

THE TOTAL PATIENT



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Early palliative care: A focus on enhancing quality of life that begins at diagnosis

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Early access to palliative care can significantly improve the lives of patients with metastatic non-small cell lung cancer (NSCLC), according to a new study. Globally, metastatic NSCLC causes more cancer deaths than any other type of cancer.¹ Estimated life expectancy is less than 1 year after diagnosis, and that limited survival time is fraught with difficult symptoms and reduced quality of life.^{2,3} Could early palliative care along with standard oncologic care have a positive effect on patients, as well as on their utilization of health services, during that difficult time? Jennifer S. Temel, MD, and colleagues hoped to find the answer by conducting a study of such patients at the Massachusetts General Hospital in Boston, Massachusetts.⁴ In their resulting paper published in *The New England Journal of Medicine*, the authors wrote:

We hypothesized that patients who received early palliative care in the ambulatory care setting, as compared with patients who received standard oncologic care, would have a better quality of life, lower rates of depressive symptoms, and less aggressive end-of-life-care.

STUDY DESIGN

The team evaluated 151 patients with NSCLC, the most common type of lung cancer. In a prior study they had

determined that outpatients with metastatic NSCLC would accept palliative care soon after their disease was diagnosed.⁴ Participants were randomly assigned to one of two patient groups within 8 weeks of diagnosis: one group received palliative care in addition to standard oncologic treatments; whereas the other patients received standard care only. The palliative-care team was comprised of board-certified palliative care physicians and advanced practice nurses. They met with each patient in the palliative-care group within the first 3 weeks of study participation and then at least once a month for the duration of the patient's illness. The researchers adapted guidelines for palliative care visits from the National Consensus Project for Quality Palliative Care.⁵

The palliative care team assessed each patient's psychosocial and physical symptoms, set goals regarding care, helped the patient with treatment decisions, and coordinated individual patient care. The patients in the standard-care group did not meet with the palliative care team unless they, their family, or their oncologist requested it. All of the patients received standard oncologic treatment for the duration of the project.

Before they were assigned to one of the two patient groups, all participants completed a baseline questionnaire. Follow-up evaluations of mood and

quality of life were at 12 weeks. There were no significant differences among patients in the two groups; all of the baseline characteristics and prognostic factors such as age, sex, and initial anti-cancer therapy were well matched.

THE HYPOTHESIS WAS CORRECT

Quality of life The researchers compared quality of life (QOL) measurements between the two groups at 12 weeks. They found that the patients who received early palliative care scored significantly higher than those in the standard care group.

Depression and anxiety Of course, depression and anxiety are important factors for the patient with cancer. In this study, the number of patients with depression at 12 weeks was significantly lower in the palliative-care group than in the standard-care group. However, two measures were similar in the two groups: the proportions of patients receiving new prescriptions for antidepressant medication and the percentage of patients who had elevated scores for anxiety symptoms.

Chemotherapeutic results without the drugs The improved quality of life among patients receiving early palliative care was similar to improvements seen in patients who respond well to cisplatin-based chemotherapy. Usually, as their disease progresses, patients' QOL and mood deteriorate. This happened with

the patients in this study who received standard oncologic care; however, the patients receiving early palliative care actually showed an improved QOL, although the groups' cancer therapies were similar. Approximately twice as many patients in the standard-care group reported clinically significant symptoms of depression compared with the patients in the early palliative-care group. Antidepressant medication played no role in this discrepancy.

End-of-life care There were several important differences in end-of-life care between the two groups.

- A greater percentage of patients in the standard-care group (54%) received aggressive end-of-life care than in the early palliative-care group (33%).
- More patients in the palliative-care group documented their resuscitation preferences than those in the standard-care group.
- Duration of hospice care was also longer in the palliative-care group, 11 days versus 4 days in the standard care-group.

Longer survival Integrating early palliative care with standard oncologic care led to a 2-month survival benefit. Earlier studies demonstrated shorter survival among patients with metastatic NSCLC who also had depression and a poor quality of life.⁶⁻⁸ Temel and colleagues hypothesize that one reason patients in the early palliative-care group survived longer was that their depression and anxiety were addressed early enough to improve. Also, providing palliative care along with standard oncologic care may have led to optimal anticancer treatment, while referring patients to hospice care early played a role in managing and stabilizing the disease and its symptoms.

Health care services Temel's study also demonstrated that early outpatient palliative care can have a positive effect on health care services. A reduction in

chemotherapy and aggressive end-of-life care were also noted. According to the authors: "Given the trends toward aggressive and costly care near the end of

Early palliative care may have led to optimal anticancer treatment.

life among patients with cancer, timely introduction of palliative care may serve to mitigate unnecessary and burdensome personal and societal costs."⁴

A SHIFTING PARADIGM

In an accompanying editorial in *The New England Journal of Medicine*, Amy S. Kelly, MD, and Diane E. Meier, MD, note that 80% of US hospitals with more than 300 beds have palliative care programs.⁹ Despite this availability, physicians define palliative care as "what we do when there is nothing more that we can do."¹⁰ According to Drs. Kelly and Meier, who are in the Department of Geriatrics and Palliative Medicine at New York's Mount Sinai School of Medicine:

This study is an example of research that shifts a long-held paradigm that has limited access to palliative care to patients who were predictably and clearly dying. The new approach recognizes that life-threatening illness, whether it can be cured or controlled, carries with it significant burdens of suffering for patients and their families and that this suffering can be effectively addressed by modern palliative care teams.⁹ ■

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