End of Life Care 2017

SESSION CHAIR:

Kavitha Ramchandran, MD

Thoracic Oncology and Palliative Medicine
Stanford Hospital and Clinics

Panel Members:
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John Hausdorff MD, Medical Oncology, Pacific Cancer Care
David Magnus PhD, Center for Biomedical Ethics, Stanford
Daniel Mirda MD, Medical Oncology, Annadel Medical Group
Mike Rabow MD, Palliative Care, UCSF
Piyush Srivastava MD, Medical Oncology, TPMG

Assistant to session chair:
Diane Tseng MD PhD, Oncology Fellow, Stanford

Case 1: California's End of Life Options Act

Mrs. Mobitz is 75 years old and was diagnosed one month ago with squamous cell carcinoma of the lung. She is not interested in chemotherapy or immunotherapy, and would like the option of ending her life on her terms. She seems to interact normally with you, and does not appear to be clinically depressed – rather, she is resigned.

EOLA California Requirements:

- Attending physician and consulting physician have diagnosed the patient with terminal illness with six month or less life expectancy
- Patient has voluntarily expressed a desire to receive aid-in-dying medication
- Patient has the mental capacity to make and communicate healthcare decisions
- Patient is a resident of California
- Patient is at least 18 years old
- Patient has the physical ability to self-administer and swallow the aid-in-dying medication
- Applicable documentation must be completed by patient's attending and consulting physician

Case 1: California's End of Life Options Act
Mrs. Mobitz is 75 years old and was diagnosed one month ago with squamous cell carcinoma of the lung.

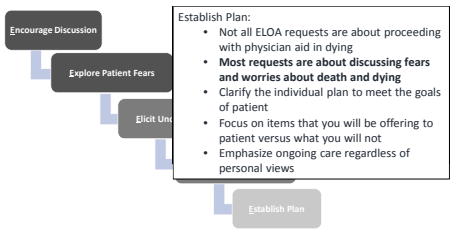
1.1) Her husband asks: "Is she eligible for the pill?"
a. Yes, because she has less than six months, meeting the "definition" of terminal illness.
b. Yes, if she continues to show evidence of having "capacity".
c. Yes, if there is no good evidence of depression or anxiety interfering with her judgment. If present, this require evaluation by a psychiatrist or clinical psychologist.
d. Yes, if she asks now, and again at least 15 days from today, and signs the "Attestation" form (thereby providing a written request).
e. All of the above
f. Not of the above

Case 1: California's End of Life Options Act

1.2) You say, " What makes you ask for something like this?" She answers that she does not want to die in terrible pain. How might you respond?

a. Most cancer patients don't die in terrible pain.
b. We have lots of good pain medications
c. Getting on to hospice care opens the door to having the focus of care be pain and symptom management, and that hospice nurses are experts in this.
d. Point out that for patients with intractable pain, "palliative sedation" brings state of unconsciousness, so they don't feel any pain.
e. All of the above.

Initial Steps, EOLA Road Map:



Adapted from Palliative Care Network of Wisconsin. Palliative Fast Facts 23 Discussing DNR Orders. Von Gunten F, Weissman D, May 2015.

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Requirements for the Consulting Physician

In addition to the attending physician, a consulting physician who is independent from the attending physician needs to evaluate the patient.
The consulting physician needs to:

A. Examine the individual and his or her relevant medical records.
B. Confirm in writing the attending physician's diagnosis and prognosis.
C. Determine that the individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision.
D. If there are indications of a mental disorder, refer the individual for a mental health specialist assessment.
E. Fulfill the record documentation required under this part.
F. Submit the compliance form to the attending physician.

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Case 1: California's End of Life Options Act

1.3) A few weeks later, she says she still wants to pursue having the "pills," because she wants to maintain as much control as possible. She seems to have capacity, has no apparent psychiatric condition, and you have her sign the "Attestation" form and you work through the MD "Checklist" form with her. What's the next step?

a. Give her the pills.
b. There needs to be a second opinion from another MD.
c. Refer to psychiatry because psychiatric evaluation is mandatory.
d. You've decided you cannot participate – "Above all, do no harm"
e. You don't feel comfortable. The law does NOT mandate that you refer to a physician who is willing to participate.

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Case 1: California's End of Life Options Act

Question for the panel—

What have been your personal experiences at your respective institutions with California's End of Life Options Act?

Overview

Case 1: California's End of Life Options Act

Case 2: Nutrition at the end of life

Case 3: Prognosis in the era of immunotherapy

Case 4: Early integration of palliative care into oncology care

Summary of Key points

References

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Case 2: Nutrition at the end of life

2.1) A family meeting is held and the decision made to pursue hospice care. He has been on TPN during this admission. Should TPN be continued?

A) Artificial nutrition is not consistent with the philosophy of hospice and should be stopped
B) TPN should be continued for now, but if the patient appears uncomfortable, then it should be withdrawn
C) TPN should be continued until he has taken care of his business affairs
D) The benefits and risks of TPN should be discussed with the patient and the decision of whether or not to continue TPN should be a shared decision

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Case 2: Nutrition at the end of life

Mr. Jones is an 82 year old gentleman with pT3b N0 M0 high grade invasive papillary urothelial carcinoma, who underwent a radical cystectomy with ileal conduit. He experienced his first recurrence one year later, for which he was treated with carboplatin and gemcitabine. He is admitted to the hospital with nausea and vomiting and found to have a malignant bowel obstruction.

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Case 2: Nutrition at the end of life

Parenteral Nutrition: Is it Oncologically Logical?
By Ronald L. Koretz

Design:
- Review of 17 prospective, randomized controlled trials testing whether parenteral nutrition would be clinically beneficial for cancer patients receiving either chemotherapy or radiation therapy

Results/Conclusions:
- No significant evidence that parenteral nutrition has a consistent positive effect
- Most studies have small numbers of patients, so small benefits can be missed

Koretz et al. J Clin Oncol 1984;2(5):534-8

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Use of total parenteral nutrition (TPN) in terminally ill gastrointestinal (GI) cancer patients (pts) compared to other malignancies (OM): A single-institution experience.

ASCO 2013 Gastrointestinal Cancers Symposium Abstract 309
J Clin Oncol 31, 2013 (suppl 4; abstr 309)

Design:
- Single-institutional study of cancer patients with limited life expectancy given TPN between 2007 – 2012. Compared patients with GI cancer vs other malignancy. Primary outcome survival.

Results/Conclusions:
- Median time from TPN to death was 55 days in GI group vs 77 days in other malignancy group
- TPN complication rate was high, 68% of patients requiring readmission
- Quality of life did not improve

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Case 2: Nutrition at the end of life

Comfort Care for Terminally Ill Patients
The Appropriate Use of Nutrition and Hydration
Robert M. McCann, MD; William J. Hall, MD; Annmarie Groth-Juncker, MD

Design:
- Prospective study of terminally ill patients in comfort care unit in Rochester, NY
- Symptoms of hunger, thirst, dry mouth were recorded, and amount of food/fluids necessary to relieve these symptoms

Results/Conclusions:
- Of 32 patients, 20 patients (63%) did not experience hunger and 11 patients (34%) had only only initially
- 20 patients (62%) experienced no thirst or thirst only initially
- Symptoms were usually alleviated with small amounts of food, fluid, ice chips, or lubrication of lips

McCann et al. JAMA 1994;272:1263-1266

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Case 2: Nutrition at the end of life

2.2) His wife replies, if we stop artificial nutrition, aren't you going to starve him to death? How should you respond?

A) Starvation is a natural part of the dying process
B) Remind her that he is dying of cancer
C) Patient generally do not feel hungry at the end of life
D) B and C

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Case 2: Nutrition at the end of life

2.3) His wife asks, "What if he gets thirsty? Can we give him IV hydration?"

A) Sorry, we aren't permitted to give IV hydration on hospice
B) IV hydration has not been shown to improve symptoms of thirst
C) Thirst can be managed by swabbing the mouth with water, artificial saliva, ice chips, or popsicles
D) B and C

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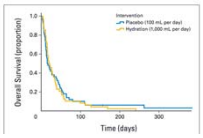
JOURNAL OF CLINICAL ONCOLOGY | ORIGINAL REPORT

Parenteral Hydration in Patients With Advanced Cancer: A Multicenter, Double-Blind, Placebo-Controlled Randomized Trial

Design:
- 129 patients with cancer from six hospices randomized to receive hydration

(normal saline 1 L per day) vs placebo (normal saline 100 mL per day) daily over 4 hours.
- Primary outcome = sum of four dehydration sx (fatigue, myoclonus,

sedation and hallucinations) between day 4 and baseline.
Secondary outcomes = QOL, survival



Results/Conclusions:
- No significant differences between the two groups for change in the sum of four dehydration symptoms
- 1 L of normal saline hydration daily did not improve symptoms, quality of life, or survival

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Overview

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Case 3: Prognosis in the era of immunotherapy

Case 4: Early integration of palliative care into oncology care

Summary of Key points

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Case 2: Nutrition at the end of life

Question for the panel:

How do you navigate discussions around artificial nutrition in terminally ill patients, particularly in the face of social and emotional factors that may influence these conversations?

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Case 3: Prognosis in the era of immunotherapy

59-year-old woman was diagnosed with p16 negative squamous cell carcinoma (T2 N2b M0) of the right tonsillar region. She underwent chemo-radiation, but recurred 4 months later with pulmonary metastases. She was started on an experimental phase 1 drug trial with nivolumab.

3.1) What do you tell her about her prognosis?
A) You tell her that her prognosis is guarded and she has likely months to live
B) You let her know that phase 1 trials are looking primarily at safety, and we cannot tell the efficacy at this point in time
C) You let her know that you are hopeful for the future, and that she should plan on attending her planned family events over the coming year
D) A and B

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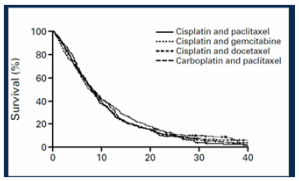
We used to know…but we over-estimated



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Case 3: Prognosis in the era of immunotherapy

3.2) How should the palliative care doctor advise the patient?

A) Encourage her to come off the clinical trial since it is not in line with her goals of care
B) Let her know that you will support her while she is on trial, and that if the toxicities become too burdensome you will work with her to consider alternatives including supportive care and hospice
C) Ask her to complete her AD as soon as possible. It is clear that there is limited time left
D) B and C

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Case 3: Prognosis in the era of immunotherapy

She was seen by palliative medicine in May of 2015. They went over many aspects of her illness and also spoke about prognosis and her fears about end of life. Her palliative care doctor notes that:
--Pt understands her malignancy is not curable.
--Pt fears/worries about how the end will look. Cared for her mother as she died from cancer.
--Pt's hopes/goals are: Patient doesn't want to suffer. Wants to die at home. Control over the process.
--Pt does not have an advance directive. Introduced role of AD. Reviewed how to complete. Patient to review at home and continue discussions at future appointments.

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Case 3: Prognosis in the era of immunotherapy

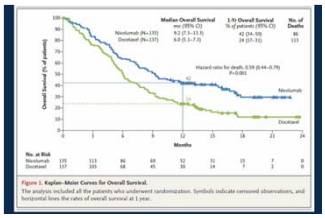
She continued on clinical trial for 1.5 years. In November of 2016 her lipase was significantly elevated and she was discontinued from clinical trial due to drug toxicity. At this time she also looked more frail, and had lost about 5% of her body weight.

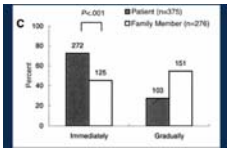
3.3) In light of this information, what would recommend?

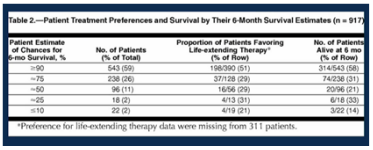
A) Enrollment on hospice
B) Wait and see. A follow up in a few months might be appropriate
C) Re-engaging in a discussion around her goals of care
D) All of the above

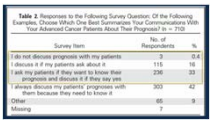
Case 3: Prognosis in the era of immunotherapy

Talking about prognosis in the era of immunotherapy is fraught with uncertainty









- Patients want to know, and often soon after their diagnosis.
- Oncologists often wait to talk to their patients about prognosis
- If patients know their prognosis they are able to make good decisions

Case 3: Prognosis in the era of immunotherapy

She was seen by her team in January of 2017. Her lipase has come back to normal. Her scans show no evidence of recurrence. She has plans to travel on vacation with her family and continues to take care of her grand-daughter full time. She hopes to re-start nivolumab with her local oncologist when her disease returns

3.4) How would you approach discussions about the future?

A) You realize you should have never shared prognosis with her, we are always wrong
B) You tell her that you are glad that she is doing well, and hope she continues to do so for a long time, but we are not sure how long that will be
C) Communicate with compassion and empathy
D) B and C

So what now? Thought question for the panel:

When we knew definitely about prognosis we were not great at sharing that information (the days of chemotherapy only). Now in the era of targeted therapy and immunotherapy how do we share prognostic information in an accurate and empathic way?

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Case 4: Early integration of palliative care into oncology care

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Case 4: Early integration of palliative care into oncology care

4.1) When should palliative care referral be made?

A) At the time of diagnosis
B) Difficult-to-manage symptoms, regardless of prognosis
C) Poor prognosis
D) When there are frequent hospital visits or hospital readmissions
E) All of the above

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Case 4: Early integration of palliative care into oncology care

Ms. McKenna is a 68 year old woman with a history of metastatic mesothelioma, who was diagnosed in 2012, and has now progressed after carboplatin/pemetrexed, gemcitabine, navelbine, and pembrolizumab. She is interested in more treatment. She also has been struggling with nausea, constipation, and lower extremity edema. She is self-referred to the medical oncology clinic for a second opinion.

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Case 4: Early integration of palliative care into oncology care

- Review of 7 published randomized controlled trials
- Integration of palliative of care into standard oncology care may improve symptoms, quality of life, mood, satisfaction, cost of care, and potentially survival in patients with cancer

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Case 4: Early integration of palliative care into oncology care

Question for the audience—

How many practitioners in the audience have access to a palliative care physician? (please raise your hand)

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Case 4: Early integration of palliative care into oncology care

Thought question for the panel—

What kinds of health policy, reimbursement mechanisms, or clinical models would support additional clinic-based and community-based palliative care services?

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Case 4: Early integration of palliative care into oncology care

Reflection question for the panel—

What are some of the barriers you have experienced to early palliative care referral?

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Case 1: California's End of Life Options Act

Key points:
- Attending physician and consulting physician have diagnosed the patient with terminal illness with six month or less life expectancy
- Patient has voluntarily expressed a desire to receive aid-in-dying medication
- Patient has the mental capacity to make and communicate healthcare decisions
- Patient has the physical ability to self-administer and swallow the aid-in-dying medication
- Be open to discussing fears and worries about death and dying

Case 3: Prognosis in the era of immunotherapy

Key points
- Until there are more reliable biomarkers for predicting response to immunotherapy, discussing prognosis continue to be a challenge
- Patients want to know their prognosis, often soon after diagnosis
- There is still much to be learned

Case 2: Nutrition at the end of life

Key points:
- There is no significant evidence that parenteral nutrition at the end of life has a consistent positive effect
- Many patients at the end of life do not experience thirst or hunger. Symptoms were usually alleviated with small amounts of food, fluid, ice chips, or lubrication of lips
- 1 L of normal saline hydration daily did not improve symptoms, quality of life, or survival in the hospice setting

Case 4: Early integration of palliative care into oncology care

Key points:
- Integration of palliative of care into standard oncology care may improve quality of life, cost of care, and potentially survival in patients with cancer
- There are still physician, patient, and system barriers to early palliative care referrals
- There is potential for further development of clinic-based and community palliative care programs

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References

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