Advances in Palliative Care

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Palliative Care

...comprehensive, interdisciplinary care, focusing primarily on promoting quality of life for patients living with a terminal [or serious, chronic] illness and for their families... assuring physical comfort [and] psychosocial support. [It is offered simultaneously with all other appropriate medical treatments.]

Billings JA. J Pall Med 1999;1:73-81
Palliative Care: What Patients Want

- Palliation of symptoms
- Communication about illness and death
- Psychosocial support

Singer et al. *JAMA* 1999;281:163-8

UCSF Palliative Care Program
SCHOOL OF MEDICINE * UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
Advances in Palliative Care

- Palliation of Symptoms
  - MethylNaltrexone for constipation
- Communication about illness and death
  - Family meetings
  - End-of-life discussions
  - Prognosis
  - Better words to say
Constipation in Palliative Care

- Constipation affects 32-87% of patients
- A reason some patients stop opioids
- An ounce of prevention is worth a pound of cure
- Patient-defined condition
  - Worry if more than 3 days since last BM
- Clinical recommendation of The European Consensus Group on Constipation in Palliative Care

Prevention of Constipation

- Provide privacy and opportunity
- Maintain good fluid and fiber intake
- Encourage activity
- Provide laxatives prophylactically
  - Senna ± docusate
  - Unblinded study of patients on inpatient cancer ward found senna more effective than senna plus docusate

Hawley PH and Byeon JJ J Pall Med 2008;11:575-81
Evaluation of Constipation

- Complete history and exam
  - Usual bowel habits
  - Last BM
  - Quality, quantity
- Assess for impaction
- Evaluate for obstruction with Xray if history of pain, cramping, nausea, vomiting
Treatment of Constipation

- Relieve impaction
  - Can have diarrhea around impacted stool
- Senna to stimulate bowel and colace or polyethylene glycol to soften stool
- Oral treatment when possible
- Rectal suppository (bisacodyl) and/or enema
- Consider methylnaltrexone
Methylnaltrexone for opioid-induced constipation

- Opioid-induced constipation mediated by mu-opioid receptors in the bowel
- Methylnaltrexone blocks mu-opioid receptors in the bowel but has limited ability to cross the blood-brain barrier
- Randomized, double-blind, placebo controlled trial in 27 centers in US and Canada

Methylnaltrexone for opioid-induced constipation

- 133 Patients on stable opioid and laxative regimen for at least 3 days
- Fewer than 3 BMs in past week or no clinically meaningful BM in past 24 hours
- Methylnaltrexone 0.15mg/kg subq or placebo
- Outcome: BM w/in 4 hours of first dose of study drug

Portenoy RK et al. *JPSM* 2008;35:458-68
Methylnaltrexone for opioid-induced constipation

- Age: 71 years old; 43% men; 58% with cancer; 70% WHO performance status 3 or 4
- Most on laxatives already; 36% with very much constipation-related distress
- 48% of patients on methylnaltrexone had BM w/in 4 hrs vs. 15% on placebo
- No change in pain scores
- No evidence of opioid withdrawal

Methylnaltrexone for opioid-induced constipation

- For most patients (62-114kg) give 12mg subcutaneously every other day and no more than every 24 hours
- For patients 38-62kg give 8mg subcutaneously every other day and no more than every 24 hours
- Above 114kg or below 62kg give 0.15mg/kg

Thomas J et al. NEJM 2008;358:2332-43
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The VALUE of Good Communication

- 22 ICUs in France
- 108 family members randomly assigned
- VALUE communication and brochure about bereavement vs usual care
- All patients had life-sustaining interventions withdrawn
  - 90% had mechanical ventilation
  - 72% had vasopressors
  - 76% sedated

Lautrette A et al. NEJM 2007;356:469-78
VALUE Intervention

- **V**alue and appreciate what the family members said
- **A**cknowledge the family members’ emotions
- **L**isten
- Ask questions that would allow the caregiver to **U**nderstand who the patient was as a person
- **E**licit questions from the family members
VALUE Intervention Results

- Longer conferences
  - 30 min vs 20 min
- Family talked more (physician talked the same)
  - 14 min vs 5 min
- Lower prevalence of PTSD-like symptoms, anxiety, and depression 90 days later
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End-of-Life Discussions Good for Patients and Families

- Association of end-of-life discussions and quality of life, care near death, and caregiver bereavement
- 332 patients with advanced cancer and their caregivers
- “Have you and your doctor discussed any particular wishes you have about the care you would want to receive if you were dying?”

Wright AA et al. *JAMA* 2008;300:1665-73
End-of-Life Discussions Good for Patients and Families

- Assessed patient mood, care in last week of life
- Assessed caregiver for patient quality of life in last week of life and bereavement adjustment
- Reviewed chart for care received in last week of life

Wright AA et al. JAMA 2008;300:1665-73
End-of-Life Discussions Good for Patients and Families

- 123 (37%) patients had discussions with their physicians
- No patient characteristics associated with having a discussion
- Discussion not associated with feeling depressed, sad, terrified or worried

Wright AA et al. JAMA 2008;300:1665-73
End-of-Life Discussions Good for Patients and Families

- Patients with discussions had fewer invasive interventions near death
  - Mechanical ventilation (2% vs 11%)
  - ICU admission (4% vs 12%)
  - Resuscitation (1% vs 7%)
- Invasive interventions associated with worse quality of life

Wright AA et al. JAMA 2008;300:1665-73
End-of-Life Discussions Good for Patients and Families

- Caregivers of patients with invasive interventions near death more likely to:
  - Develop major depression (OR 3.37, 1.12-10.13)
  - Experience regret and feel unprepared for patient’s death

- Higher caregiver quality of life at 6 months after death of patient associated with higher patient quality of life near death

Wright AA et al. JAMA 2008;300:1665-73
End-of-Life Discussions Good for Patients and Families

- End-of-life discussions associated with better quality of life near death, fewer invasive interventions, and better outcomes for caregivers and don’t make patients depressed, sad, terrified or worried

So what are we waiting for?

Wright AA et al. JAMA 2008;300:1665-73
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- **Symptoms**
  - Methylnaltrexone for constipation

- **Communication**
  - Family meetings
  - End-of-life discussions
  - Prognosis
  - Better words to say
Prognosis

- False hope is no hope
- Often patients want to know
- Absent explicit information, people infer
- Information influences decisions

We would all live our lives differently if we knew we had only one year to live
With whom should we discuss prognosis?

“Would I be surprised if this patient died in the next year?”

- If the answer is no, talk about prognosis
- Not based on estimated lifespan, time, or likelihood of survival as these are too hard to predict


National Consensus Project for Quality Palliative Care, second edition, 2009

[www.nationalconsensusproject.org](http://www.nationalconsensusproject.org)
Prognosis: Bad News is Good News

- What communication factors influence patient physician concordance about chance of cure?
- Audio recordings of first encounters between 51 oncologists and 141 patients
  - Patient selection: “Would not be surprised…”
- After visit MD and patient gave chance of cure
  - 11 categories: 0%, 1-10%, 11-20%...

Robinson et al. Supp Care Cancer 2008 16:1049-1057
Prognosis: Bad News is Good News

- Concordance
  - Good: physician and patient cure estimates within 2 categories (0% and 11-20%)
  - Bad: chance of cure estimates differ by 6-10 categories (e.g. 11-20% and 81-90%)
- Analysis of conversations with good (n=69) or poor (n=72) concordance

Robinson et al. Supp Care Cancer 2008 16:1049-1057
Prognosis: Bad News is Good News

- Oncologists are optimistic, but patients are even more
  - Patients were always more optimistic
  - MD optimistic statements: mean=3.3/discussion
  - MD pessimistic statements: mean=1.2/discussion
- Physicians made pessimistic statements in only 46% of discussions

Robinson et al. Supp Care Cancer 2008 16:1049-1057
Prognosis: Bad News is Good News

- If MD made at least one pessimistic statement, patients more likely to agree with physician’s estimated chance of cure (OR=2.59)
- Diagnosis, age, gender, patient education not associated with concordance
- No assessment of patient emotional state after discussion

Robinson et al. Supp Care Cancer 2008 16:1049-1057

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Communicating prognosis

- Communicate optimistic aspects of treatment while acknowledging pessimistic prognosis
  - “The radiation should really help control the pain even if it can’t cure the cancer.”
  - “I wish…”
- Accuracy is not critical: hr-d, d-wk, wk-mo

Robinson et al. Supp Care Cancer 2008 16:1049-1057
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Better Words to Say

- “There is nothing more we can do”
  “I wish there was something we could do to cure your cancer.”
- “Would you like us to do everything possible?”
  “How were you hoping we could help your mother?”

Pantilat JAMA 2009;301:1279-81
Bringing closure to relationships

- Forgive me
- I forgive you
- Thank you
- I love you
- Good bye

Ira Byock, *Dying Well* 1997
Conclusion

- Prevent constipation and consider methylnaltrexone for refractory constipation
- Allow families to talk in meetings
- End-of-life discussions are good for patient and their loved ones
- Communicating some bad news communicates prognosis more effectively
- Attention to good communication and better words to say can improve outcomes for patients, families and providers