



Palliative care: Earlier is better

For patients with metastatic cancer, early palliative care—with a referral at diagnosis—has many benefits.

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PRACTICE CHANGER

Recommend a palliative care consultation at the time of diagnosis. Early palliative care can improve quality of life, decrease depressive symptoms, and prolong life in patients with metastatic cancer.¹

STRENGTH OF RECOMMENDATION

B: Based on a single well-done randomized controlled trial (RCT).

Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med.* 2010;363:733-742.

ILLUSTRATIVE CASE

A 73-year-old patient you've known for your entire career comes in for follow-up after a recent hospitalization, during which he was diagnosed with metastatic non-small-cell lung cancer. "I know things don't look good," he says. "I don't want to die a miserable, painful death. But I'm not going to just roll over and die without fighting this." What can you do to improve his quality of life while he undergoes cancer treatment?

Palliative care focuses on the prevention and treatment of pain and other debilitating effects of serious illness, with a goal of improving quality of life for patients and their families. Unlike hospice care, which requires a prognosis of less than 6 months of life to qualify for Medicare reimbursement,² eligibility for palliative care is not dependent on prognosis. Indeed, palliative care can occur at the same time as curative or life-prolonging treatment. Palliative care programs include psychosocial and spiritual care for patient and family; management of symp-

toms such as pain, fatigue, shortness of breath, depression, constipation, and nausea; support for complex decisions, such as discussions of goals, do not resuscitate (DNR) orders, and requests for treatment; and coordination of care across various health care settings.³

Palliative care lowers health care spending

One study found that palliative care consultation was associated with an average savings of \$1700 per admission for patients who were discharged, and \$4900, on average, for every patient who died in the hospital.⁴ Another study demonstrated an association between states with a higher percentage of hospitals with palliative care services and fewer Medicare hospital deaths; fewer admissions to, and days in, intensive care units in the last 6 months of life; and lower total Medicare spending per enrollee.⁵

A 2008 systematic review of the effectiveness of palliative care revealed that there were methodological limitations in all the existing studies of palliative care, and called for higher quality studies.⁶ The RCT detailed here is a first step toward filling the gap in palliative care research.

STUDY SUMMARY

Intervention group lived longer and felt better

Temel et al enrolled 151 ambulatory patients with biopsy-proven non-small-cell lung cancer. The average age of the enrollees was 64 years, and slightly more than half (51.6%) were female. All had been diagnosed with metastatic cancer within 8 weeks of enrollment in the study.

CONTINUED

The patients were randomized to receive either an early referral to the palliative care team along with standard oncology care or standard oncology care alone. Race, marital status, smoking history, presence of brain metastases, and initial cancer therapy—radiation, chemotherapy, or a combination—were similar for both groups.

The study ran for 12 weeks. Those in the intervention group had an initial meeting with a member of the palliative care team, which consisted of board-certified palliative care physicians and advanced practice nurses. Follow-up meetings with the team were scheduled at least monthly, and more frequently if requested by the patient or recommended by either the palliative care team or the oncology team—with an average of 4 meetings over the course of the study. Palliative care team members worked with patients to assess physical and emotional symptoms, coordinate care, and determine and document goals of treatment.

■ **The primary outcome was the change in quality of life (QOL) from baseline to 12 weeks after the initial meeting with the palliative care team.** QOL was measured with the Functional Assessment of Cancer Therapy-Lung (FACT-L) tool; scores range from 0 to 136, with higher scores indicating a higher QOL. The researchers used 3 subscales of the FACT-L—physical well-being, functional well-being, and a lung-cancer subscale (LCS) based on questions about 7 symptoms—to create a Trial Outcome Index (TOI), the main outcome measure. The TOI, which is the sum of the subscales, has a range of 0 to 84, with higher scores indicating higher QOL.

■ **Secondary outcome measures were mood, use of health care services, and survival.** The researchers assessed mood with 2 tools: the Patient Health Questionnaire-9 (PHQ-9) and the Hospital Anxiety and Depression Scale (HADS). The PHQ-9 is a 9-question survey that uses criteria from the *Diagnostic and Statistical Manual of Psychiatric Disorders*, 4th edition (DSM-IV) to diagnose depression. HADS is a 14-question survey with subscales for depression (HADS-D) and anxiety (HADS-A).

■ **Intervention group had better scores.** At study's end, the control group had av-

erage scores of 91.5, 19.3, and 53.0 on the FACT-L, LCS, and TOI, respectively, vs 98.0, 21.0, and 59.0 for the intervention group. The palliative care group had an average increase on the TOI of 2.3 points, while the average for the control group decreased by 2.3 points ($P=.04$). A comparison of the mean change in scores between the 2 groups indicated statistically significant improvements in the FACT-L and TOI results for the intervention group. The improvement in LCS was not statistically significant.

The palliative care group also had a lower prevalence of depression compared with the controls (4% vs 17% on the PHQ-9 [$P=.04$]; 16% vs 38% on the HADS-D [$P=.01$]). For every 8 patients who received early palliative care, 1 less patient was diagnosed with depression. The prevalence of anxiety was not significantly different between groups.

Among patients who died during the study period, those in the palliative care group were less likely to have received aggressive end-of-life interventions compared with the controls (33% vs 54%, respectively, $P=.05$). Aggressive care was defined as chemotherapy within 14 days of death or little or no hospice care. Those in the early palliative care group also lived significantly longer; median survival was 11.6 months, vs 8.9 months for the control group ($P=.02$).

WHAT'S NEW

This study highlights the need for early referral

This is the first high-quality RCT to demonstrate improved patient outcomes when palliative care is begun close to the time of cancer diagnosis. Previous studies of late palliative care referrals did not demonstrate improved QOL or more appropriate use of health care services. This study established that patients with lung cancer are less depressed and live longer when they receive palliative care services soon after diagnosis. It also showed a link between palliative care and a reduction in aggressive, possibly inappropriate, end-of-life treatment of metastatic cancer.

Several recent practice guidelines, including that of the Institute for Clinical Systems Improvement (ICSI), recommend that



Do you recommend palliative care to patients with metastatic cancer at the time of diagnosis?

- Yes, I do so routinely.
- Often
- Rarely or never
- Other _____

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➤ **Despite receiving less aggressive care, patients in the intervention group lived longer.**

palliative care referrals be made early in the course of a progressive, debilitating illness, regardless of the patient's life expectancy.⁷ Other organizations, including the Institute of Medicine and the World Health Organization, recommend palliative care as an essential component of comprehensive cancer care.⁸ This study supports both of these recommendations.

CAVEATS

Would extra attention from any clinician work equally well?

No attempt was made to control for the extra attention (an average of 4 visits) that the palliative care team provided to those in the intervention group. Thus, it is possible that the study results could be replicated by having patients meet with their primary care physician or another health professional instead of a palliative care team.

The reduction in depression and increase in survival are clinically significant outcomes. But the improvement in QOL (an average of 7 points better on the 136-point FACT-L scale, or 6 points on the 84-point TOI scale) may not be.

It is important to note, too, that the survival benefits the researchers found may not be generalizable to other kinds of cancers. In

addition, most patients (97%) in this study were white, so the findings may be less generalizable to patients of other races. Nonetheless, we think it's likely that the improvements in QOL and mood revealed in this study would be realized by most patients with terminal cancer who received early palliative care.

CHALLENGES TO IMPLEMENTATION

Palliative care must be explained—and available

Physicians must be able to explain to their patients the difference between palliative care and hospice—most notably, that patients can continue to receive anticancer treatment while receiving palliative care. The recommendation to seek palliative care should not be considered “giving up” on the patient.

In order to refer patients to palliative care early in the course of cancer care, physicians must have access to a palliative care team, which may not be available in all cases. In 2006, only 53% of hospitals with more than 50 beds reported having a palliative care program.⁵ If there is no such program available, physicians can refer to the ICSI guideline on palliative care for more information on how to implement elements of palliative care for their patients with advanced cancer.⁷ **JFP**

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