PALLIATIVE CARE FOR PATIENTS WITH LUNG CANCER AND MESOTHELIOMA

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PALLIATIVE CARE

- An approach which improves QUALITY OF LIFE of PATIENTS and their FAMILIES facing LIFE-THREATENING ILLNESS through prevention and RELIEF OF SUFFERING by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Cancer pain relief and palliative care. Geneva; World Health Organization: 2002

PALLIATIVE CARE AND LUNG MALIGNANCY

Proof of Principle for
Early Palliative Care

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

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

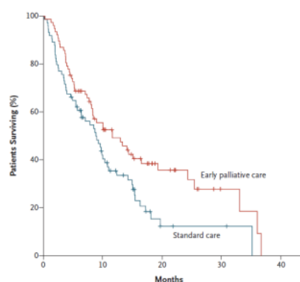
Jennifer S. Temel, M.D., Joseph A. Greer, Ph.D., Alona Muzikansky, M.A., Emily R. Gallagher, R.N., Sonal Admane, M.B., B.S., M.P.H., Vicki A. Jackson, M.D., M.P.H., Constance M. Dahlin, A.P.N., Craig D. Blinderman, M.D., Juliet Jacobsen, M.D., William F. Pirl, M.D., M.P.H., J. Andrew Billings, M.D., and Thomas J. Lynch, M.D.

Temel, NEJM, 2010

PALLIATIVE CARE AND LUNG MALIGNANCY

- 151 patients with NSCLC randomised to ‘early palliative care’ or ‘standard care’
- 107/151 completed 12 weeks follow-up
- Patients assigned to early palliative care got:
  - Better quality of life
  - Less depression
  - Less aggressive care
  - Longer median survival

SURVIVAL OUTCOME



SUBGROUPS OF PATIENTS TO RECEIVE BENEFITS FROM EPC – Nipp 2018

BJC

Best supportive care in clinical trials: review of the inconsistency in control arm design

SUBGROUPS OF PATIENTS TO RECEIVE BENEFITS FROM EPC – Nipp 2018

- Secondary data analysis from RCT of 350 patients
  Aim: If age & sex moderate the effects of palliative care on QOL, depression, coping strategies among patients with advanced lung & GI cancers
- Male patients with lung cancer assigned to EPC experienced better QOL and mood
- Younger patients with lung cancer (<65 yrs) who received EPC reported increased use of active coping and decreased use of avoidant coping
- Female patients with lung cancer in both study groups experienced improvements in their QOL & mood

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EVIDENCE OF EPC

- Palliative care in US is different from UK
- Most studies have been in advanced stage of cancer
- Intervention: 'EPC' may lead to little actual PC input
- Temel 2010: showed significant QoL/survival differences
- Subsequent studies have shown mixed results on survival or QoL

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BARRIERS TO EARLY PALLIATIVE CARE

- Doctors fear that referral to palliative care may alarm patients/families
- Families/patients reluctance to accept referral due to misinformation or the idea that palliative care = terminal care
- Lack of knowledge and education about palliative care practices and referral policies

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PALLIATIVE CARE

- Prognostication
- Symptom Management
- Psychological support
- Care of the dying
- Ethical decision making
- Bereavement support

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PROGNOSTICATION

- Surprise question:

  Would you be surprised if this patient were to die in the next few months, weeks, days'?

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PROGNOSTICATION

- General indicators of decline - deterioration, increasing need or choice for no further active care
- Specific clinical indicators related to certain conditions
- Biochemical markers (Persistently ↑ CRP, ↓ Serum Albumin)

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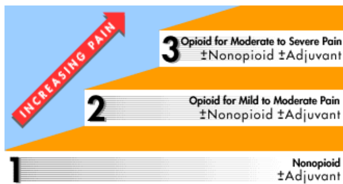
SYMPTOM MANAGEMENT

- Pain
- Shortness of breath
- Painful wounds
- Fatigue
- Loss of appetite
- Anxiety and depression

PAIN

- Post-thoracotomy syndrome
- Chemotherapy-induced peripheral neuropathy
- Involvement of the intercostal nerves by tumour invading the chest wall
- Dyspnoea

PAIN



PAIN

- Opioids
- Methadone

NEUROPATHIC PAIN

- Tricyclic anti-depressants
- (Amitriptyline 10 mg nocte – 75 mg a day)
- Anti-epileptics
- (Pregabalin 75 mg BD)
- Capsaicin cream
- Lidocaine
- Methadone
- Ketamine

SHORTNESS OF BREATH

- Cancer Dyspnoea Scale

SHORTNESS OF BREATH

- Management of Pleural effusion

SHORTNESS OF BREATH

- NON-DRUG TREATMENT:
  - Explore the perception of the patient and carers
  * Decide on realistic goals
  * Explain
  * 'Breathlessness itself not life-threatening, you would not suffocate to death'
  * Counselling

SHORTNESS OF BREATH

- NON-DRUG TREATMENT:
  -Maximise the feeling of control over breathlessness
  * Breathing control exercise
  * Relaxation Techniques
  * Simple written action plan
  * Use of Electric fan
  * Complementary therapies

SHORTNESS OF BREATH

- NON-DRUG TREATMENT:
  - Maximise functional ability
  * Multidisciplinary Approach
  * Reduce feelings of personal and social isolation
  * Day centres
  * Respite admissions

SHORTNESS OF BREATH

- DRUG THERAPY:
  - Bronchodilators:
  * B-agonist
  Salbutamol 2.5 mg – 5 mg 4-6 hourly
  * Antimuscirinic
  Ipratropium 500mcg 6 hourly

SHORTNES OF BREATH

- DRUG THERAPY:
  - Corticosteroids (Dexamethasone 4 mg BD) if tumour mass effect

SHORTNESS OF BREATH

- DRUG THERAPY:
  - Morphine
  - * 2.5 – 5 mg PRN in opioid naive patients
  - * If more than 2 doses needed, prescribe regularly
  - * If on opioids, calculate the Oramorph dose as per pain
  - * No evidence for nebulized Morphine

SHORTNESS OF BREATH

- DRUG THERAPY:
  - Anxiolytics
  - * Diazepam 2-5 mg PRN with 5 mg TDS
  - * Lorazepam 0.5-1 mg Sublingual (quicker)
  - * Buspirone 5 mg TDS (less sedative)
  - * Levomepromazine 12.5 – 50 mg in 24 hours (more sedative)

SHORTNESS OF BREATH

- OXYGEN:
  - Not always helpful but a trial is useful
  - 60% (other than COPD, where 28%)
  - Many patients will have some hypercapnia, therefore consider 28%

ANXIETY AND DEPRESSION

- Integrated Palliative care outcome Scale (IPOS)
- Hospital Anxiety and Depression Scale (HADS)

ANXIETY AND DEPRESSION

- Level 1: Effective information giving, compassionate communications and general psychological support *(All health & social care professionals)*
- Level 2: Using standardised screening tools e.g. the Distress Thermometer, HADS etc. *(Health & social care professionals with additional expertise including CNS)*

ANXIETY AND DEPRESSION

- Level 3: Counselling and specific psychological interventions such as anxiety management and solution focused therapy, delivered according to an explicit therapeutic framework *(Trained and accredited professionals)*
- Level 4: Specialist psychological and psychiatric interventions such as psychotherapy, including cognitive behavioural therapy. *(Mental Health Specialists)*

CARE OF THE DYING

- Only ONE chance to get it right
- If done well: significant family growth
- If done badly: life closure may be incomplete, suffering may occur and there may be problems in bereavement
- Careful management will lead to smooth passage for patient and carers alike

CARE OF THE DYING

- Decrease medications
- Review route
- Consider Syringe Driver
- PRN Medications
- Review repeatedly
- Personal Hygiene
- Mouth care
- Pressure areas care

PRINCIPLES

- ETHICS:
  - Beneficence: Do good
  - Maleficence: Do not do harm
  - Autonomy: Respect wishes
  - Justice: Treat fairly

ETHICAL DECISION MAKING

- Withdrawing and withholding treatment
- Resuscitation
- Euthanasia
- Organ donation

BEREAVEMENT

- Post Bereavement:
- Needs notification to Coroner
  (Prepare family early)
- May need Post Mortem
- Support from Mesothelioma UK, Local Hospice, Specialist Nurses

SUMMARY

- Early Palliative care in Lung malignancies is evidence based.
- Main symptom are pain, shortness of breath and psychological distress
- Need holistic care and multidisciplinary approach
- Family support
- Ethical decision making