Integrating Palliative Care into the Management of Bladder Cancer Patients

Perspective from a Future Urologic Surgeon

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Slide 1

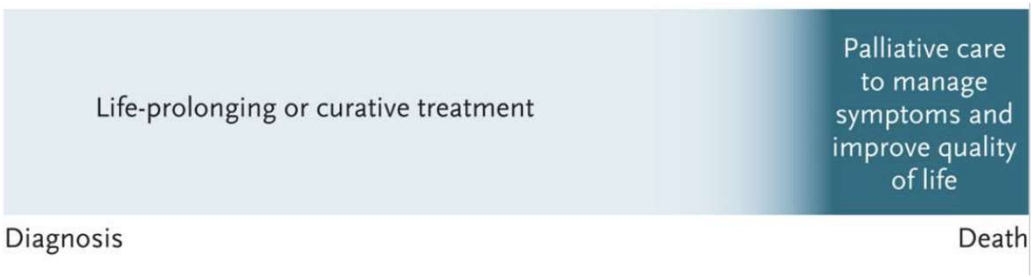
pi1 Progress Indicator: Ignore this slide
Progress Indicator, 4/16/2018

- What palliative care isn't
- What palliative care is
- Origins of palliative care
- Bladder cancer and palliative care research
- The surgeon's role in palliative care
- Future directions

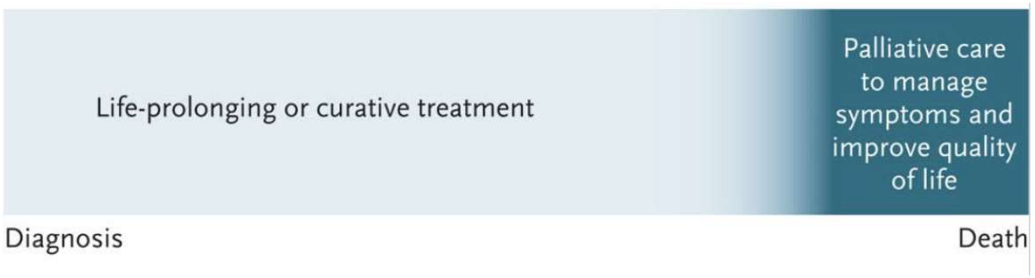
What palliative care isn't

Palliative care = 

Palliative care = Hospice



Palliative care = ~~Hospice~~



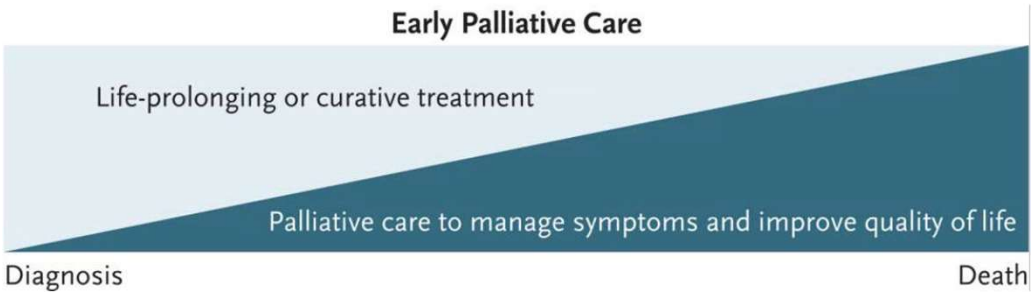
What palliative care is

Specialized multidisciplinary medical care for people living with serious illnesses, focusing on the relief of symptoms and stress of an illness, with the goal to improve quality of life for both the patient and their family.

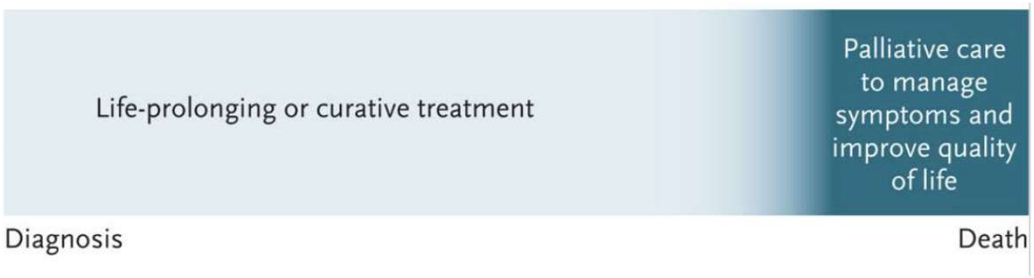
Whole person care…

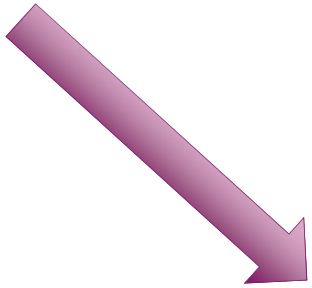
- Physical
- Intellectual
- Emotional
- Social
- Spiritual

…at any stage of illness.



Tenets of palliative care

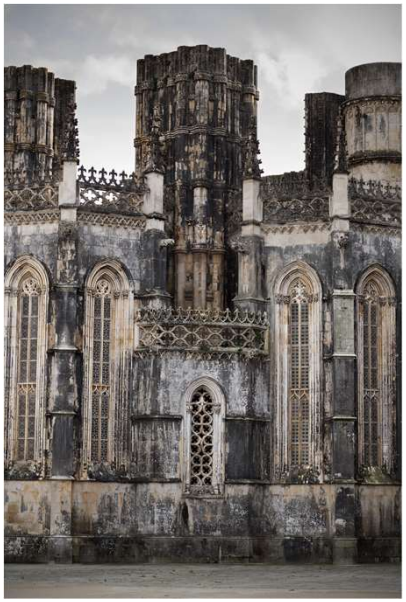

Life-prolonging or curative treatment
Palliative care to manage symptoms and improve quality of life
Diagnosis
Death




Life-prolonging or curative treatment
Palliative care to manage symptoms and improve quality of life
Diagnosis
Death

Origins of palliative care

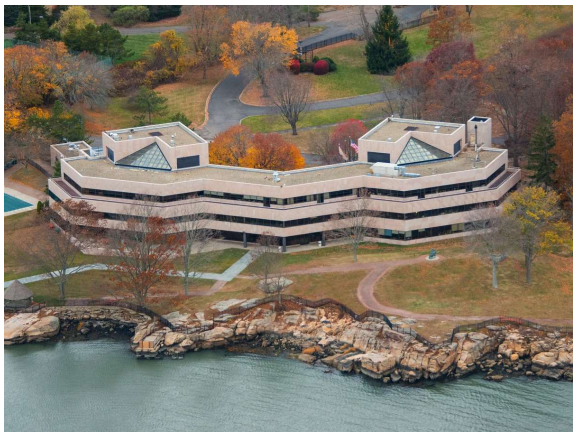
Hospes – “guest or stranger”
Hospitale – “guest house or inn”

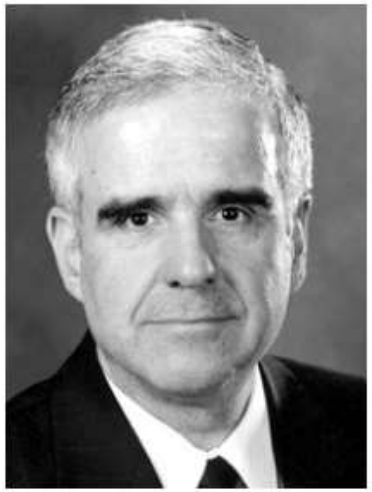


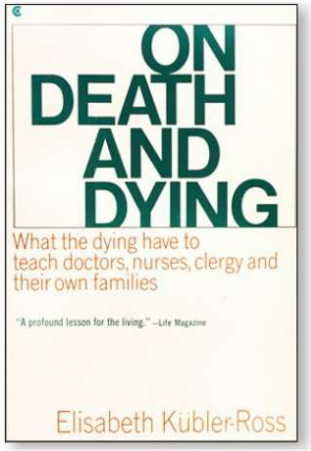
“Cure sometimes, treat often, comfort always”

Shaw, Br, J Gen Pract, 2009

Figure 1: Cicely Saunders working as a nurse in the 1940s







Denial
Anger
Bargaining
Depression
Acceptance

Urology. 1974 Dec;4(6):741-8.

Death and dying: attitudes in a teaching hospital.

Mount BM, Jones A, Patterson A.

The problem of caring for the dying in a general hospital; the palliative care unit as a possible solution

BALFOUR M. MOUNT, FRCS[C]

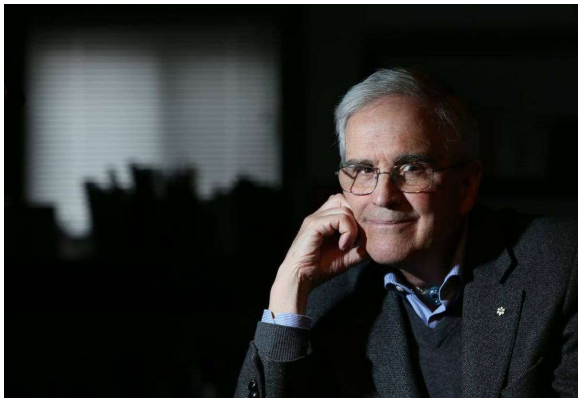
Cancer. 1980 Apr 15;45(7 Suppl):1985-92.

Psychological impact of urologic cancer.

Mount BM.

aahpm

AMERICAN ACADEMY OF HOSPICE AND PALLIATIVE MEDICINE



Bladder cancer and palliative care research

Symptom burden in bladder cancer

Palapattu et al show a high prevalence of psychologic distress prior to cystectomy with minimal significant change postoperatively (J Urol 2004)

	No. Preop (%)
High depression	26 (42)
High anxiety	34 (55)
High somatization	15 (24)
High general distress	30 (48)

Brenner and Rabow show significantly increased brief pain inventory (BPI) scores postoperatively (J Urol, 2014)

Outcomes with time

Survey (time point)	Av Score (95% CI)	p Value for Score Trend
BPI:		
Initial visit	4.0 (0–8.0)	0.03
2 Mos	9.2 (3.8–14.6)	
4 Mos	11.3 (1.0–18.6)	
6 Mos	9.8 (1.9–17.6)	

Symptom burden in bladder cancer

Klaassen and Terris show a high burden of suicide in patients with genitourinary cancer, especially in patients with bladder cancer (Cancer, 2015)

TABLE 3. Suicide in Patients With Cancer by Disease Site and Years Since Diagnosis

	Time Since Diagnosis			
Cancer Site	0 to 5 Years	5 to 10 Years	10 to 15 Years	≥15 Years
Prostate				
Suicides, no.	953	468	144	48
Person-y accrued	3,114,400	1,434,147	450,948	113,017
SMR[a]	1.33	1.42	1.39	1.84
95% CI	0.95-1.81	1.02-1.91	0.99-1.86	1.39-2.41
Bladder				
Suicides, no.	312	88	29	10
Person-y accrued	743,899	300,270	100,701	33,355
SMR[a]	3.05	2.13	2.09	2.18
95% CI	2.26-3.96	1.53-2.94	1.47-2.86	1.53-2.94

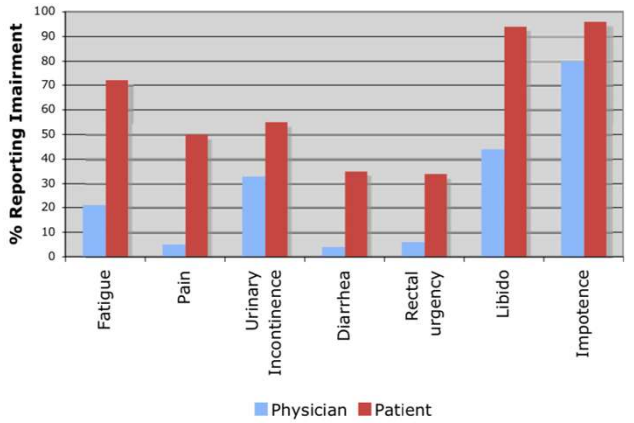
Symptom assessment in bladder cancer

Gilbert et al report that the Bladder Cancer Index is sensitive to differences in function and bother across treatment approaches (Cancer 2007)

Adjusted Mean BCI Domain Scores

	Native bladder		Cystectomy	
BCI Score	No intravesical Tx n = 52	Intravesical Tx n = 75	Ileal conduit n = 66	Neobladder n = 122
Urinary domain				
Function	90.7†	89.2‡	86.5*	49.8*‡†
Bother	95.4*	93.4‡	88.4	86.3*‡
Bowel domain				
Function	82.0	88.6*‡	77.6*	76.6‡
Bother	93.0*†	92.3‡§	80.8*‡	85.7†§
Sexual domain				
Function	45.7*†	42.2‡§	20.0*‡	25.5†§
Bother	67.4*†	71.7‡§	50.3*‡	49.9†§

Sonn et al show that physicians underestimate patient health related quality of life and that this assessment does not improve over time (J Urol, 2012)



Palliative care use in bladder cancer

Rabow and colleagues found improved fatigue, depression, and anxiety in a serial cohort study of patients with muscle invasive bladder cancer undergoing cystectomy with and without concurrent palliative care.
(Urol Oncol, 2015)

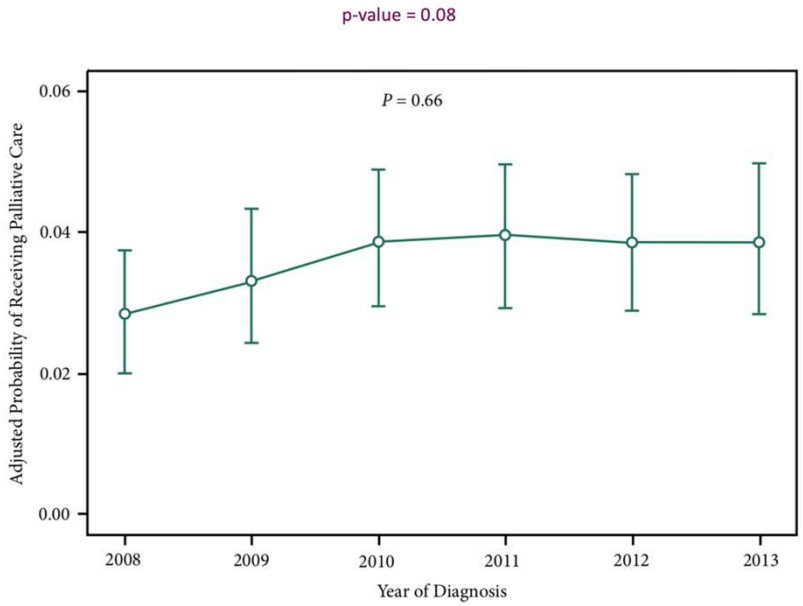
Table 2
Control and intervention group outcomes

Survey	Time point	Average score (95% CI)		*P* value for score trend		*P* value for comparison of trends	Adjusted comparison *P* values*
		Control	Intervention	Control	Intervention		
Brief Pain Inventory	Initial visit	4.0 (0–8.0)	17.4 (8.2–26.7)	**0.03**	0.13	0.09	0.13
	2 Months	9.2 (3.8–14.6)	26.2 (14.3–38.0)				
	4 Months	11.3 (1.0–18.6)	8.9 (0.2–17.6)				
	6 Months	9.8 (1.9–17.6)	11.4 (4.0–18.8)				
Cancer Fatigue Scale	Initial Visit	18.6 (17.0–20.2)	34.3 (30.0–38.5)	0.12	**0.02**	**0.002**	**0.002**
	2 Months	18.0 (15.9–20.2)	34.3 (30.2–38.4)				
	4 Months	21.8 (18.7–24.9)	28.7 (25.0–32.3)				
	6 Months	21.0 (17.2–24.8)	29.7 (25.7–33.7)				
Hospital Anxiety and Depression Scale	Initial visit	7.6 (5.1–10.0)	9.8 (7.6–11.9)	0.37	**0.02**	**0.01**	**0.01**
	2 Months	6.6 (4.3–8.9)	10.5 (8.1–12.8)				
	4 Months	8.4 (6.0–10.7)	7.3 (4.9–9.6)				
	6 Months	8.4 (6.0–10.8)	7.2 (4.8–9.6)				
Depression Subscale	Initial visit	3.2 (2.1–4.3)	4.1 (3.0–5.3)	0.11	**0.01**	**0.003**	**0.004**
	2 Months	3.3 (2.2–4.5)	5.4 (4.1–6.7)				
	4 Months	4.4 (2.8–5.9)	3.6 (2.2–5.0)				
	6 Months	4.4 (2.8–6.0)	3.0 (1.8–4.2)				

Trends in palliative care use

Hugar and Jacobs show poor use of palliative care in Medicare beneficiaries with bladder cancer. Age, male sex, and lower comorbidity was associated with decreased palliative care use. (BJUI, 2019)

Group	% of cohort	% receiving palliative care
Advanced disease	34%	4.1%
Localized disease	66%	3.3%



Co-location of palliative care

Yu and Schenker find 19x greater odds of palliative care use when co-located with oncology clinic. Travel time also impactful with 2-3x greater odds when time <60 minutes (J Oncol Pract, 2019)

Bergman shows that palliative care consultation at the urology point of care is feasible, improves care, and increases clinician satisfaction. (Cancer 2007)

Theme 1. Clinicians felt that it was feasible and appropriate to address pain and comfort issues within the surgical clinic;
Theme 2. When incorporating pain and comfort issues, perceived quality of care was improved, and patients were happier;
Theme 3. Offering a palliative care consultation to patients did not require an undue amount of time;
Theme 4. Participants viewed the terminology of the "integrated" clinic to be a misnomer, and offered opportunities for improvement of the clinic organization.

The surgeon's role in palliative care

Palliative care

Specialized multidisciplinary medical care for people living with serious illnesses, focusing on the relief of symptoms and stress of an illness, with the goal to improve quality of life for both the patient and their family.

Palliative surgery

A surgical procedure used with the primary intention of improving quality of life or relieving symptoms caused by an advanced illness, the success of which is measured by symptoms resolution.

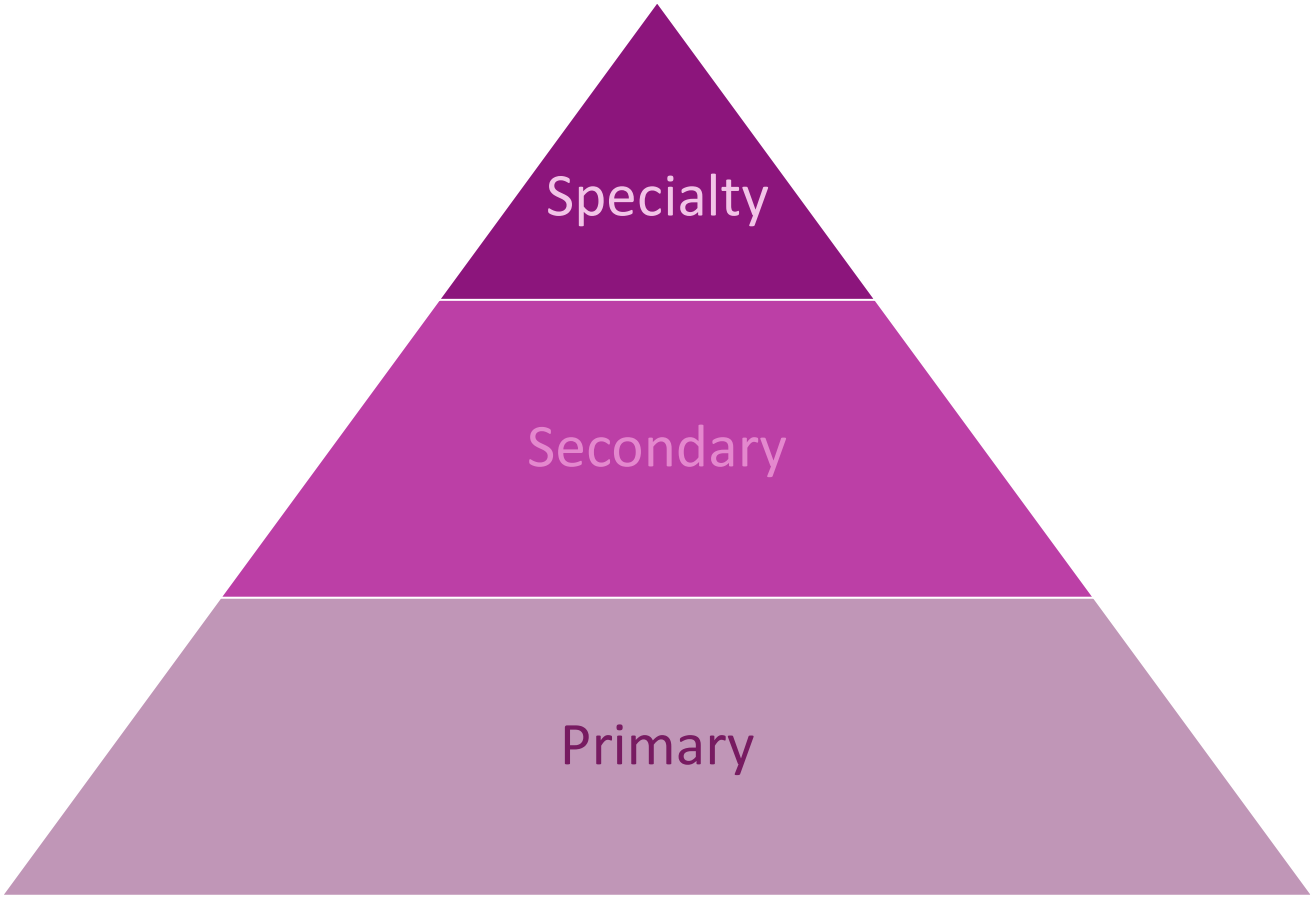
Dunn, American College of Surgeons, 2009

Principles of palliative surgery

Principles of Palliative Surgery

- Palliation is not the opposite of cure; it has its own distinct indications and goals and should be evaluated independently
- Asymptomatic patients cannot be palliated.
- Palliative surgery is as morally and ethically legitimate as surgery for curative intent.
- Day-to-day surgical decisions are best made in the framework of ethical, scientific, and technical principles.
- The patient or surrogate must acknowledge the personal relevance of the symptom to be treated.
- Meaningful survival expectations should exist before offering surgical palliation.
- Goals must be clearly and honestly defined to patient and family, yourself, the surgical team, and other members of the health care team.

Hierarchy of palliative care



Primary palliative care

Basic management of pain

Basic symptom management

Basic discussions on:

- Prognosis
- Goals of care
- Suffering and symptom burden
- Code status

Specialty palliative care

Management of refractory pain

Management of complex symptoms

Assistance with conflict resolution:

- Within families
- Between families and providers
- Among treatment teams

Addressing cases of near futility

Quill, NEJM, 2009

The importance of primary palliative care

- Current palliative care workforce meets only 20-25% of demand
- Estimated growth of palliative care physicians over next two decades: 1%
- Estimated growth of patients eligible for palliative care: 20%

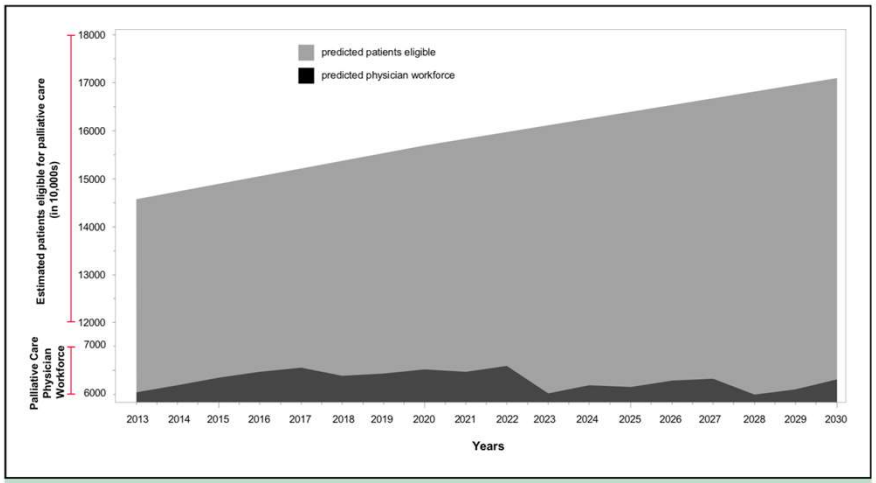


Figure Projected changes in palliative care physician workforce and seriously ill patients eligible for services.

Lupu, J Pain Symptom Manage, 2010
Kamal, Am J Med, 2017

Screening for palliative care needs

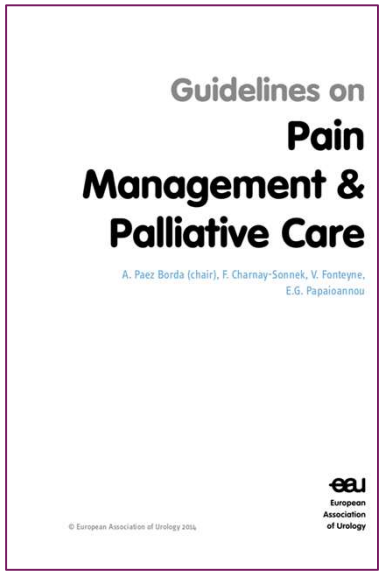
TABLE 3. CRITERIA FOR A PALLIATIVE CARE ASSESSMENT AT THE TIME OF ADMISSION

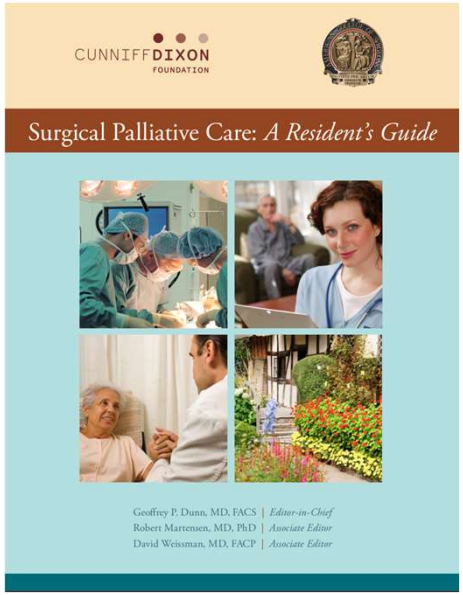
A potentially life-limiting or life-threatening condition *and* . . .
Primary Criteria[a]

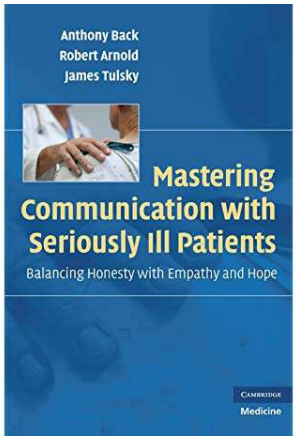
- The "surprise question": *You would not be surprised if the patient died within 12 months or before adulthood* [23–25]
- Frequent admissions (e.g., more than one admission for same condition within several months)[26–30]
- Admission prompted by difficult-to-control physical or psychological symptoms (e.g., moderate-to-severe symptom intensity for more than 24–48 hours)[6, 31]
- Complex care requirements (e.g., functional dependency; complex home support for ventilator/antibiotics/feedings)[6]
- Decline in function, feeding intolerance, or unintended decline in weight (e.g., failure to thrive)[6, 31]

Weissman, JPM, 2011

Surgical palliative care resources







Future directions

Pursue more data

- Include more surgical patients in palliative care studies
- Research the role of palliative care for patients with early-stage disease
- Identify/test triggers for palliative care
- Identify the highest impact specific elements of palliative care
- Identify and address disparities in the receipt and quality of palliative care
- Focus more research on family caregivers
- Identify end-points and outcomes which matter most to patients

Ferrell, JCO 2017
Lilley, Ann Surg, 2018

Reframe decision making process

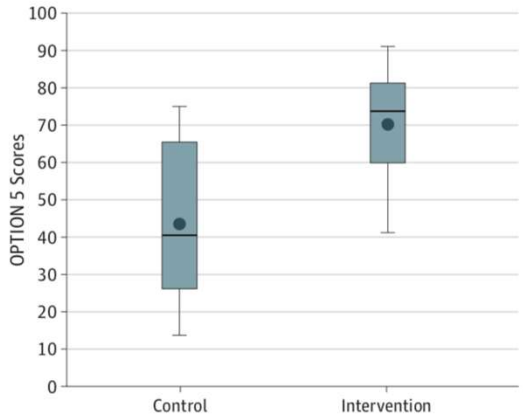
Dr. Zara R. Cooper

"Embrace the uncertainty. It is because it is uncertain that we need to engage in difficult conversations."

"Not doing surgery is not doing nothing."

Dr. Margaret L. Schwarze

Figure 2. OPTION 5 Scores



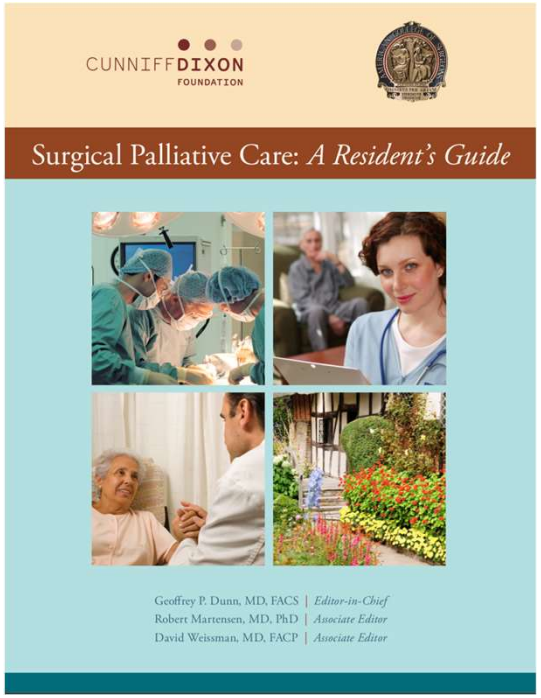
Box plots depicting OPTION 5 scores for patients in the control and intervention arms. Dot indicates mean score within each treatment arm.

Taylor, JAMA Surgery, 2017
Best Case/Worse Case Communicaiton Tool-Whiteboard Video

Find a go-to palliative care colleague

Early exposure to palliative care

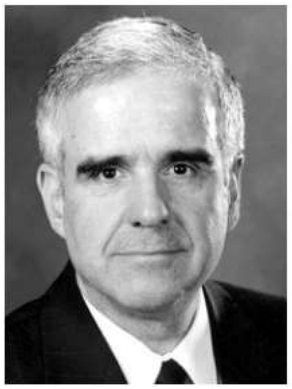
EMORY
UNIVERSITY
SCHOOL OF
MEDICINE



Continue the discourse

Dr. Zara Cooper

Dr. Margaret Schwarze



Dr. Balfour Mount

Dr. Michael Rabow

Dr. Jonathan Bergman

Palliative care is not the same as hospice

Palliative care is appropriate for any patient with a life limiting disease

Secondary palliative care skills are crucial to ease the burden on specialty palliative care providers

Research on the impact and implementation of palliative care in patients with bladder cancer is needed

Balfour Mount's legacy should inspire future Urologists (and other specialists) interested in this area of study

Sarah and Jack

Lizzie (1 year) and Jack