Palliative Care for people with GU Cancers

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Main Points

- Definition
- Need
- Benefit
- Availability

"Palliative Care…"
Once They Know About Palliative Care...

- Extremely positive about it and want access
- 92% say:
  - It is important
  - Patients with serious illness and their families should be educated
  - Likely to consider PC for a loved one
  - It is important that palliative care services be made available at all hospitals

The Current Definition of Palliative Care

- Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness whatever the diagnosis.
- The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient’s other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.

Comprehensive Care
Focused on the Relief of Symptoms & Suffering

- Bio
  - Pain
  - Dyspnea
  - Constipation/Diarrhea
  - Nausea/Vomiting
  - Weight loss
  - Nutrition/Hydration
- Psycho
  - Depression
  - Anxiety
  - Fatigue
  - Agitation/Delirium

Comprehensive Care
Focused on Aligning Care with Patients' Preferences

- Advance Care Planning
  - Advance directives (DPOA, POLST)
  - Finances
  - Legacy work
  - Leave-taking
- Communication
  - Defining QOL, a life worth living
  - Decision-making
  - Reconciliation
Palliative Care is Not…

- For cancer only
- For old people only
- End-of-life care
- Hospice

The “Both/And” of Modern Palliative Care

Disease-Directed Therapies

Diagnosis  Palliative Care  Death and Bereavement

The Current Model of PC: Co-Management, Concurrent Care

PC and Oncologic Surgeons / Oncologists Focused on Different but Complimentary Tasks

- Palliative Care:
  - Initial visits focused on sx mgmt, coping, rapport-building, prognostic awareness
  - Later on resuscitation preferences and hospice
- Oncologic Surgeons / Oncologists:
  - Cancer treatment and management of medical/surgical complications
- Co-management allows each to focus on their expertise

Yoong, JAMA Intern Med, 2013

The Symptom Management Service

- Early Leader in Concurrent Care
- Outpatient palliative care co-management
- One of the first in a cancer center (2006)
  - 12/05-11/06  GU pilot project
  - Since 7/08  Available cancer center-wide

Meier, J Pall Med, 2008
Rabow, Arch Intern Med, 2010
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Should and Supposed To

- Burdens: Patients and families suffer with serious illness and at the end of life (so we should provide palliative care)
- Requirements: People with sticks say we have to

Burdens of GU Cancers

- Physical Symptoms
  - Pain
  - Fatigue
  - Bowel and Bladder dysfunction
  - Sexual functioning

- From disease and from treatment

Burdens of GU Cancers

- Psychological Symptoms
  - Depression
  - Anxiety
Burdens of GU Cancers

- Spiritual Distress
  - Identity
  - Sexuality
  - Libido
  - Function

- Caregiver Distress
  - Physical
  - Emotional
  - Financial

Prostate Cancer

- Men with localized disease suffer primarily from treatment
  - Incontinence (30-47%)
  - Impotence (60-70%)
  - Pain (post-op)
  - Impaired quality of life
    - especially sexual and urinary outcomes
  - Follow-up, survivorship, and PSA anxiety

- Men with metastatic disease suffer from both treatment and disease
  - Pain, especially bony mets (70-90%)
  - Fatigue, Hot Flashes, ED
  - Impaired QOL
  - Depression (up to 50%), Anxiety
  - Little known about intimacy and spirituality issues
UCSF Prostate Cancer: Reasons for Referral to the SMS

**Bladder Cancer**

- Little research available
- Bleeding, pain, dysuria, and urinary obstruction
- Depression (42%), anxiety (55%)
- Cystectomy does not improve pre-surgery symptoms (fatigue, depression, anxiety) and may worsened others (pain).

Benner, J Urol. 2014

**Should and Supposed To (cont)**

- Burdens: Patients and families suffer with serious illness and at the end of life (so we should provide palliative care)
- Requirements: Powerful organizations say we have to
ASCO Provisional Clinical Opinion

American Society of Clinical Oncology Provisional Clinical Opinion: The Integration of Palliative Care into Standard Oncology Care

"...combined standard oncology care and palliative care should be considered early in the course of illness for any patient with metastatic cancer and/or high symptom burden."

Commission on Cancer

S2.4 “Palliative care services are available to patients either on-site or by referral.”

American Urological Association

⇒ Recommends palliative care for some patients with advanced prostate cancer
⇒ No guidance regarding palliative care for bladder cancer patients

Main Points

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http://www.auanet.org/education/guidelines/castration-resistant-prostate-cancer.cfm
Treating Disease

- Even though treatment itself can cause symptoms, often the best treatment for cancer symptoms is treatment of the underlying disease
- E.g. In prostate cancer, good evidence of palliative benefits from radiotherapy, bisphosphonates, chemotherapy

Proven Benefits of Palliative Care

I. Improved patient and family satisfaction
II. Reduction in symptom burden
III. Reduced costs
IV. Prolonged life

Some GU cancer-specific data. Most data for cancer generally


I. Improved Satisfaction

- Patients
- Family
- Clinicians

SMS Prostate Cancer Patient Satisfaction

- Satisfaction surveys completed by 28 (21.2%) prostate cancer patients 2 months following their initial visit
- Patients reported:
  - being very comfortable with their visits (4.95)
  - that they were very likely to recommend the service (4.95)
  - that they were very likely to recommend UCSF because of the service (4.35)
  - that the SMS improved their access to UCSF (4.36)

Rabow, JPM, 2014
II. Improved Symptoms

- Improved outcomes in pre/post studies and in controlled trials
  - Pain, Fatigue, Nausea, Depression, Anxiety, Drowsiness, Appetite, Dyspnea, Insomnia, Constipation, and Satisfaction

- Improved outcomes pre/post for prostate CA
  - 55 pts with met PCa at MD Anderson, 66 yo, 73% white, 15d f/u
  - Pain, Drowsiness, Fatigue, Depression, Sleep, Sense of Well-being, Anxiety

  Yennurajalingam, JPSM, 2012


SMS Outcomes Persist, Universal

- Improvements observed at the 1st follow-up persisted to the 2nd follow-up (p<0.02 for each symptom)

- Similar symptomatic improvement regardless of
  - Gender
  - Age
  - Ethnicity
  - Disease stage
  - Disease progression
  - Concurrent oncologic treatments

Concurrent PC for Bladder CA

- Improvement in
  - Depression and anxiety
  - Fatigue
  - Quality of life
  - Post-traumatic growth

  Rabow, Benner, Shepard, Meng
III. Utilization & Cost

Impact of Early Palliative Care on Quality of EOLC Life in Cancer Patients

- Early PC (>3mos) associated with
  - Fewer ER visits, hospitalizations, hospital deaths in the last 30 days
  - Hui, Cancer, 2014

Cost in the Temel Study: “Both/And”

- Mean cost savings of $2,282
- Accounted for by a good balance of costs/savings...
  - Some increased costs
    - Longer lengths of hospice stays
    - Higher hospice costs (mean of $1,125/patient)
  - But more reduced costs
    - Inpatient visits (mean of $3,110/patient)
    - Chemotherapy (mean of $640/patient)


IV. Prolonged Survival in Hospice
[Connor, J Pain Sx Mgmt, 2007]

<table>
<thead>
<tr>
<th>Disease</th>
<th>Added survival</th>
</tr>
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<tbody>
<tr>
<td>CHF</td>
<td>+ 81 days, P = 0.0540</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>+ 39 days, P &lt; 0.0001</td>
</tr>
<tr>
<td>Pancreatic cancer</td>
<td>+ 21 days, P = 0.0102</td>
</tr>
<tr>
<td>Colon cancer</td>
<td>+ 33 days, P = 0.0792</td>
</tr>
<tr>
<td>Breast</td>
<td>+ 12 days, P = 0.6136</td>
</tr>
<tr>
<td>Prostate</td>
<td>+ 4 days, P = 0.8266</td>
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Prolonged Survival in Lung Cancer: The Post Temel Universe

- 151 patients with NSCLC at Mass General
- Immediate vs. delayed palliative care along with usual oncologic care
- Early pc patients with...
  - Improved QOL
  - Less depression
  - Less chemo in last 2 weeks
  - Fewer hospitalizations in last month
- Nearly 3 months longer survival (11.6 mos. vs. 8.9 mos., p<0.02)

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Outpatient PC in Cancer Centers

- 142 cancer centers (Hui et al. JAMA. 2010)

<table>
<thead>
<tr>
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<th>NCI site</th>
<th>Non-NCI site</th>
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<tbody>
<tr>
<td>Palliative care program</td>
<td>98%</td>
<td>78%</td>
</tr>
<tr>
<td>Inpatient palliative care consult team</td>
<td>92%</td>
<td>56%</td>
</tr>
<tr>
<td>Outpatient palliative care</td>
<td>55%</td>
<td>22%</td>
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</tbody>
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### 2012 Outpatient Services among California Inpatient PC Programs

- 18% with Adult outpatient PC services; 19% with Pediatric
- But services are limited
  - 159 new patients/year
  - 2.1 total FTE
  - 10.7 day wait time

Rabow, O’Riodan, Pantilat, AAHPM, 2013

### Availability of Expertise: Certification in Palliative Care

- **Physicians**
  - ABMS approved PC as a sub-specialty (2006)
  - Grandfathering ended 2012
  - 10 participating boards
  - 5,000 physicians certified in HPM (under 300 in California)
- **Nurses**
  - National Board for Certification of Hospice & Palliative Care RNs
  - 17,000 nurses, advanced, pediatric, nursing asst.
- **Social Workers**
  - Certified Hospice & Palliative Social Worker and Advanced Certified Hospice & Palliative Social Worker
- **Chaplains**
  - Palliative Care Chaplaincy Specialty Certificate
    (HealthCare Chaplaincy & The CSU Institute for Palliative Care)

### But…

- 1 cardiologist for every 71 heart attacks
- 1 oncologist for every 145 new patients with cancer
- 1 PC doc for every 300 deaths
- 1 PC doc for every 1300 patients with serious illness

= 6,000-18,000 projected gap in pc physicians
(Just for hospitals and hospices)

Lupu, J Pain Sx Mgmt, 2010

### Take Aways…

Symptom management is needed
Palliative care has benefits beyond just improving symptoms
Cancer is not an either/or proposition
It’s “both/and”
Cancer care and palliative care
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