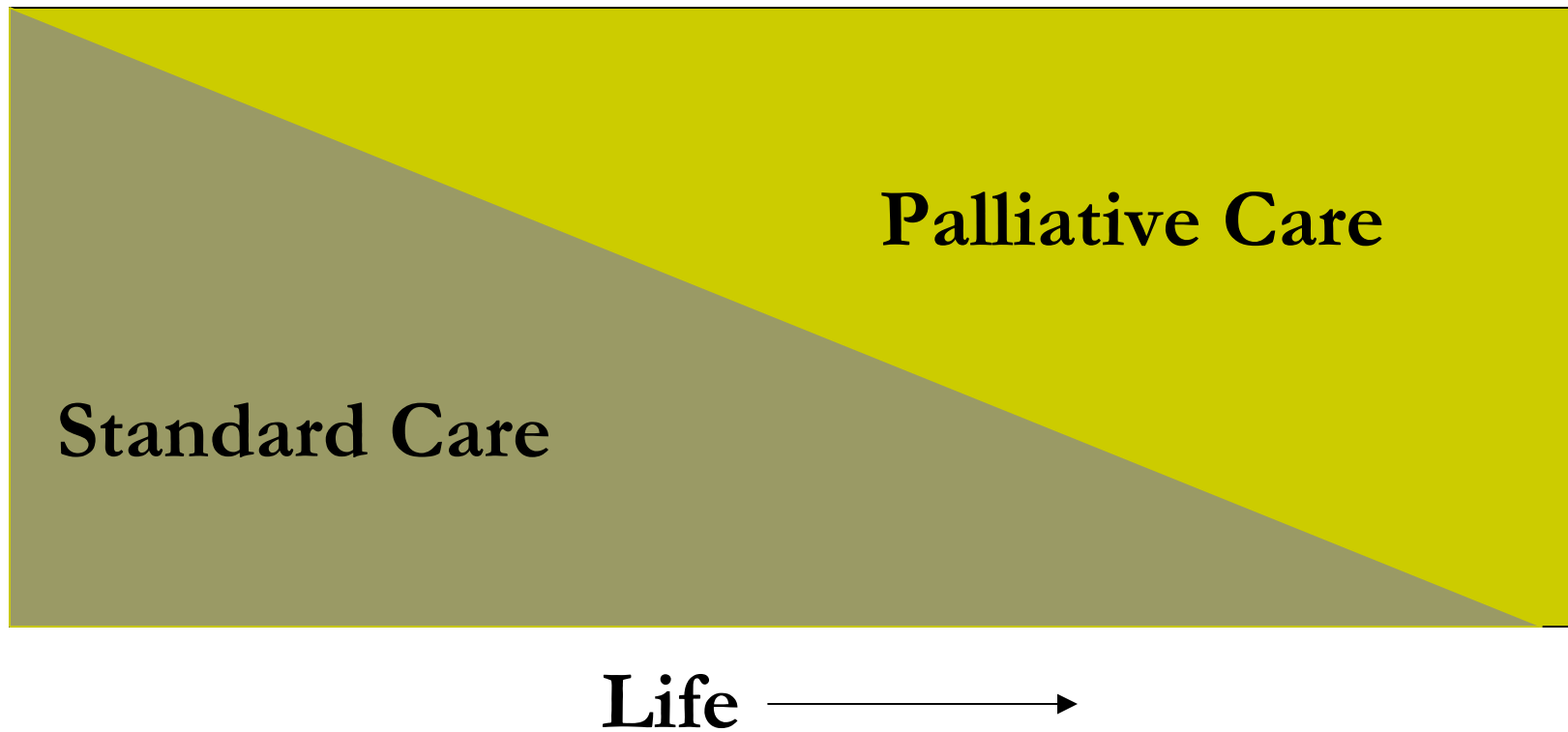
Traditional View



Life →

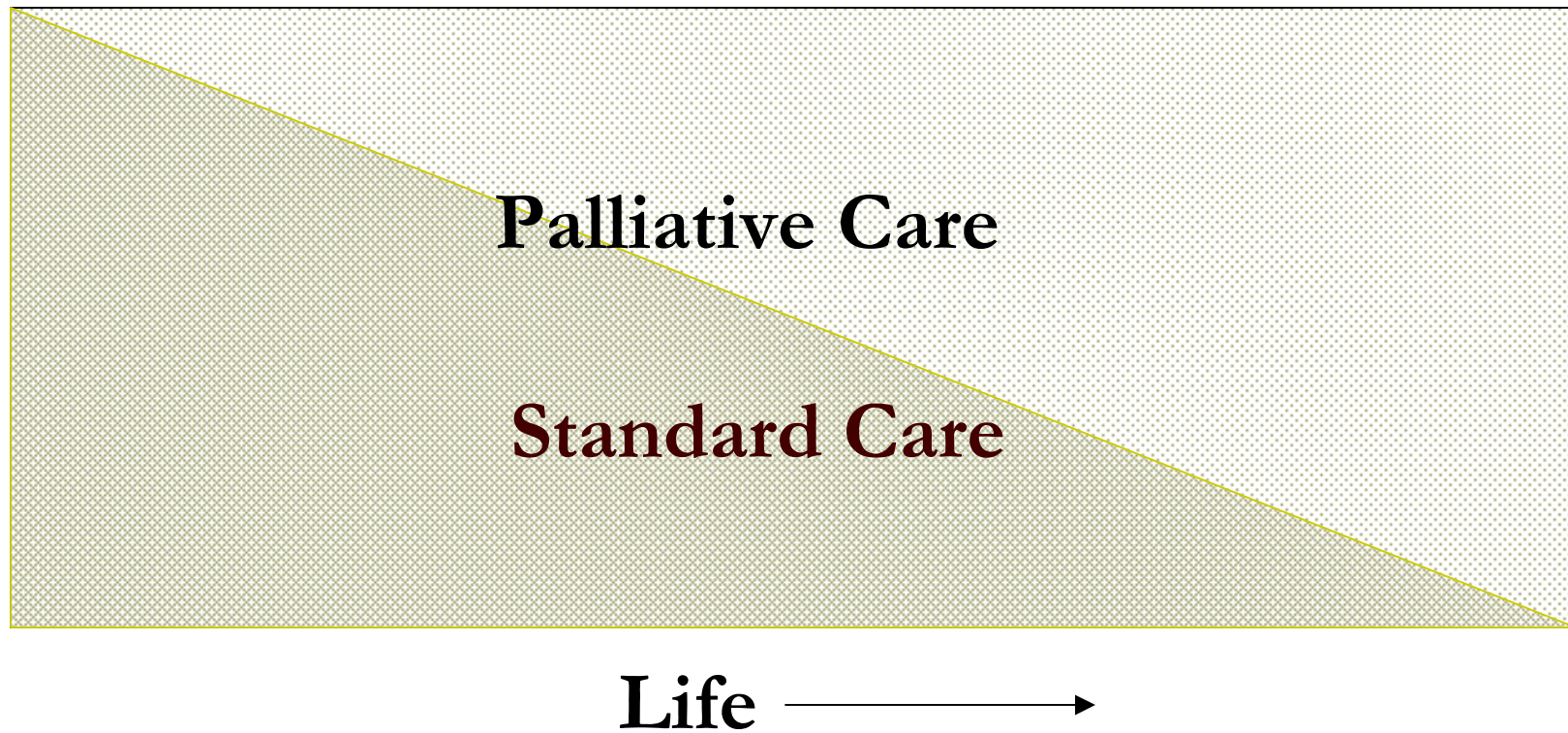
What Is Palliative Care?

Better View



What Is Palliative Care?

Ideal View





Palliative Care Goals

- Improve pain and symptom control
- Prognosticate and communicate
- Advance care directives and code status
- Appropriate hospice referral



Lung Cancer:

In the United States in 2007:

- Estimated 215,000 new cases of lung cancer
- Estimated 162,000 deaths from lung cancer
- Colorectal, breast, and prostate cancers combined to only 124,000 deaths.
- At the turn of the 20th century, lung cancer was a rare disease.



Lung Cancer Distribution:

Non-Small Cell lung cancer (80%)

- Adenocarcinoma – 38%
- Squamous Cell Carcinoma – 20%
- Large Cell Carcinoma – 5%
- Other NSCLC, not further classified – 18%

Small Cell Carcinoma (13%)

Metastatic or odd types (6%)



Staging Lung Cancer:

Stage IA

Tumor < 3cm

- Treatment: surgical resection
- 5-year survival: 61%

Stage IB

Tumor more extensive; no lymph involvement.

- Treatment: surgical resection
- 5-year survival: 38%



Staging Lung Cancer:

Stage IIA and IIB

Stage II tumor with positive peribronchial and/or hilar lymph nodes, notably NOT mediastinal nodes.

- Treatment: surgical resection and adjuvant chemotherapy (5-10% survival advantage). Chemo is usually a platinum doublet.
- 5 year survival IIA: 34%
- 5 year survival IIB: 24%



Staging Lung Cancer:

Stage IIIA

- Lymph nodes in mediastinum ipsilateral to the primary tumor.
- Treatment: Combined chemo-radiation.
- 5-year survival: 13%

Stage IIIB

- Lymph nodes on both sides of the mediastinum
- Treatment: Combined chemo-radiation.
- 5-year survival: 5%



Staging Lung Cancer:

- If mediastinal nodes are confirmed, patients typically receive chemo-radiation: 50-60 Gray and a platinum doublet.
- First drug in USA and Europe: Etoposide.
Second drug: Vinblastine.
- Surgery is playing less of a role.



Staging Lung Cancer:

- The randomized trials of radiation treatment alone did not result in any longterm disease free survivors.
- Other factors that have no added benefit or increased safety profile:
 - Induction chemotherapy
 - Sequential chemotherapy
 - Lower dose chemotherapy with radiation
 - Consolidation chemotherapy



Staging Lung Cancer:

Stage IV Distant Metastatic Disease

- Treatment: Symptom management.
- No appreciable 5-year survival.
- When stages IA-III B recur, it is usually as metastatic disease that was not detectable at the time of diagnosis. For the purpose of treatment, they can be thought of as Stage IV disease.



So What About Chemotherapy?

Erlotinib (Tarciva): Evidence

- Double-blinded, placebo controlled, randomized trial
- Trial included 731 patients with median age of 61.4 years and Stage III B or IV non-small cell lung cancer, ECOG 0-3, with progression after treatment with a platinum doublet as first line or even second line regimen
- Lack of progression was seen in 8.9% in the Erlotinib group compared to 0.9% in the placebo group ($p < .001$) Overall survival in the Erlotinib group was 6.7 months versus 4.7 months in the placebo group



ECOG Performance Status

- 0 Fully active, able to carry on all pre-disease performance without restriction
- 1 Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature
- 2 Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours
- 3 Capable of only limited self care; confined to a bed or chair more than 50% of waking hours
- 4 Completely disabled. Unable to provide self-care. Totally confined to bed or chair.
- 5 Dead



ECOG Performance Status

- Chemotherapy benefits those with ECOG 0, 1, or 2.
- Treatment benefits decline as ECOG increases and performance status (PS) declines.
- Palliative Care can improve PS into the range where chemotherapy is considered or can maintain PS during treatment to allow for optimal benefit.



So What About Chemotherapy???

Cost?

- Erlotinib comes in a 25mg tablet.
- Recommended dose: 6 tabs or 150mg/day.
- The tablets are \$25 each, averaging \$150/day, \$4,500/month, and between \$55,000-\$60,000 annually.
- The above costs do NOT include: physician visits, blood work, radiographs, etc.



So What About Chemotherapy???

Lets look at two identical groups of patients with non-small cell lung cancer, each with 100 individuals.

- $100 \times 4.7 = 470$ months of survival for the placebo group
- $100 \times 6.7 = 670$ months of survival for the Erlotinib group
- We see 200 extra months of survival in the Erlotinib group.

So What About Chemotherapy???

So then the conclusion is patients with stage IV lung cancer will live for 6 months or two months longer with Tarciva, right???





So What About Chemotherapy???

- However, this 200 month survival advantage is not distributed evenly among the 100 patients.
- Only 0.9% or 1 out of 11 respond
- Patients that have an objective response have all of the survival advantage.
- $200 \text{ months} \div (8.9\% - 0.9\%) = 25 \text{ months}$
- Survival rates follow a Bell curve



So what should you tell your patient?

- a. You have less than a 10% chance of having a response.
- b. We should discuss your Advance directives and what goals that you have.
- c. It is likely that you will live an additional 2 months with treatment.
- d. You could live another 2 years.
- e. All of the above



Prognostication

Prognostication has two aspects:

1. Foreseeing - formulating the prediction
2. Foretelling – communicating the prediction



Karnofsky Scale

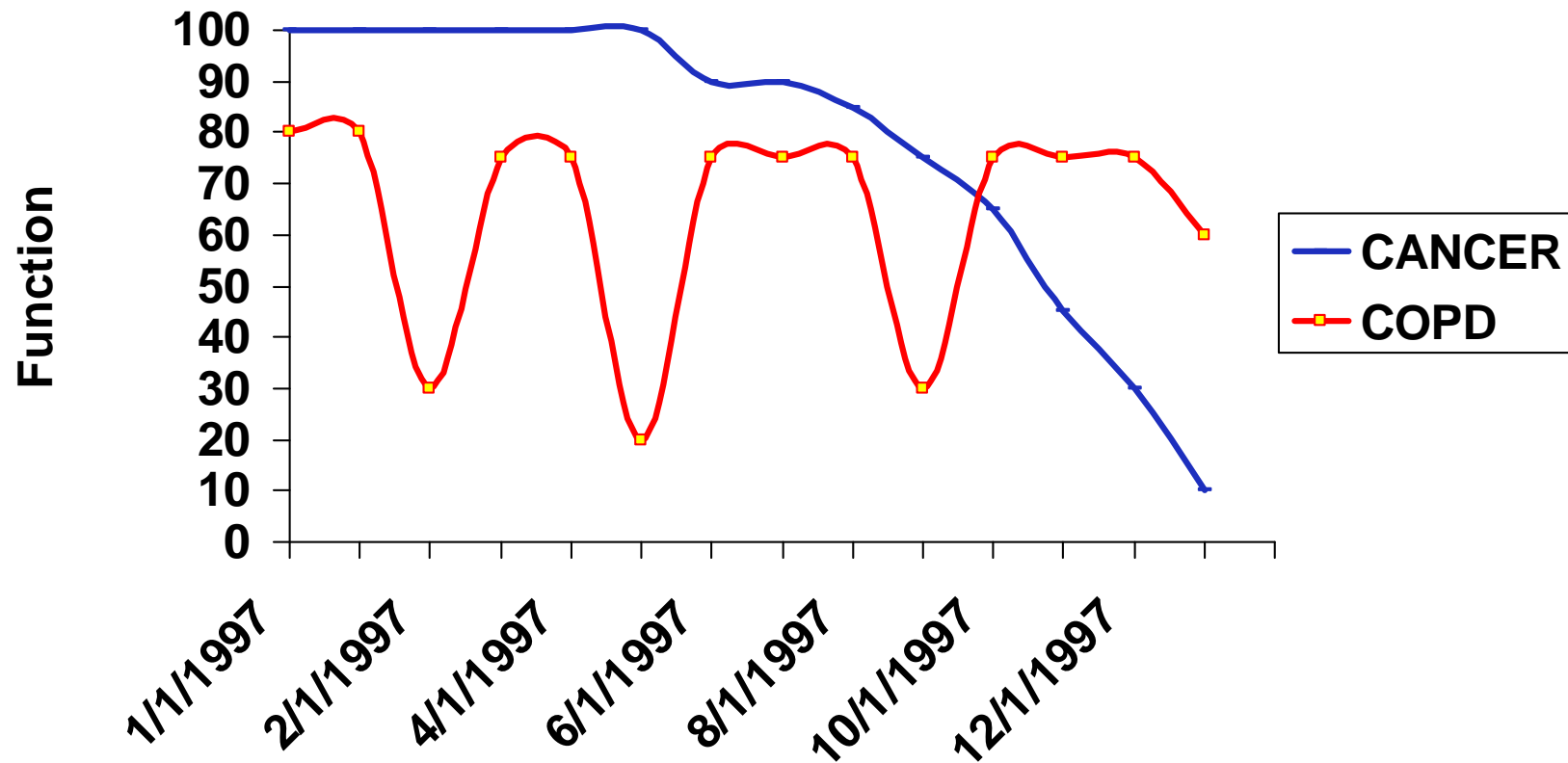
- 100 Able to work. Normal; No complaints; No evidence of disease.
- 90 Able to work. Able to carry on normal activity; Minor symptoms.
- 80 Able to work. Normal activity with effort; Some symptoms.
- 70 Independent; not able to work. Cares for self; Unable to carry on normal activity.
- 60 Disabled; dependent. Requires occasional assistance; cares for most needs.



Karnofsky Scale

- 50 Moderately disabled; dependent. Requires considerable assistance and frequent care.
- 40 Severely disabled; dependent. Requires special care and assistance.
- 30 Severely disabled. Hospitalized, death not imminent.
- 20 Very sick. Active supportive treatment needed.
- 10 Moribund. Fatal processes are rapidly progressing
- 0 Dead

Is Death Predictable?





Foreseeing

How to do it?

- One's own experience (limited bias)
- Consult an expert (not possible)
- Consult a textbook (little information)
- Use an algorithm (complicated)
- Search the medical literature (few systemic reviews)



Foreseeing

Temporal predictions

Survival as a probability



Foretelling

Lamont and Christakis conclude that patients are twice removed from the reality of their prognosis because:

1. Prognosis is not formulated accurately
2. It is communicated over-optimistically



In one study by Dr. Christakis

- The actual median survival period was 26 days.
- Doctors privately believed that patients had 75 days to live ...
- but told the patients and their families they had 90 days to live

Communicating Prognosis

- Most over- estimate prognosis
- Accurate prognosis helps family and patient plan
- Avoid truth dumping
- Best to offer a range or average for life expectancy





Patient–oncologist communication in advanced cancer

- The Oncologist's perception of prognosis
- What the Oncologist tells the Patient about the prognosis
- What the Patient believes after speaking with the Oncologist



Patient–oncologist communication in advanced cancer

- Encounters were coded for communication factors that might influence oncologist–patient concordance, including oncologist statements of optimism and pessimism.
- Oncologists made more statements of optimism (mean=3.3 per encounter) than statements of pessimism (mean=1.2 per encounter).



Patient–oncologist communication in advanced cancer

- When oncologists made at least one statement of pessimism, patients were more likely to agree with their oncologist’s estimated chance of cure
- Statements of optimism and uncertainty were not associated with an increased likelihood that patients would agree or disagree with their oncologists about chance of cure.



Patient–oncologist communication in advanced cancer

Pessimistic Statements

- It looks like the cancer has grown further
- There is no cure for this type of cancer
- The chemo we gave you wasn't of benefit
- We don't have a lot of good chemo options
- What we do have is more likely to make you sick than to help
- Your tumor is at high risk for relapse.”

Support Care Cancer (2008) 16:1049–1057

Patient–oncologist communication in advanced cancer

Optimistic Statements

- Your scans look great
- Your cancer is responding
- Your cancer is in remission
- The chemo will improve





Patient–oncologist communication in advanced cancer

Conclusion:

- Communication of pessimistic information to patients with advanced cancer increases the likelihood that patients will report concordant prognostic estimates
- Communication of optimistic information does not have any direct effect



Patients want to know the truth....

- Of 126 terminally ill patients, 98% said they wanted their oncologists to be realistic. (Hagerty 2005)
- Patients want oncologists to be compassionate, stay the course, and be truthful. (Kirk 2004)
- Impossible to take away hope. Patients will double the odds you give them. Many will take a Phase I drug with 10% chance of death....

You can't handle the truth!

Col. Jessep: You want answers?

Kaffee: I think I'm entitled.

Col. Jessep: You want answers?

Kaffee: I want the truth.

Col. Jessep: ...





Why bother to bring up the “D” word?

People who have a discussion about dying...(and only 37% did)

- No difference in mental health or worry
- Less likely to want heroic measures, undergo ventilation, or be admitted to ICU
- More likely to admit being terminally ill, complete DNR, and use hospice



Why bother to bring up the “D” word?

- More family, spiritual, life review opportunities
- \$304 MILLION difference in EOL care expenditures between individuals who had EOL discussions and those who did not (Zhang B Arch Int Med 2008)
- 50+% savings for dying hospital pts with PC vs no PC. (Smith T, JPM 2003)



Why bother to bring up the “D” word?

- Having these conversations is never easy
- Many oncologists and their patients do not like to do them
- Our job is to facilitate the discussion
- Our primary customer is the ONCOLOGIST

Treatment Options for Recurrent Pancreatic Cancer

- **Chemotherapy.**
- **Palliative surgery** or **stent** placement to bypass blocked areas in **ducts** or the **small intestine**.
- Palliative **radiation therapy**.
- Other palliative medical care to reduce **symptoms**, such as **nerve blocks** to relieve pain.
- **Clinical trials** of chemotherapy, new anticancer therapies, or **biologic therapy**

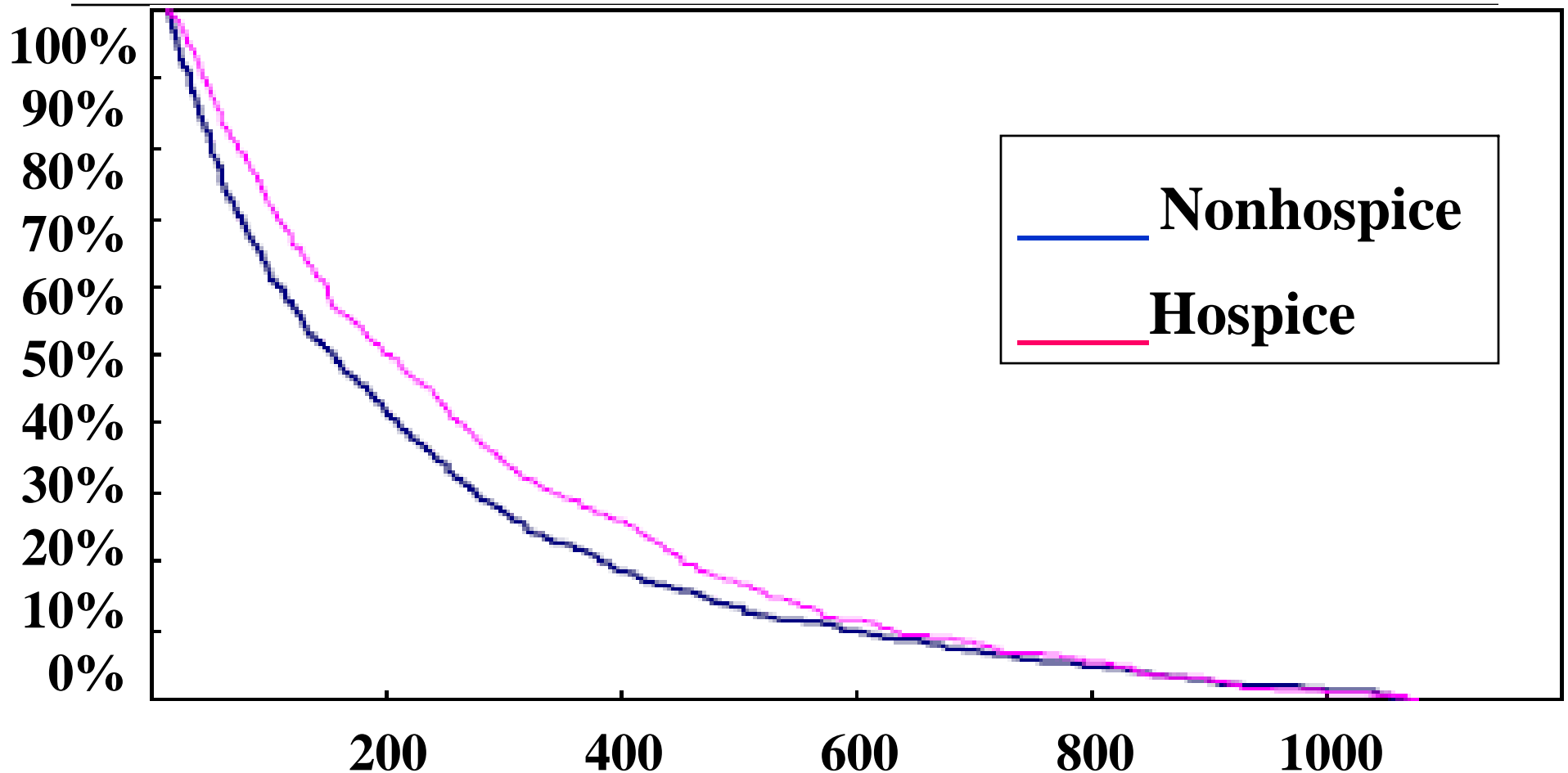
95% dead in one year



Hospice Referrals

- Patients who had end-of-life discussions received less aggressive medical care and were more likely to receive hospice services for more than a week
- Earlier hospice referrals were associated with better patient quality of life near death
- Patients who received less than a week of hospice care had the same quality of life scores as patients who did not receive hospice at all
- Short LOS in hospice might be an important measure of poor quality of life for terminally ill cancer patients

Survival curve for patients with pancreatic cancer.





Who Has Advance Directives?

- 16.2 % of adult Pennsylvanians
Pennsylvania Medical Society website
- 33% of cancer patients
J Palliat Med. 2000 Spring;3(1):23-5
- 32% of healthcare professionals at a cancer center
Mayo Clin Proc. • December 2007;82(12):1487-1490



Common End-of-Life Medical Decisions

- Cardiopulmonary Resuscitation (CPR)
- Do Not Resuscitate Order (DNR) a.k.a.,
Allow a Natural Death
- Do Not Intubate Order (DNI)
- Artificial Nutrition and Hydration

“Doctor, I want everything done”





Making Difficult Decisions Easier

- Integrating palliative care upstream in the cancer care continuum should be considered the standard of care for patients with advanced or metastatic disease
- Hospice care is important program of care for people dying from cancer and can be offered as a part of comprehensive plan of high quality cancer care



Making Difficult Decisions Easier

- Among cancer patients hospice use has increased over time, but the percentage of patient to use hospice in the last 3 days of life is also increasing.
- Late hospice referral and short hospice lengths of stay are concerning because the benefits of hospice are tied to longer length of stay.



Ways That Oncologists and Palliative Care Specialists Can Work Together

- Evidence suggests that “concurrent” palliative or hospice care alongside routine oncology care improves health outcomes
- The group with concurrent care lived slightly longer had quality of life preserved longer, used less chemotherapy, and transitioned to hospice enrollment sooner



Ways That Oncologists and Palliative Care Specialists Can Work Together

- A randomized trial showed palliative care consultation alongside usual medical care saved the insurer \$4855 per patient with no decrement in survival or symptoms
- Proof of symptom control or survival improvement at a cost society can afford will require rigorous testing, preferably in randomized clinical trials



Phase II Study of an Outpatient Palliative Care Intervention in Patients With Metastatic Cancer

- Outpatients are referred to the OPCC oncologists for management of pain or other symptoms and end-of-life planning
- This study demonstrates efficacy of an OPCC for improvement of symptom control and patient satisfaction with care



An Interdisciplinary Care Approach for Integration of Palliative Care in Lung Cancer

- Patients with lung cancer continue to suffer from multiple, debilitating symptoms that negatively affect overall QOL
- Interdisciplinary palliative care continues to be underutilized in ambulatory care settings
- Interdisciplinary palliative care approach was feasible to address these complex, multi-dimensional patient needs



ASCO Palliative Care Recommendations

- Old "cure vs. care" model should disappear
- Palliative medicine needs to occur through the course of disease
- It is not appropriate to wait for treatment to improve symptoms
- Consider hospice admission of greater than 7 days a quality measure
- The society also is considering requiring a one-month palliative care rotation for all oncology fellows

ASCO Task Force on Palliative Care 2009



BIBLIOGRAPHY

1. Harrington SE, Smith TJ. The Role of Chemotherapy at the End of Life: “When is Enough, Enough?” *JAMA* 2008;299(22):2667-2678.
2. Finlay E, Casarett D. Making Difficult Discussions Easier. Using Prognosis to Facilitate Transitions to Hospice. *CA Cancer J Clin* 2009;59:250-263.
3. Audrey S, Abel J, Blazeby JM, et al. What Oncologists tell Patients about Survival Benefits of Palliative Chemotherapy and Implications for Informed Consent: Qualitative Study. *BMJ* 2008;337:a752.
4. Cancer doctors dodge the death talk. *CW.com/health*. (June 16, 2008)
5. Robinson TM, Alexander SC, Hay M, et al. Patient-oncologist Communication in Advanced Cancer: Predictors of Patient Perception of Prognosis. *Support Care Cancer* 2008;16:1049-1057.
6. Jackson VA, Mack J, Matsuyama R, et al. A Qualitative Study of Oncologists’ Approaches to End-of-Life Care. *J Palliat Med* 2008;11(6):893-902.
7. Wright AA, Zhang B, Ray A, et al. Associations Between End-of-Life Discussions, Patient Mental Health, Medical Care Near Death, and Caregiver Bereavement Adjustment. *JAMA* 2008;300(14):1665-1673.