PALLIATIVE CARE AND ADVANCED CANCER

RAIMUNDO CORREA, MD

GYNECOLOGIC ONCOLOGIST & PALL CARE SUB SPECIALIST

CLINICA LAS CONDES & HOSPITAL SANTIAGO ORIENTE, CHILE

HEAD, PALL CARE WORKING GROUP INTERNATIONAL GYNECOLOGIC CANCER SOCIETY

BACKGROUND

- Care as a continuum.
- Impact of incurable diseases, role of a multidisciplinary approach.
- QOL & Patient – Centered Medicine.
- Family Members & Caregivers.
- Disparity/Inequity.

DEFINITION

- 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 PROBLEMS, PHYSICAL, PSYCHOSOCIAL AND SPIRITUAL.

WHO.INT

WHO DEFINITION

- Holistic.
- Not only pain.
- All dimensions.
- Multidisciplinary team.
- Relatives/Caregivers.
- Loss of hope.

IAHPC DEFINITION 2018

PALLIATIVE CARE IS THE ACTIVE HOLISTIC CARE OF INDIVIDUALS ACROSS ALL AGES WITH SERIOUS HEALTH-RELATED SUFFERING DUE TO SEVERE ILLNESS AND ESPECIALLY THOSE NEAR THE END OF LIFE. IT AIMS TO IMPROVE THE QUALITY OF LIFE OF PATIENTS, THEIR FAMILIES AND THEIR CAREGIVERS.

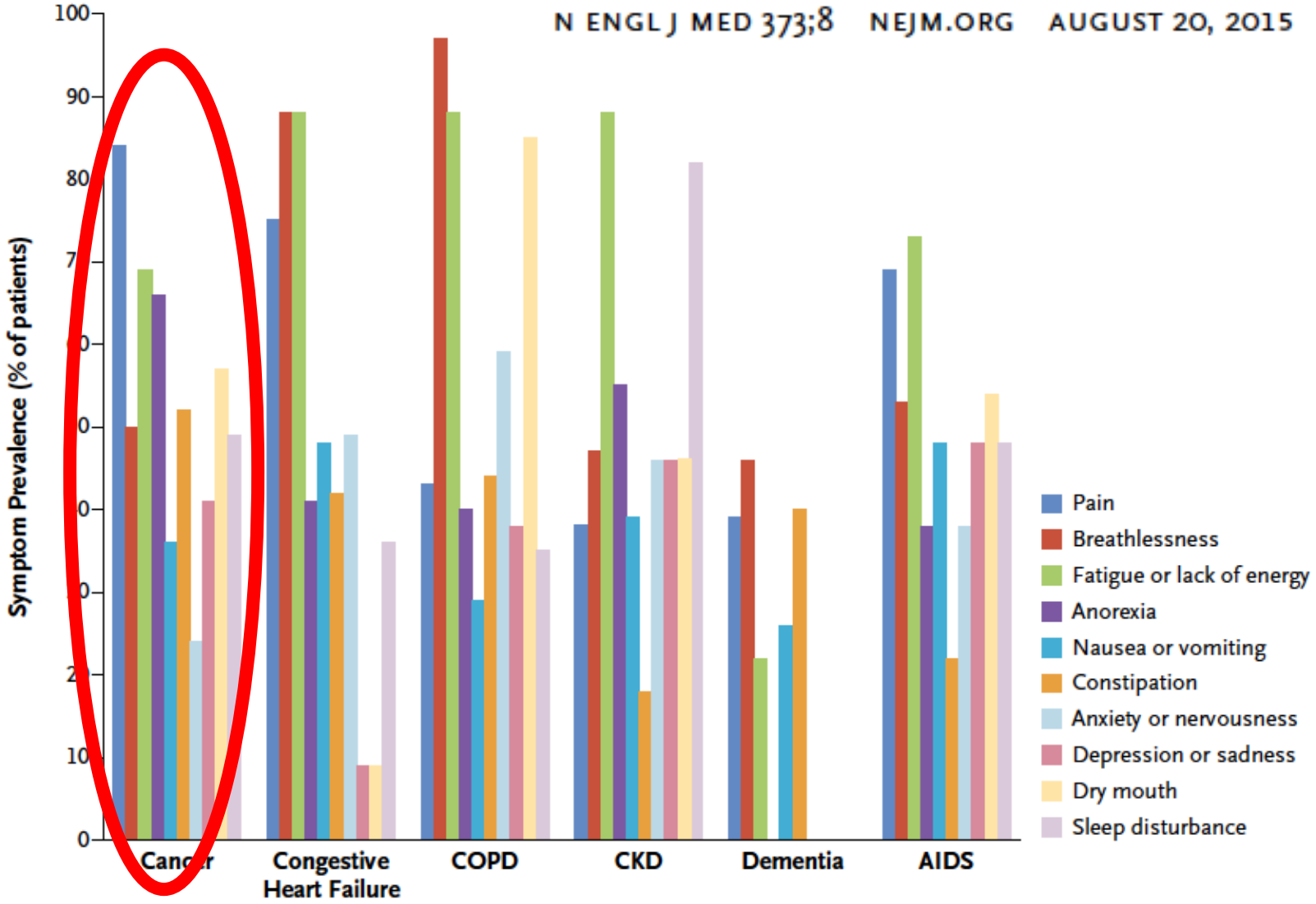
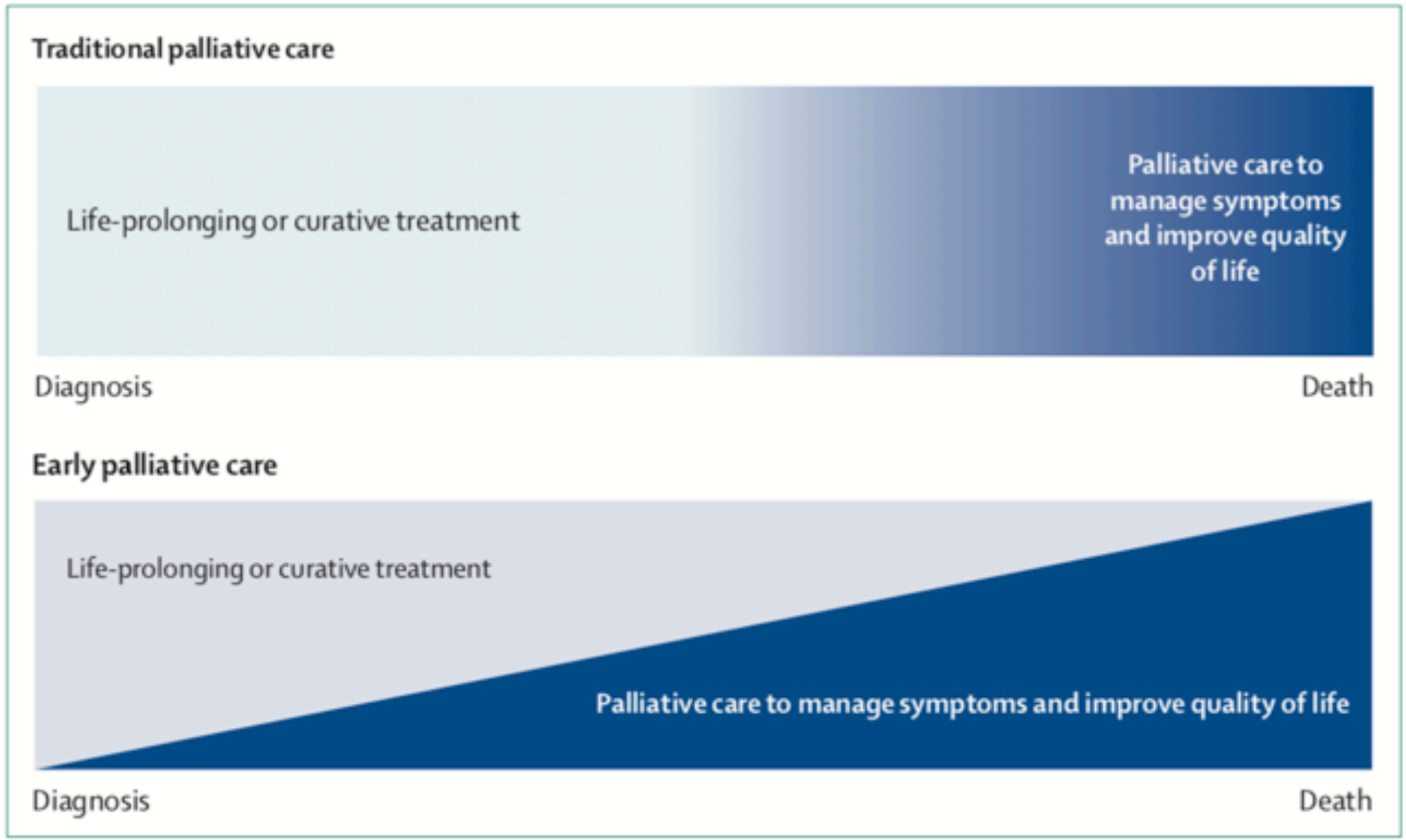


Figure 1. Symptom Prevalence in Advanced Illness.

Data are from representative studies of symptom prevalence among patients with cancer,[8-12] congestive heart failure,[13,14] chronic obstructive pulmonary disease (COPD),[15] chronic kidney disease (CKD),[13,14] or dementia[16,17] and among patients who received highly active antiretroviral therapy for the acquired immunodeficiency syndrome (AIDS).[18] Self-reported data regarding some symptoms were unavailable for patients with dementia.


Traditional palliative care
Life-prolonging or curative treatment
Palliative care to manage symptoms and improve quality of life
Diagnosis
Death
Early palliative care
Life-prolonging or curative treatment
Palliative care to manage symptoms and improve quality of life
Diagnosis
Death

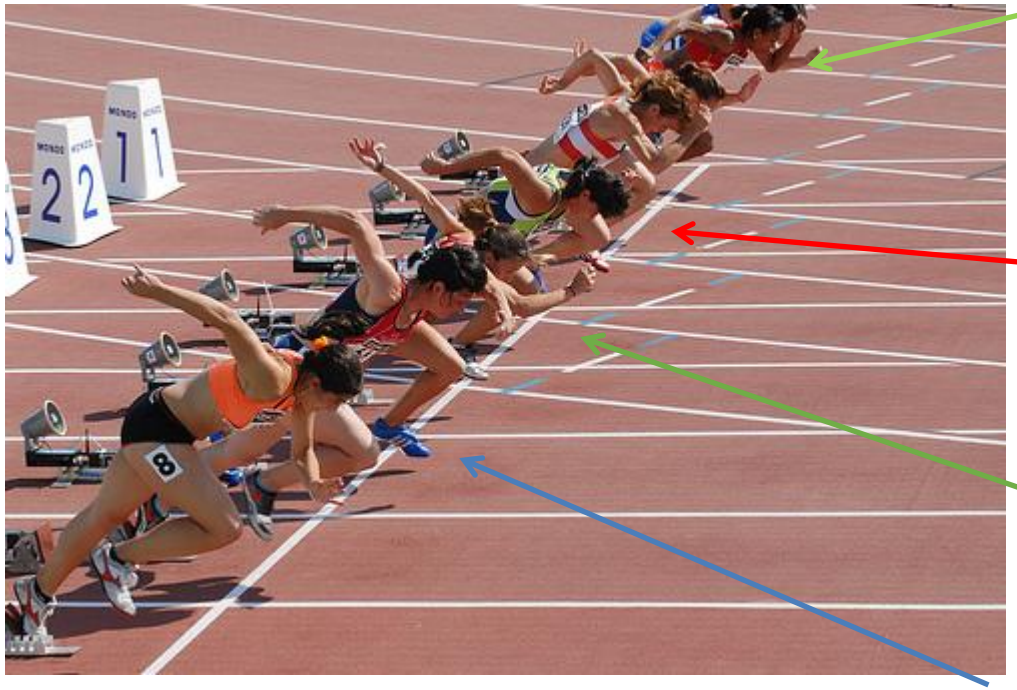
DIAGNOSIS

SPECIFIC TREATMENT

SUPPORTIVE ONCOLOGY

RECURRENCE/ PROGRESSION

SUPPORTIVE ONCOLOGY



SUPPORTIVE ONCOLOGY

RADIOTHERAPY

MEDICAL ONCOLOGY

SURG/GYN ONCOLOGY

Cochrane Library

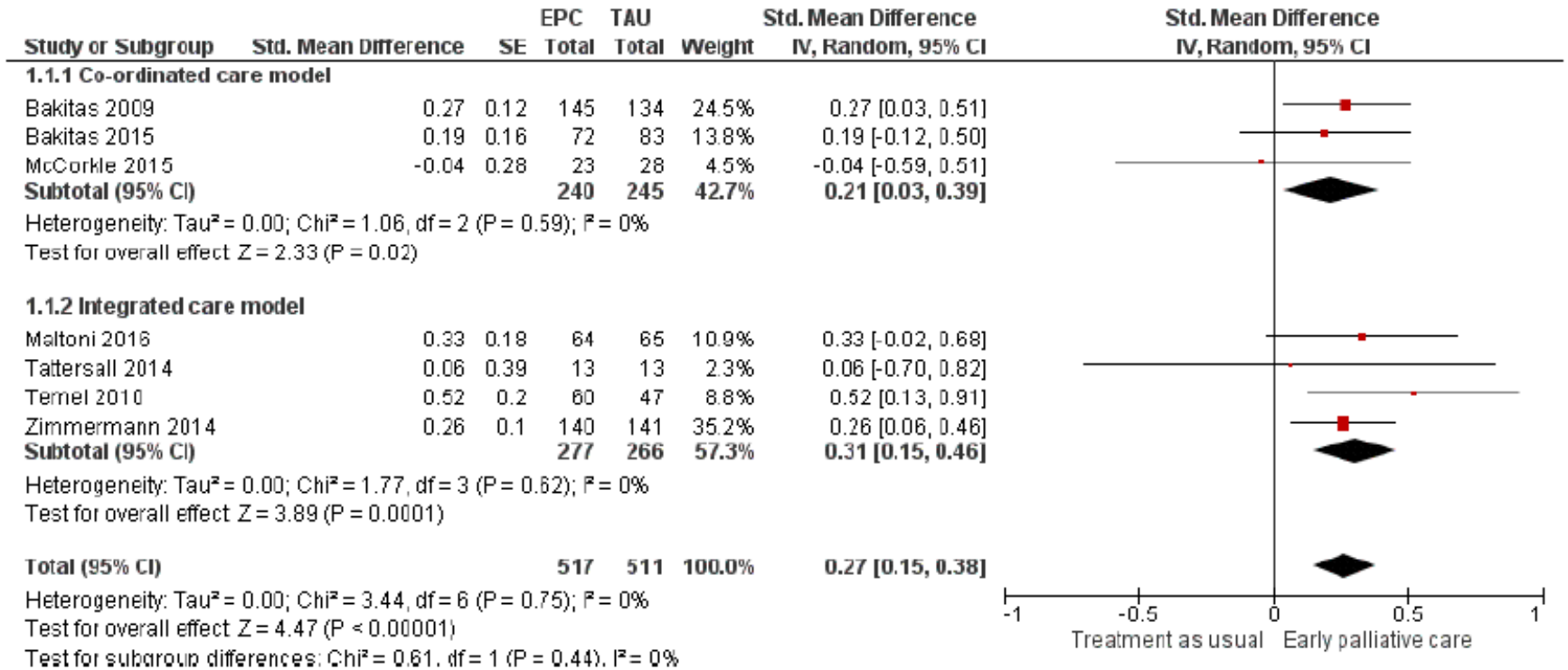
Cochrane Database of Systematic Reviews

Early palliative care for adults with advanced cancer (Review)

Haun MW, Estel S, Rücker G, Friederich HC, Villalobos M, Thomas M, Hartmann M

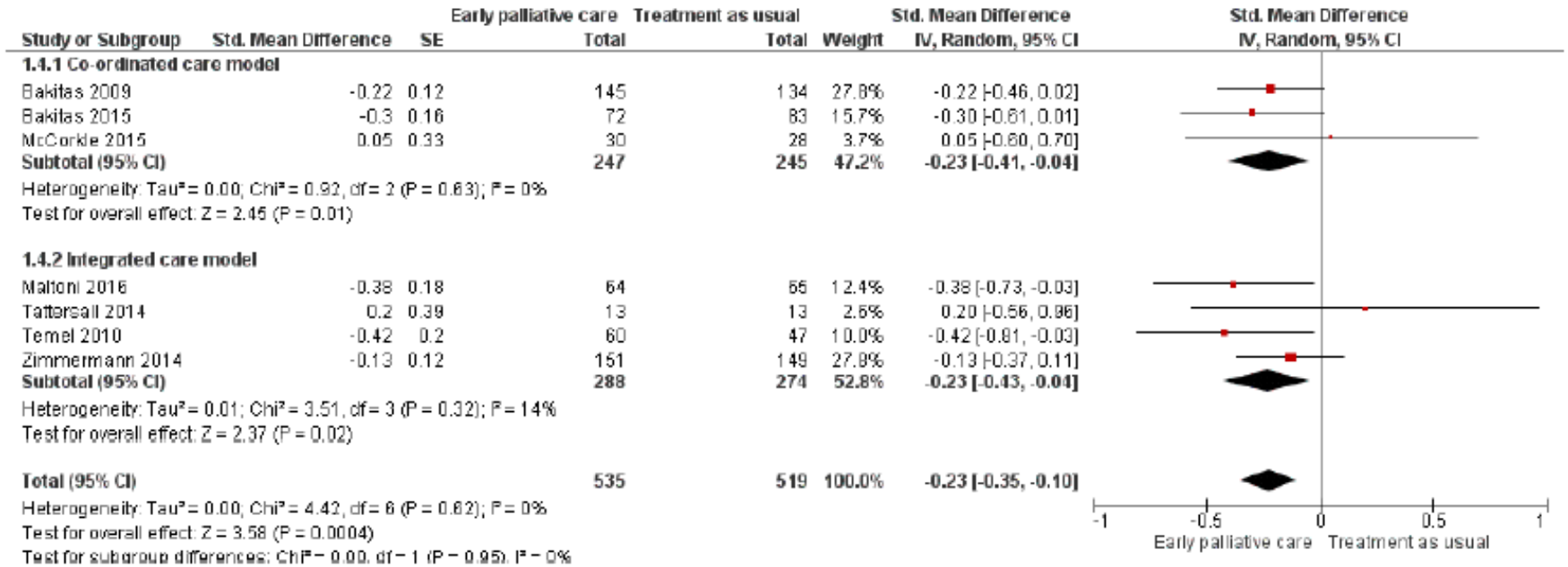
Cochrane Database of Systematic Reviews 2017, Issue 6. Art. No.: CD011129.
DOI: 10.1002/14651858.CD011129.pub2.

Figure 4. Forest plot of comparison: 1 Health-related quality of life, outcome: 1.1 Health-related quality of life.



Cochrane Database of Systematic Reviews 2017, Issue 6. Art. No.: CD011129.
DOI: 10.1002/14651858.CD011129.pub2.

Figure 7. Forest plot of comparison: 1 Early palliative care vs standard oncological care, outcome: 1.4 Symptom intensity.



Cochrane Database of Systematic Reviews 2017, Issue 6. Art. No.: CD011129.
DOI: 10.1002/14651858.CD011129.pub2.

Figure 5. Forest plot of comparison: 1 Early palliative care vs TAU, outcome: 1.2 Survival.

Study or Subgroup	log[Hazard Ratio]	SE	Treatment as usual Total	Early palliative care Total	Weight	Hazard Ratio IV, Random, 95% CI
Bakitas 2009	-0.22	0.15	161	161	26.6%	0.80 [0.60, 1.08]
Bakitas 2015	-0.45	0.21	103	104	23.7%	0.64 [0.42, 0.96]
Tattersall 2014	0.47	0.19	60	60	24.8%	1.60 [1.10, 2.32]
Temel 2010	-0.46	0.19	74	77	24.8%	0.63 [0.44, 0.92]
Total (95% CI)			**398**	**402**	**100.0%**	**0.85 [0.56, 1.28]**

Heterogeneity: Tau² = 0.14; Chi² = 15.55, df = 3 (P = 0.001); I² = 81%
Test for overall effect: Z = 0.78 (P = 0.43)

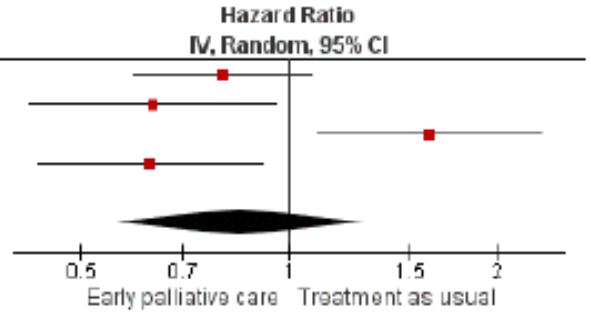
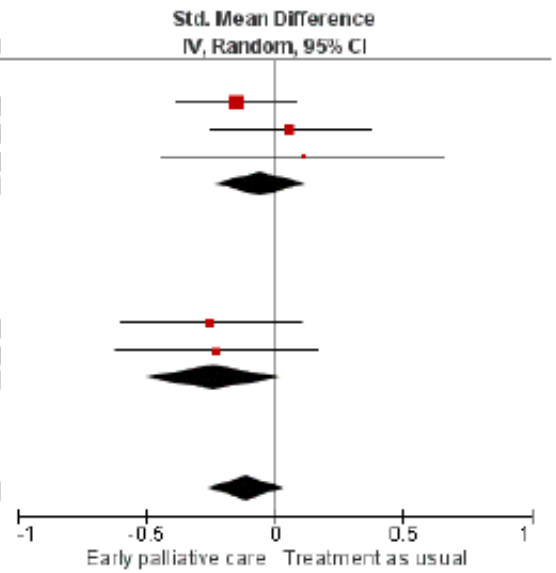


Figure 6. Forest plot of comparison: 1 Early palliative care vs standard oncological care, outcome: 1.2 Depression.

Study or Subgroup	Std. Mean Difference	SE	Treatment as usual Total	Early palliative care Total	Weight	Std. Mean Difference IV, Random, 95% CI
1.2.1 Co-ordinated care model						
Bakitas 2009	-0.15	0.12	134	145	39.2%	-0.15 [-0.39, 0.09]
Bakitas 2015	0.06	0.16	83	72	22.1%	0.06 [-0.25, 0.37]
McCorkle 2015	0.11	0.28	56	36	7.2%	0.11 [-0.44, 0.66]
Subtotal (95% CI)			**273**	**253**	**68.5%**	**-0.06 [-0.23, 0.12]**
Heterogeneity: Tau² = 0.00; Chi² = 1.49, df = 2 (P = 0.47); I² = 0%						
Test for overall effect: Z = 0.61 (P = 0.54)						
1.2.2 Integrated care model						
Maltoni 2016	-0.25	0.18	65	64	17.4%	-0.25 [-0.60, 0.10]
Temel 2010	-0.23	0.2	47	60	14.1%	-0.23 [-0.62, 0.16]
Subtotal (95% CI)			**112**	**124**	**31.5%**	**-0.24 [-0.50, 0.02]**
Heterogeneity: Tau² = 0.00; Chi² = 0.01, df = 1 (P = 0.94); I² = 0%						
Test for overall effect: Z = 1.80 (P = 0.07)						
Total (95% CI)			**385**	**377**	**100.0%**	**-0.11 [-0.26, 0.03]**
Heterogeneity: Tau² = 0.00; Chi² = 2.82, df = 4 (P = 0.59); I² = 0%						
Test for overall effect: Z = 1.51 (P = 0.13)						
Test for subgroup differences: Chi² = 1.32, df = 1 (P = 0.25), I² = 24.5%						



Cochrane Database of Systematic Reviews 2017, Issue 6. Art. No.: CD011129.
DOI: 10.1002/14651858.CD011129.pub2.

SIXTY-SEVENTH WORLD HEALTH ASSEMBLY **WHA67.19**

Agenda item 15.5 **24 May 2014**

Strengthening of palliative care as a component of comprehensive care throughout the life course

The Sixty-seventh World Health Assembly,

Having considered the report on strengthening of palliative care as a component of integrated treatment throughout the life course;[1]

Recalling resolution WHA58.22 on cancer prevention and control, especially as it relates to palliative care;

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. Firn, Judith A. Paice, Jeffrey M. Peppercorn, Tanyanika Phillips, Ellen L. Stovall,† Camilla Zimmermann, and Thomas J. Smith

Betty R. Ferrell, City of Hope Medical Center, Duarte, CA; Jennifer S. Temel and Jeffrey M. Peppercorn, Massachusetts General Hospital; Tracy A. Balboni,

J Clin Oncol 34.

NCCN Guidelines Version 2.2019
Palliative Care

NCCN Guidelines Index
Table of Contents
Discussion

Definition of Palliative Care[a,c]

Palliative care is an approach to patient/family/caregiver-centered health care that focuses on optimal management of distressing symptoms, while incorporating psychosocial and spiritual care according to patient/family/caregiver needs, values, beliefs, and cultures. The goal of palliative care is to anticipate, prevent, and reduce suffering and to support the best possible quality of life for patients/families/caregivers, regardless of the stage of the disease or the need for other therapies. Palliative care can begin at diagnosis and should be delivered concurrently with disease-directed, life-prolonging therapies and should facilitate patient autonomy, access to information, and choice. Palliative care becomes the main focus of care when disease-directed, life-prolonging therapies are no longer effective, appropriate, or desired. Palliative care should be provided by the primary oncology team and augmented as needed by collaboration with an interdisciplinary team of palliative care experts.

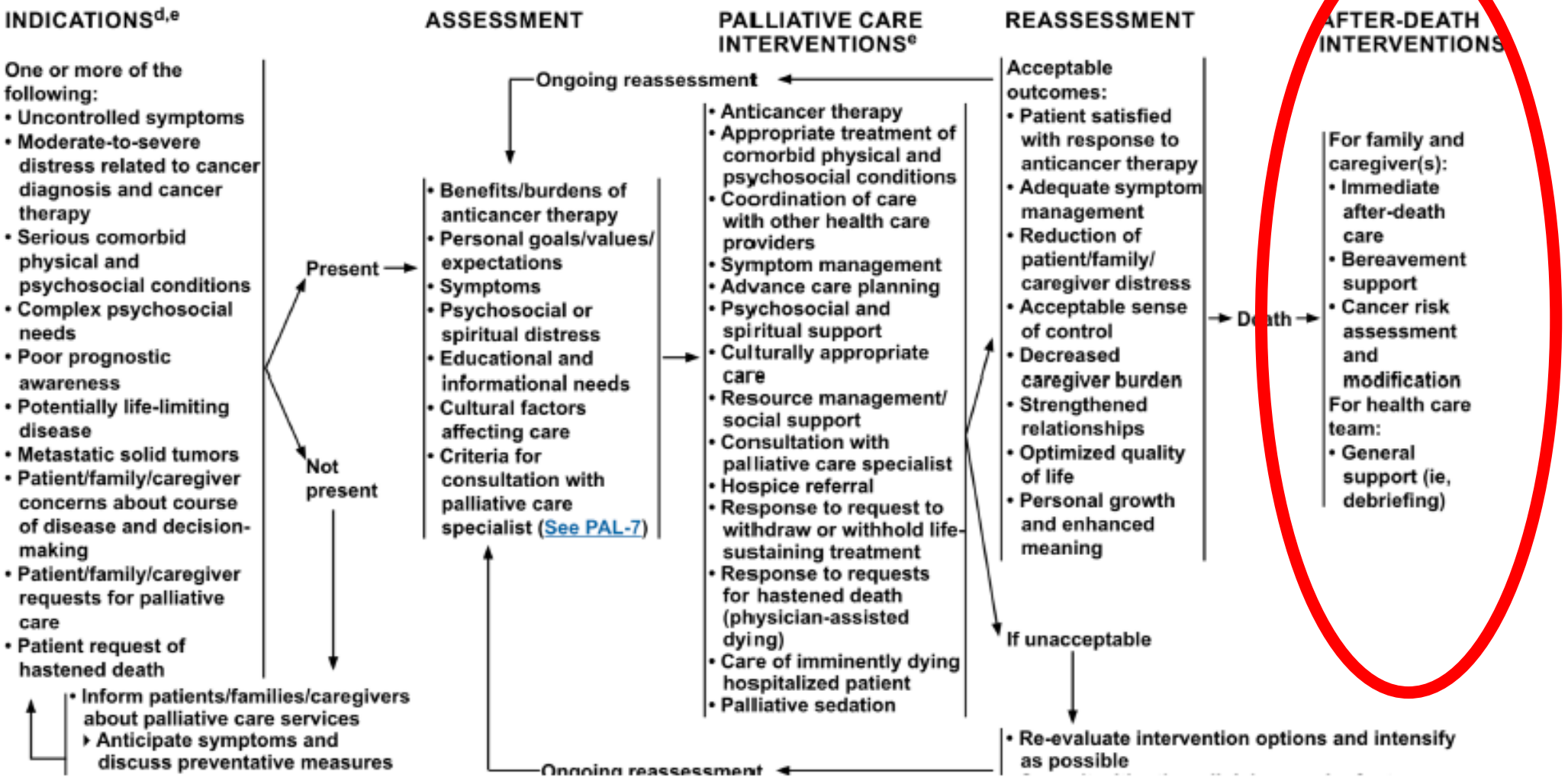
Standards of Palliative Care[b,c]

- Institutions should develop processes for integrating palliative care into cancer care, both as part of usual oncology care and for patients with specialty palliative care needs.
- All cancer patients should be screened for palliative care needs at their initial visit, at appropriate intervals, and as clinically indicated.
- Patients/families/caregivers should be informed that palliative care is an integral part of their comprehensive cancer care.
- Educational programs should be provided to all health care professionals and trainees so that they can develop effective palliative care knowledge, skills, and attitudes.
- Palliative care specialists and interdisciplinary palliative care teams, including board-certified palliative care physicians, advanced practice nurses, physician assistants, social workers, chaplains, and pharmacists, should be readily available to provide consultative or direct care to patients/families/caregivers and/or health care professionals who request or require their expertise.
- Quality of palliative care should be monitored by institutional quality improvement programs.

National Comprehensive Cancer Network®

NCCN Guidelines Version 2.2019
Palliative Care

NCCN Guidelines Index
Table of Contents
Discussion



Lancet Oncology Commission

Integration of oncology and palliative care: a *Lancet Oncology* Commission

www.thelancet.com/oncology Vol 19 November 2018

PATIENT - CENTRED CARE

ELEMENTS

- Respect for patients' values, preferences and expressed needs.
- Coordination & integration of care.
- Information, communication & education.
- Physical comfort (bothersome symptoms).
- Emotional support (fear & anxiety).
- Involvement of family & friends.

RECOMMENDATIONS

- Integrate the concept "patient – centred care".
- Implement routine use of patient – reported outcomes (PROMs).
- Integrate shared – decision making and Advanced Care Planning.
- Involve and assess the family as part of early integration of cancer palliative care.
- Develop the content and basic method of standardised care pathway for use as a tool for early integration of pall care into oncology.
- Mandatory training of oncology & pall care specialists in patient – centred care.

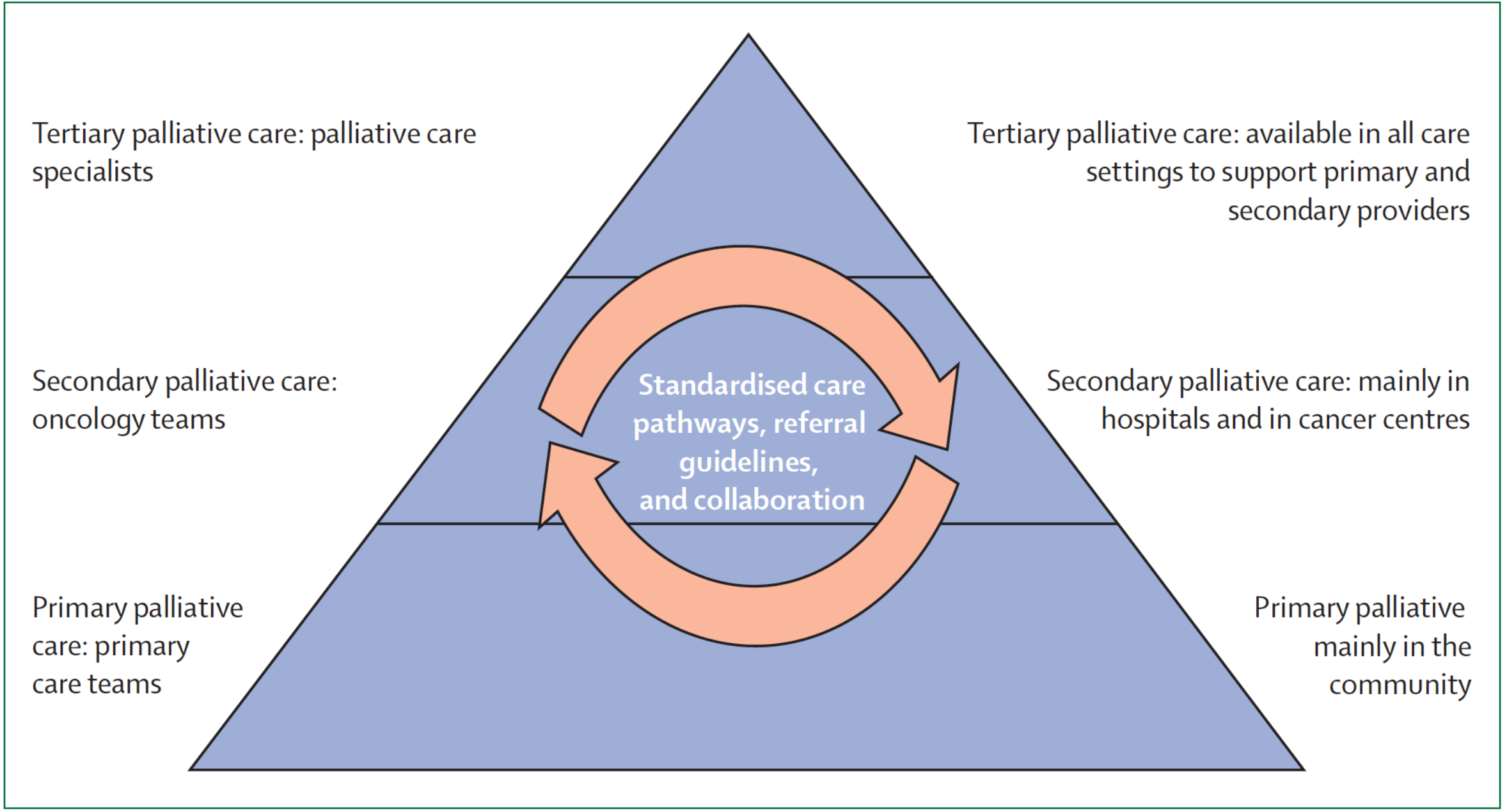


Figure 5: **Proposed model of optimal oncology palliative care provision, including integration across providers and settings**

PATIENT'S MANAGEMENT

DISEASE-DIRECTED THERAPIES

- Disease-directed therapies. .
- Treatment options: balance risks & benefits.
- Personalized treatments.

SUPPORTIVE ONCOLOGY

- Symptom management
- Psychosocial Oncology Services.
- Patient-Physician Communication (prognosis, end-of life.
- Advance care planning.
- End of Life.

Hui et al. JCO, 2015

PALL CARE/SUPPORTIVE ONCOLOGY AND GYNECOLOGICAL MALIGNANCIES

TREATMENT – RELATED

A. Surgery.

B. Chemotherapy:

-Neuropathic pain.

C. Radiotherapy:

-Fistulae.

-Actinic Disease.

-Lymphedema.

ADVANCED DISEASE

A. General Symptom Burden.

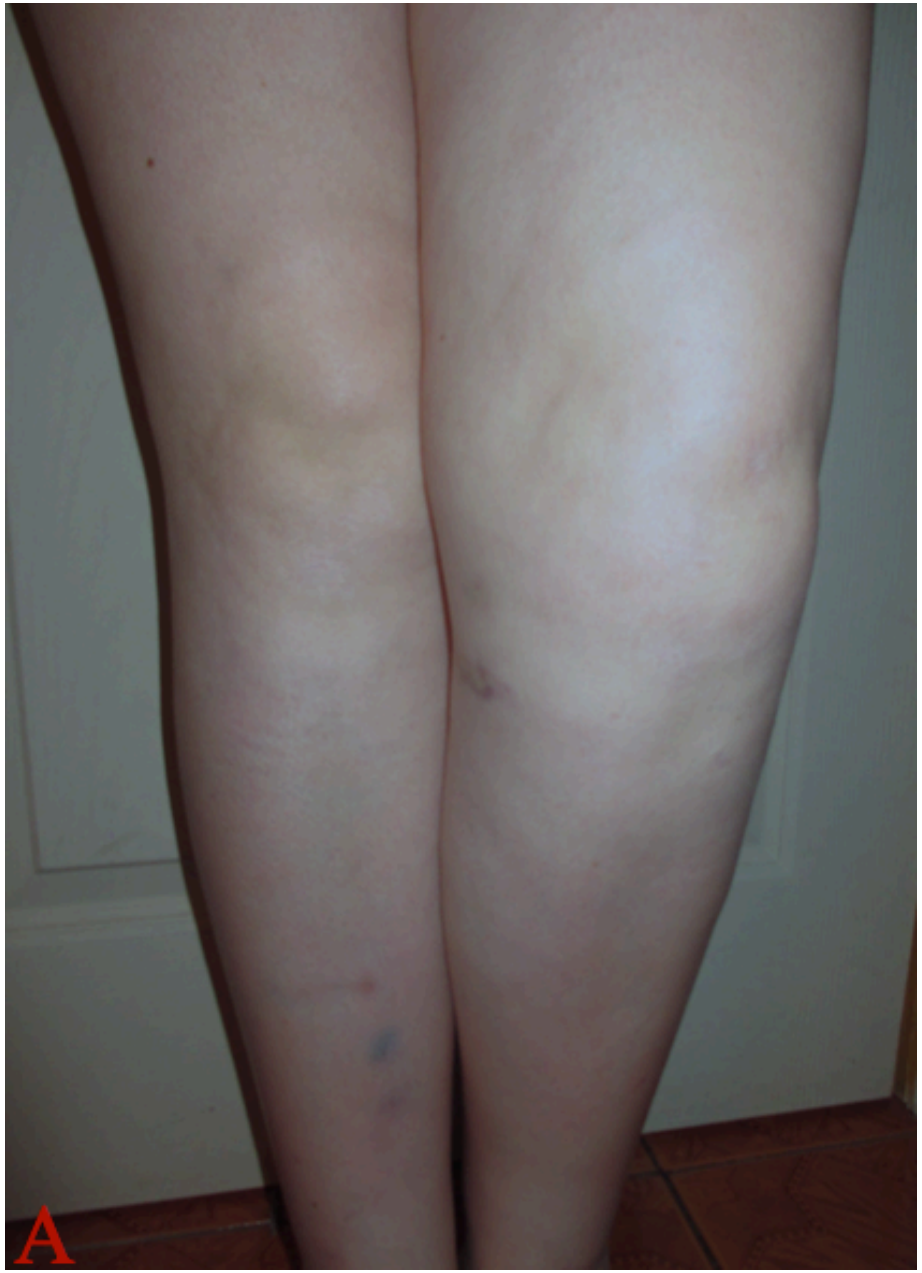
B. Specific Symptoms:

-Central Pelvic Recurrence.

-Pelvic Sidewall Recurrence.

-Peritoneal Carcinomatosis.

Malignant Ureteric Obstruction.
Malignant Bowel Obstruction.
Fistulae/Vaginal Discharge.


A

PALL CARE/SUPPORTIVE ONCOLOGY AND BREAST CANCER

TREATMENT – RELATED

A. Surgery.

B. Chemotherapy:

-Neuropathic pain.

C. Radiotherapy:

-Actinic Disease.

-Lymphedema.

ADVANCED DISEASE

A. General Symptom Burden.

B. Specific Symptoms:

-Bone/Brain Metastases.

-Breast Lump:

-Ulcerated.

-Malodorous.

-Hemorrhagic.

-Nodal Metastases:

-Superior Cava Vein Syndrome.

wpca
worldwide palliative
care alliance

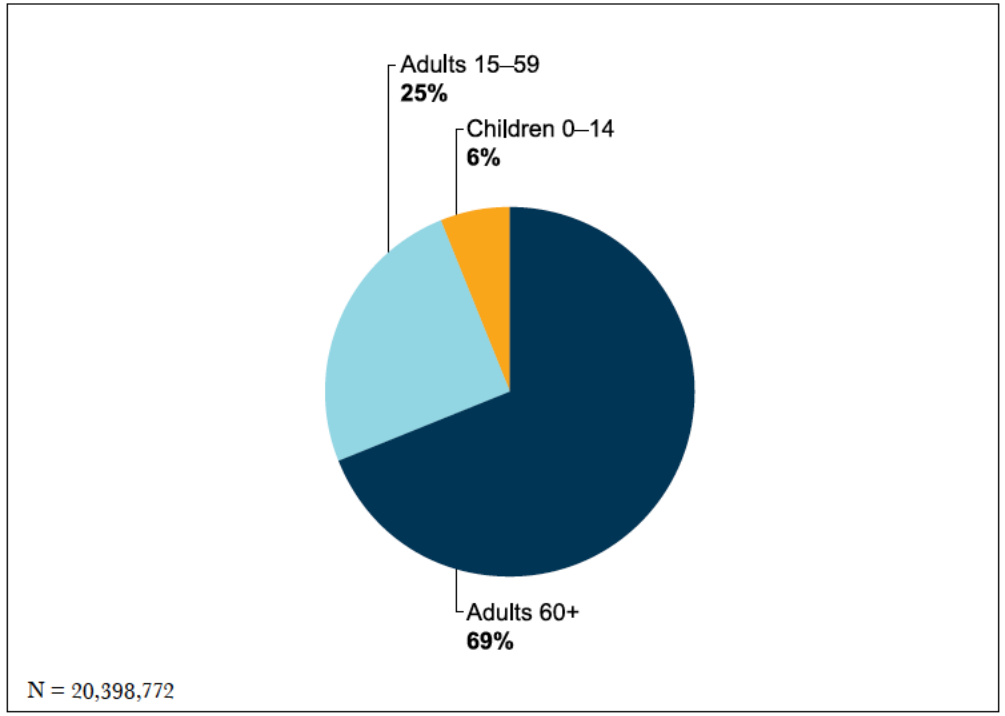
World Health
Organization

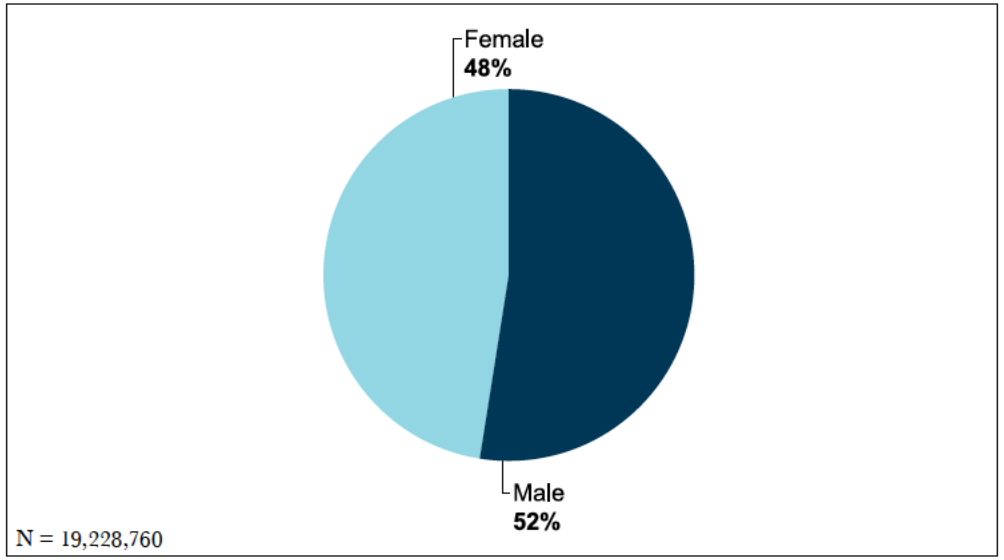
Global Atlas of Palliative Care at the End of Life


Rates for people in need of palliative care
All ages and both sexes per 100,000 (including adults and children)
178.36 - 272.85
272.86 - 281.84
281.85 - 307.16
307.17 - 467.52
Data not available
Not applicable
0
2'500
5'000
7'500
10'000 Kilometers
© WHO 2013. All rights reserved.

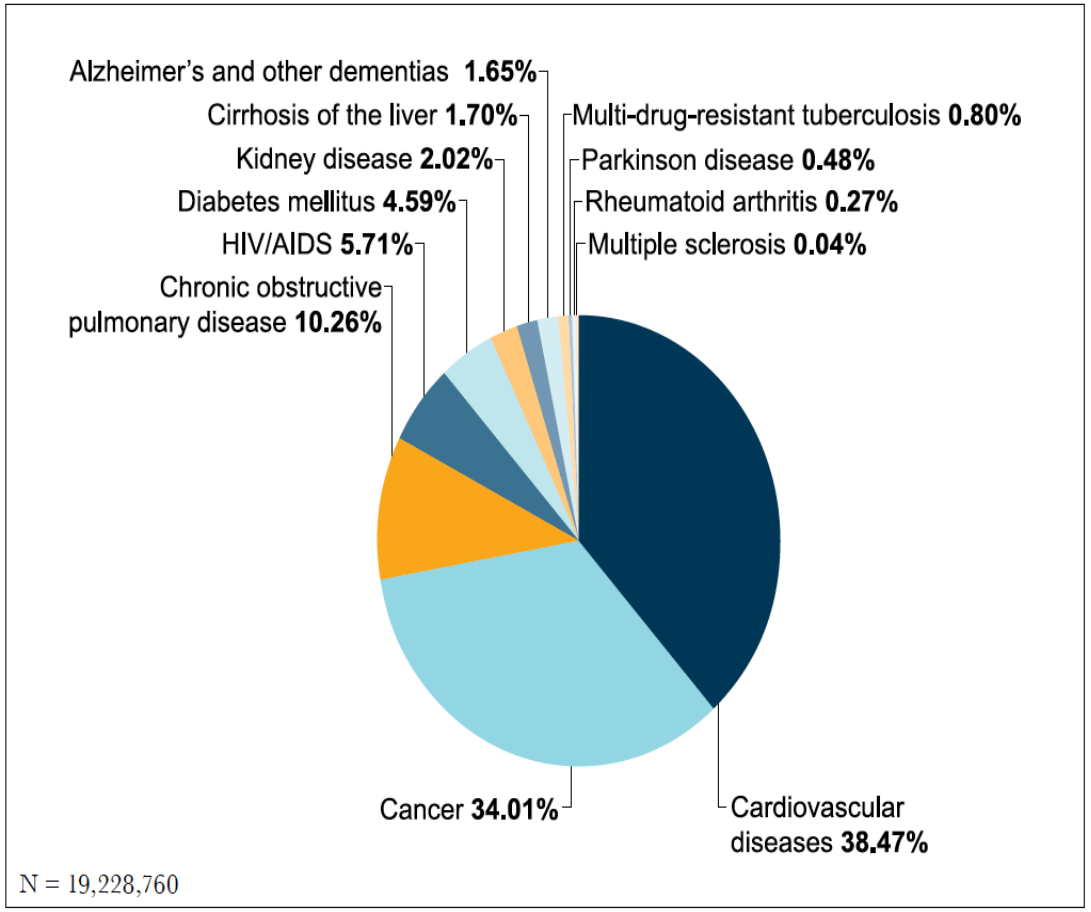

Rates for adults in need of palliative care
Both sexes per 100,000
234.12 - 353.39
353.40 - 365.78
365.79 - 378.45
378.46 - 561.52
Data not available
Not applicable
0
2'500
5'000
7'500
10'000 Kilometers
© WHO 2013. All rights reserved.

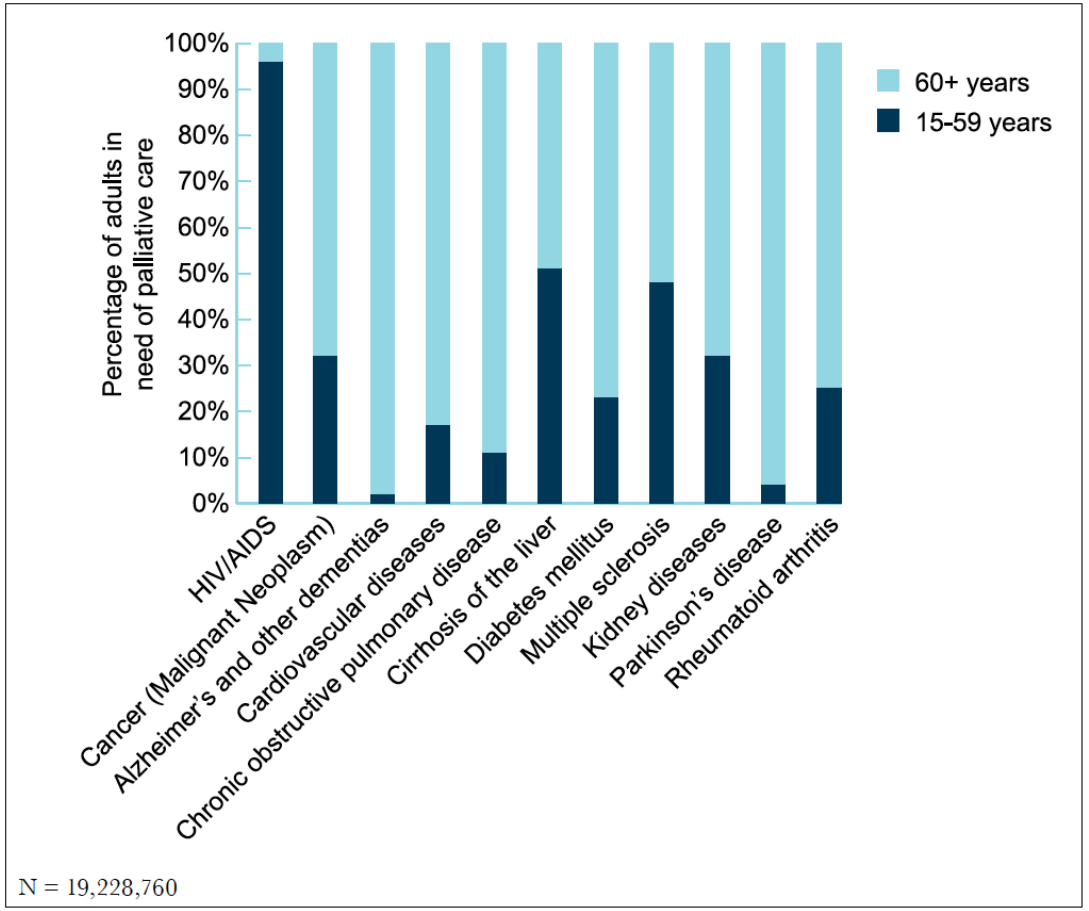
DISTRIBUTION PER AGE AND SEX

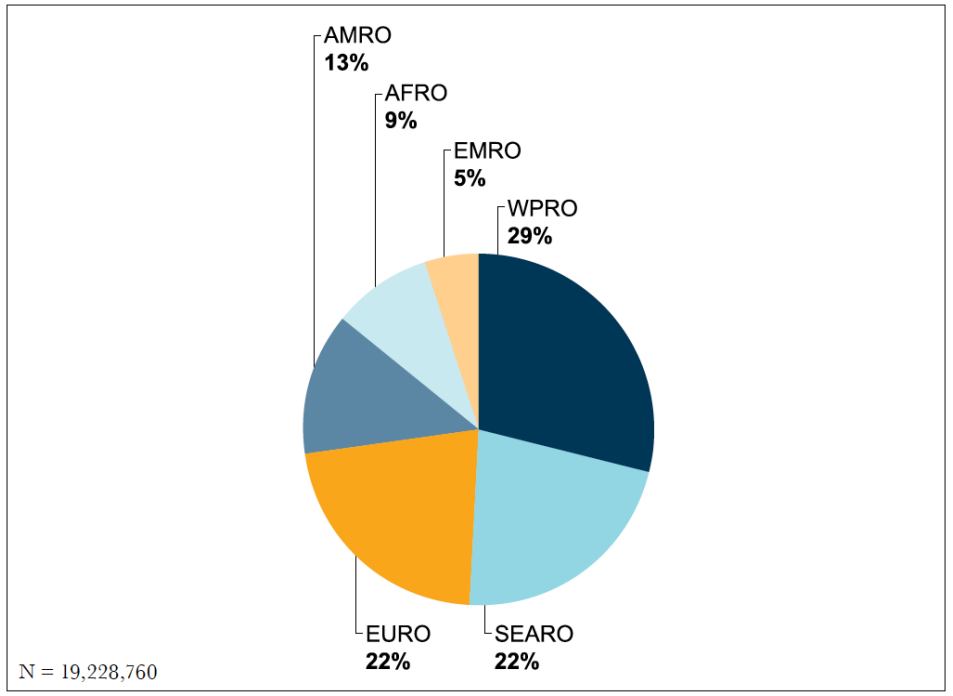


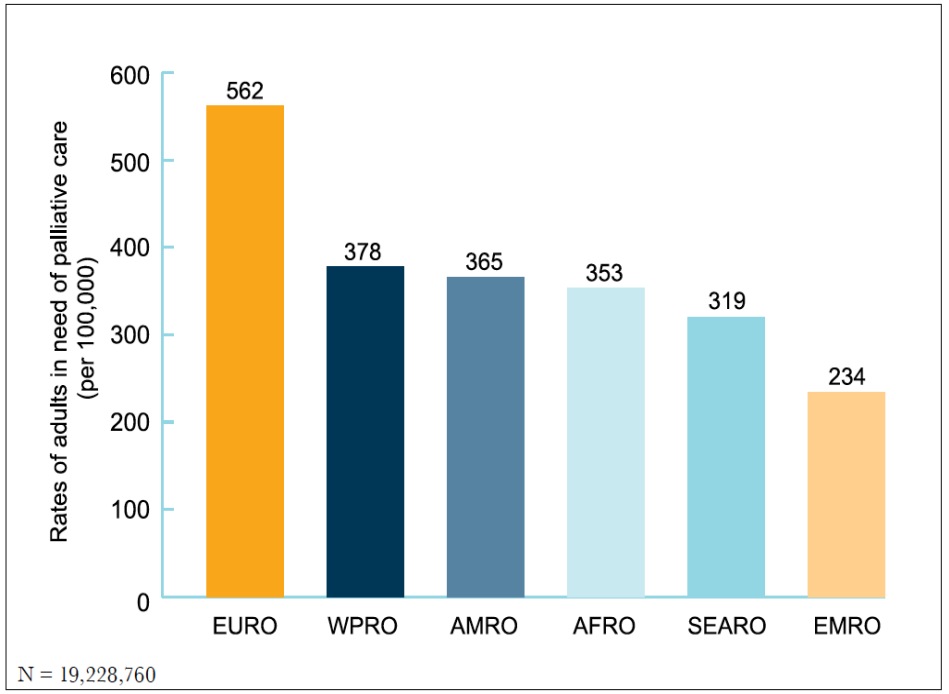


TYPE OF INCURABLE DISEASES IN ADULTS

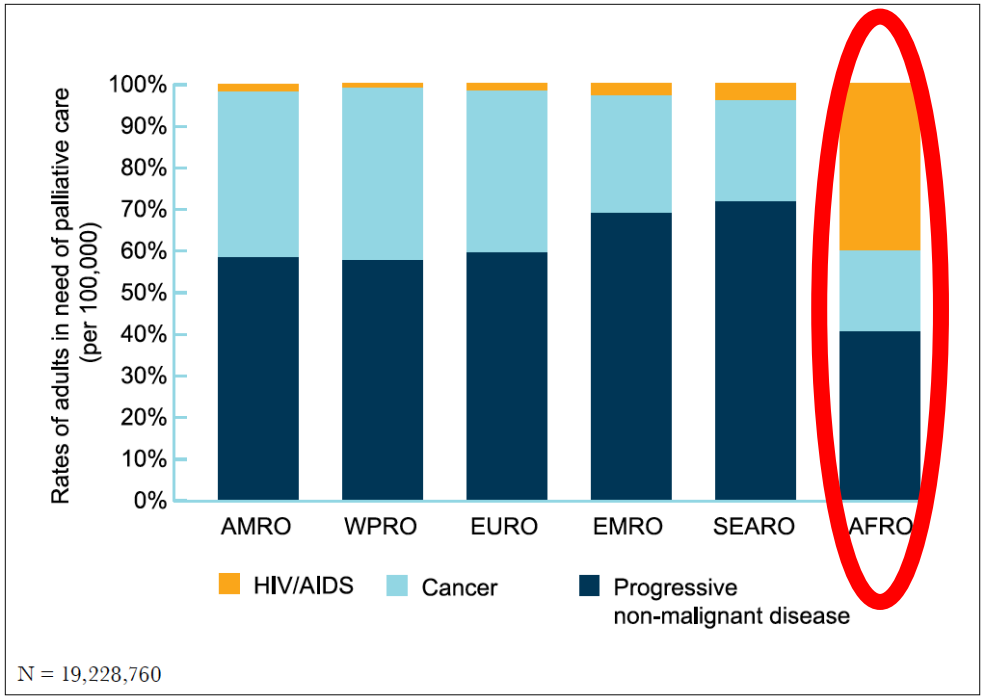




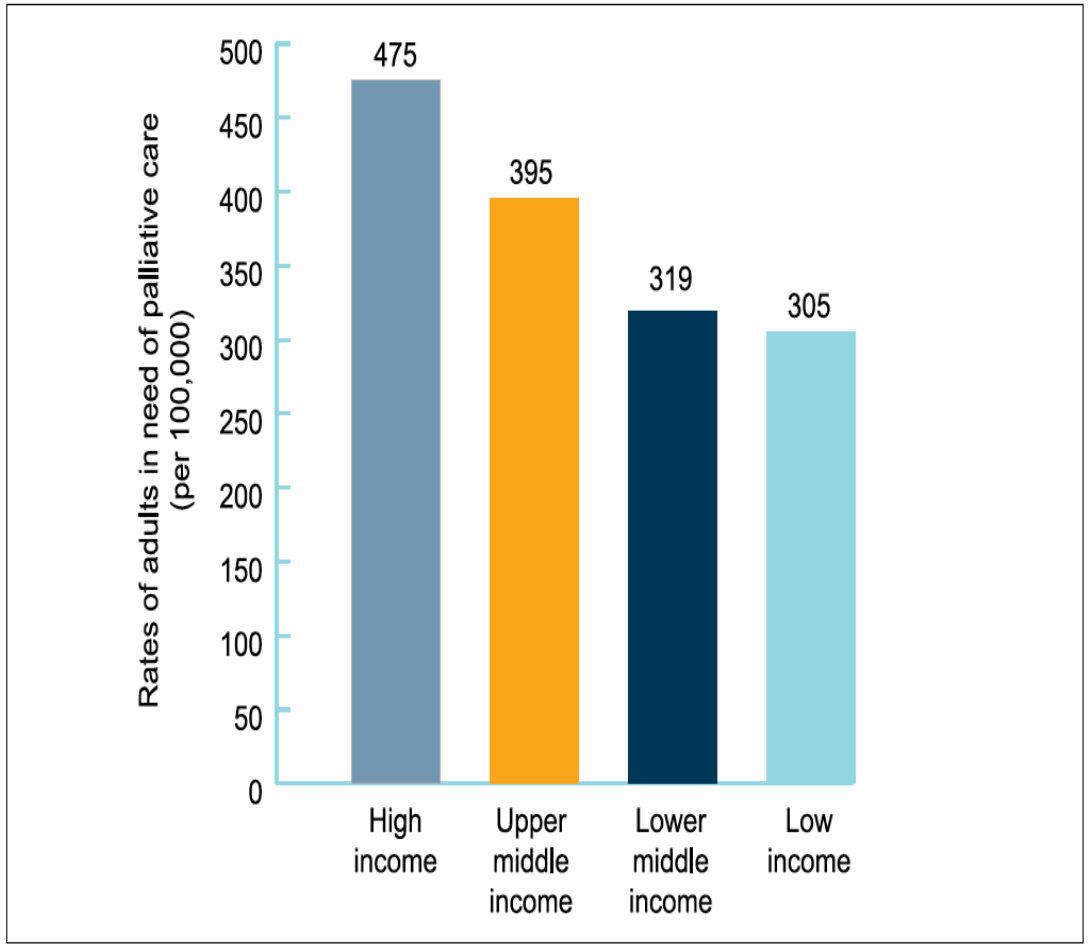


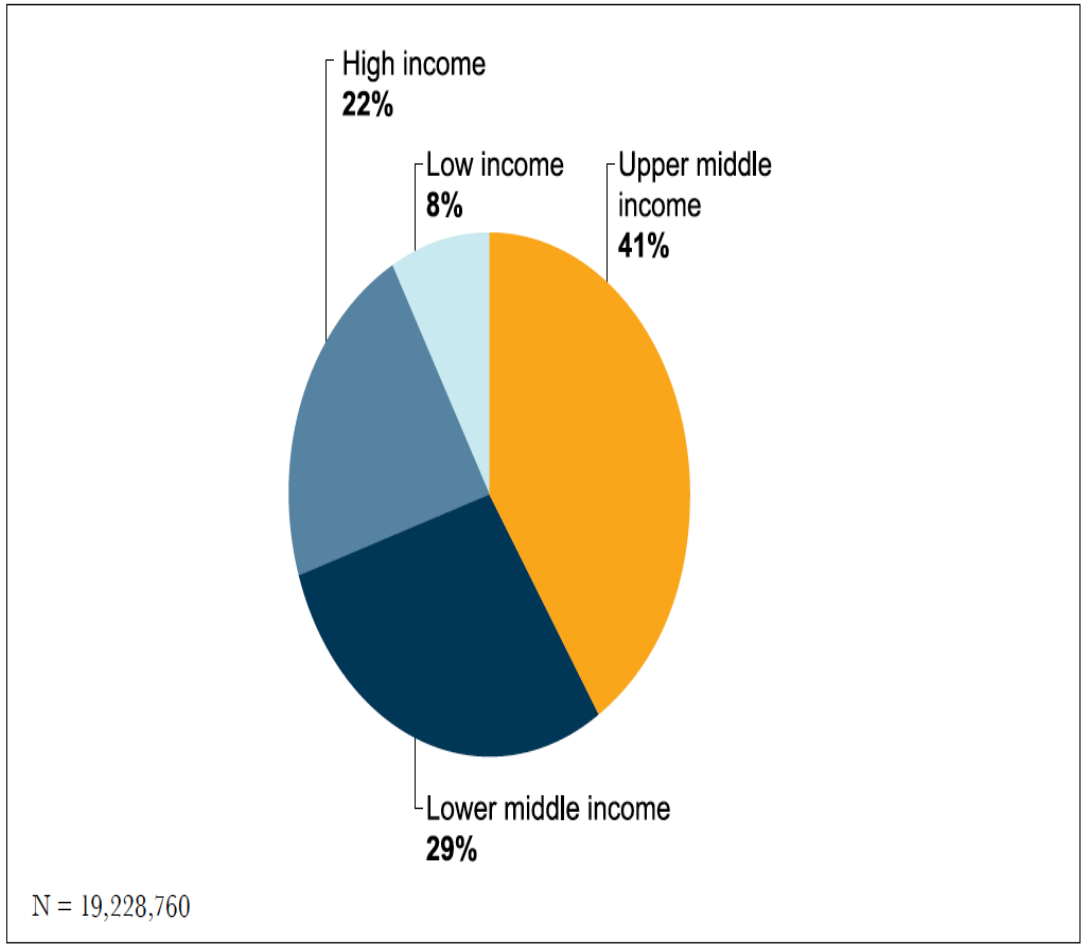


WPRO: Western Pacific.
EURO: Europe.
SEARO: South East.
AMRO: Americas.
AFRO: Africa.
EMRO: Eastern Mediterranean.

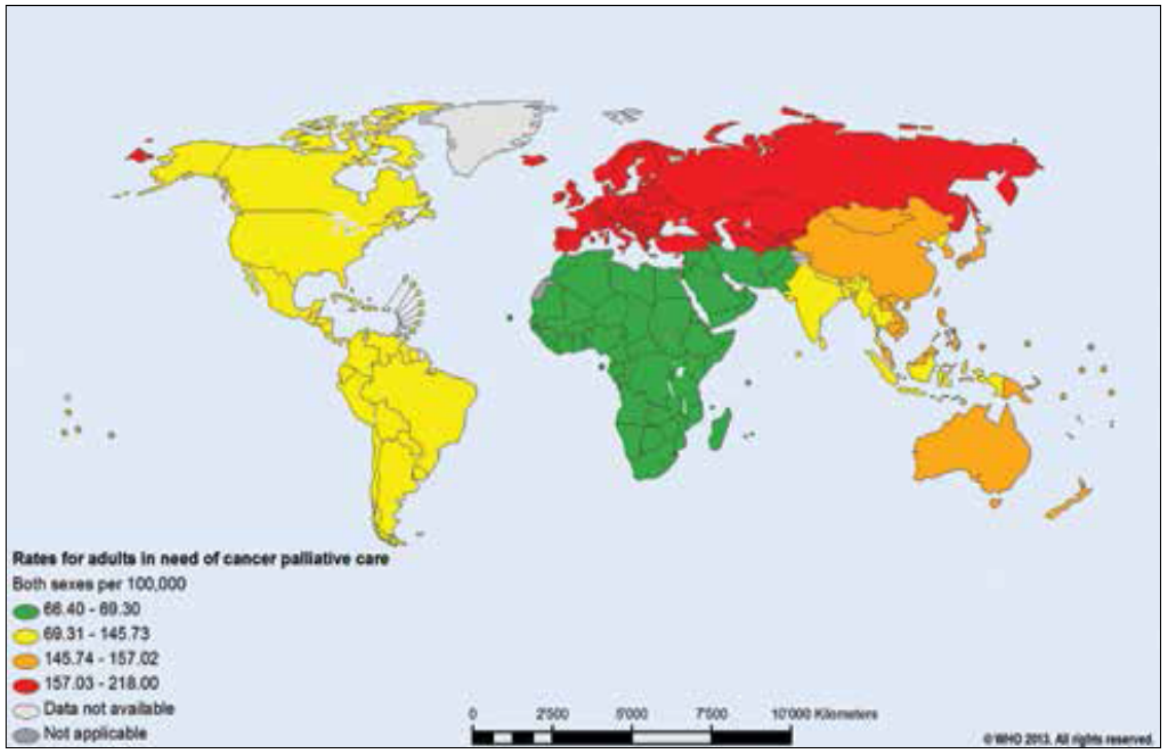


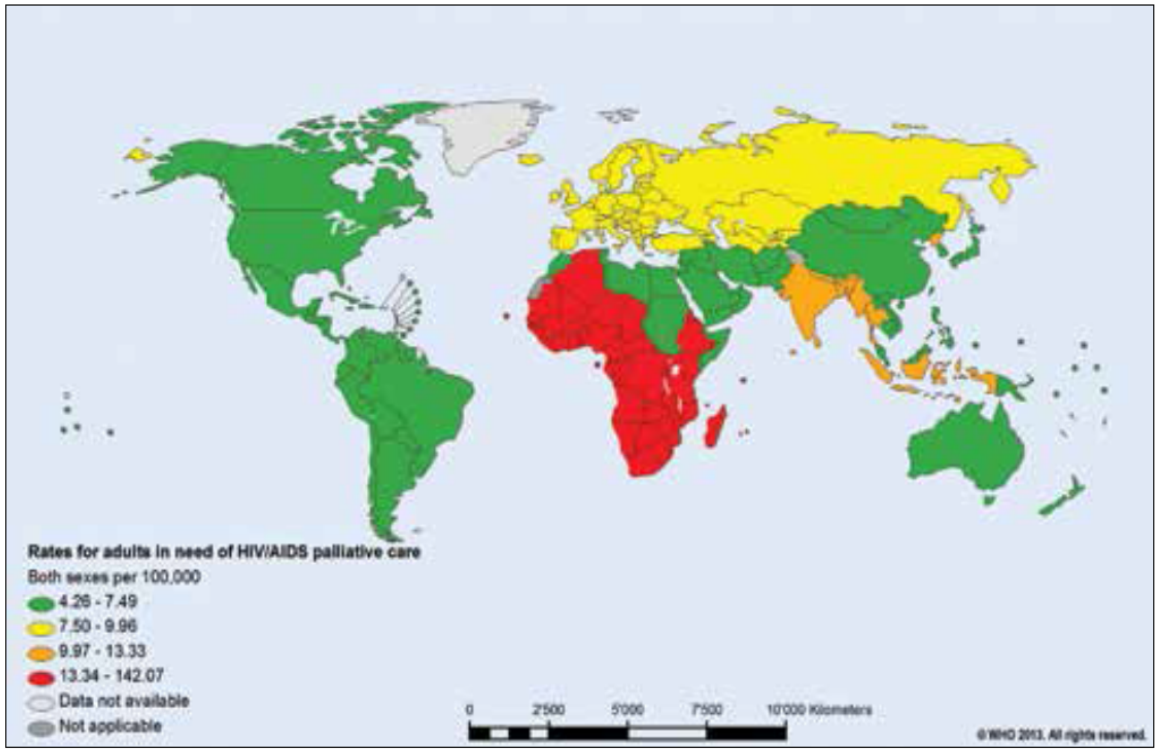
DISTRIBUTION ACCORDING TO WORLD BANK CLASSIFICATION





CANCER AND HIV NEED FOR PALLIATIVE CARE





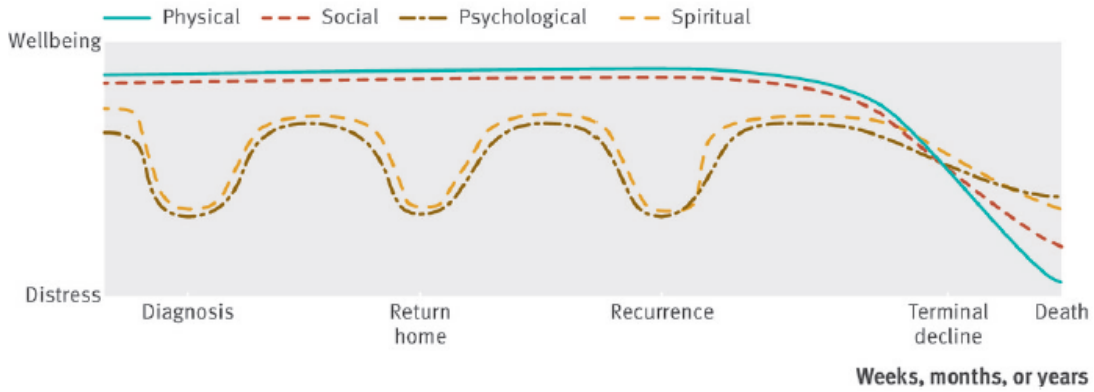


Fig 1 Wellbeing trajectories in patients with conditions such as cancer causing rapid functional decline

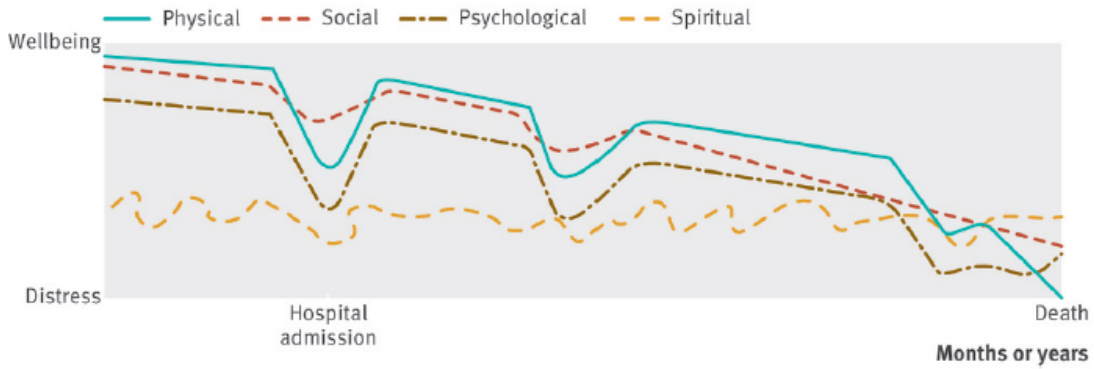


Fig 2 Wellbeing trajectories in patients with intermittent decline (typically organ failure or multimorbidity)

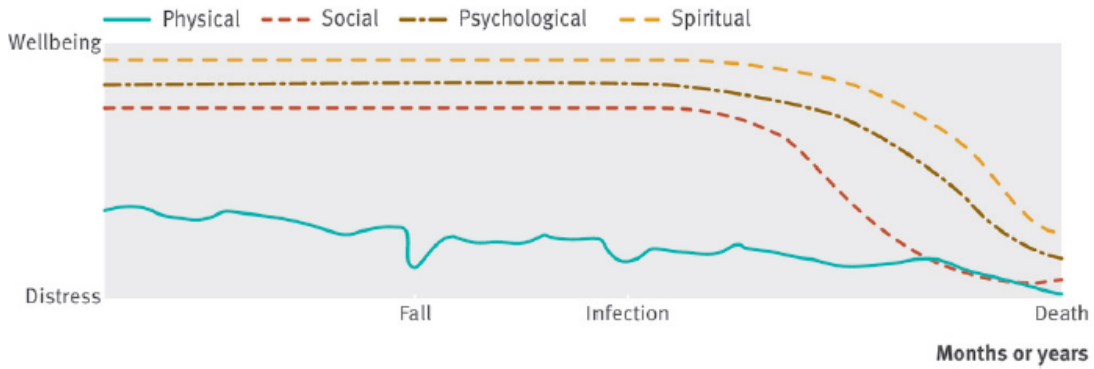


Fig 3 Wellbeing trajectories in patients with gradual decline (typically frailty or cognitive decline)

BMJ 2017

BARRIERS

- Policy.
- Education.
- Medications.
- Implementation.

Policy

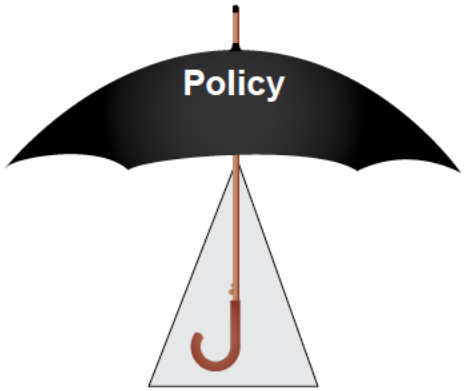
- Palliative care part of national health plan, policies, related regulations
- Funding/service delivery models support palliative care delivery
- Essential medicines

(Policy makers, regulators, WHO, NGOs)

Medicine availability

- Opioids, essential medicines
- Importation quota
- Cost
- Prescribing
- Distribution
- Dispensing
- Administration

(Pharmacists, drug regulators, law enforcement agents)



Education

- Media and public advocacy
- Curricula, courses – professionals, trainees
- Expert training
- Family caregiver training and support

(Media and public, healthcare providers and trainees, palliative care experts, family caregivers)

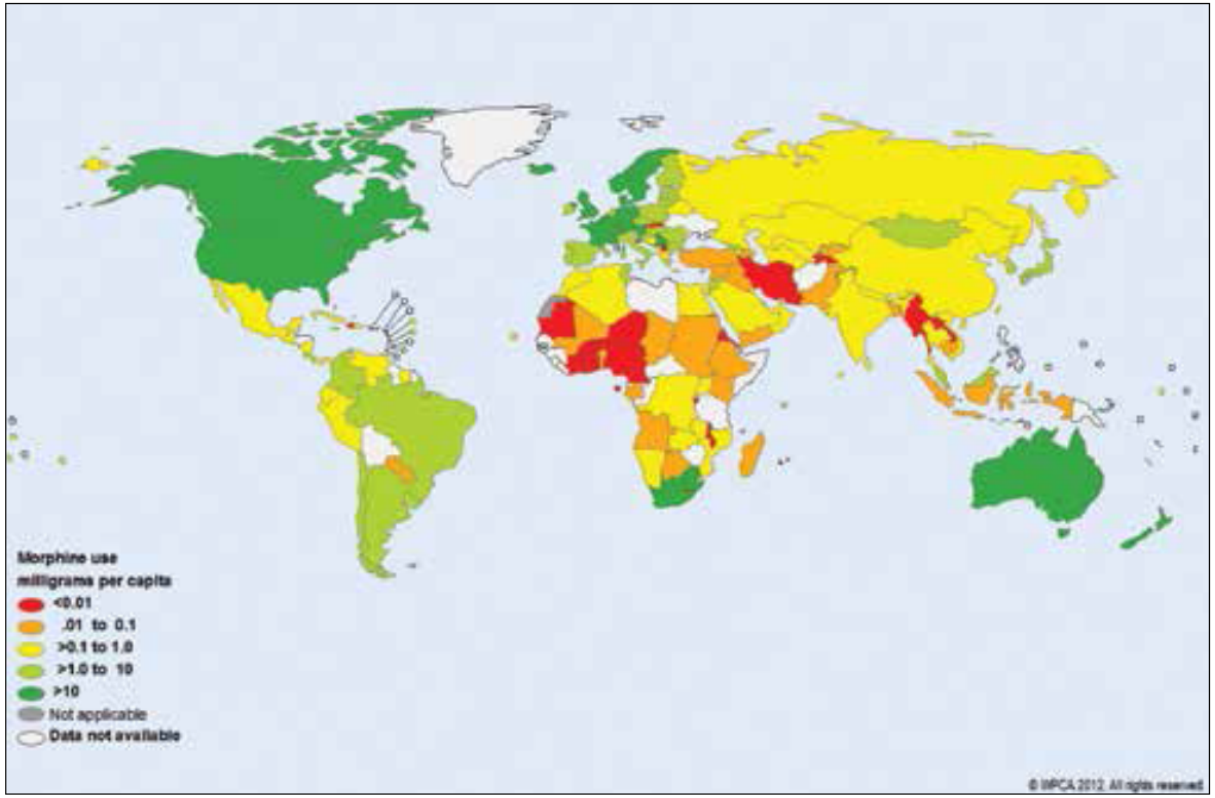
Implementation

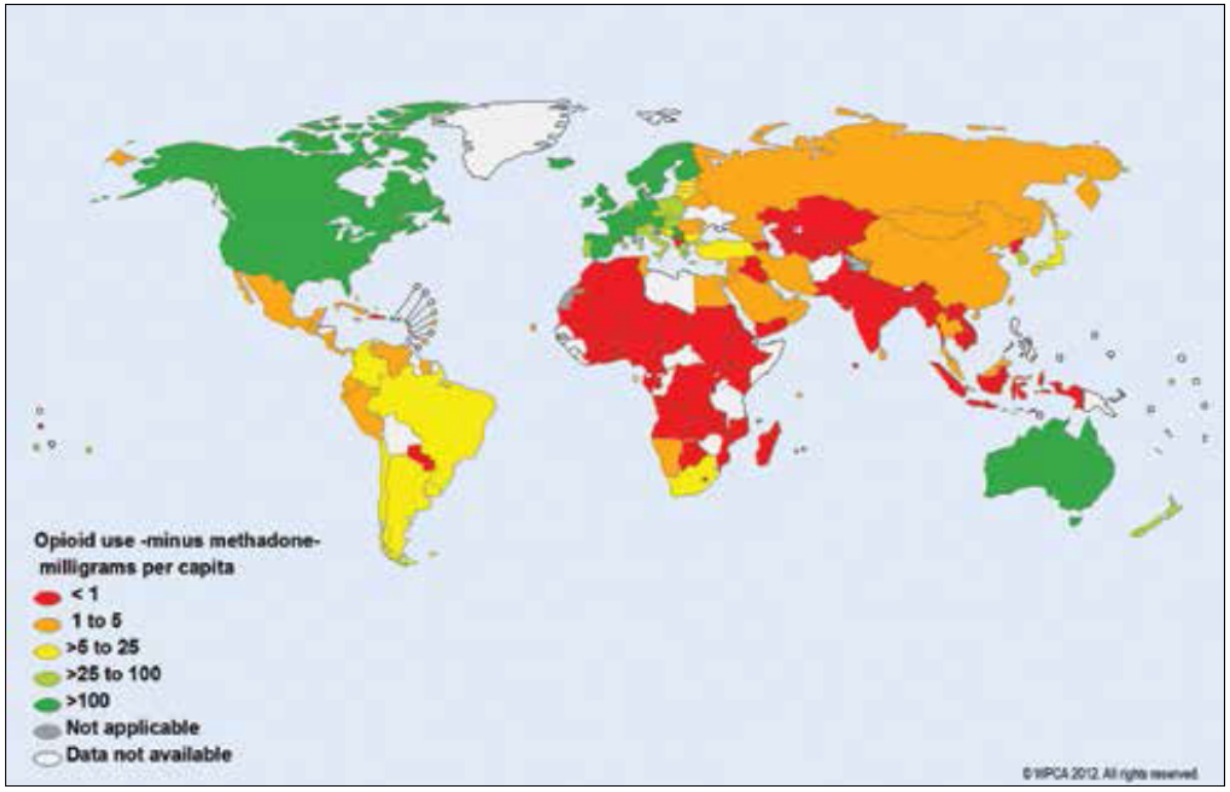
- Opinion leaders
- Trainer manpower
- Strategic and business plans – resources, infrastructure
- Standards, guidelines measures

(Community and clinical leaders, administrators)

Stjernsward et al. 2007[33]. Used with permission.

MORPHINE AND OPIOID CONSUMPTION WORLDWIDE



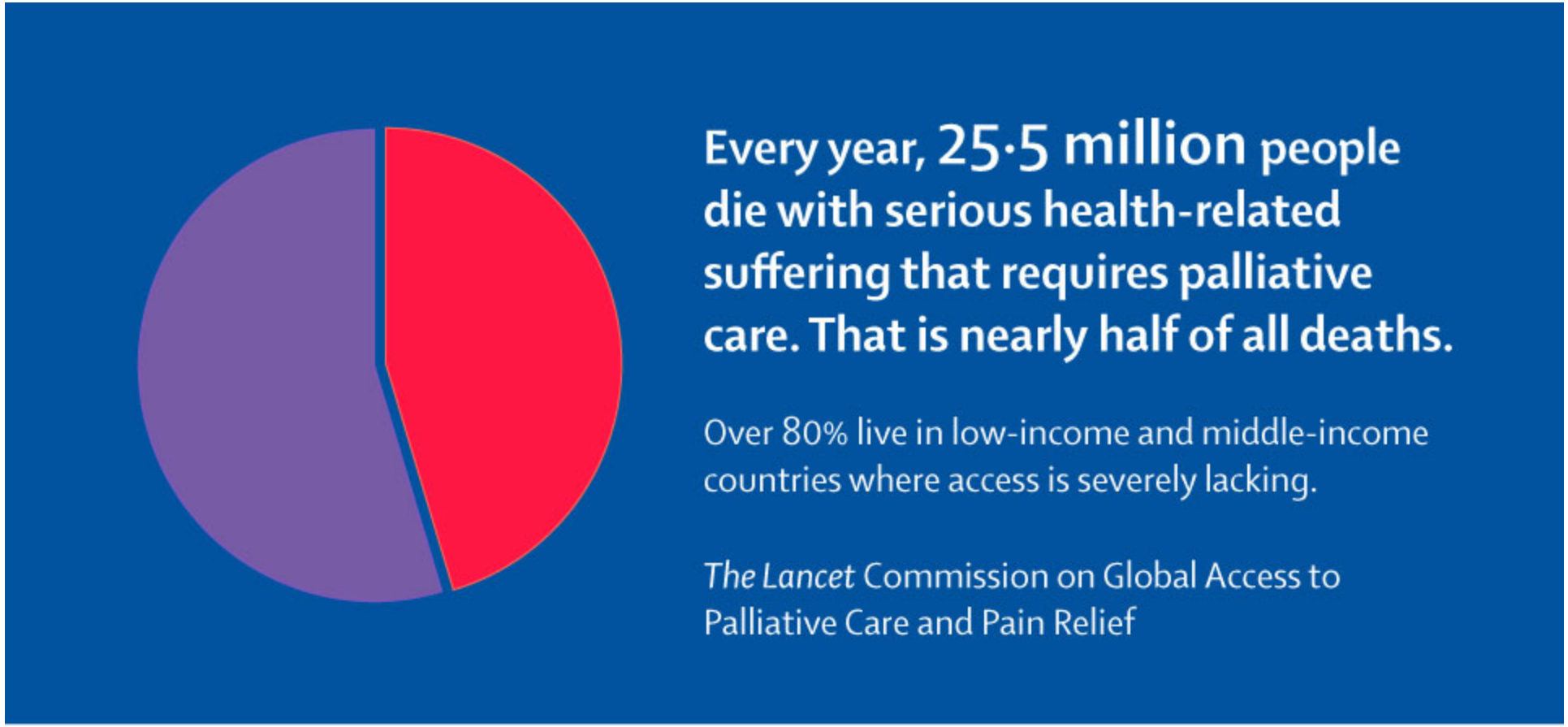


The Lancet Commissions

Alleviating the access abyss in palliative care and pain relief—an imperative of universal health coverage: the *Lancet* Commission report

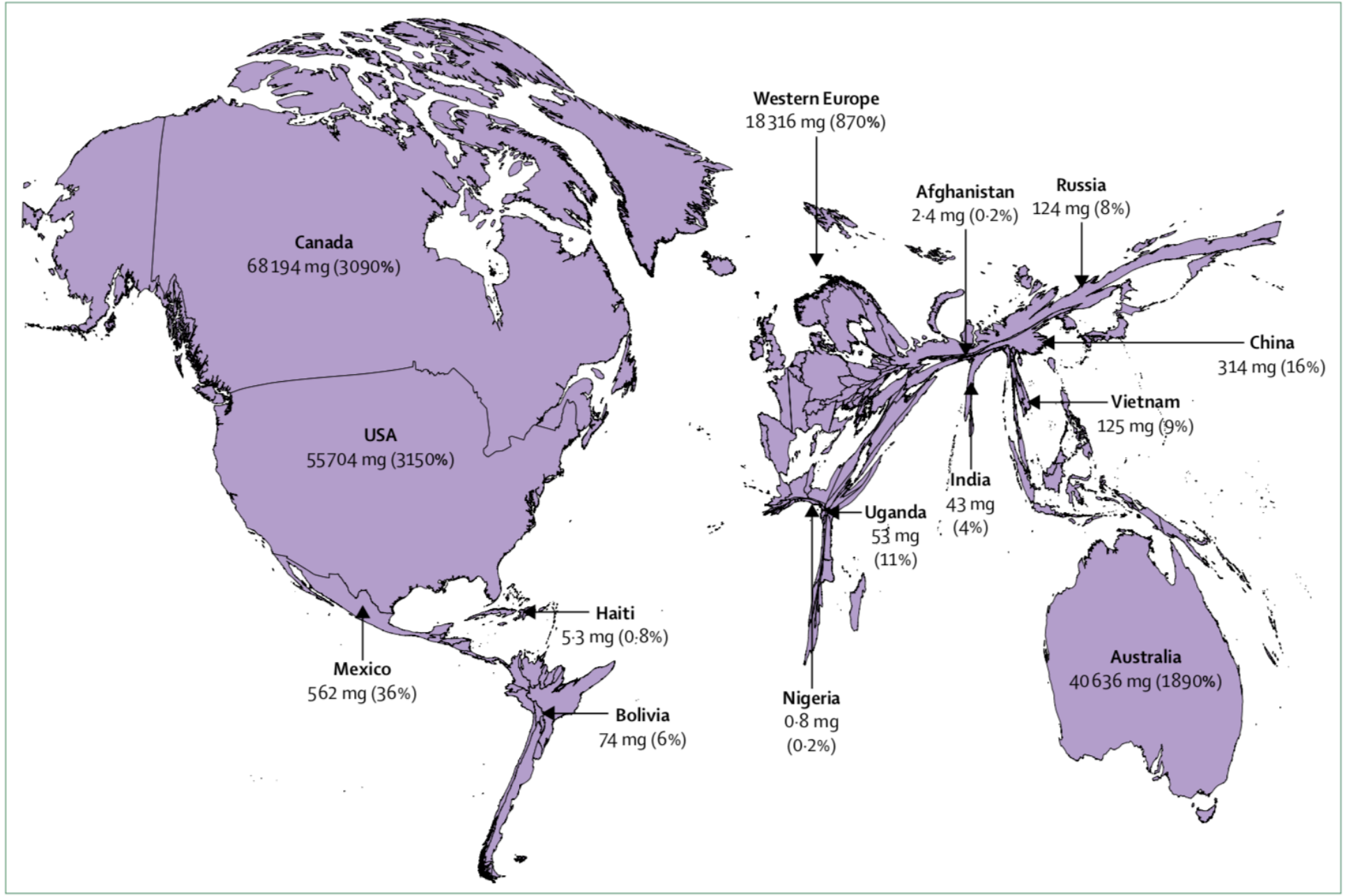
Felicia Marie Knaul, Paul E Farmer, Eric L Krakauer*, Liliana De Lima, Afsan Bhadelia, Xiaoxiao Jiang Kwete, Héctor Arreola-Ornelas, Octavio Gómez-Dantés, Natalia M Rodriguez, George A O Alleyne, Stephen R Connor, David J Hunter, Diederik Lohman, Lukas Radbruch, María del Rocío Sáenz Madrigal, Rifat Atun†, Kathleen M Foley†, Julio Frenk†, Dean T Jamison†, M R Rajagopal†, on behalf of the* Lancet *Commission on Palliative Care and Pain Relief Study Group‡*

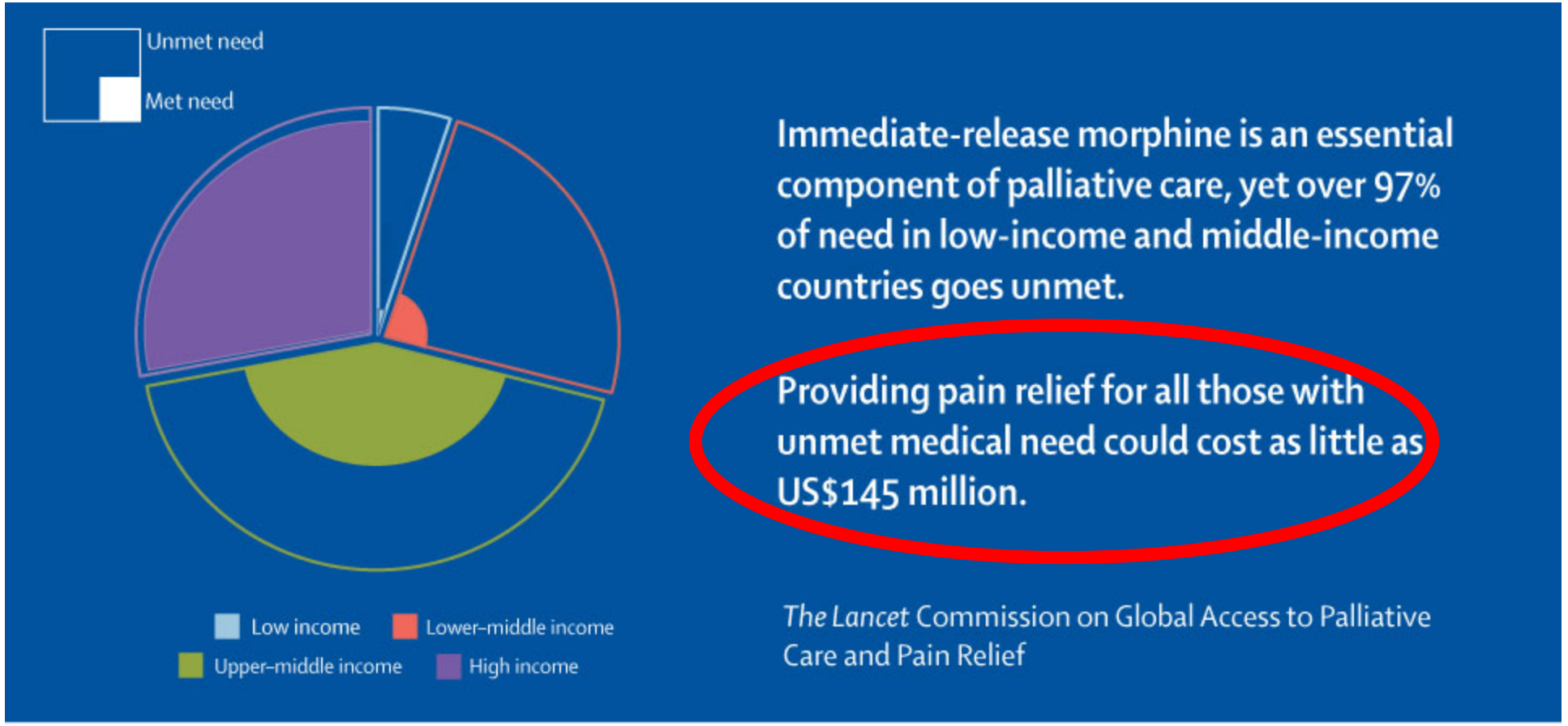
www.thelancet.com **Published online October 12, 2017 http://dx.doi.org/10.1016/S0140-6736(17)32513-8**



THE LANCET

The best science for better lives


Western Europe
18316 mg (870%)
Afghanistan
2·4 mg (0·2%)
Russia
124 mg (8%)
China
314 mg (16%)
Vietnam
125 mg (9%)
India
43 mg
(4%)
Uganda
53 mg
(11%)
Nigeria
0·8 mg
(0·2%)
Australia
40636 mg (1890%)
Canada
68194 mg (3090%)
USA
55704 mg (3150%)
Haiti
5·3 mg (0·8%)
Mexico
562 mg (36%)
Bolivia
74 mg (6%)



THE LANCET

The best science for better lives

Panel 2: An Essential Package Of Palliative Care And Pain Relief Health Services

The Essential Package contains the inputs for safe and effective provision of essential palliative care and pain relief interventions to alleviate physical and psychological symptoms, including the medicines and equipment that can be safely prescribed or administered in a primary care setting. The list of essential medicines in the Essential Package is based on WHO's list of essential medicines,[15] and considers the medicines, doses, and administration routes for palliative care for both adults and children.

The Essential Package is designed to be lowest cost by including only off-patent formulations, frugal innovation for needed equipment, and a staffing model based on competencies rather than professions. Tasks often undertaken by specialised medical personnel in high-income countries can be performed by other specialised and general practitioners and nurses or by community health workers empowered with the necessary training and medical supervision to participate effectively in the delivery of palliative care and pain treatment at all levels of care, from the hospital to the home.[16,17]

With the key exception of morphine, the medicines in the Essential Package are available in most countries even if supply is limited. For morphine, an essential palliative care medicine, assuring safety and accessibility is complex. Ensuring a balance between appropriate medical access to controlled medicines and the prevention of their diversion and non-medical use is crucial, and the Commission not only designed appropriate human resource models but also the strategies to provide the complementary policy and stewardship to expand access to an Essential Package that includes morphine.[12]

The health services of the Essential Package must be complemented by interventions for the relief of social and spiritual suffering to preserve the dignity of patients, facilitate access to health interventions, and prevent financial hardship and impoverishment. Yet, these social supports are neither part of the remit of health ministries nor should they be financed from a health budget.

Antipoverty and social development policies, publicly funded safety nets, programmes, and ministries must give special attention to ensure that families do not sacrifice their basic needs in desperate attempts to care for loved ones. These persons with life-limiting or life-threatening health conditions and their families should be mainstreamed into existing social support and social welfare programmes, yet they are often ignored, excluded, or marginalised, preventing them from being effectively integrated into these programmes.

Medicines

- Amitriptyline
- Bisacodyl (Senna)
- Dexamethasone
- Diazepam
- Diphenhydramine (chlorpheniramine, cyclizine, or dimenhydrinate)
- Fluconazole
- Fluoxetine or other selective serotonin-reuptake inhibitors (sertraline and citalopram)
- Furosemide
- Hyoscine butylbromide
- Haloperidol
- Ibuprofen (naproxen, diclofenac, or meloxicam)
- Lactulose (sorbitol or polyethylene glycol)
- Loperamide
- Metaclopramide
- Metronidazole
- Morphine (oral immediate-release and injectable)
- Naloxone parenteral
- Omeprazole
- Ondansetron
- Paracetamol
- Petroleum jelly

Medical equipment

- Pressure-reducing mattress
- Nasogastric drainage or feeding tube
- Urinary catheters
- Opioid lock box
- Flashlight with rechargeable battery (if no access to electricity)
- Adult diapers (or cotton and plastic, if in extreme poverty)
- Oxygen

Human resources (varies by referral, provincial or district hospital, community health center, or home

- Doctors (specialty and general, depending on level of care)
- Nurses (specialty and general)
- Social workers and counsellors
- Psychiatrist, psychologist, or counsellor (depending on level of care)
- Physical therapist
- Pharmacist
- Community health workers
- Clinical support staff (diagnostic imaging, laboratory technician, nutritionist)
- Non-clinical support staff (administration, cleaning)

Additional detail is provided in the additional online material.

special article

Palliative Care in the Global Setting: ASCO Resource-Stratified Practice Guideline

Hibah Osman
Sudip Shrestha
Sarah Temin
Zipporah V. Ali
Rumalie A. Corvera
Henry D. Ddungu
Liliana De Lima
Maria Del Pilar Estevez-Diz
Frank D. Ferris
Nahla Gafer
Harmala K. Gupta
Susan Horton
Graciela Jacob
Ruinuo Jia
Frank L. Lu
Daniela Mosoiu
Christina Puchalski
Carole Seigel
Olaitan Soyannwo
James F. Cleary

executive summary

Purpose The purpose of this new resource-stratified guideline is to provide expert guidance to clinicians and policymakers on implementing palliative care of patients with cancer and their caregivers in resource-constrained settings and is intended to complement the *Integration of Palliative Care Into Standard Oncology Care: American Society of Clinical Oncology Clinical Practice Guideline Update* of 2016.

Methods ASCO convened a multidisciplinary, multinational panel of experts in medical oncology, family medicine, radiation oncology, hematology/oncology, palliative and/or hospice care, pain and/or symptom management, patient advocacy, public health, and health economics. Guideline development involved a systematic literature review, a modified ADAPTE process, and a formal consensus-based process with the Expert Panel and additional experts (consensus ratings group).

Results The systematic review included 48 full-text publications regarding palliative care in resource-constrained settings, along with cost-effectiveness analyses; the evidence for many clinical questions was limited. These provided indirect evidence to inform the formal consensus process, which resulted in agreement of ≥ 75% (by consensus ratings group including Expert Panel).

Recommendations The recommendations help define the models of care, staffing requirements, and roles and training needs of team members in a variety of resource settings for palliative care. Recommendations also outline the standards for provision of psychosocial support, spiritual care, and opioid analgesics, which can be particularly challenging and often overlooked in resource-constrained settings. Additional information is available at www.asco.org/resource-stratified-guidelines.

Recommendations It is the view of ASCO that health care providers and health care system decision makers should be guided by the recommendations for the highest stratum of resources available. The guideline is intended to complement but not replace local guidelines.

- CHILEAN EXPERIENCE.

- IGCS ENVISION.

TAKE HOME MESSAGES

- Real need for palliative care.
- Importance of multidisciplinary approach and not only pain management.
- Huge differences among countries and areas.
- Promissory future, but still a lot of work ahead of us!!

KEY MESSAGE: EARLY INTEGRATION NOT REFERRAL

HOSPITAL SANTIAGO ORIENTE
Dr. Luis Tisné Brousse

IGCS

CLC
Clínica Las Condes

THANKS

CONTACT INFORMATION

EMAIL: RACOBUL@YAHOO.COM

TWITTER: @RACOBUL