“Shifting Gears” Towards Palliative Therapy for Recurrent Breast Cancer

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Diminishing Response rates in Subsequent Lines of Therapy

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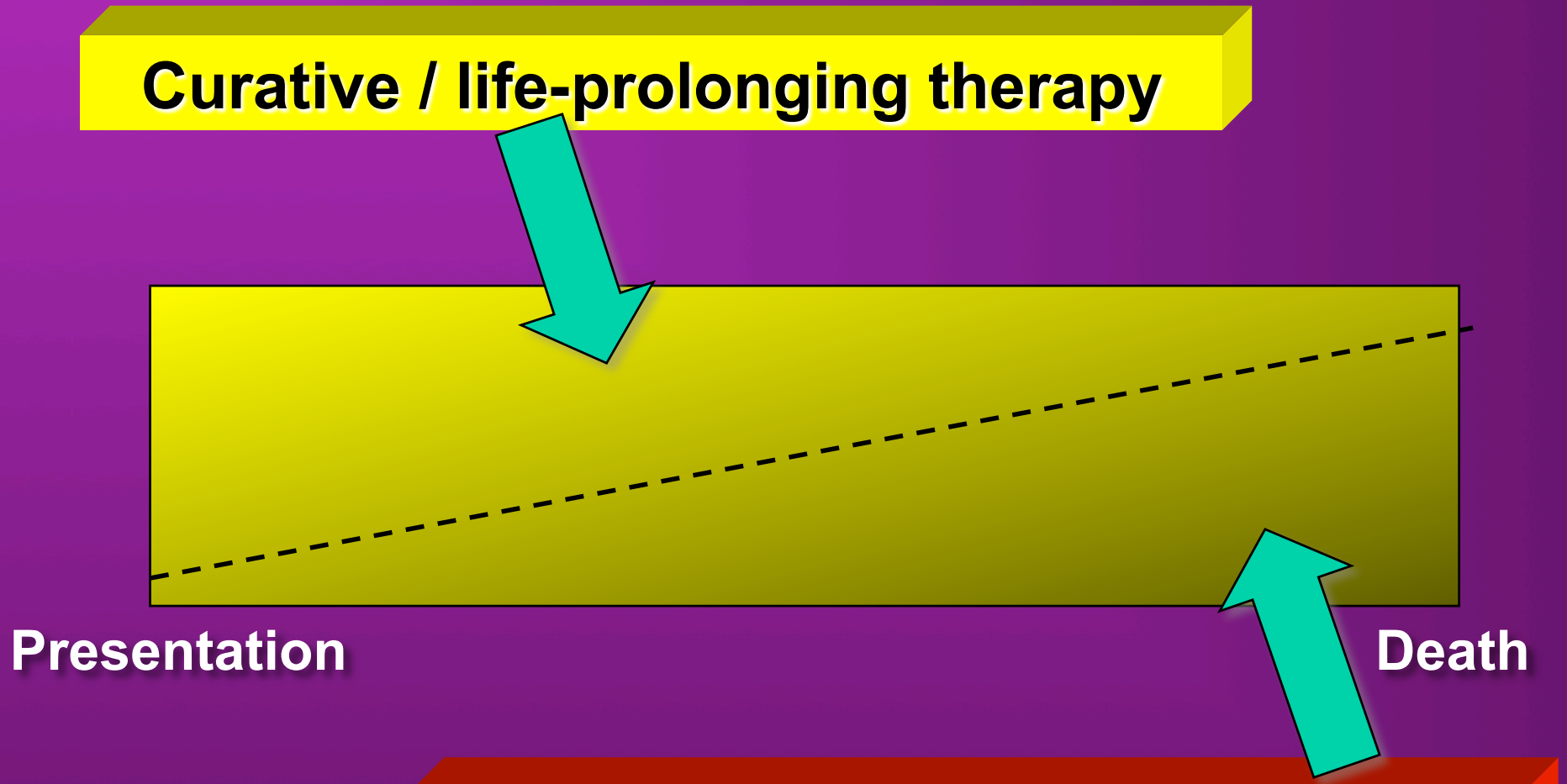
The interrelationship of therapies with curative and palliative intent



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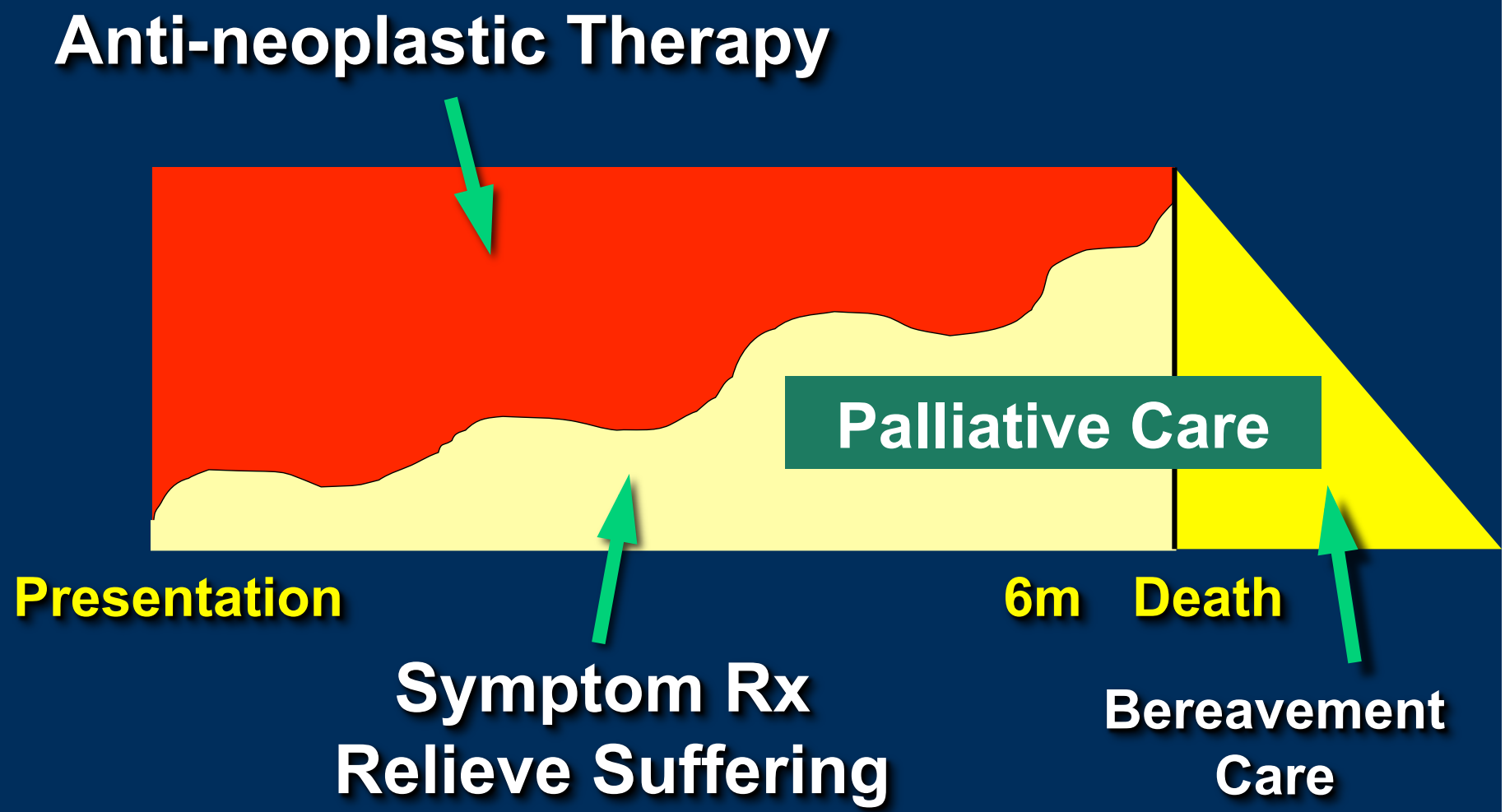
Comprehensive cancer care



Shifting Emphasis of Care

DURING ANTITUMOR TREATMENT:

- Cure of disease
- Avoidance of premature death
- Maintenance or improvement in function
- Prolongation of life

AFTER STOPPING ANTITUMOR TREATMENT:

- Relief of suffering
- Quality of life
- Staying in control
- A comfortable death
- Support for families and loved ones

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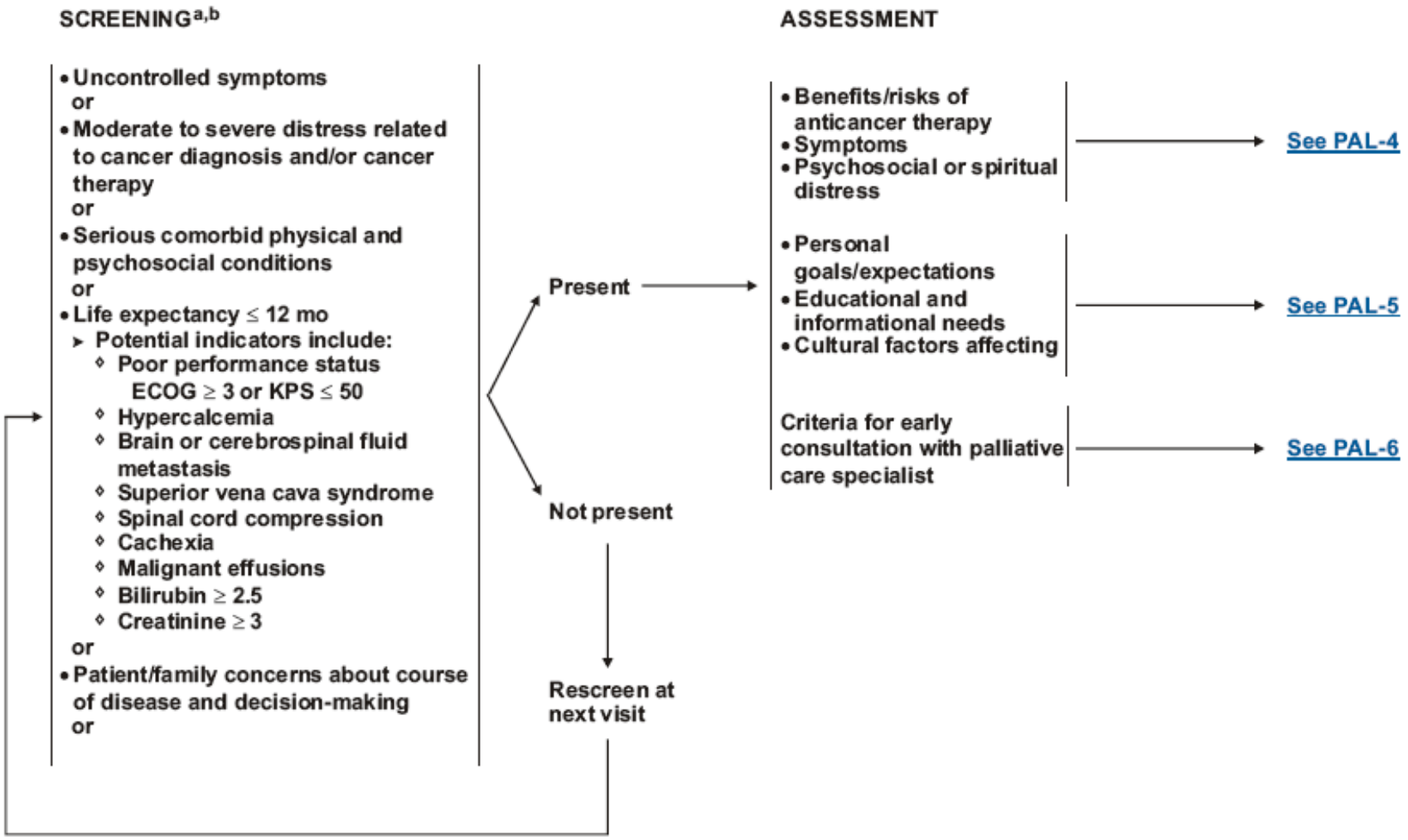
Palliative Care



[a]Management of any patient with positive screening requires a care plan developed by a interdisciplinary team of physicians, nurses, mental health professionals, and chaplains.

[b]Oncologists should integrate palliative care into general oncology care for patients who meet screening criteria. Consultation/collaboration with a palliative care specialist/hospice team is recommended for patients with more complex issues.

Note: All recommendations are category 2A unless otherwise indicated.
Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

5 steps for successful advance care planning

1. Introduce the topic
2. Engage in structured discussions
3. Document patient preferences
4. Review, update
5. Apply directives when need arises

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Breaking Bad News

Definition:

Bad news is any news that seriously And adversely affects the patient's View of his or her future

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Breaking Bad News

S Getting the SETTING right,

P What the patient PERCEIVES,

I An INVITATION to share the news,

K Giving the KNOWLEDGE.

E EMPATHISING & EXPLORING the patient's emotions, and

S STRATEGY and SUMMARY.

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Breaking Bad News

The Empathic Response

1. Identify the emotion (theirs or yours)
2. Identify the source of the emotion
3. Respond in a way that shows you have made that connection
    - You don’t have to agree with the viewpoint
    - You don’t have to feel the emotion yourself

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Palliative Care: Expanding the Options

- Interdisciplinary care
- Symptom control
- Supportive care

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Palliative Care

PALLIATIVE CARE ASSESSMENT

Benefits/risks of anticancer therapy →
- Natural history of specific tumor
- Potential for response to further treatment
- Meaning of anticancer therapy to patient and family
- Impairment of vital organs
- Performance status

→ Interventions (See PAL-7)

Symptoms →
- Pain → Pain interventions (See PAL-8)
- Dyspnea → Dyspnea (See PAL-9)
- Anorexia/cachexia → Anorexia/cachexia interventions (See PAL-11)
- Nausea/Vomiting → Nausea/Vomiting (See PAL-13)
- Constipation → Constipation (See PAL-15)
- Malignant bowel obstruction → Malignant Bowel Obstruction (See PAL-16)
- Fatigue/weakness/asthenia → See NCCN Cancer-Related Fatigue Guidelines
- Insomnia
- Sedation
- Delirium → Delirium (See PAL-18)

Psychosocial distress →
- Psychosocial/psychiatric
- Spiritual or existential crisis

→ See NCCN Distress Management Guidelines

- Social support problems
  - Family
  - Community
- Resources problems
  - Financial

→ Social Support/Resource Management (See PAL-20)

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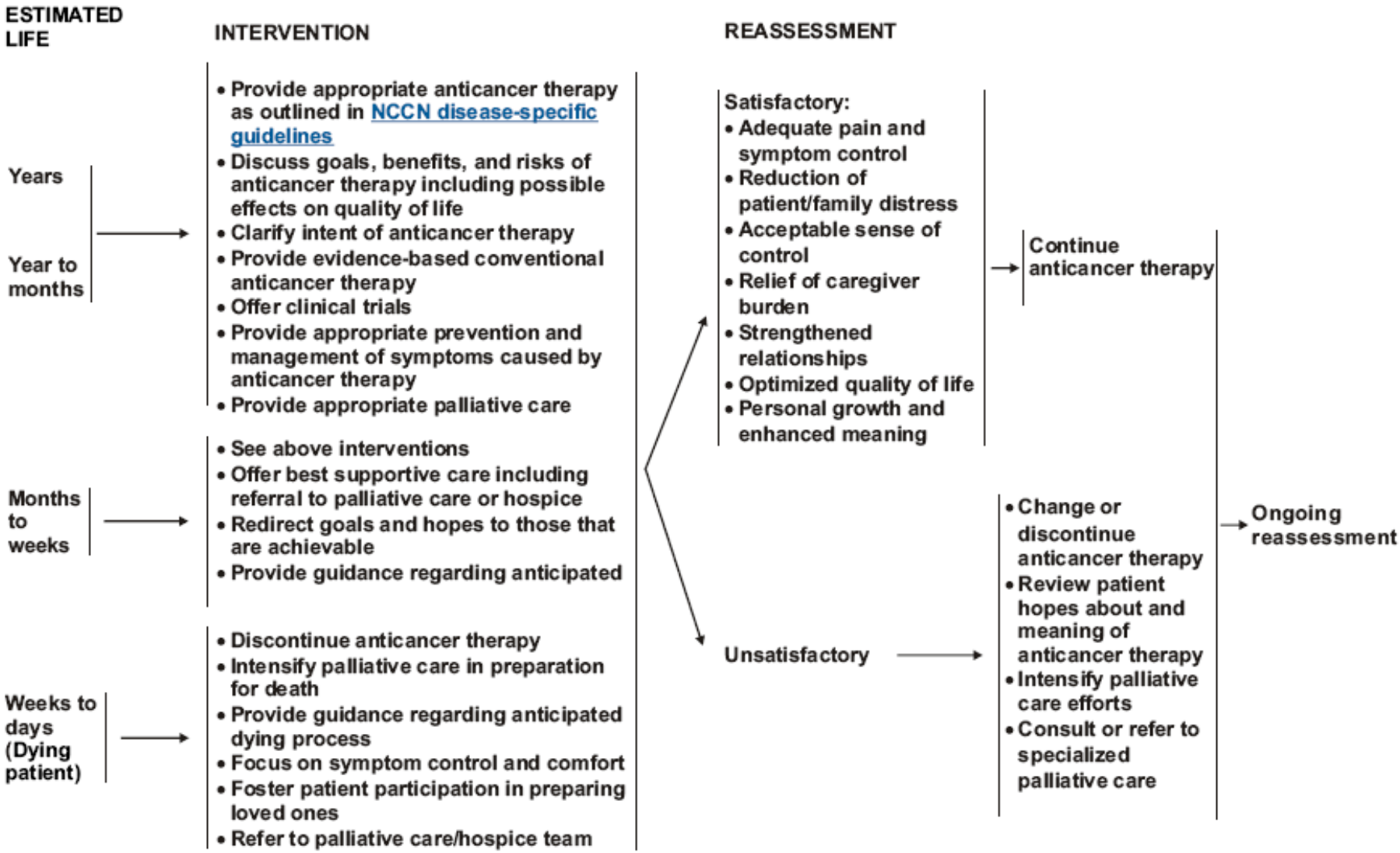
Palliative Care

BENEFIT/RISK OF ANTICANCER THERAPY



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Approach to Palliative Care

- Principles of symptom management
  - Understand the pathophysiology
  - Manage quickly; continuous & breakthrough dosing
  - Rationalize multisymptom management
- Coordination of care
  - Patient, family education
  - Interdisciplinary team
- Intended versus unintended effects
  - Terminal sedation requires consultation

The EPEC-O™ Project

Education in Palliative and End-of-life Care - Oncology

Emanuel LL, Ferris FD, von Gunten CF, Von Roenn J.

EPEC-O: Education in Palliative and End-of-life Care - Oncology.

NorthWestren University

Feinberg School of Medicine

Chicago, Illinois

USA

The EPEC-O Curriculum is produced by the EPEC™ Project with major funding provided by NCI, with supplemental funding provided by the Lance Armstrong Foundation.

Common Symptoms in Terminal Cancer

- Pain
- Anorexia/Cachexia
- Fatigue
- Dyspnea
- Constipation
- Bowel Obstruction
- Anxiety/Depression

Selected Common Symptoms

- Pain
- Anorexia
- Fatigue
- Depression

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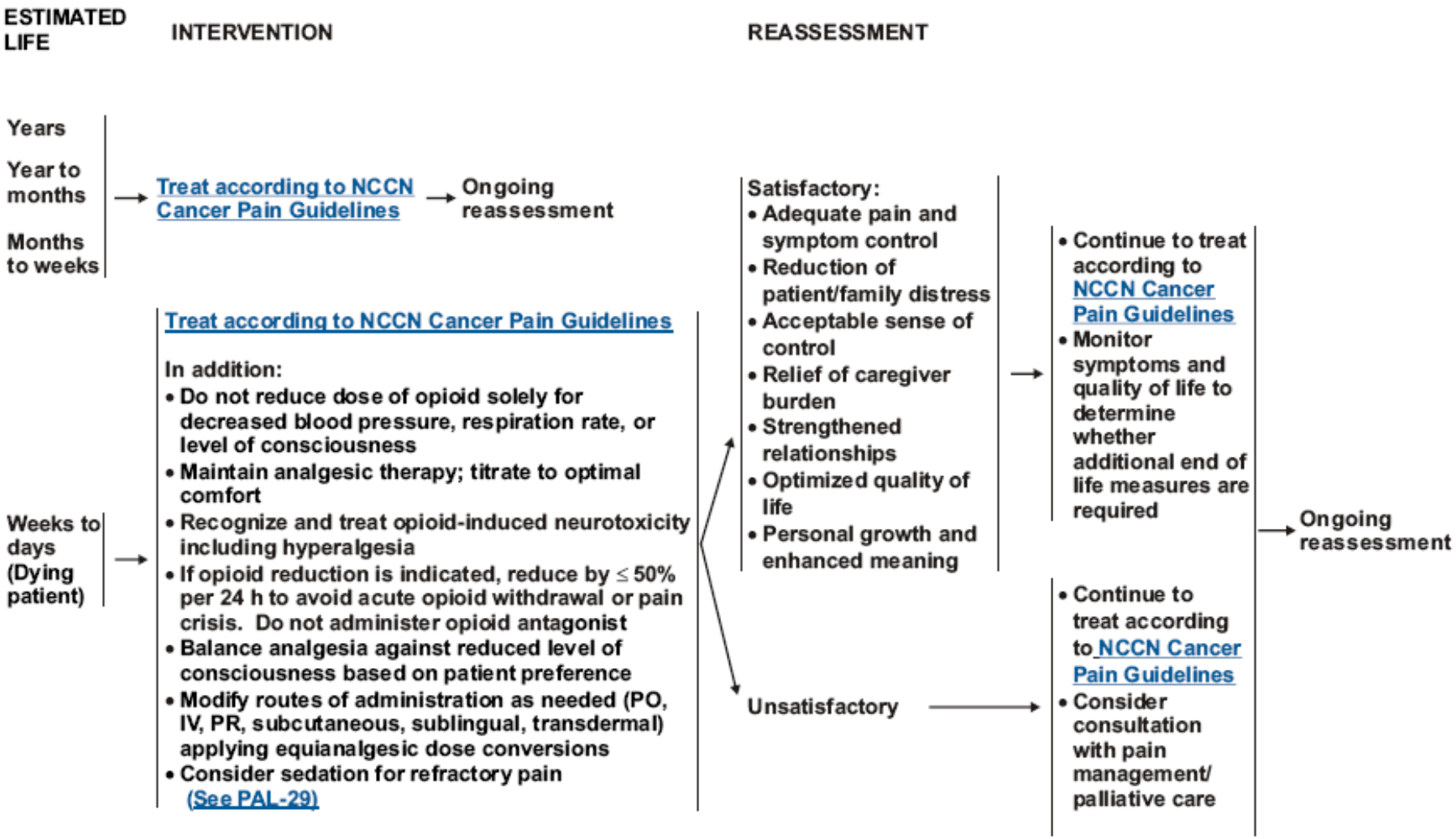
PAIN



See Special Palliative Care Interventions: Imminently Dying Patient (PAL-28)

See List of Symptoms in Palliative Care Table of Contents

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Pain Pathophysiology

- Acute pain
  - Identified event, resolves days–weeks
  - Usually nociceptive
- Chronic pain
  - Cause often not easily identified, multifactorial
  - Indeterminate duration
  - Nociceptive and / or neuropathic

Wolf CJ. *Ann Intern Med*. 2004.

Nociceptive pain

- Direct stimulation of intact nociceptors
- Transmission along normal nerves
  - Somatic
    - Easy to describe, localize
  - Visceral
    - Difficult to describe, localize

Wolf CJ. *Ann Intern Med*. 2004.

Neuropathic pain

- Disordered peripheral or central nerves
- Compression, transection, infiltration, ischemia, metabolic injury
- Varied types

  Peripheral, deafferentation, complex regional syndromes

Wolf CJ. *Ann Intern Med*. 2004.

WHO 3-step Ladder

1 mild

ASA

Acetaminophen

NSAID's

± *Adjuvants*

2 moderate

A/Codeine

A/Hydrocodone

A/Oxycodone

A/Dihydrocodeine

Tramadol

± *Adjuvants*

3 severe

Morphine

Hydromorphone

Methadone

Levorphanol

Fentanyl

Oxycodone

± *Adjuvants*

WHO Geneva, 1996.

Non-pharmacological pain management . . .

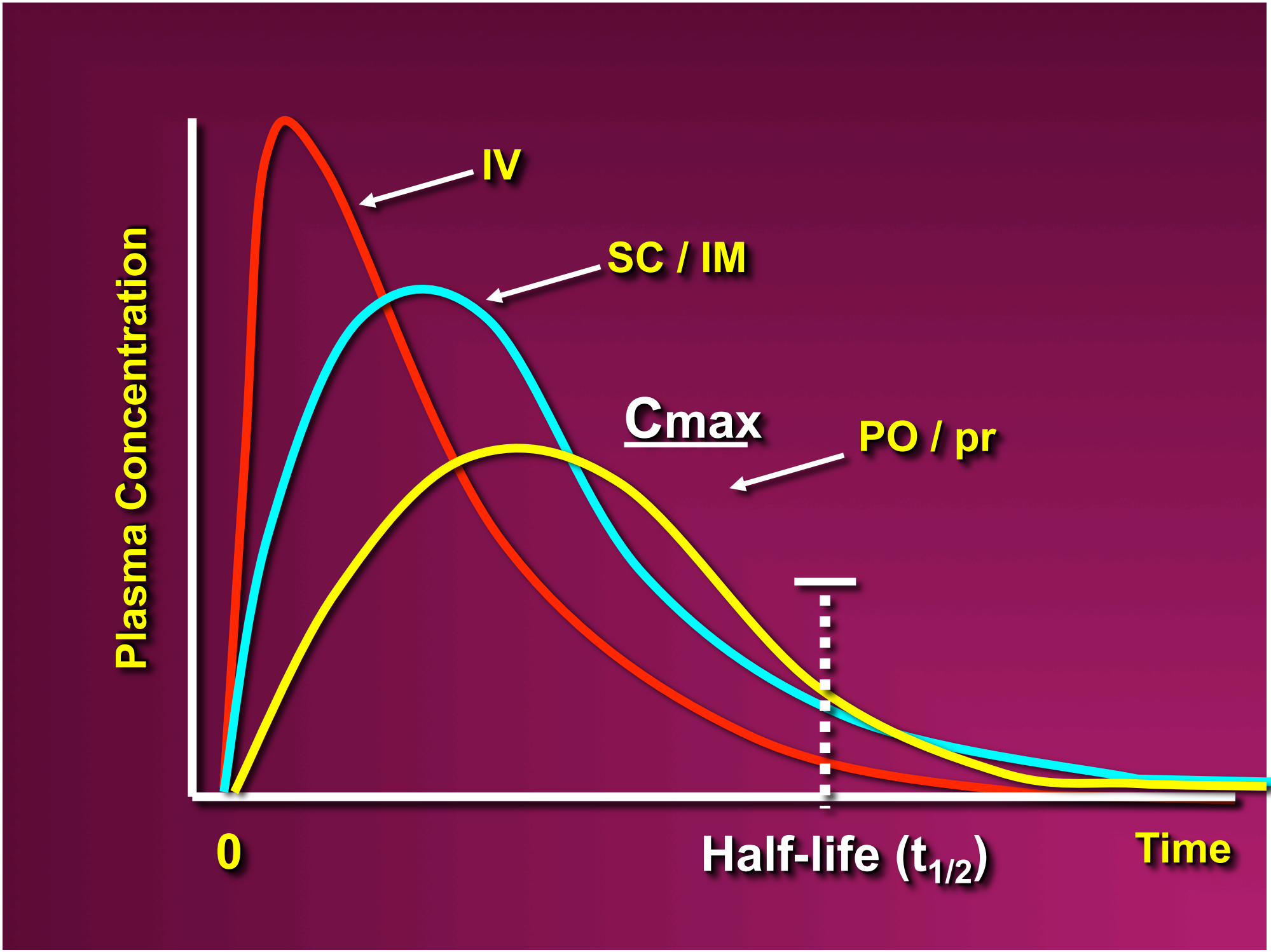
- **Neurostimulation**
  - TENS, acupuncture
- **Anesthesiological**
  - Nerve block
- **Surgical**
  - Cordotomy
- **Physical therapy**
  - Exercise, heat, cold

Non-pharmacological pain management

- Psychological approaches
  - Cognitive therapies (relaxation, imagery, hypnosis)
  - Biofeedback
  - Behavior therapy, psychotherapy
- Complementary therapies
  - Massage
  - Art, music, aroma therapy

Placebos

- No role for placebos to assess or treat pain!


IV
SC / IM
Cmax
PO / pr
Plasma Concentration
0
Half-life ($t_{1/2}$)
Time

Nociceptive pain

- Tissue injury apparent
- Management
  - Opioids
  - Adjuvant / coanalgesics

Neuropathic pain

- Pain may exceed observable injury
- Described as burning, tingling, shooting, stabbing, electrical
- Management
  - Opioids
  - Adjuvant / coanalgesics often required

Pain management

- Don’t delay for investigations or disease treatment
- Unmanaged pain => nervous system changes
  - Permanent damage
    - amplify pain
- Treat underlying cause (eg, radiation for a neoplasm)

Anorexia and Cachexia

Cachexia – wasting syndrome

- ↓ Lean tissue
- ↓ Performance status
- Altered resting energy expenditure
- ↓ Appetite

Palliative Care

Guidelines Index
Palliative Care TOC
MS, References

ANOREXIA/CACHEXIA

ESTIMATED LIFE

Years

Year to months

INTERVENTION

- Evaluate rate/severity of weight loss
- Treat readily reversible cause of anorexia:
  - Early satiety
    - Metoclopramide
  - Symptoms that interfere with intake
    - Depression
    - Eating disorders/body image
    - Constipation
    - Pain
    - Mucositis
    - Nausea/vomiting
    - Fatigue
- Review/modify medications that interfere with intake
- Evaluate for endocrine abnormalities:
  - Hypogonadism
  - Thyroid dysfunction
  - Metabolic abnormalities (eg, increased calcium)
- Consider appetite stimulant (eg, megestrol acetate)
- Exercise program
- Assess economic factors
- Consider nutrition consult
- Consider nutrition support clinical trials

REASSESSMENT

Satisfactory:
- Weight stabilization or gain
- Improvement in symptoms that interfere with intake
- Improved energy
- Resolution of metabolic or endocrine

→ Continue to treat and monitor symptoms and quality of life to determine whether status warrants change in strategies → Ongoing reassessment

Unsatisfactory →
- Intensify palliative care interventions
- Dietary consultation

Months to weeks

Weeks to days (Dying

→ See Interventions (PAL-12)

See Special Palliative Care Interventions; Imminently Dying Patient (PAL-28)

See List of Symptoms in Palliative Care Table of Contents

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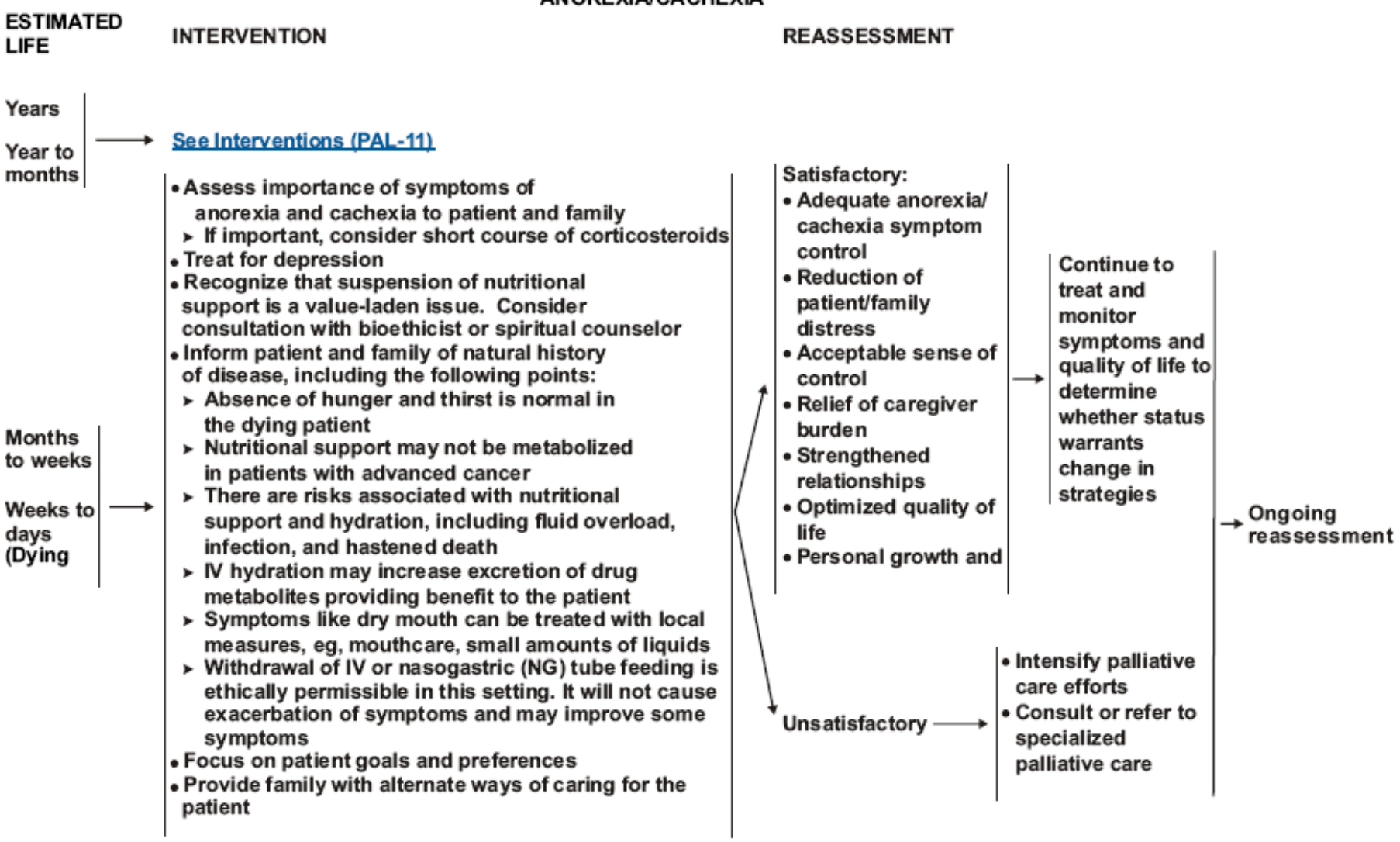
Palliative Care

ANOREXIA/CACHEXIA



See Special Palliative Care Interventions; Imminently Dying Patient (PAL-28)

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Anorexia/Cachexia: Pathophysiology

- Chronic inflammation
- Metabolic changes
- Lipolytic / proteolytic substances
- Hormonal changes
- Role of neurotransmitters
- Cytokine impact on hypothalamus

Todorov P, et al. *Nature*, 1996.
Todorov P, et al. *Cancer Research*, 1998.
Zigman JM, et al. *Endocrinology*, 2003.
Balkwill F, et al. *Lancet*, 2001.

Anorexia/Cachexia: Assessment

- Appetite / weight loss history
- Identify reversible causes
- Physical signs of wasting
- Biochemical markers
- Radiographic studies as indicated

Management of Anorexia

- Dexamethasone
- Megestrol acetate
- Tetrahydrocannabinol (THC)
- Androgens

Loprinzi CL, et al. *JCO*, 1999.
VonRoenn JH, et al. 2003.
Moertel CG, et al. *Cancer*, 1974.

Management of Cachexia

- Investigational
  - Anabolic steroids
  - Omega-3-fatty acids
  - Amino acids
  - NSAIDs
  - Multi-vitamins
  - Exercise

Von Roenn JH, et al. *ASCO*, 2003.
Jatoi A, et al. *ASCO*, 2003.
Fearon KCH, et al. *Gut*, 2003.
McMillan DC, et al. *Br J Ca*, 1999.

Fatigue

Definition

- Persistent sense of tiredness
- Interferes with function
- Unrelieved by rest

Cella D, Peterman A, et al. *Oncology*, 1998.

Fatigue

Epidemiology

- High prevalence-varies with stage and primary
- High impact
- Patterns of fatigue
  - Chemotherapy
  - Radiotherapy

Volgelzang N, Breitbart W, et al. *Semin Hematal*, 1997.
Cella D, Peterman A. *Oncology*, 1998.
Stone P, Richardson A, et al. *Ann Oncol*, 2000.
Schwartz AL, Nail LM, et al. *Cancer Invest*, 2000.

Fatigue: Pathophysiology

- Multifactorial
- Abnormal energy metabolism
- Increased cytokine production
- Contributing factors
  - Depression
  - Sleep disorders
  - Muscular dysfunction

Fatigue: Assessment

- Subjective; 0-10 rating scale

  4-6 = moderate fatigue

  7-10 = severe fatigue

- Fatigue history
- Current medications
- Associated symptoms/Comorbidities
- MaInutrition / Deconditioning

Mock V, Atkinson, et al. *NCCN*, 2003.

Fatigue: Management

Treatable etiologies

- Anemia
- Depression
- Pain
- Hypothyroidism
- Hypogonadism

Fatigue: Management

Non-pharmacologic therapies…

- Educate – patterns of fatigue
- Clarify role of underlying illness, treatment
- Optimize fluid, electrolyte intake, nutrition
- Physical activity/Energy conservation
- Involve other disciplines

Winningham ML. *Cancer*, 2001.

Fatigue: Pharmacologic Management

- Methylphenidate
- Dexamethasone, prednisone
- Modafinil

Bruera E. *Cancer Treatment Rep*, 1985.
Bruera E, et al. *JCO*, 2004.
Rammohan KW, et al. *J Neurol Neurosurg Psychiatry*, 2002.

Depression

- Depressed mood
- Anhedonia – loss of interest or pleasure
- > 2 weeks
- Prevalence: up to 58% of cancer patients
- Untreated, associated with poor prognosis
- Knowledge of true extent of disease and prognosis do not lead to depression or adverse outcomes

Symptoms of Depression-1

- Irritability
- Changes in
  - Appetite or weight
  - Sleep
  - Psychomotor activity
- Decreased energy
- Worthlessness, helplessness, hopelessness
- Guilt

Symptoms of Depression-2

- Difficulty thinking, concentrating, making decisions
- Suicidal ideation or wishes to hasten death
- Somatic symptoms often not helpful in this population

Depresssion: Risk Factors-1

- Poorly controlled pain
- Progressive physical impairment
- Advanced disease
- Medications
  - Steroids
  - Chemotherapeutics

Depresssion: Risk Factors-2

- Particular diseases
  - Pancreatic, breast, lung, mets to nervous system
- Younger age
- Spiritual pain
- Risk factors in general population
  - Prior Hx, family Hx, social stress
  - Suicide attempts, substance use

Depression: Pathophysiology

- Involved neurotransmitters
  - Norepinephrine
  - Serotonin
  - Dopamine
- Genetics
- Environmental influences

Depression: Assessment

- Assess for signs and symptoms noted above
  - Do you feel depressed most of the time?
- Family observations
- Screening tools

Depression: Assessment

- Differentiate between
  - Grief reactions
  - Adjustment disorders
  - Delirium, particularly hypoactive
  - Dementia
- Consult with mental health professionals

Depression: Management

- Counseling
- Complementary therapies
- Pharmacotherapy
- Combinations are best
- Lack of improvement within weeks suggests more aggressive therapy or psychiatry consult needed

Complementary therapies

- Relaxation
- Distraction
- Guided imagery
- Meditation
- Massage therapy
- Aromatherapy
- Self-hypnosis
- Exercise
- Sunlight

Depression: Pharmacotherapy

- Tricyclic antidepressants
- SSRIs
  - Preferred as less adverse effects
- Psychostimulants
- Other antidepressants

Depression: Pharmacotherapy

- Choose by time to effect
  - Days – psychostimulants
  - Weeks / months – SSRIs, other antidepressants
- Start dosing low, titrate slowly
- Consider consultation

Palliative Care

Death →

A "good death":

- Free from avoidable distress and suffering for patients, families, and caregivers
- In general accord with patient's and family's wishes
- Reasonably consistent with clinical, cultural, and ethical

→

AFTER DEATH CARE

For family and caregivers:

- Immediate after death care
  - Remove implanted devices
  - Ensure culturally sensitive, respectful treatment of the body
  - Provide family time with the body
  - Address survivor concerns about organ donation and/or autopsy
  - File death certificate, complete forms and provide necessary information for funeral director
  - Offer guidance regarding normal bereavement process
  - Inform other health care providers of patient's death
- Bereavement support
  - Formally express condolences on patient's death (eg, card, call, or letter)
  - Refer to appropriate bereavement services within the institution or in the community
  - Attend debriefing meeting with family if family desires one
- Discuss cancer risk assessment and modification with family members

For health care professionals
General:

- Legitimize discussion of personal issues that impact on patient care
- Create climate of safety for discussion of patient deaths
- Provide regular opportunities for reflection and remembering for staff through memorial ritual

Post-death:

- Review medical issues related to patient death
  - Explore concerns and questions regarding quality of patient care
- Review family emotional responses to patient death
- Review staff emotional responses to patient death
  - Include nurses, nursing assistants, physician team members (including medical students, residents, fellows), social work, chaplaincy as appropriate

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Summary and Conclusions

- Need to ‘shift gears’ when tumor is no longer the target
- There is a systematic way to break bad news to the patient
- Most symptoms of terminal cancer are manageable
- NCCN palliative and supportive care guidelines are a useful and accessible tool for the practitioner