Systematisering af den tidlige palliative indsats ved lungekræft

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Hvad ved vi?
Temel studiet, 2010

The NEW ENGLAND JOURNAL of MEDICINE

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

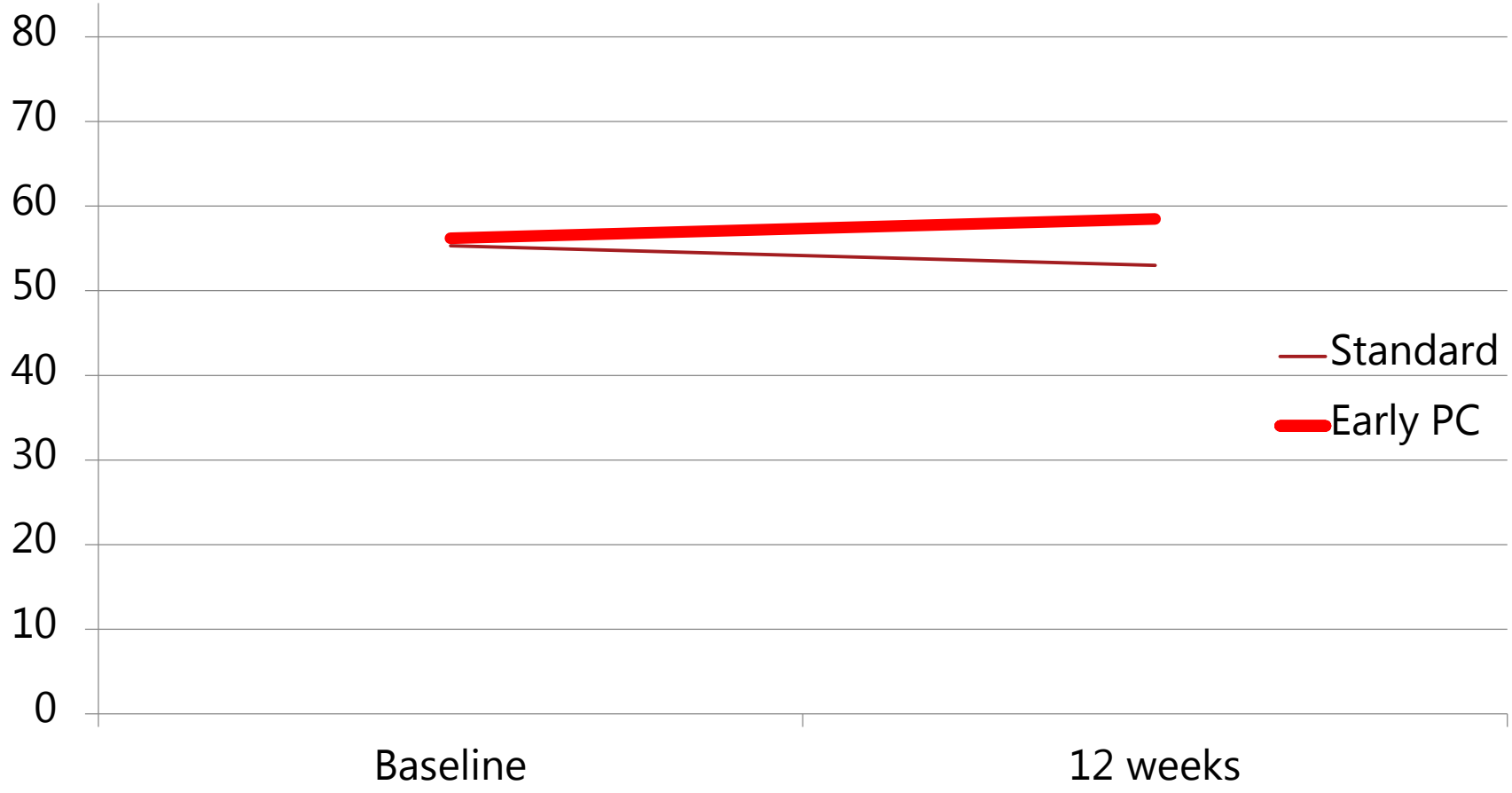
Temel-studiets design

- Metastatisk lungekræft, performance status 0-2 (< 8 uger efter diagnose)
- Sædvanlig behandling +/- palliativt team (start inden for 3 uger, dernæst mindst 1 gang/måned)
- Fokus for palliative team
  - Assessing physical and psychosocial symptoms
  - Establish goals of care
  - Assisting with decision-making regarding treatment
  - Coordination of care
- Primært outcome: Ændring i 'gennemsnitlige livskvalitet' (FACT-L Trial Outcome Index) fra tid 0 til 12 uger

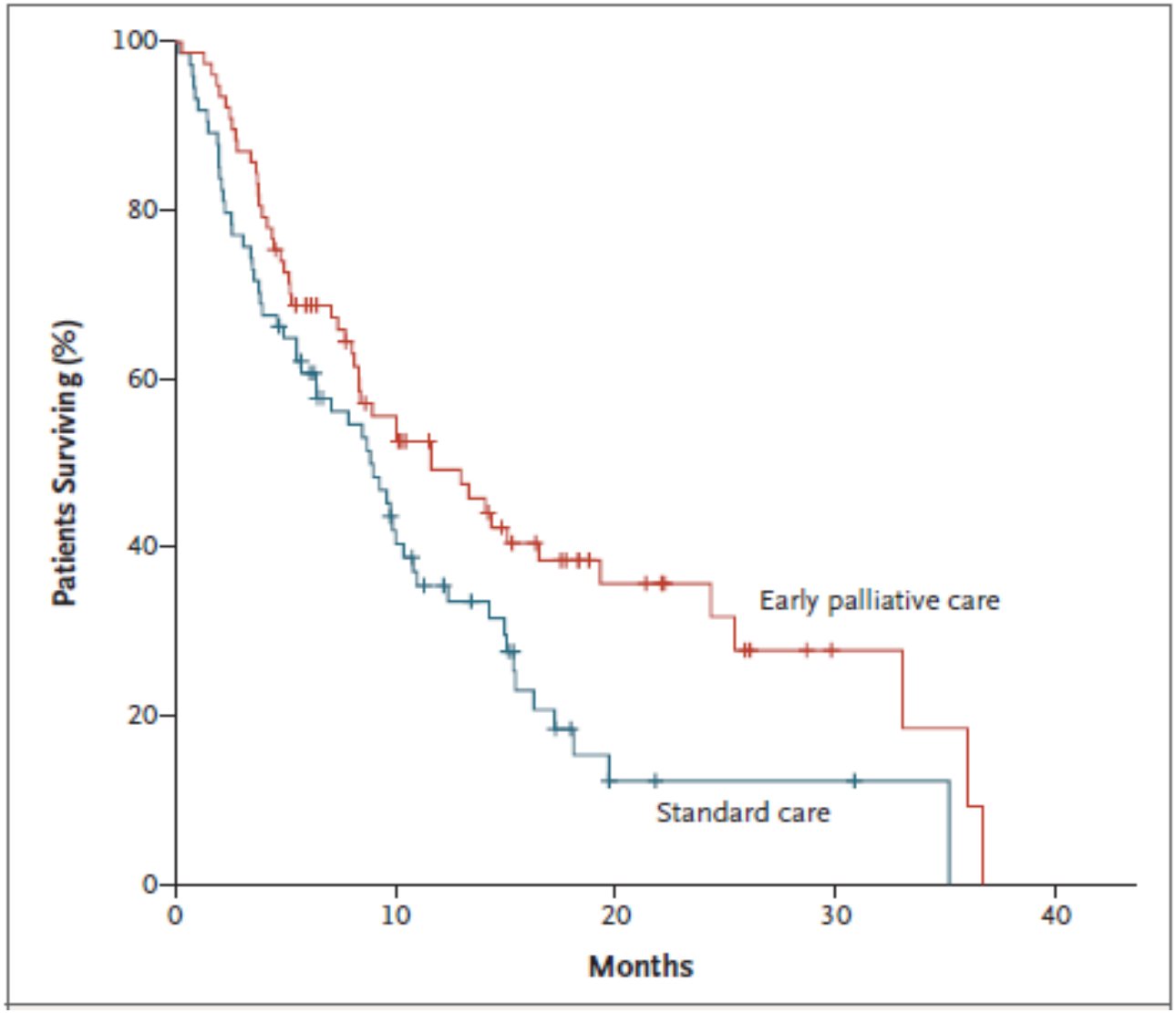
Temel studiets resultater

- I alt 151 patienter i løbet af 3 år (2006-2009)
  - Early PC 76 (+1, som fik det ved en fejl), ialt 77
  - Standard 75 (-1, som fik early), i alt 74
- Spørgeskema ved 12 (+/- 3) uger
  - Early PC 60 (76%) (10 døde)
  - Standard 47 (64%) (17 døde)
  - I alt 107
- Compliance med protokol
  - 75/76 Early PC havde mindst et besøg (mean 4, range 0-8) indenfor 12 uger
  - 10/75 Standard fik early PC (7 et besøg, 3 to besøg)

Temel studiet – primære outcome TOI
(Score 0-84, ændring hhv. 2.3 og -2.3, dvs. 4.6 forskel)



Temel-studiet



Median estimates of survival:

11.6 months (95% CI, 6.4 to 16.9) in the *group assigned to early palliative care* (77 patients), and

8.9 months (95% CI, 6.3 to 11.4) in the *standard care group* (74 patients)

(P = 0.02 with the use of the log-rank test).

(Temel JS, NEJM 2010)

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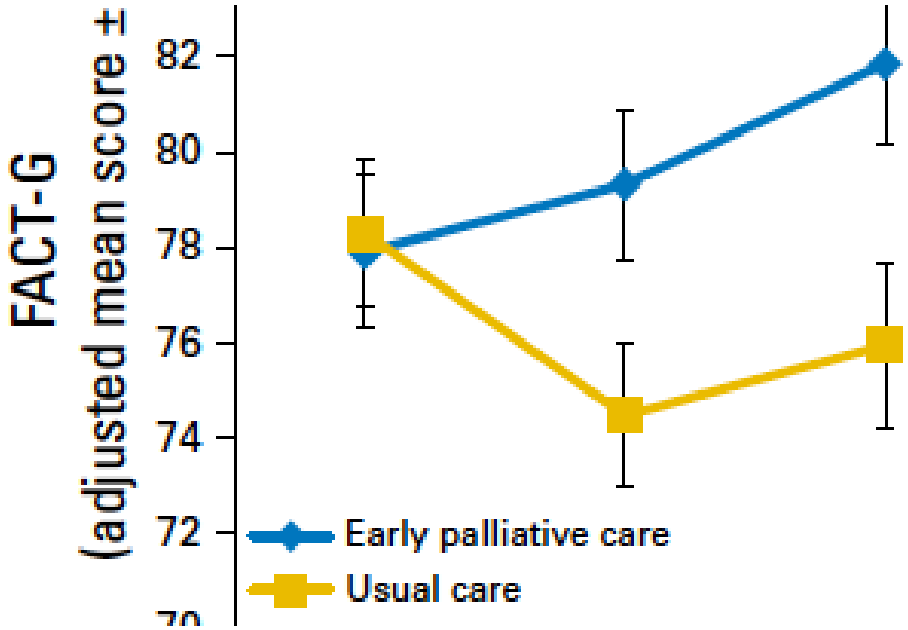
JOURNAL OF CLINICAL ONCOLOGY

ORIGINAL REPORT

Effects of Early Integrated Palliative Care in Patients With Lung and GI Cancer: A Randomized Clinical Trial

Jennifer S. Temel, Joseph A. Greer, Areej El-Jawahri, William F. Pirl, Elyse R. Park, Vicki A. Jackson, Anthony L. Back, Mihir Kamdar, Juliet Jacobsen, Eva H. Chittenden, Simone P. Rinaldi, Emily R. Gallagher, Justin R. Eusebio, Zhigang Li, Alona Muzikansky, and David P. Ryan



Tal for lungekræft (N=96+97)

ER 1 · JANUARY 1, 2017

LINICAL ONCOLOGY ASCO SPECIAL ARTICLE

Integration of Palliative Care Into Standard Oncology Care: American Society of Clinical Oncology Clinical Practice Guideline Update

Betty R. Ferrell, Jennifer S. Temel, Sarah Temin, Erin R. Alesi, Tracy A. Balboni, Ethan M. Basch, Janice I. Firn, Judith A. Paice, Jeffrey M. Peppercorn, Tanyanika Phillips, Ellen L. Stovall,† Camilla Zimmermann, and Thomas J. Smith

ABSTRACT

Purpose

To provide evidence-based recommendations to oncology clinicians, patients, family and friend caregivers, and palliative care specialists to update the 2012 American Society of Clinical Oncology (ASCO) provisional clinical opinion (PCO) on the integration of palliative care into standard oncology care for all patients diagnosed with cancer.

Methods

Hvad ved vi?

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Author affiliations appear at the end of this article.

†Deceased.

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Clinical Practice Guideline Committee approved: August 15, 2016.

A B S T R A C T

Purpose

To provide evidence-based recommendations to oncology clinicians, patients, family and friend caregivers, and palliative care specialists to update the 2012 American Society of Clinical Oncology (ASCO) provisional clinical opinion (PCO) on the integration of palliative care into standard oncology care for all patients diagnosed with cancer.

Recommendations

Inpatients and outpatients with advanced cancer should receive dedicated palliative care services, early in the disease course, concurrent with active treatment. Referral of patients to interdisciplinary palliative care teams is optimal, and services may complement existing programs. Providers may refer family and friend caregivers of patients with early or advanced cancer to palliative care services.

quasiexperimental trial, and five secondary analyses from RCTs in the 2012 PCO on providing palliative care services to patients with cancer and/or their caregivers, including family caregivers, were found to inform the update.

Recommendations

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www.asco.org/guidelineswiki.

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0732-183X/17/3501w-96w/$20.00

ASCO Guideline Update 2017
Hvem skal yde den palliative indsats?

CLINICAL QUESTION 2

What are the most practical models of palliative care? Who should deliver palliative care (external consultation, internal consultations with palliative care practitioners in the oncology practice, or performed by the oncologist him- or herself)?

Recommendation 2

Palliative care for patients with advanced cancer should be delivered through interdisciplinary palliative care teams, with consultation available in both outpatient and inpatient settings (type: evidence based, benefits outweigh harms; evidence quality: intermediate; strength of recommendation: moderate).

Hvad er palliativ indsats?
ASCO (2017) anbefalinger

- Rapport and relationship building with patients and family caregivers
- Symptom, distress, and functional status management (eg, pain, dyspnea, fatigue, sleep disturbance, mood, nausea, or constipation)
- Exploration of understanding and education about illness and prognosis
- Clarification of treatment goals
- Assessment and support of coping needs (eg, provision of dignity therapy)
- Assistance with medical decision making
- Coordination with other care providers
- Provision of referrals to other care providers as indicated

Original Article

PALLIATIVE MEDICINE

Randomised clinical trial of early specialist palliative care plus standard care versus standard care alone in patients with advanced cancer: The Danish Palliative Care Trial

Mogens Groenvold[1,2], Morten Aagaard Petersen[1], Anette Damkier[3], Mette Asbjoern Neergaard[4], Jan Bjoern Nielsen[5], Lise Pedersen[1], Per Sjøgren[6], Annette Sand Strömgren[6], Tove Bahn Vejlgaard[7], Christian Gluud[8], Jane Lindschou[8], Peter Fayers[9,10], Irene J Higginson[11] and Anna Thit Johnsen[1,12]

Palliative Medicine
1–11

DOI: 10.1177/026921631
journals.sagepub.com/hon
SAGE

DanPaCT: Aim

To determine whether patients with metastatic cancer in oncological departments, **who reported palliative needs in a screening**, would benefit from early SPC (i.e. referral to a palliative care team).

Design

Multicentre (six centres) randomized controlled trial (RCT) comparing early SPC plus standard care vs. standard care

Sample size = 300

8 weeks trial period

DanPaCT: Results and conclusions

We could not show effect of early SPC, except maybe on nausea/vomiting

- **Overall effect -4.9** (-11.3 to 1.6) on 0-100 scale, **p=0.14**

We believe that

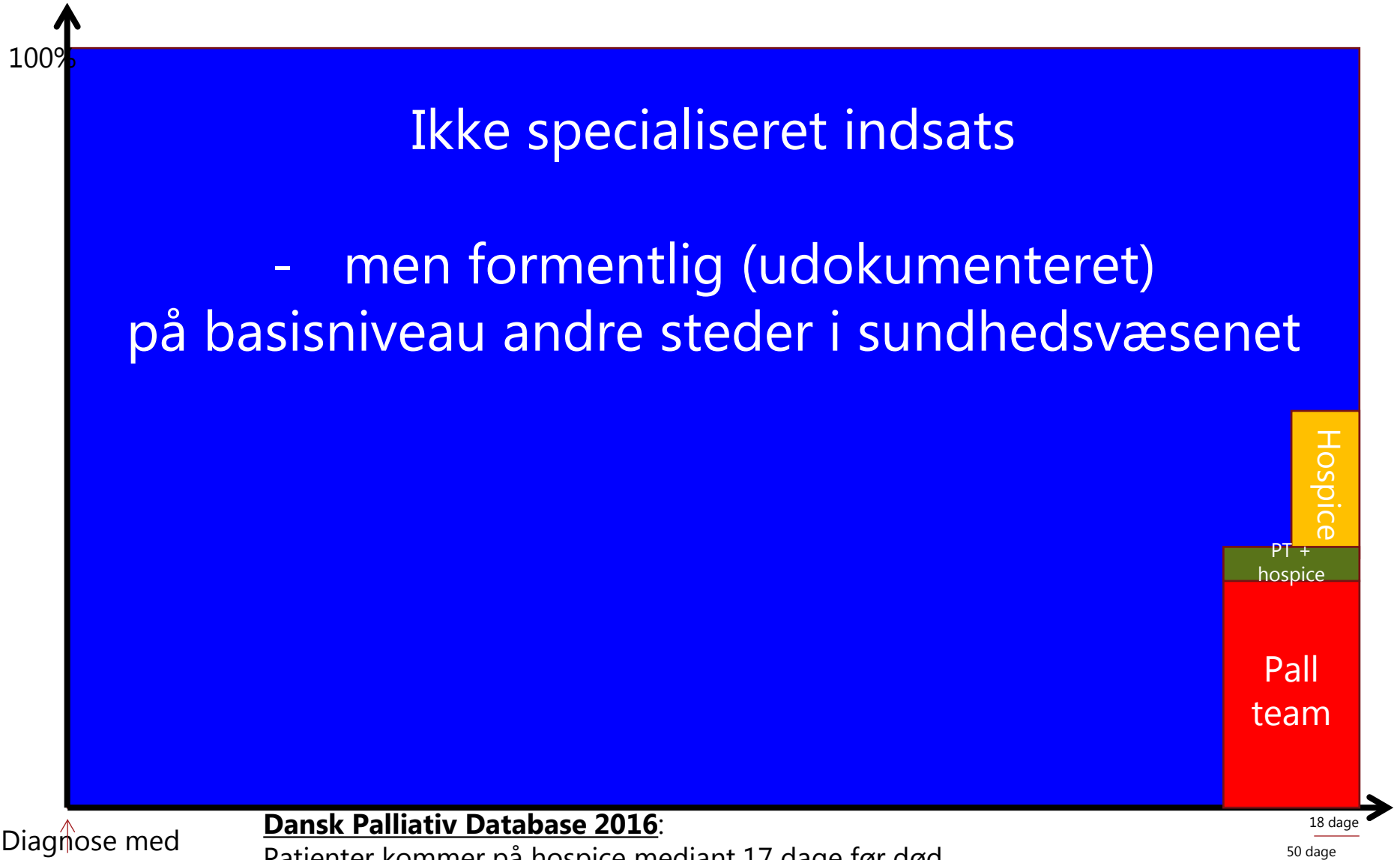
- **The trial was adequately powered, conducted and analyzed, but maybe with too short follow-up**
- **The magnitude of intervention may not been sufficient**
  - SPC staff had no 'standard early SPC model' ready and perceived many of the patients as 'without acute palliative care needs'
- **The effect may have been diluted by (cross-over) and compensation in control arm**

We learned a lot, and therefore confirmed that new interventions must be tested before implementation

Dansk Palliativ Database (2016)

- 53% af alle patienter, der dør af kræft, får specialiseret palliativ indsats
- Ca. 40% af alle patienter, der dør af kræft, får kontakt med et palliativt team (minimum et tilsyn)
- Andelen, der modtages, er lidt større for lungekræft end for andre diagnoser (OR 1,15)
  - Adsersen, BMC Pall care 2017
- 25% af alle patienter i specialiseret palliativ indsats (hospice, palliativt team/afdeling) har lungekræft, ialt 2.031 i 2016
- Median overlevelse 42 dage fra første kontakt (hospice 17 dage, palliativt team 51 dage)

Palliativ specialistniveau (palliativt team og hospice) fortsat forbeholdt halvdelen af patienterne i de sidste 1-2 måneder



Dansk Palliativ Database 2016:
Patienter kommer på hospice mediant 17 dage før død.
Patienter har første kontakt med palliativt team mediant 51 dage før død.

Konklusion, tidlig palliativ indsats ved et palliativ team

- Anbefales entydigt af ASCO m.fl.
- Er ikke et tilbud til mere end en forsvindende brøkdel af danske lungekræftpatienter

Status, tidlig palliativ indsats i DK

- Vi ved ikke, om det virker i DK
  - Store forskelle mellem sundhedssystemer, herunder rollefordeling, indsatser, afregningssystemer, etc.
  - Store kulturelle forskelle
- En udbygning vil kræve betydelige ressourcer
  - Skal vi gøre det ud fra en antagelse om generaliserbarhed af amrikanske resultater?
  - Eller kræve egen evidens?
- Og hvordan skaffes ressourcerne i givet fald
  - Politisk
  - Videnskabeligt

Projektforslag
Systematisering af den tidlige palliative indsats med start fra diagnosetidspunktet

- **Motivation**
  - Udenlandske undersøgelser og anbefalinger: Tidlig palliativ indsats - som supplement til den øvrige behandling - **fremmer patienternes livskvalitet og er omkostningseffektiv.**
  - Hvis dette skal komme fremtidige danske patienter til gode, skal **det afklares, hvordan det bedst mulige samspil mellem de behandlende afdelinger, eksisterende rehabiliterende tiltag og de palliative specialister tilrettelægges**.
  - Et forslag om henvisning til palliativt team tidligt i forløbet kan opleves som et dårligt tegn ('så syg er jeg ikke'). Kan forebygges ved at etablere en **fast praksis om at henvise alle lungekræftpatienter.**

Målsætning

- Sikring af, at alle danske lungekræftpatienter får den bedste mulige palliative indsats gennem hele forløbet
- Afklaring af, hvordan tidlig palliativ indsats bedst tilrettelægges som led i danske lungekræftpatienters behandlings- og opfølgningsprogram

Projektforslag

- Afprøvning (RCT eller præ/post sammenligning) af effekten af tidlig palliative indsats: Henvisning til behovsvurdering med det palliative team på diagnosetidspunktet (efter modtagelse på onkologisk afdeling)
- Teamet afklarer behov og henviser til og inddrager relevante parter.
- Teamet registrerer resultatet af behovsvurderingen og konsultationen, herunder plan og henvisninger, i DLCR.

Projektforløb

- Fase 1 (ca. 1 år)
  - Udarbejdelse af protokol for samtale og samarbejde med andre aktører
  - Pilottestning af protokol på et mindre antal patienter
  - Revision af protokol
  - Etablering af registreringssystem for indsatser i DLCR
  - Afdækning og ensretning af behovsvurderings – og PRO skemaer, som bruges før og til opfølgning, fx hver 3.måned efterfølgende, integrering af disse i DLCR og regionale IT systemer
- Fase 2 (ca. 2 år)
  - Multicenterstudium af den færdige model (ud fra punkt 3) i en kontrolleret undersøgelse, sammenlignet med 'hidtidige standard'

Tovholdere

- Mogens Grønvold
- Patientforeningen Lungekræft
- Vibeke May (Onk. Amb. Herning)
- Anne-Marie Hill (Onk. Amb. Herning)