

Does Palliative care improve end of life care?

SIR Noble

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Declarations

“I have nothing to declare but my genius”
Oscar Wilde

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 Jacobson, M.D., William F. Pirl, M.D., M.P.H., J. Andrew Billings, M.D., and Thomas J. Lynch, M.D.

ABSTRACT

BACKGROUND

Patients with metastatic non–small-cell lung cancer have a substantial symptom burden and may receive aggressive care at the end of life. We examined the effect of introducing palliative care early after diagnosis on patient-reported outcomes and end-of-life care among ambulatory patients with newly diagnosed disease.

METHODS

We randomly assigned patients with newly diagnosed metastatic non–small-cell lung cancer to receive either early palliative care integrated with standard oncologic care or standard oncologic care alone. Quality of life and mood were assessed at baseline and at 12 weeks with the use of the Functional Assessment of Cancer Therapy–lung (FACT-L) scale and the Hospital Anxiety and Depression Scale, respectively. The primary outcome was the change in the quality of life at 12 weeks. Data on end-of-life care were collected from electronic medical records.

RESULTS

Of the 151 patients who underwent randomization, 27 died by 12 weeks and 107 (86% of the remaining patients) completed assessments. Patients assigned to early palliative care had a better quality of life than did patients assigned to standard care (mean score on the FACT-L scale [in which scores range from 0 to 136, with higher scores indicating better quality of life], 98.0 vs. 91.5; $P=0.03$). In addition, fewer patients in the palliative care group than in the standard care group had depressive symptoms (16% vs. 38%, $P=0.01$). Despite the fact that fewer patients in the early palliative care group than in the standard care group received aggressive end-of-life care (33% vs. 54%, $P=0.05$), median survival was longer among patients receiving early palliative care (11.6 months vs. 8.9 months, $P=0.02$).

CONCLUSIONS

Among patients with metastatic non–small-cell lung cancer, early palliative care led to significant improvements in both quality of life and mood. As compared with patients receiving standard care, patients receiving early palliative care had less aggressive care at the end of life but longer survival. (Funded by an American Society of Clinical Oncology Career Development Award and philanthropic gifts; ClinicalTrials.gov number, NCT01038271.)

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Does Palliative care improve end of life care?

- **It really depends on what questions you are asking**
 - How are we defining end of life
 - How you measure outcomes end of life care?
 - What outcome measures?
 - Improve against what?

NICE Quality statements

Statement 1 Adults who have signs and symptoms that suggest they may be in the last days of life are monitored for further changes to help determine if they are nearing death, stabilising or recovering.

Statement 2 Adults in the last days of life, and the people important to them, are given opportunities to discuss, develop and review an individualised care plan.

Statement 3 Adults in the last days of life who are likely to need symptom control are prescribed anticipatory medicines with individualised indications for use, dosage and route of administration.

Statement 4 Adults in the last days of life have their hydration status assessed daily, and have a discussion about the risks and benefits of hydration options.

8

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What data is there that our standard end of life medicines are effective at the end of life?





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**Cochrane
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Cochrane Database of Systematic Reviews

Interventions for noisy breathing in patients near to death (Review)

Wee B, Hillier R

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Interventions for noisy breathing in patients near to death.

Cochrane Database of Systematic Reviews 2008, Issue 1. Art. No.: CD005177.

DOI: 10.1002/14651858.CD005177.pub2

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Interventions for noisy breathing in patients near to death (Review)
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Interventions for noisy breathing in patients near to death (Review)

Wee B, Hillier R

In our original Cochrane review, we concluded that there was no evidence to show that any intervention, be it pharmacological or non-pharmacological, was superior to placebo in the treatment of noisy breathing. This conclusion has not changed. We acknowledge that in the face of heightened emotions when death is imminent, it is difficult for staff not to intervene. It is therefore likely that the current therapeutic options will continue to be used. However, patients need to be closely monitored for lack of therapeutic benefit and adverse effects while relatives need time, explanation and reassurance to relieve their fears and concerns. There remains a need for well-designed multi-centre studies with objective outcome measures which demonstrates the efficacy of intervention against placebo for this condition.

Palliative pharmacological sedation for terminally ill adults (Review)

Beller EM, van Driel ML, McGregor L, Truong S, Mitchell G

Beller EM, van Driel ML, McGregor L, Truong S, Mitchell G.
Palliative pharmacological sedation for terminally ill adults.
Cochrane Database of Systematic Reviews 2015, Issue 1. Art. No.: CD010206.
DOI: 10.1002/14651858.cd010206.pub2.

www.cochranelibrary.com



Palliative pharmacological sedation for terminally ill adults (Review)

Beller EM, van Driel ML, McGregor L, Truong S, Mitchell G

Candy B, Jackson RC, Jones L, Lescarot B, Treisman A, King H.
Drug therapy for delirium in terminally ill adult patients.
Cochrane Database of Systematic Reviews 2012, Issue 11. Art. No. CD004770.
DOI: 10.1002/14651958.CD004770.pub2

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Drug therapy for delirium in terminally ill adult patients (Review)
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Palliative pharmacological sedation for terminally ill adults (Review)

Beller EM, van Driel ML, McGregor L, Truong S, Mitchell G

Authors' conclusions

There was insufficient evidence about the efficacy of palliative sedation in terms of a person's quality of life or symptom control. There was evidence that palliative sedation did not hasten death, which has been a concern of physicians and families in prescribing this treatment. However, this evidence comes from low quality studies, so should be interpreted with caution. Further studies that specifically measure the efficacy and quality of life in sedated people, compared with non-sedated people, and quantify adverse effects are required.

Opioids for cancer pain - an overview of Cochrane reviews (Review)

Wiffen PJ, Wee B, Derry S, Bell RF, Moore RA

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Opioids for cancer pain - an overview of Cochrane reviews

Cochrane Database of Systematic Reviews 2017, Issue 7. Art. No.: CD012552.

DOI: 10.1002/14651858.CD012552.pub2

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Opioids for cancer pain - an overview of Cochrane reviews (Review)

Authors' conclusions

The amount and quality of evidence around the use of opioids for treating cancer pain is disappointingly low, although the evidence we have indicates that around 19 out of 20 people with moderate or severe pain who are given opioids and can tolerate them should have that pain reduced to mild or no pain within 14 days. This accords with the clinical experience in treating many people with cancer pain, but overstates to some extent the effectiveness found for the WHO pain ladder. Most people will experience adverse events, and help may be needed to manage the more common undesirable adverse effects such as constipation and nausea. Perhaps between 1 in 10 and 2 in 10 people treated with opioids will find these adverse events intolerable, leading to a change in treatment.



A cluster randomised feasibility trial of clinically assisted hydration in cancer patients in the last days of life

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SAGE

Andrew N Davies^{1,2}, Melanie Waghorn¹, Katherine Webber^{1,2},
Sigurd Johnsen¹, Jeewaka Mendis¹ and Julia Boyle²

Abstract

Background: The provision of clinically assisted hydration at the end-of-life is one of the most contentious issues in medicine.

Aim: The aim of this feasibility study was to answer the question ‘can a definitive (adequately powered) study be done?’

Design: The study was a cluster randomised trial, with sites randomised on a one-to-one basis to intervention ‘A’ (regular mouth care and usual other care) or intervention ‘B’ (clinically assisted hydration, mouth care and usual other care). Participants were assessed every 4 h, and data collected on clinical problems, therapeutic interventions and overall survival.

Setting/participants: The study was conducted at 12 sites/‘clusters’ with specialist palliative care teams (4 cancer centres and 8 hospices), and participants were cancer patients in the last week of life who were unable to maintain sufficient oral fluid intake.

Results: The study achieved top-re-determined criteria for success. Two hundred patients were recruited to the study, and 199 participants completed the study over a 1-year period. A total of 38.5% participants discontinued clinically assisted hydration due to adverse effects; none of these adverse events were rated as ‘severe’ or worse in intensity. The primary reasons for discontinuation were site problems ($n = 2$), localised oedema ($n = 13$), generalised oedema ($n = 5$), respiratory secretions ($n = 6$) and nausea and vomiting ($n = 1$).

Conclusion: The results of this feasibility study suggest that a definitive study can be done, but that minor changes are needed to the protocol to standardise the administration of clinically assisted hydration (which may reduce the incidence of certain adverse effects).

Keywords

Fluid therapy, terminal care, neoplasms, cluster analysis

What is already known about the topic?

- The Cochrane systematic review of clinically assisted hydration identified three randomised, controlled trials (RCTs) and concluded that ‘there are insufficient good-quality studies to inform definitive recommendations’.
- None of the previous RCTs addressed the specific issue of the routine use of clinically assisted hydration at the end-of-life (and until death).
- All of the previous RCTs included patients with dehydration, and the volume of fluid administered was inadequate to maintain hydration (and certainly inadequate to reverse dehydration).

What this paper adds?

- This feasibility study is the first RCT to investigate the routine use of clinically assisted hydration in cancer patients at the end-of-life.

Implications for practice, theory or policy


- The results of this feasibility study suggest that a definitive study can be done.
- The results of the feasibility study should not influence current clinical practice.

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- The results of the feasibility study should not influence current clinical practice.

To conclude

1. The evidence base supporting current therapies used to manage end of life care are embarrassingly poor
2. There is an ethical imperative to address this shortfall
3. Interventions need to be evaluated against a core outcome set



**Marie
Curie**

**Care and support
through terminal illness**