CUC2 SGIM Update in Palliative Medicine 2013

Contributors to the Update:

Stephanie Harman
Arnold P. Gold Clinical Assistant Professor, Stanford Division of General Medical Disciplines
Medical Director, Palliative Care Service
Associate Program Director, Internal Medicine Residency
email: smharman@stanford.edu

Rahwa Ghermay MD
rgherma@emory.edu
Site Director, Palliative Medicine Grady Memorial Hospital
Emory School of Medicine
Department of Medicine

Rashmi K. Sharma, MD, MHS
Assistant Professor of Medicine
Division of Hospital Medicine

Ursula Braun MD, MPH
ubraun@bcm.edu
Assistant Professor of Medicine and Medical Ethics, Baylor College of Medicine
Director, Palliative Care, Michael E DeBakey VA Medical Center
The Houston HSR&D CoE, Michael E DeBakey VA Medical Center

Anna Skold MD, MPH
a_skold@yahoo.com
Physician, Palliative Care Clinic Lead
Kaiser Permanente
Palliative Care & Internal Medicine
2359 Harrington Drive
Decatur Georgia 30033

Patricia F Harris MD, MS
patricia.harris.md@gmail.com
Director, Geriatrics
Keck School of Medicine at USC
Department of Medicine

Sangeeta Ahluwalia PhD, MPH
sangeeta.ahluwalia@va.gov
Research Health Scientist VA Greater Los Angeles
Assistant Professor of Health Services, UCLA
METHODS: We conducted two separate literature searches for articles published between January 1, 2012 and December 31, 2012. First, we conducted a Medline search with the key words “palliative care,” “hospice care,” “terminal care” and “end-of-life care.” Second, we reviewed title pages from 2012 issues in the following journals: American Journal of Hospice and Palliative Medicine, Annals of Internal Medicine, British Medical Journal (BMJ), BMJ Supportive and Palliative Care, European Journal of Palliative Care, Fast Article Critical Summaries for Clinicians in Palliative Care (PC-FACS), Journal of the American Geriatrics Society, Journal of the American Medical Association, Journal of Clinical Oncology, Journal of General Internal Medicine, Journal of Pain and Symptom Management, Journal of Palliative Care, Journal of Palliative Medicine, Lancet, New England Journal of Medicine, Palliative Medicine, Pain, Progress in Palliative Care, and Supportive Care in Cancer. Medline articles and articles from the individual journal search were divided and reviewed by individual authors who presented from 1 to 20 relevant articles to the group for consideration. All authors reviewed these abstracts, and when needed, full text publications. We focused on articles relevant to general internists. We rated the articles individually, eliminating by consensus those that were not deemed of highest priority, and discussed the final choices as a group.
The 16 articles chosen for presentation at the Update:

A) Improved Communication


Patient survey (interview) and chart review. N= 1193 patients with newly diagnosed metastatic (stage IV) lung or colorectal cancer alive 4 months after diagnosis and receiving palliative chemotherapy. 69% of patients with lung cancer and 81% of those with colorectal cancer did not report understanding that chemotherapy was not at all likely to cure their cancer. Belonging to a minority (Hispanic or African American) was associated with being almost 3x more likely to have inaccurate beliefs about chemotherapy than whites and rating their communication with their physician very favorably, as compared with less favorably was associated with being almost 2x as likely to have inaccurate beliefs about CTX. Educational level, functional status, and the patient's role in decision making were not relevant factors. While physicians may be able to improve patients' understanding, it may come at the cost of patients' satisfaction with them.


N= 1231 patients with stage IV lung or colorectal cancer who died during the 15-month study period but survived at least 1 month. Patients who had EOL discussions with their physicians before the last 30 days of life were less likely to receive aggressive measures at EOL, including chemotherapy (P = .003), acute care, or any aggressive care (P < .001). Such patients were also more likely to receive hospice care (P < .001) and to have hospice initiated earlier (P < .001). National guidelines recommend early discussions about EOL care planning for patients with incurable cancer; this study demonstrated that this will decrease aggressive care near death and lead to earlier and greater hospice enrollment.

Jennifer W. Mack, MD, MPH; Angel Cronin, MS; Nathan Taback, PhD; Haiden A. Huskamp, PhD; Nancy L. Keating, MD, MPH; Jennifer L. Malin, MD, PhD; Craig C. Earle, MD, MSc; and Jane C. Weeks, MD, MSc. End-of-Life Care Discussions Among Patients With Advanced Cancer: A Cohort Study. Ann Intern Med. 2012;156:204-210.

Prospective cohort study of 2155 patients with stage IV lung or colorectal cancer (HMO or VA). 73% of patients had EOL care discussions identified by at least 1 source ([patient]/surrogate interviews or chart review) through 15 months after diagnosis. Although most patients discussed EOL care planning with physicians before death, many discussions occurred during acute hospital care, with providers other than oncologists, and late in the course of illness (median of 33 days before death).

This cluster-randomized trial of 92 clinicians contributing 376 VA outpatients assessed with self-reported questionnaires patients’ preferences for communication, life-sustaining therapy, and experiences at the EOL. Then intervention clinicians and patients received a 1-page patient-specific feedback form, based on questionnaire responses, to stimulate conversations. Control patients completed questionnaires but did not receive feedback. Patient-reported occurrence and quality of EOL communication (QOC) were assessed within 2 weeks of a targeted visit. Intervention patients reported an almost 3-fold higher rate of EOL care discussions, and statistically significant higher-quality EOL communication, although the overall improvement was small (Cohen effect size, 0.21).

B) Symptom Management


This trial investigated treatment for refractory cough in 62 patients from Australia. Participants had failed standard therapy with asthma drugs, antibiotics, corticosteroids or antihistamines, and anti-reflux drugs. Those in the treatment arm received the maximum daily dose of gabapentin, 1800mg daily, for 10 weeks. Subjects who received gabapentin experienced significant improvement in cough-specific quality of life, cough severity and frequency. Results suggest that treatment with gabapentin may impede central sensitization of the cough reflex. This study highlights a less commonly known mechanism for refractory chronic cough – a central mode of action – and it reframes how we view anti-tussive therapy (central versus peripheral).


Among patients with advanced illness, fatigue is one of the most common symptoms. In this paper, Kerr et al. randomized 31 hospice patients with at least moderate fatigue to receive either 5 mg of methylphenidate (MP) or placebo twice daily. Uniquely, they rapidly uptitrated doses by 10 mg every three days if symptoms warranted. Significant improvements in fatigue scores were seen as early as day three and became more marked throughout the observation period. The study duration was only 14 days – both a strength with this population who needs prompt effect, and a weakness as long term side effects and results may not have been captured. These results add to the growing body of evidence that methylphenidate may help fatigue, and that rapid dose titration may be appropriate.

In this meta-analysis out of Israel, the authors conducted an examination of several interventions to treat dyspnea in cancer patients. Although they reviewed studies using opioids, oxygen, benzodiazepines, and furosemide, they were only able to draw conclusions about two of these modalities. They found oxygen conferred no benefit over controls such as room air or helium enriched air. They did, however, find evidence to support the use of opioids to improve dyspnea. These data support a broader role for opioids in the cancer patient.

C) The truth about palliative care


Prior research has shown improvements in quality of life from early integration of palliative care for patients with non-small cell lung cancer (NSCLC). In this prospective randomized controlled study, Greer et al. sought to evaluate the association between early integration of palliative care and 1) decreased frequency and earlier timing of chemotherapy, and 2) increased access to hospice care (earlier referral and longer enrollment). One hundred and fifty one patients were randomly assigned to receive early palliative care (initial palliative care consult within 3 weeks of study enrollment and monthly follow-up) or standard care. Compared to standard care, patients who received early palliative care were less likely to receive chemotherapy in the last 60 days of life and were more likely to enroll in hospice for longer than one week. There were no differences in number or timing of cycles of chemotherapy between the two groups. These findings further support the integration of early palliative care with standard oncologic care for patients with NSCLC by showing improvements in key quality measure of end-of-life care.


The American Society of Clinical Oncology (ASCO) published a “provisional clinical opinion” advocating for the early integration of palliative care for patients with non-small cell lung cancer (NSCLC) based on the findings of the study by Temel et. al. in 2010. The authors further support their recommendation based on findings from seven randomized trials that demonstrate the feasibility of providing aspects of palliative care concurrently with standard oncologic care. This expert consensus opinion is important because it is an evidence based recommendation for early integration of palliative care, and it recognizes the need for additional research on strategies to optimize delivery of palliative care to patients, particularly those with metastatic cancer and/or high symptom burden.

This systematic review explores the literature on the effect of palliative sedation on survival. The authors identified 11 articles (10 retrospective or prospective nonrandomized studies) which described the experience of 1807 consecutive patients of whom 621 received palliative sedation. Benzodiazepines were the most common drug category prescribed and the most frequent clinical indication for sedation was terminal delirium. The authors did not find a statistically significant difference between median survivals for patients who were sedated compared to those who were not. Since a randomized controlled trial on palliative sedation would be unethical, this review of observational studies provides important data on the lack of an association between palliative sedation and shortened survival. Palliative sedation remains an important palliative care tool for patients in extremis.

D) Elder Care Education and Prognosis


A 2009 Cochrane review reported that the evidence was inconclusive regarding whether feeding tubes improved or prevented pressure ulcers. Teno et al’s well designed propensity-matched cohort study of nursing home residents with advanced cognitive impairment and recent need for assistance in eating indicates that PEG feeding tube insertion doubles the risk of new pressure ulcers and furthermore that PEG feeding tubes do not promote the healing of existing pressure ulcers. Since three-quarters of physicians state that improved pressure ulcer healing is a reason they give to families for PEG tube insertion, this data should change current practices.


A retrospective cohort study of 408 managed care patients 65 years of age or older hospitalized with serious illness and receiving an inpatient palliative care consult were examined to look at factors associated with 30 day readmission rates. Of this diverse population examined, 10% were readmitted, usually within 5-10 days of discharge. Factors associated with readmission included the diagnoses of CHF and ESRD, not having an advanced directive, no or distant relative as emergency contact, discharged to home without home care or to a nursing home facility. Factors significantly associated with fewer readmissions included discharge home with hospice or with home-based palliative care services. Further research is needed but this study spotlights the need for a longitudinal palliative care approach with inpatient, home-based, and clinic-based palliative care programs.

Soubeyran et al enrolled 348 patients age 70 or older who were newly diagnosed with cancer and awaiting first line chemotherapy into a prospective study evaluating factors associated with death less than 6 months after initiating chemotherapy. Factors which were associated with higher risk of death included male gender, advanced cancer, a low Mini Nutritional Assessment (MNA) (<23.5), and a long Get Up and Go (GUG) Test (> 20 seconds). This supports the knowledge that good functional and nutritional status are important for chemotherapy tolerance and benefit. It takes this information one step further and allows for objective information to be obtained in a timely manner in the clinic to help prognosticate and give meaningful information to older cancer patients and their families. Both could be completed prior to an oncology appointment in minutes with the aid of a nurse.

E) Quality of Life Factors


Although data exist regarding what patients and caregivers consider important to their quality of life near the end of life (EOL), little is known about what factors predict better quality of life at EOL. In this multisite, prospective, longitudinal cohort study, 396 advanced cancer patients and their caregivers were interviewed at baseline, and caregivers completed postmortem evaluations. Nine factors significantly predicted patients’ QOL at the EOL. Of note, ICU stays in the final week of life, hospital death, and patient worry at baseline predicted poor QOL, while religious prayer or meditation at baseline predicted higher QOL. Study findings suggest that preventing unnecessary hospitalizations and receipt of life-prolonging care, while reducing patient worry and encouraging contemplation, might help patients achieve better QOL in their final days.


In the general population, neuropathic pain causes greater pain intensity and worse quality of life than nociceptive pain. The authors sought to confirm this in a population of 1051 inpatients and outpatients with incurable cancer using a computerized assessment of symptoms, function and quality of life. Of the patients, 670 had pain; 534 with nociceptive and 113 with neuropathic pain. Patients with neuropathic pain were more likely that patients with nociceptive pain to have a greater analgesic load and reduced performance status, and reported worse physical, cognitive and social function. Findings underscore the need to facilitate early identification of neuropathic
cancer pain using validated assessment methods, to target interventions and reduce burden on patients.


Although prognostic information is critical to individualizing care for older adults with late life disability, little is known about the preferences of diverse elders for prognosis communication. In this qualitative cross-sectional study, the authors interviewed 60 older adults recruited from San Francisco’s On Lok program, the first Program of All-inclusive Care for the Elderly. Up to 75% of participants reporting wanting to discuss prognosis with their doctor. Primary reasons for wanting to discuss prognosis were to prepare, to make the most of remaining life and to make healthcare decisions. Those who preferred not to discuss prognosis described emotional difficulty, the uncertainty of prognostic information, or that it would not be useful. Nearly all participants preferred that doctors not make assumptions about prognosis communication on the basis of race/ethnicity. Clinicians should ask patients about their preferences regarding prognosis discussions before sharing estimates.
The top 98 choices of the reviewers:

32. Hirsch CA, Marriott JF, Faull CM. Influences on the decision to prescribe or administer anticholinergic drugs to treat death rattle: A focus group study. *Palliat med.* 2012.
34. Saleem TZ, Higginson IJ, Chaudhuri KR, Martin A, Burman R, Leigh PN. Symptom


36. Lindsey C Yourman, MD; Sei J. Lee, MD, MAS; Mara A. Schonberg, MD, MPH; Eric W. Widera, MD; Alexander K. Smith, MD, MS, MPH, Prognostic Indices for Older Adults: A systematic review. *JAMA.* 2012;307(2):182-192


61. Schenker, Y., et al. (2012). "I don't want to be the one saying 'we should just let him die': intrapersonal tensions experienced by surrogate decision makers in the ICU." *Journal of General Internal Medicine* 27(12): 1657-1665.


96. Carlos Centeno1Alvaro Sanz, Miguel Angel Cuervo, Daniel Ramos, Silvia Hernansanz, Jesús Gonzalez, Maria Jose Almaraz, Marcos Lama, Francisco Vara, Maria Nabal1, Antonio


