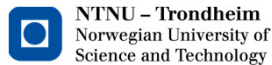


PRC

Supportive and palliative care in lung cancer

Tora Skeidsvoll Solheim, MD, PhD
Manchester, March 2018



DISCLOSURE SLIDE

No conflicting interest to declare

- The MENAC trial receives nutritional supplements free of charge from Abbott

Lung cancer

- Lung cancer is still the leading cause of cancer death worldwide
- Despite the advent of novel therapies, irresectable or metastatic non-small-cell lung cancer (NSCLC) remains an incurable disease and the prognosis is less than a year

– Ref: Hanna et al., 2017



- A high proportion of patients with advanced NSCLC experience symptoms, e.g.: fatigue (100 %), loss of appetite (97 %), shortness of breath (95 %), cough (93 %), pain (92 %), and blood in sputum (63 %)

– *Ref: Iyer et al. The symptom burden of non-small cell lung cancer in the USA: a real-world cross-sectional study. 2014.*

LCSS symptom	N	Agreement (%)	Kappa	Concordance level
Loss of appetite	424	36.3	0.17	Slight
Fatigue	420	39.8	0.20	Slight
Cough	420	38.6	0.24	Fair
Shortness of breath	414	45.4	0.29	Fair
Blood in sputum	417	70.0	0.46	Moderate
Pain	412	45.4	0.28	Fair
Overall	392	37.5	0.16	Slight

LCSS Lung Cancer Symptom Scale

Ref: Iyer et al. The symptom burden of non-small cell lung cancer in the USA: a real-world cross-sectional study. Supportive Care in Cancer, 2014.

Edmonton Symptom Assessment System:
 (revised version) (ESAS-R)

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

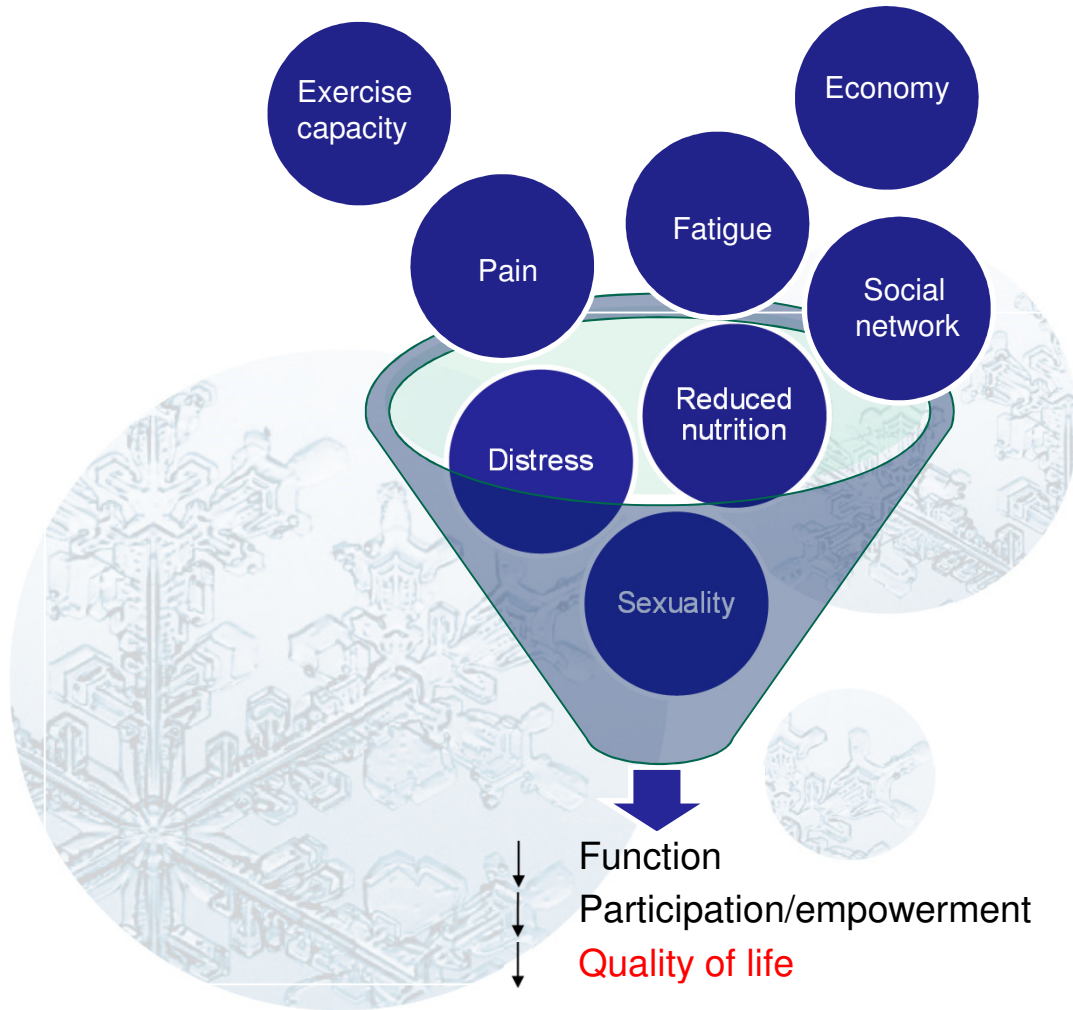
No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness <i>(Tiredness = lack of energy)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness <i>(Drowsiness = feeling sleepy)</i>	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea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

Patient's Name _____

Date _____ Time _____

Completed by (check one):

- Patient
 Family caregiver
 Health care professional caregiver
 Caregiver-assisted



WHO's definition of palliative care

- Palliative care is an approach that improves the quality of life of patients and their families facing the problem 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, physical, psychosocial and spiritual.(...)

WHO's definition of palliative care

- Palliative care is an approach that **improves the quality of life** of patients and their families facing the problem 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, physical, psychosocial and spiritual.(...)

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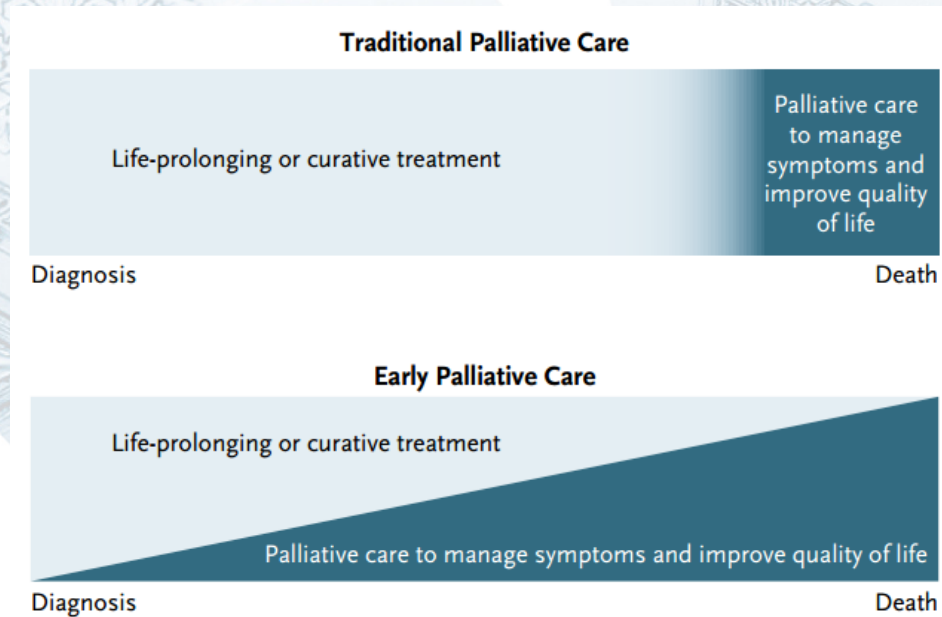
WHO's definition of palliative care

- Palliative care is an approach that improves the quality of life of patients and their families facing the problem 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, physical, psychosocial and spiritual. (...)

Palliative care

- Relationship building with patient and family caregivers
- Symptom, distress, and functional status management
- Exploration of understanding and education about illness and prognosis
- Clarification of treatment goals
- Assessment and support of coping needs
- Assistance with medical decision making
- Coordination of, and referrals to, other care providers

Palliative care is applicable early in the course of illness



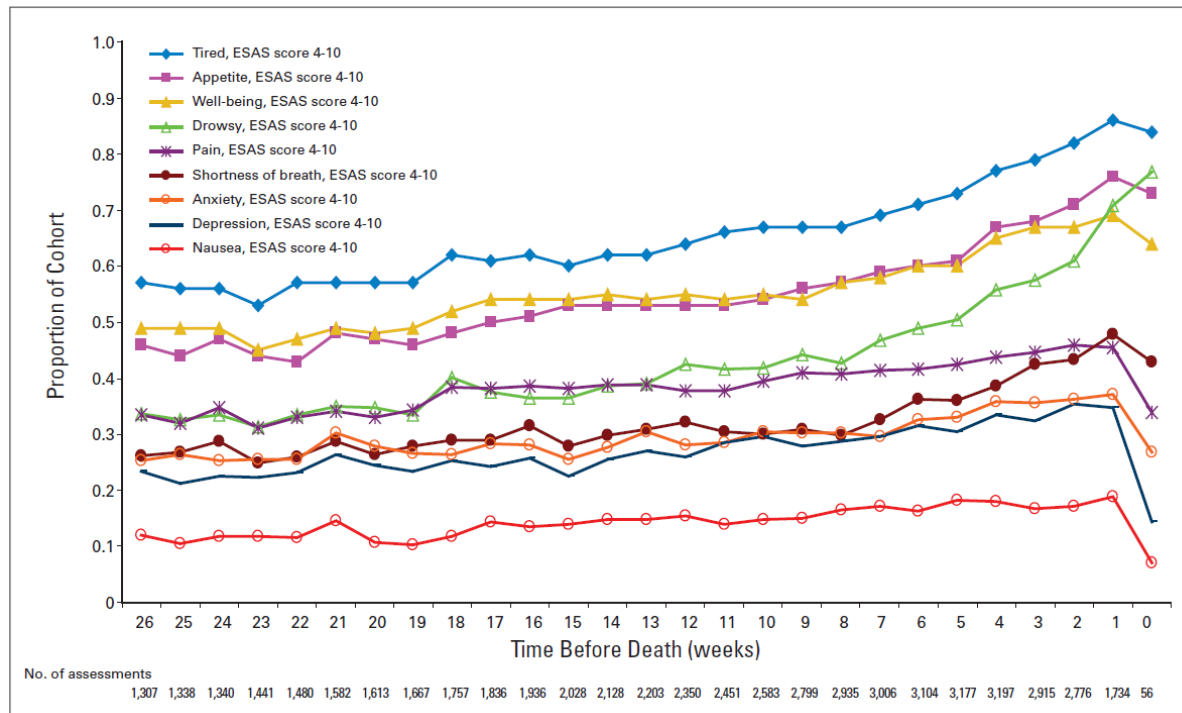
Parikh NEJM 2013



"He's our new Palliative Specialist!"

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, Anna Husain, Jonathan Sussman, and Craig Earle



Ref: Seow H et al, JCO March 2011

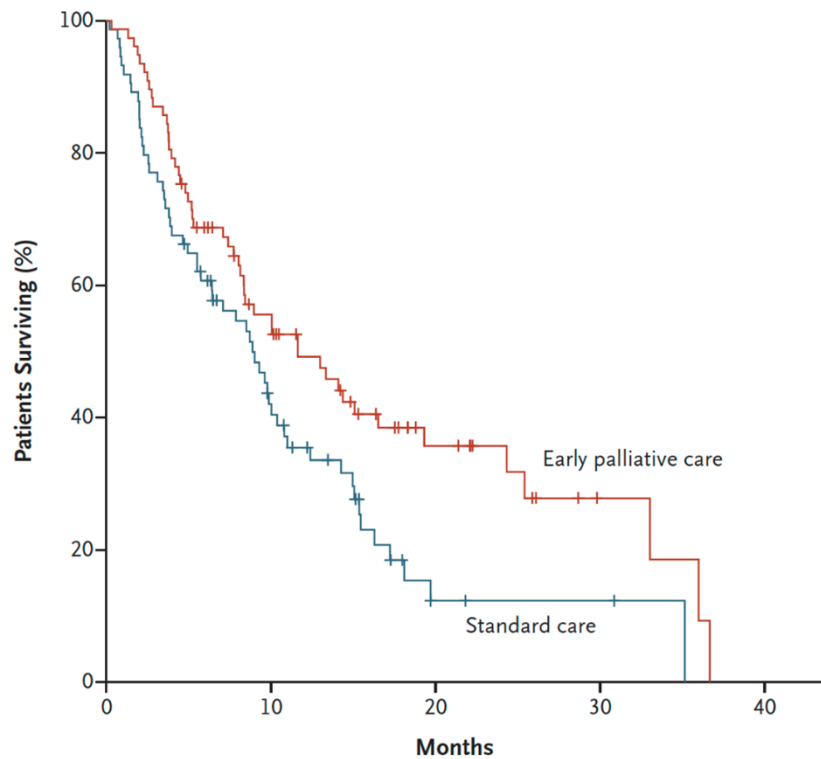
The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

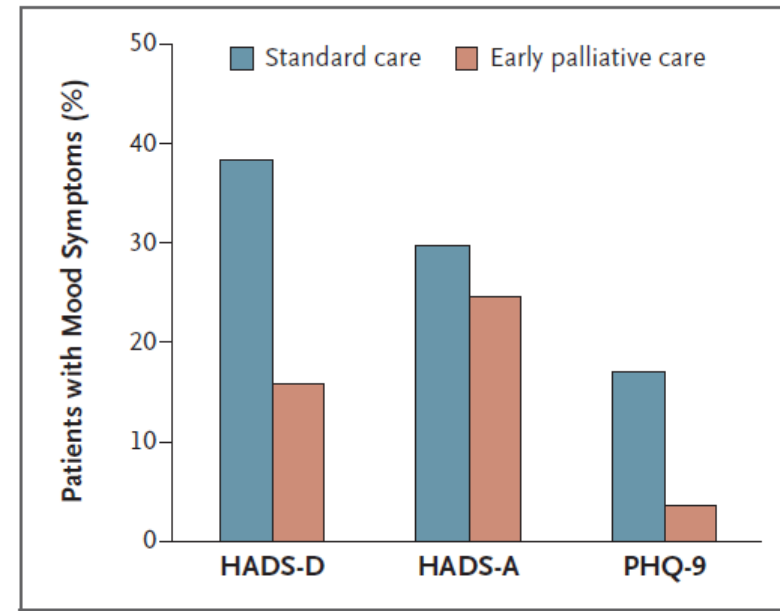
Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer

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.

Ref: Temel et al. NEJM 2010



O.S 11.6 vs 8.9 months



Fewer patients in the palliative care group than in the standard care group had depressive symptoms (16% vs. 38%, $P = 0.01$)

Quality of life: FACT-L scale 98.0 vs. 91.5; $P = 0.03$

Several other studies followed

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

VOLUME 33 · NUMBER 13 · MAY 1 2015

JOURNAL OF CLINICAL ONCOLOGY

ORIGINAL REPORT

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Wi

Marie A. Bakitas, J. Nicholas Dionne-Odom, and Andros Azaro, University of Alabama at Birmingham, Birmingham, AL; Marie A. Bakitas, Jennifer Frost, and Konstantin H. Dragnev, Dartmouth-Hitchcock Medical Center; Zhongze Li, Norris Cotton Cancer Center, Lebanon; Tor D. Tosteson, Kathleen D. Lyons, and Mark T. Hegel, Geisel School of Medicine at Dartmouth; Zhigang Li and Jay G. Hull, Dartmouth College, Hanover, NH; and Tim A. Ahles, Memorial Sloan-Kettering Cancer Center, New York, NY.

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CPFB in Applied and Clinical Research from the American Cancer Society (K.D.L.).

Presented at the 50th Annual Meeting of the American Society of Clinical Oncology, Chicago, IL, May 20–June 2, 2014.

Authors' disclosures of potential conflicts of interest and author contributions are found at the end of this article online at www.jco.org. Author disclosures are found at the end of this article.

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, Andros Azaro and Tim A. Ahles

See accompanying editorial on page 1420

A B S T R A C T

Purpose

Randomized controlled trials have supported integrated oncology and palliative care, but optimal timing has not been evaluated. We investigated the effect of delayed PC on quality of life (QOL), symptom impact, mood, 1-year survival, and resource use.

Patients and Methods

Between October 2010 and March 2013, 207 patients with advanced cancer at a Cancer Institute cancer center, a Veterans Affairs Medical Center, and community clinics were randomly assigned to receive an in-person PC consultation, a telephone nurse coaching session (once per week for six sessions), and month either early after enrollment or 3 months later. Outcomes were QOL, symptom impact, 1-year survival, and resource use (hospital/intensive care unit days, emergency chemotherapy in last 14 days, and death location).

Results

Overall patient-reported outcomes were not statistically significant after enrollment (C symptom impact, $P = .09$; mood, $P = .33$) or before death (QOL, $P = .73$; symptom impact, $P = .30$; mood, $P = .82$). Kaplan-Meier 1-year survival rates were 63% in the early group; the delayed group (difference, 15%; $P = .038$). Relative rates of early to delayed resource use were similar for hospital days (0.73; 95% CI, 0.41 to 1.27; $P = .26$), in-unit days (0.68; 95% CI, 0.23 to 2.02; $P = .49$), emergency room visits (0.73; 95% CI, $P = .21$), chemotherapy in last 14 days (1.57; 95% CI, 0.37 to 6.7; $P = .27$), and hospitalization (1.47%; $P = .60$).

Conclusion

Early-entry participants' patient-reported outcomes and resource use were not different; however, their survival 1-year after enrollment was improved compared with began 3 months later. Understanding the complex mechanisms whereby PC may impact remains an important research priority.

J Clin Oncol 33:1438-1445. © 2015 by American Society of Clinical Oncology

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the end of life. *Lancet* 2014; 383:1721-30
Quality of life. Published Online
February 19, 2014
1 Dec 1, 2006. <http://dx.doi.org/10.1016/>



Effect of early and systematic integration of palliative care in patients with advanced cancer: a randomised controlled trial

Gaëlle Vanbutssele, Koen Pardon, Simon Van Belle, Veerle Surmont, Martine De Laet, Roos Colman, Kim Eecloo, Veronique Cocquyt, Karen Geboes, Luc Deliens

Summary

Background The benefit of early integration of palliative care into oncological care is suggested to be due to increased psychosocial support. In Belgium, psychosocial care is part of standard oncological care. The aim of this randomised controlled trial is to examine whether early and systematic integration of palliative care alongside standard psychosocial oncological care provides added benefit compared with usual care.

Methods In this randomised controlled trial, eligible patients were 18 years or older, and had advanced cancer due to a solid tumour, an European Cooperative Oncology Group performance status of 0–2, an estimated life expectancy of 12 months, and were within the first 12 weeks of a new primary tumour or had a diagnosis of progression. Patients were randomly assigned (1:1), by block design using a computer-generated sequence, either to early and systematic integration of palliative care into oncological care, or standard oncological care alone in a setting where all patients are offered multidisciplinary oncology care by medical specialists, psychologists, social workers, dietitians, and specialist nurses. The primary endpoint was change in global health status/quality of life scale assessed by the European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire Core 30 items (EORTC QLQ C30) at 12 weeks. The McGill Quality of Life Questionnaire (MQOL), which includes the additional existential wellbeing dimension, was also used. Analysis was by intention to treat. This trial is ongoing, but closed for accrual, and is registered with ClinicalTrials.gov, number NCT01865396.

Findings From April 29, 2013, to Feb 29, 2016, we screened 468 patients for eligibility, of whom 186 were enrolled and randomly assigned to the early and systematic palliative care group (92 patients) or the standard oncological care group (94). Compliance at 12 weeks was 71% (65 patients) in the intervention group versus 72% (68) in the control group. The overall quality of life score at 12 weeks, by the EORTC QLQ C30, was 54.39 (95% CI 49.23–59.56) in the standard oncological care group versus 61.98 (57.02–66.95) in the early and systematic palliative care group (difference 7.60 [95% CI 0.59–14.60]; $p=0.03$); and by the MQOL Single Item Scale, 5.94 (95% CI 5.50–6.39) in the standard oncological care group versus 7.05 (6.59–7.50) in the early and systematic palliative care group (difference 1.11 [95% CI 0.49–1.73]; $p=0.0006$).



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See Online/Comment/
[http://dx.doi.org/10.1016/S1473-2045\(18\)30061-5](http://dx.doi.org/10.1016/S1473-2045(18)30061-5)

End-of-Life Care Research Group, Vrije Universiteit Brussel and Ghent University, Brussels, Belgium (G Vanbutssele MSc, K Pardon PhD, K Eecloo MSc, Prof L Deliens PhD); Department of Medical Oncology (Prof S Van Belle MD, V Cocquyt MD); Department of Respiratory Medicine and Thoracic Oncology (V Surmont MD); Palliative Care Team (M De Laet MD, V Cocquyt); and Department of Gastroenterology, Division of Digestive Oncology (K Geboes MD), Ghent University Hospital, Ghent, Belgium; and Biostatistics Unit, Department of Public Health, Faculty of Medicine and Health Sciences, Ghent

Integration of Palliative Care Into Standard Oncology Care; ASCO Clinical Practice Guidelines Update

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JOURNAL OF CLINICAL ONCOLOGY

ASCO SPECIAL ARTICLE

Integration of Palliative Care Into Standard Oncology Care: American Society of Clinical Oncology Clinical Practice Guideline Update

Betty R. Ferrell, Jennifer S. Temel, Sarah Temin, Erin R. Alesi, Tracy A. Balboni, Ethan M. Basch, Janice I. Finn, Judith A. Paice, Jeffrey M. Peppercorn, Tanyanika Phillips, Ellen L. Stovall,† Camilla Zimmermann, and Thomas J. Smith

Author affiliations appear at the end of this article.

†Deceased.

Published at ascopubs.org/journal/jco on October 31, 2016.

Clinical Practice Guideline Committee approved: August 15, 2016.

Editor's note: This American Society of Clinical Oncology clinical practice guideline provides recommendations, with comprehensive review and analyses of the relevant literature for each recommendation. Additional information, including a Data Supplement with additional evidence tables, a Methodology Supplement, slide sets, clinical tools and resources, and links to patient information at www.cancer.net, is available at www.asco.org/palliative-care-guideline and www.asco.org/guidelineswiki.

Reprint requests: 2318 Mill Rd, Suite 800, Alexandria, VA 22314; e-mail: guidelines@asco.org.

Corresponding author: American Society of Clinical Oncology, 2318 Mill Rd, Suite 800, Alexandria, VA 22314; e-mail: guidelines@asco.org.

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0732-183X/17/3501w-96w/\$20.00

A B S T R A C T

Purpose

To provide evidence-based recommendations to oncology clinicians, patients, family and friend caregivers, and palliative care specialists to update the 2012 American Society of Clinical Oncology (ASCO) provisional clinical opinion (PCO) on the integration of palliative care into standard oncology care for all patients diagnosed with cancer.

Methods

ASCO convened an Expert Panel of members of the ASCO Ad Hoc Palliative Care Expert Panel to develop an update. The 2012 PCO was based on a review of a randomized controlled trial (RCT) by the National Cancer Institute Physicians Data Query and additional trials. The panel conducted an updated systematic review seeking randomized clinical trials, systematic reviews, and meta-analyses, as well as secondary analyses of RCTs in the 2012 PCO, published from March 2010 to January 2016.

Results

The guideline update reflects changes in evidence since the previous guideline. Nine RCTs, one quasiexperimental trial, and five secondary analyses from RCTs in the 2012 PCO on providing palliative care services to patients with cancer and/or their caregivers, including family caregivers, were found to inform the update.

Recommendations

Inpatients and outpatients with advanced cancer should receive dedicated palliative care services, early in the disease course, concurrent with active treatment. Referral of patients to interdisciplinary palliative care teams is optimal, and services may complement existing programs. Providers may refer family and friend caregivers of patients with early or advanced cancer to palliative care services.

J Clin Oncol 35:96-112. © 2016 by American Society of Clinical Oncology

Based on nine RCTs, five quasi-experimental studies, five secondary publications (from RCTs)

Inpatients and outpatients with advanced cancer should receive dedicated palliative care service

- Early
- Concurrent with active treatment

Systemic Therapy for Stage IV Non–Small-Cell Lung Cancer: American Society of Clinical Oncology Clinical Practice Guideline Update

Nasser Hanna, David Johnson, Sarah Temin, Sherman Baker Jr, Julie Brahmer, Peter M. Ellis, Giuseppe Giaccone, Paul J. Hesketh, Ismael Jaiyesimi, Natasha B. Leigh, Gregory J. Riely, Joan H. Schiller, Bryan J. Schneider, Thomas J. Smith, Joan Tashbar, William A. Biermann, and Gregory Masters

General Recommendations

A1. Clinical question—General (note: clinical question from 2015). Which patients with stage IV NSCLC should be treated with chemotherapy?

Recommendation A1.a. (from 2015): For patients with performance status (PS) of 0 or 1 *receiving chemotherapy* (italicized words added in 2017), a combination of two cytotoxic drugs is recommended. Platinum combinations are recommended over nonplatinum therapy; however, nonplatinum therapy combinations are recommended for patients who have contraindications to platinum therapy. Chemotherapy may also be used to treat selected patients with PS of 2 who desire aggressive treatment after a thorough discussion of the risks and benefits of such treatment.

Recommendation A1.b. (from 2015): Because there is no cure for patients with stage IV NSCLC, early concomitant palliative care assistance has improved the survival and well-being of patients and is therefore recommended.

Content of palliative care in these studies?

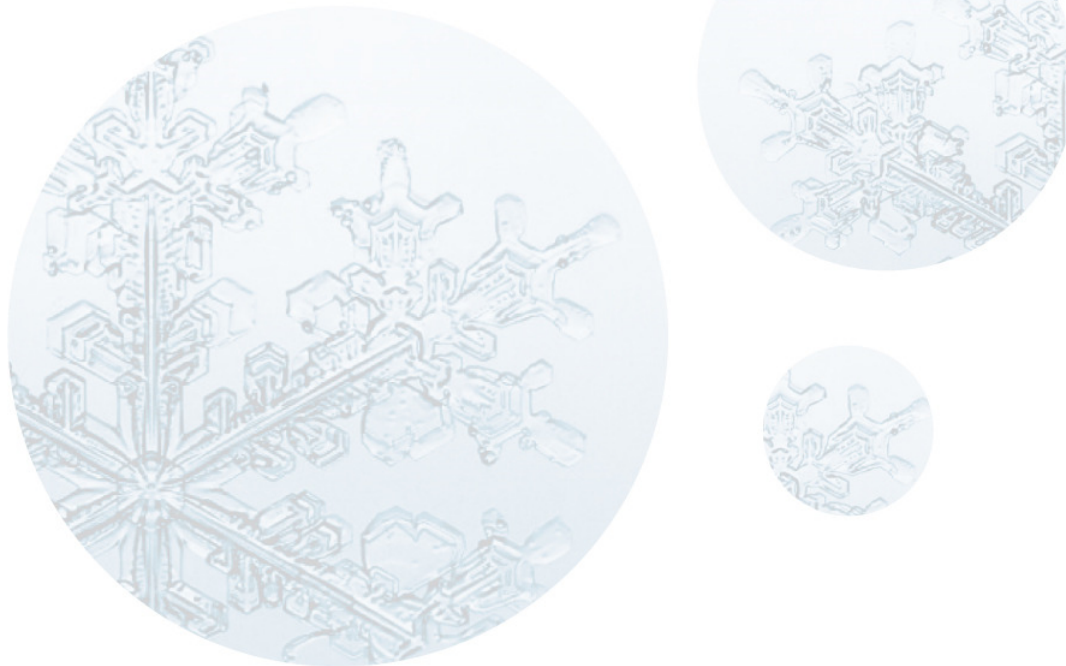
- Intervention shortly after diagnosis of advanced cancer
- Varying interventions, different combinations
 - Appointments with palliative care specialist and nurses
 - Phone calls (weekly/monthly)
 - Comprehensive assessments / systematic checklists
 - Education: prognosis, options, advance care planning, use of hospice
 - Interdisciplinary team



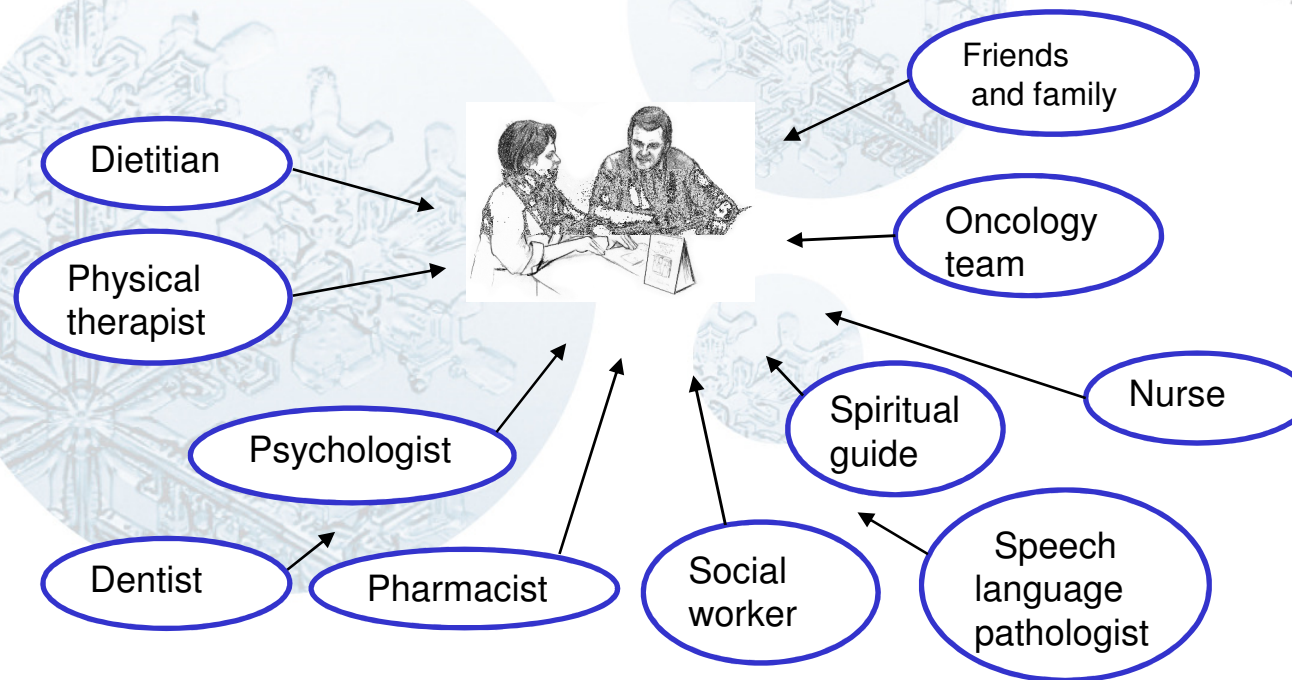
We do not know:

- When is “early”?
- What is the optimal content of palliative care?
- What is the optimal level of integration?
- For whom should early integrated palliative care be introduced?

Teamwork is necessary to achieve good palliative care



Teamwork is necessary to achieve good palliative care

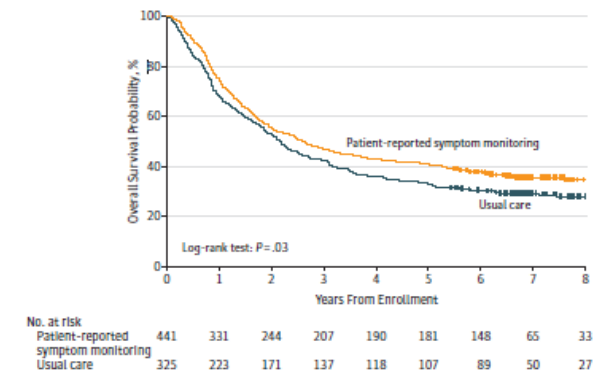


Symptom Monitoring With Patient-Reported Outcomes During Routine Cancer Treatment: A Randomized Controlled Trial

Ethan Basch, Allison M. Deal, Mark G. Kris, Howard I. Scher, Clifford A. Hudis, Paul Sabbatini, Lauren Rogak, Antonia V. Bennett, Amylou C. Dueck, Thomas M. Atkinson, Joanne F. Chou, Dorothy Dulko, Laura Sit, Allison Barz, Paul Novotny, Michael Fruscione, Jeff A. Sloan, and Deborah Schrag

- HRQL improved more (34% v 18%) and worsened among fewer (38% v 53%)
- Less frequently admitted to the ER (34% v 41%)
- Remained on chemotherapy longer (8.2 v 6.3 m)

Figure. Overall Survival Among Patients With Metastatic Cancer Assigned to Electronic Patient-Reported Symptom Monitoring During Routine Chemotherapy vs Usual Care



jama.com

JAMA

O.S 31.2 months (95% CI, 24.5-39.6)
vs 26.0 months (95% CI, 22.1-30.9)

How to deal with symptoms and complaints?

- All physicians working with patients with cancer
- At first meeting, do not accept «this is how it is to live with lung cancer»
- Most important:
 - Preferably do a systematic registration of symptoms
 - Take a proper medical history and do a proper work up
- Early palliative care



Literature on palliative and supportive care

- Palliative Care Formulary (PCF6)
- Your local national/institutional palliative care guidelines
- NICE guidelines
- <http://esmo.org/Guidelines/Supportive-and-Palliative-Care>
- <https://www.asco.org/practice-guidelines/quality-guidelines/guidelines/>



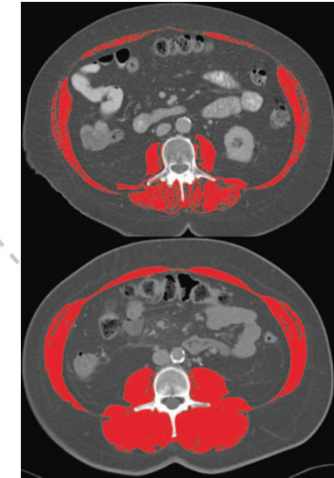
Example: cachexia



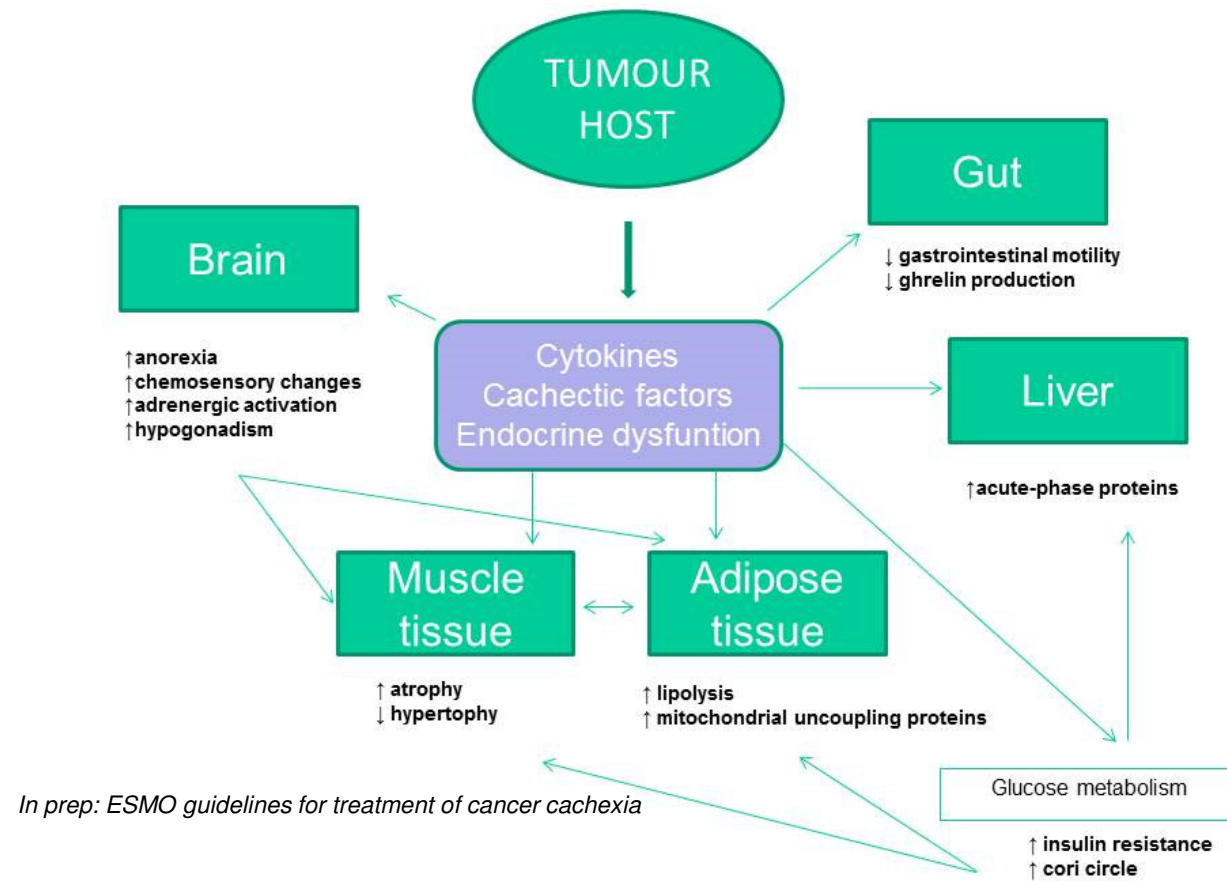
Example: cachexia

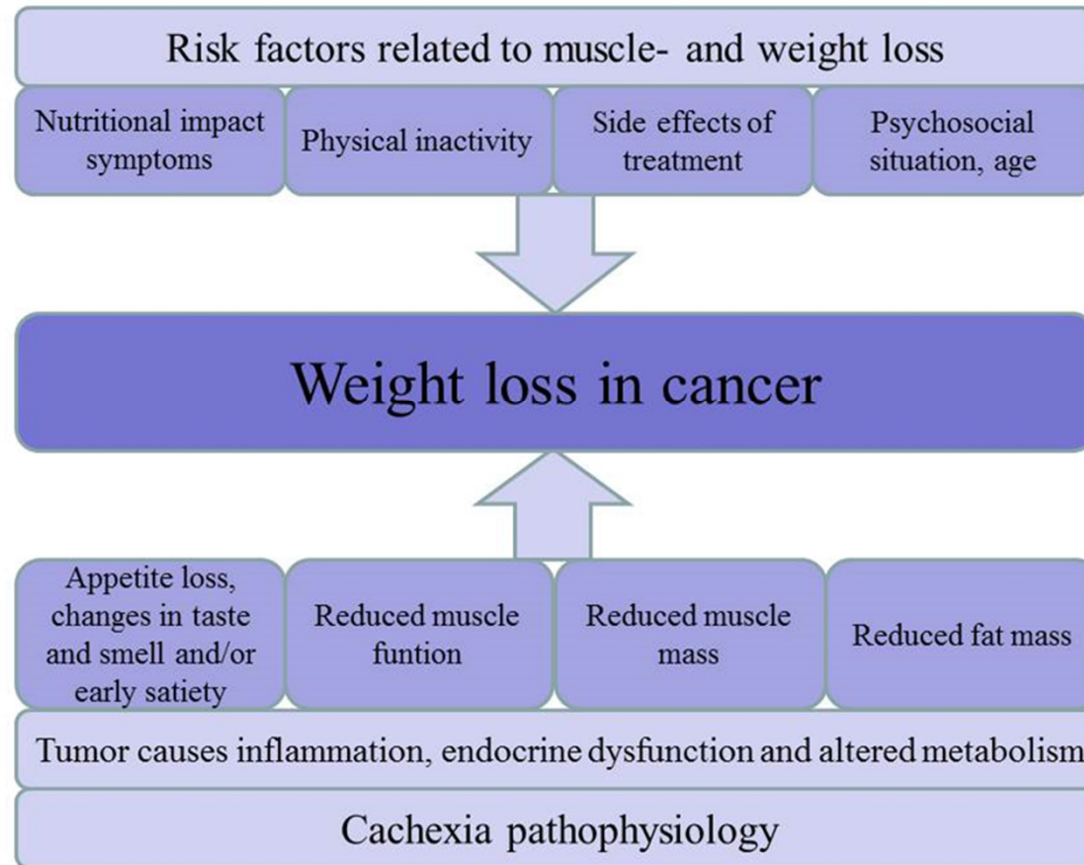
- Cancer cachexia is a multidimensional syndrome with on-going muscle loss (and often fat loss)
- **It cannot be cured by conventional nutrition alone**
- Leads to progressive functional impairment

Fearon K, et al. Definition and classification of cancer cachexia: An international consensus. Lancet Oncology 2011



Example: cachexia

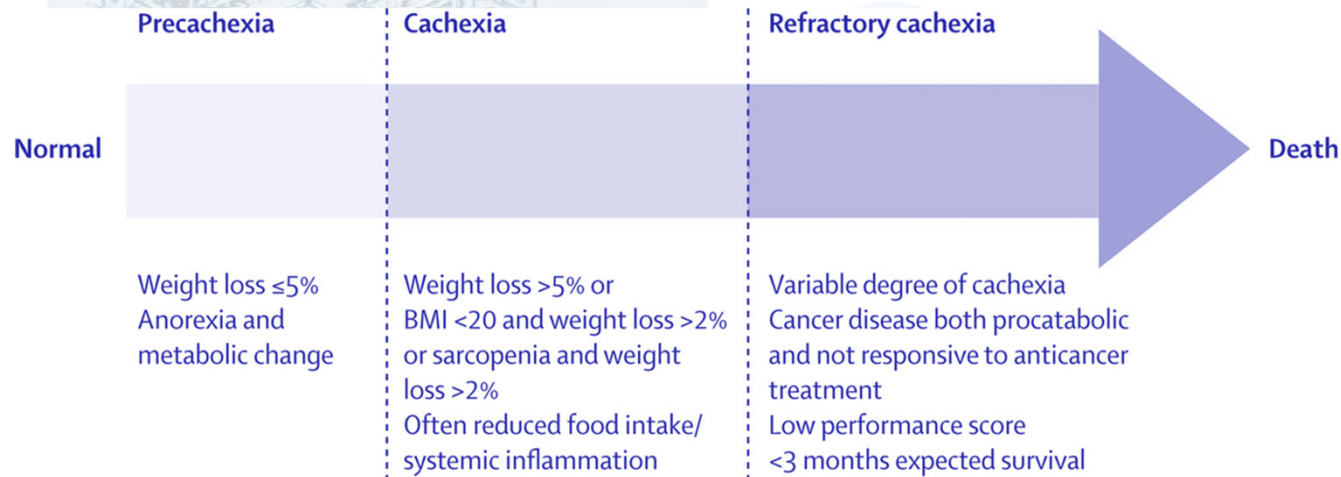




In prep: ESMO guidelines for treatment of cancer cachexia

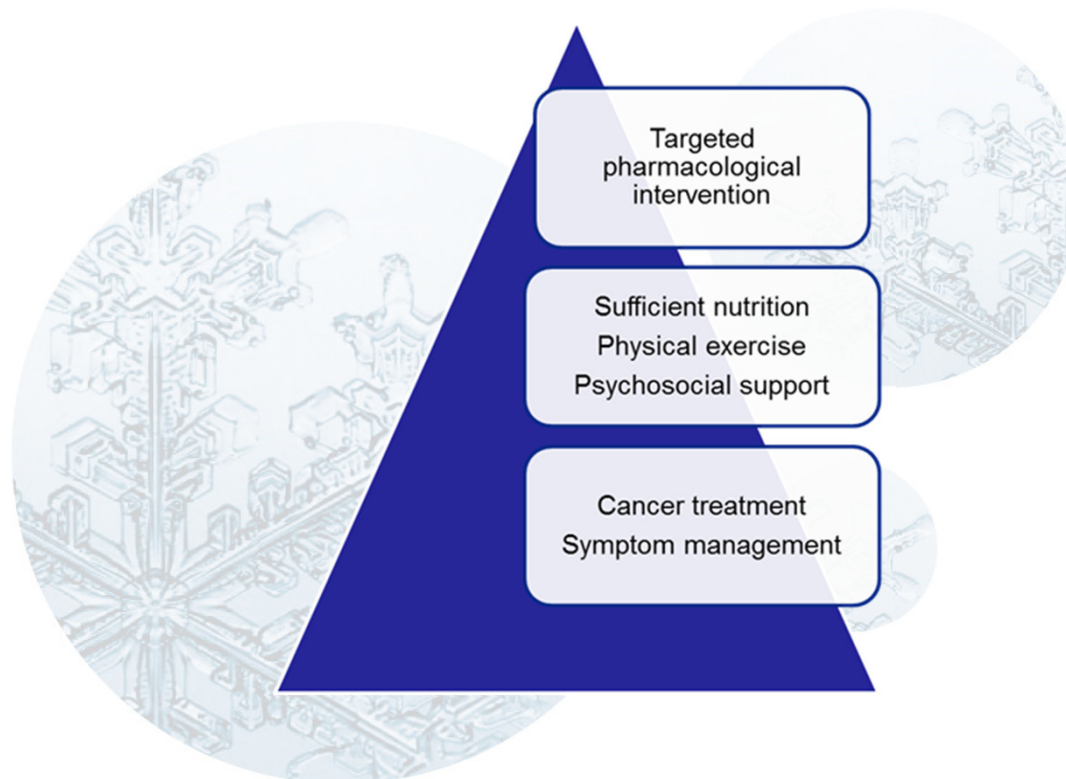


Trajectory of cachexia



ref. Fearon K, *et al.* 2008

Example: cachexia



In prep: ESMO guidelines for treatment of cancer cachexia

Summary: Supportive and palliative care in lung cancer

- Patient-centered, always include caregivers if possible
- Early integration
- Interdisciplinary teams
- Systematic symptom assessment
- Diagnostics
- Treatment
 - Treatment includes both starting and withdrawal of medications (as well as radiotherapy and surgery)
 - Information and education (illness, prognosis, coping needs, treatment goals)

Thank you for your attention



Trondheim University Hospital