From Screening to End of Life: Caring for Patients across the Cancer Control Continuum

SGIM Annual Meeting
2015
Larissa Nekhlyudov, MD MPH

• Institute of Medicine 2013 Report: The Role of the Internist in the Cancer Control Continuum
• Associate Professor in the Department of Population Medicine at Harvard Medical School and a general internist at Harvard Vanguard Medical Associates.
• She works to improve the care of cancer survivors and the interplay between primary care and oncology care.
Mara Schonberg, MD MPH

• Screening, Detection, And Diagnosis; Special Focus on the Aging Population
• Mara Schonberg, MD, MPH is a clinical researcher and general internist at Beth Israel Deaconess Medical Center and Harvard Medical School.
• Her research focuses on improving the quality and outcomes of older women’s decision-making around breast cancer screening and treatment.
Lisa Diamond, MD MPH MHS

- Care for the Hospitalized Cancer Patient: Enhancing Patient-Centered Care and Inter-Specialty Communication
- Assistant Professor in the Immigrant Health and Cancer Disparities Service and Hospitalist at Memorial Sloan Kettering
- Her research focuses on understanding how clinician non-English language proficiency affects the quality of care delivered to patients with limited English proficiency (LEP)
Emily Tonorezos, MD MPH

- Key Elements of Cancer Survivorship Care: Treatment Exposures and Guidelines
- Assistant Professor in the Adult Long-Term Follow-Up Program at Memorial Sloan Kettering.
- Research focus on obesity and insulin resistance among cancer survivors.
Jean Kutner, MD MSPH

- Evidence Based End of Life and Palliative care
- Dr. Kutner is a tenured Professor of Medicine in the Divisions of General Internal Medicine (GIM), Geriatric Medicine, and Health Care Policy and Research at the University of Colorado School of Medicine (UC SOM).
- Her research focuses on improving symptoms and quality of life for hospice and palliative care patients and their family caregivers.
Enhancing Care of Patients Across the Cancer Continuum

Larissa Nekhlyudov, MD, MPH
Associate Professor, Harvard Medical School

SGIM Annual Meeting 2015
Cancer and the Aging Demographics
The Majority of Cancer Diagnoses are in Older adults

- Total people diagnosed with cancer: 1.6 million
- 53% of cancer diagnoses were in individuals ≥65 years old in 2012
- Cancer diagnoses ≥65 years old: 868,000
The Majority of Cancer Deaths are in Older Adults

68% of cancer deaths were in individuals ≥65 years in 2009

Deaths from cancer in all age groups: 567,000

Deaths from cancer in people ≥65 years old: 391,000
The Majority of Cancer Survivors are Older Adults

59% of cancer survivors were ≥65 years old in 2012

Total Cancer Survivors: 13.7 million

Cancer Survivors ≥65 years old: 8+ million
18 Million Cancer Survivors are Projected in 2022
Cancer is Complex

• Not a single disease
• Lots of treatment options, and complicated regimens
• Limited engagement of patients in decision making
• Numerous oncology specialists involved in cancer care
• Lack of coordination of care
• Internists with limited training in oncology
Cancer is Costly

• Costly to individuals
• 1/3 of personal bankruptcies due to cancer (75% of those had insurance)
• Costly to society
• Therapies vary in costs and reimbursements
• Costs not discussed with patients before treatment begins
To read the report online, please visit www.nap.edu/qualitycancercare

To watch the dissemination video, please visit www.iom.edu/qualitycancervideo
Patient-Centered, Evidence-Based, and Cost-Conscious Cancer Care Across the Continuum: Translating the Institute of Medicine Report into Clinical Practice

Larissa Nekhlyudov, MD, MPH\(^1\)*; Laura Levit, JD\(^2\); Arti Hurria, MD\(^3\); Patricia A. Ganz, MD\(^4\)

In 2013, the Institute of Medicine (IOM) concluded that cancer care in the United States is in crisis. Patients and their families are not receiving the information that they need to make informed decisions about their cancer care. Many patients do not have access to palliative care and too few are referred to hospice at the appropriate point in their disease trajectory. Simultaneously, there is a growing demand for cancer care with increases in new cancer diagnoses and the number of patients surviving cancer. Furthermore, there is a workforce shortage to care for this growing and elderly population. The IOM’s report, *Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis*, outlined recommendations to improve the quality of cancer care. This article provides an overview of the IOM report and highlights the recommendations that are most relevant to practicing clinicians who care for patients with cancer across the continuum. The implementation of the recommendations in clinical practice will require better patient-clinician communication, improved care coordination, targeted clinician training, effective dissemination of evidence-based guidelines and strategies for eliminating waste, and continuous quality assessment and improvement efforts. *CA Cancer J Clin* 2014;64:408-421. © 2014 American Cancer Society.

**Keywords:** cancer, patient-centered care, communication, decision-making, quality of health care, evidence-based health care.
Goals of the Recommendations

1. Provide clinical and cost information to patients.
2. End-of-life care consistent with patients’ values.
3. Coordinated, team-based cancer care.
4. Appropriate core competencies for the workforce.
5. Expand breadth of data collected in cancer research.
6. Expand depth of data collected in cancer research.
7. Develop a learning healthcare IT system for cancer.
8. A national quality reporting program for cancer care.
9. Reduce disparities in access to cancer care.
10. Improve the affordability of cancer care.
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### TABLE 1. Decision Aids for Cancer Prevention, Screening, and Treatment

<table>
<thead>
<tr>
<th>Breast Cancer Prevention, Screening, and Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• BRCA1 And BRCA2: Cancer Risk And Genetic Testing (National Cancer Institute)</td>
</tr>
<tr>
<td>• Breast Cancer Risk: Should I Have a BRCA Gene Test? (Healthwise)</td>
</tr>
<tr>
<td>• A Patchwork of Life-One Woman’s Story, For Women Making Breast Cancer Treatment Decisions (Dan L. Duncan Cancer Center at Baylor College of Medicine)</td>
</tr>
<tr>
<td>• Adjuvant Endocrine Therapy For Hormone Receptor-Positive Breast Cancer (American Society of Clinical Oncology)</td>
</tr>
<tr>
<td>• Breast Cancer Screening And Dense Breasts: What Are My Options? (Healthwise)</td>
</tr>
<tr>
<td>• Breast Cancer Screening: When Should I Start Having Mammograms? (Healthwise)</td>
</tr>
<tr>
<td>• Breast Cancer Surgery (Option Grid Collaborative)</td>
</tr>
<tr>
<td>• Breast Cancer: Should I Have Breast-Conserving Surgery Or A Mastectomy For Early-Stage Cancer? (Healthwise)</td>
</tr>
<tr>
<td>• Breast Cancer: Should I Have Chemotherapy For Early-Stage Breast Cancer? (Healthwise)</td>
</tr>
<tr>
<td>• Breast Cancer: What Should I Do If I’m At High Risk? (Healthwise)</td>
</tr>
<tr>
<td>• BresDec: Breast Cancer Decision Explorer (Decision Laboratory, Cardiff University)</td>
</tr>
<tr>
<td>• Choosing Whether to Continue or Stop Mammography Screening At 70 (University of Sydney)</td>
</tr>
<tr>
<td>• Information On Mammography For Women Aged 40 And Older: A Decision Aid For Breast Cancer Screening In Canada (Public Health Agency of Canada)</td>
</tr>
<tr>
<td>• Making Decisions About Your Breast Cancer Treatment: A Decision Aid For Women With Early Breast Cancer (Department of Primary Care Medicine, Faculty of Medicine, University of Malaya)</td>
</tr>
<tr>
<td>• Prophylactic Oophorectomy: Preventing Cancer by Surgically Removing Your Ovaries (Mayo Clinic)</td>
</tr>
<tr>
<td>• Should I Start Having Mammograms To Screen For Breast Cancer? (University of Sydney)</td>
</tr>
<tr>
<td>• Surgery Choices For Women With DCIS Or Breast Cancer (National Cancer Institute)</td>
</tr>
<tr>
<td>• Breast Cancer: Should I Have Breast Reconstruction After A Mastectomy? (Healthwise)</td>
</tr>
<tr>
<td>• Prophylactic Mastectomy: Breast Cancer Prevention For High-Risk Women (Mayo Clinic)</td>
</tr>
<tr>
<td>• Childhood Cancer Bone Marrow Transplantation</td>
</tr>
<tr>
<td>• Bone Marrow Or Blood Stem Cell Transplants in Children With Severe Forms of Autoimmune Disorders or Certain Types of Cancer (Agency for Healthcare Research and Quality)</td>
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<tr>
<td>• Colon Cancer: Which Screening Test Should I Have? (Healthwise)</td>
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<tr>
<td>• Making Decisions: Should I Have a Screening Test for Bowel Cancer? (University of Sydney)</td>
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</tbody>
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<tr>
<td>• HPV: Should I Get The Vaccine? (Healthwise)</td>
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<tr>
<td>• What Can You Do To Prevent HPV And Cervical Cancer? A Decision Aid For Parents/Guardians Of Girls In Grade 8 In Ontario (Ottawa Patient Decision Aid Research Group)</td>
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<th>Head and Neck Cancer Treatment</th>
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<tr>
<td>• Understanding Radiotherapy For Head And Neck Cancer: A Guide For Adults And Their Caregivers (Agency for Healthcare Research and Quality)</td>
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[https://decisionaid.ohri.ca/](https://decisionaid.ohri.ca/)
Ovarian Cancer Prevention
• BRCA1 And BRCA2: Cancer Risk And Genetic Testing (National Cancer Institute)
• Breast Cancer Risk: Should I Have A BRCA Gene Test? (Healthwise)
• Oophorectomy for Risk of Ovarian Cancer-After The Menopause (Option Grid Collaborative)
• Oophorectomy for Risk of Ovarian Cancer-Before The Menopause (Option Grid Collaborative)
• Ovarian Cancer: Should I Have My Ovaries Removed To Prevent Ovarian Cancer? (Healthwise)
• Risk Management Options for Women at Increased Risk of Developing Ovarian Cancer (Prince of Wales Hospital)

Prostate Cancer Screening and Treatment
• Choosing the Radiation Dose in the Treatment of Prostate Cancer (Radboud University Nijmegen Medical Center)
• Decision Aid: Treatment Of Early-Stage Prostate Cancer (Division of Cancer Care and Epidemiology, Cancer Research Institute, Queen’s University)
• Knowing Your Options: A Decision Aid For Men With Clinically Localized Prostate Cancer (Agency for Healthcare Research and Quality)
• Localised Prostate Cancer-Low Risk (Option Grid Collaborative)
• ProsDex: A PSA Decision Aid (Decision Laboratory, Cardiff University)
• Prostate Cancer Risk Reduction With Finasteride: Discussion Guide For Doctor And Patient (American Society of Clinical Oncology)
• Prostate Cancer Screening With PSA Testing (American Society of Clinical Oncology)
• Prostate Cancer Screening: Should I Have A PSA Test? (Healthwise)
• Prostate Cancer Screening: Should You Get A PSA Test? (Mayo Clinic)
• Prostate Cancer: Should I Choose Active Surveillance? (Healthwise)
• Prostate Cancer: Should I Have Radiation Or Surgery For Localized Prostate Cancer? (Healthwise)
• Prostate Specific Antigen (PSA) Test (Option Grid Collaborative)
• PSA (Prostate Specific Antigen) Testing For Prostate Cancer: An Information Sheet For Men Considering A PSA Test (University of Oxford)
• Should I Have A PSA Test? (University of Sydney)
• Should You Get A PSA Test? A Patient-Doctor Decision (Virginia Commonwealth University)
• Treating Prostate Cancer: A Guide For Men With Localized Prostate Cancer (Agency for Healthcare Research and Quality)
• Treatment Choices For Men With Early-Stage Prostate Cancer (National Cancer Institute)

Testicular Cancer Treatment
• Testicular Cancer: Which Treatment Should I Have For Stage I Nonseminoma Testicular Cancer After My Surgery? (Healthwise)
• Testicular Cancer: Which Treatment Should I Have For Stage I Seminoma Testicular Cancer After My Surgery? (Healthwise)

Thyroid Cancer Screening
• Making Choices: Screening For Thyroid Disease (National Cancer Institute)

DCIS indicates ductal carcinoma in situ; HPV, human papillomavirus; PSA, prostate-specific antigen. Reproduced with permission from the Ottawa Hospital Research Institute. A to Z Inventory of Decision Aids. decisionaid.ohri.ca/azinvent.php. Accessed July 1, 2014. NOTE: For Web site links, please refer directly to the OHRI Web site. The decision aids on this Web site were not developed by the OHRI. The Web site content is not under the control of the OHRI; the inventory is constantly updated. Some developers have provided access for evaluation but not for patient use. Some decision aids require payment to access, either via a license or membership in an insurance or health care plan.
This website was designed to help healthcare professionals choose among available interactive cancer prognostic tools. Interactive cancer prognostic tools use an algorithm to calculate likely cancer-related outcomes based on a patient’s characteristics.

Use of these tools may support communication and understanding about cancer prognosis. Some of the tools can be used to support shared decision making with cancer patients. The website allows for the comparison of cancer site specific tools or search of tools using your own criteria.
Goals of the Recommendations

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A Coordinated Workforce
A Coordinated Cancer Care Team
Welcome to C-Change Cancer Core Competency Initiative

The impetus for the C-Change Cancer Core Competency Initiative is based upon current projections that the demand for cancer care services by the aging and increasingly diverse population will be outstripped by the supply of health professionals able to care for people at risk for or living with cancer. Being careful not to duplicate the efforts of the oncology professional organizations, C-Change identified the opportunity to strengthen the cancer knowledge and skills of the non-oncology health workforce as another means to improve the quality of cancer care.

C-Change, a Washington, DC-based 501 (c)(3) (not-for-profit) organization was well positioned to tackle this cancer workforce issue due to the very nature of its composition, drawing members from public, private, and not-for-profit organizations concerned with cancer issues across the continuum of research, practice, and policy. The mission of C-Change is to leverage the expertise and resources of its membership to eliminate cancer as a public health problem at the earliest possible time.

http://www.cancercorecompetency.org/
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Table 1. Selected Choosing Wisely Recommendations in Cancer Care for the General Internist

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Organization</th>
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</thead>
<tbody>
<tr>
<td>Don’t perform PSA testing for prostate cancer screening in men with no symptoms of the disease when they are expected to live less than 10 years.</td>
<td>American Society of Clinical Oncology</td>
</tr>
<tr>
<td>Avoid colorectal cancer screening tests on asymptomatic patients with a life expectancy of less than 10 years and no family or personal history of colorectal neoplasia.</td>
<td>American College of Surgeons</td>
</tr>
<tr>
<td>Don’t perform CT screening for lung cancer among patients at low risk for lung cancer.</td>
<td>American Thoracic Society</td>
</tr>
<tr>
<td>Don’t recommend screening for breast or colorectal cancer, or prostate cancer (with the PSA test), without considering life expectancy and the risks of testing, overdiagnosis and overtreatment.</td>
<td>American Geriatrics Society</td>
</tr>
<tr>
<td>Don’t screen for ovarian cancer in asymptomatic women at average risk.</td>
<td>American College of Obstetricians and Gynecologists</td>
</tr>
<tr>
<td>Don’t perform routine cancer screening for dialysis patients with limited life expectancies without signs or symptoms.</td>
<td>American Society of Nephrology</td>
</tr>
<tr>
<td>Don’t perform Pap smears on women younger than 21 or who have had a hysterectomy for non-cancer disease.</td>
<td>American Academy of Family Physicians</td>
</tr>
<tr>
<td>Don’t perform surveillance testing (biomarkers) or imaging (PET, CT, and radionuclide bone scans) for asymptomatic individuals who have been treated for breast cancer with curative intent.</td>
<td>American Society of Clinical Oncology</td>
</tr>
<tr>
<td>Avoid using advanced imaging technologies—PET, CT and radionuclide bone scans—to monitor for a cancer recurrence in patients who have finished initial treatment and have no signs or symptoms of cancer.</td>
<td>American Society of Clinical Oncology</td>
</tr>
</tbody>
</table>

*PSA prostate-specific antigen, CT computed tomography, PET positron emission tomography*
IOM Conclusions

• **All participants and stakeholders** must reevaluate their current roles and responsibilities in cancer care and **work together** to develop a higher quality cancer care delivery system.

• By working toward this shared goal, the cancer care community can **improve the quality of life and outcomes** for people facing a cancer diagnosis.
Case(s)

- A 75 year-old woman and her 73 year-old husband are seeing you for their Medicare annual wellness visits (AWV)

- The woman has a history of arthritis and diabetes

- The man has a history of a myocardial infarction, COPD, and quit smoking 10 years ago

- Medicare AWV requires establishment of a written screening schedule as appropriate based on:
  - USPSTF recommendations and considering patient’s age, health status and screening history
Overview

• Guideline recommendations (breast, colon, cervical, prostate, and lung)

• Rationale

• Improve cancer screening decisions among older adults
Breast Cancer Screening
<table>
<thead>
<tr>
<th>Society</th>
<th>Mammography Screening Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>USPSTF</td>
<td>Biennial mammogram for women 50-74. Insufficient evidence for women 75+ <em>(discuss pros/cons).</em></td>
</tr>
<tr>
<td>ACS/ACR</td>
<td>Yearly mammogram starting at 40 and continue as long as pt is in good health. <em>Discuss pros/cons.</em></td>
</tr>
<tr>
<td>ACOG</td>
<td>No consensus on the upper age limit. Women 75 and older should <em>discuss with their physician</em> whether to continue getting mammograms.</td>
</tr>
<tr>
<td>Choosing wisely</td>
<td>SGIM/AGS- Don’t recommend cancer screening in adults with life expectancy &lt;10 years</td>
</tr>
</tbody>
</table>
Rationale

• Unknown whether screening mammography results in survival benefit for women ≥75 years

• Benefits: 2 fewer breast cancer deaths per 1000 women 70-79 screened over 10 years

• Harms:
  – 200 of 1000 experience a false positive
  – 13 of 1000 diagnosed with a breast cancer that otherwise would not have caused problems in a woman’s lifetime (overdiagnosis)
Other Modalities: Breast Imaging

• Tomosynthesis- allows 3-D reconstruction of breast
  – Increases cancer detection while reducing false positives particularly for women <50 with dense breasts
  – Increases radiation exposure (double mammo alone)
• Digital - more sensitive than film for women <50, premenopausal, and with dense breasts.
  – For women 65+ without dense breasts digital may perform worse at greater costs
Clinical/Self Breast Exam

• No compelling evidence that breast self examination (BSE) decreases breast cancer morbidity & mortality (USPSTF recommends against teaching)

• USPSTF- insufficient evidence to recommend for or against clinical breast exam (CBE), ACS recommends annual CBE for women 40+

  – Among women 50-69, 1 more women out of 10,000 may have breast cancer detected by CBE when added to mammography; however 55 more women would have a false-positive screens
Colorectal Cancer Screening
<table>
<thead>
<tr>
<th>Society</th>
<th>Colorectal Cancer Screening Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>USPSTF</td>
<td>Recommends against screening adults 76 to 85 years, unless there are individual considerations that favor screening and recommends against screening all patients over age 85</td>
</tr>
<tr>
<td>ACS/ACR</td>
<td>Stop if life expectancy &lt;10 years</td>
</tr>
<tr>
<td>Choosing Wisely</td>
<td>SGIM/AGS-Don’t recommend cancer screening in adults with life expectancy &lt;10 years</td>
</tr>
</tbody>
</table>
Rationale

• Adenomatous polyps develop in 30%–50% of adults 50+; 1%–10% of these polyps will progress to cancer in 5–10 years

• Recommended tests:
  – Annual high-sensitivity FOBT
  – Sigmoidoscopy every 5 years + FOBT every 3 yrs
  – Colonoscopy every 10 years

• Colonoscopy is the most sensitive (95%) and cost-effective screening test; specificity (90%)
  – initial screening colonoscopy up to age 83 may be cost-effective
Risks of Colorectal Cancer Screening

- Polyethylene glycol: commonly used for prep but associated with dizziness, abdominal pain, fecal incontinence, and nausea
- 10 per 1,000 adults 65+ experience cardiovascular events after colonoscopy
- 2.1 per 1,000 experience gastrointestinal bleeding (even when no polypectomy is performed)
- 0.6 per 1,000 experience perforation after colonoscopy
Cervical Cancer Screening
<table>
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<tr>
<th>Society</th>
<th>Cervical Cancer Screening Guidelines</th>
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<tbody>
<tr>
<td>USPSTF/ACS/ACOG</td>
<td>Do not screen women 65+ who have had adequate prior screening (3 neg. PAPs or 2 neg. high risk HPV co-tests in past 10 years [most recent in past 5 years]) and are not considered high risk (HIV, organ transplant, DES daughter, previous tx of CIN 2/3 or cervical cancer in past 20 years). <em>regardless of sexual history</em></td>
</tr>
<tr>
<td></td>
<td>Against screening women who have had a hysterectomy with removal of the cervix who do not have h/o CIN 2/3 or cervical cancer</td>
</tr>
</tbody>
</table>
Rationale

• The incidence of high-grade cervical lesions significantly declines after middle age

• The risk of false-positive tests increases

• ~50% of cervical cancers occur among women never screened, and an additional 10% occur among women not screened in the past 5 years

• An older woman who has never been screened or has been inadequately screened should be screened every 2–5 years, ending at age 70 -75
Prostate Cancer Screening
<table>
<thead>
<tr>
<th>Society</th>
<th>Prostate Cancer Screening Guidelines</th>
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<tbody>
<tr>
<td>USPSTF</td>
<td>Recommends against screening for prostate cancer</td>
</tr>
<tr>
<td>American Cancer Society</td>
<td>discussing potential benefits and possible harms of screening with men &gt;50 years with &gt;10 year life expectancy</td>
</tr>
<tr>
<td>American Urologic Association</td>
<td>discussing potential benefits and possible harms of screening with men 55-69 years with &gt;10-15 year life expectancy</td>
</tr>
<tr>
<td></td>
<td>Routine PSA screening is not recommended for men 70+</td>
</tr>
</tbody>
</table>
Rationale

• PLCO Trial: US men 55-74 years randomized to annual PSA for 6 years and a digital rectal examination for 4 years. No mortality reduction after 7-10 years follow-up; ~50% of controls vs. 85% in the intervention group were screened.

• European trial (ERSCP)- men 50-74 randomized to PSA screening every 2–4 years; 20% reduction in prostate cancer mortality at 9 years for men 55–69 years
  – concluded that 1,410 men 55–69 years old would need to be screened and 48 treated to prevent 1 death from prostate cancer.
Harms

• Both trials found that PSA detected numerous clinically insignificant tumors (17%–50% of all cancers detected)
• 80% of positive PSAs are false-positives when thresholds of 2.5–4 mcg/L are used
• Unnecessary biopsies-15%–20% of those screened longer than 10 years
• Overdiagnosis/overtreatment
  – complications of treatment include erectile dysfunction, urinary incontinence, and even death from surgery
Lung Cancer Screening
<table>
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<tr>
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<tbody>
<tr>
<td><strong>USPSTF</strong></td>
<td>Recommends annual screening with low-dose chest computed tomography (LDCT) in adults 55-80 yrs who have a 30 pack-yr smoking history and currently smoke or quit in the past 15 years. Do not screen those with a health problem that substantially limits life expectancy or willingness to have curative surgery.</td>
</tr>
<tr>
<td><strong>American Cancer Society</strong></td>
<td>Recommends annual LDCT to adults 55-74 years who have 30 pack-yr smoking history and currently smoke or quit in the past 15 years.</td>
</tr>
</tbody>
</table>
Rationale

• Lung cancer is the third most common cancer and the leading cause of cancer death in the United States
• Smoking results in 85% of U.S. lung cancer cases, and 37% of U.S. adults are current or former smokers
• National Lung Screening Trial (NLST): 3 annual LDCTs resulted in a 20% reduction in lung cancer mortality (3 or 4 fewer lung cancer deaths per 1000 participants who had LDCT screening over 6 years) and a 6.7% reduction in all-cause mortality after 6.5 years follow-up
Harms

• False-positive tests
  – 95% of positive results do not lead to a lung cancer diagnosis, but further imaging can usually resolve most false positive results
  – 2.5% require invasive diagnostic procedures
• Radiation exposure
• Overdiagnosis
  – 10% of screen-detected lung tumors
• Both the benefits and harms of lung cancer screening greater among adults 65-74 compared to adults 55-64
Guidance

• LDCT may be of most benefit to adults at the highest risk of lung cancer

• A decision tool (age, gender, smoking history, asbestos exposure) to assess patient risk to inform lung cancer screening is available at:

http://nomograms.mskcc.org/Lung/Screening.aspx
How do we improve older adult’s decision-making around cancer screening?

- Life Expectancy
- Risk of Disease
- Preferences and Values

Personalized Cancer Screening Decision
Life Expectancy
Each bubble represents a prognosis calculator. Click on a bubble to view the calculator.
# Risk Calculator

1. **How old is your patient?**  
   - 65 - 69

2. **What is the sex of your patient?**  
   - Female
   - Male

3. **Is your patient a former or current smoker?**  
   ( > 100 cigarettes smoked in his or her lifetime )  
   - Current

4. **Does your patient have a BMI score of less than 25?**  
   \[BMI = \frac{703 \times (\text{weight in pounds} \div \text{height in inches}^2)}{}\]  
   - Yes
   - No
   - [BMI calculator](#)

5. **Does your patient have a history of cancer (including melanoma but not other skin cancers)?**  
   - Yes
   - No

6. **Does your patient have diabetes mellitus?**  
   - Yes
   - No

7. **Does your patient have COPD?**  
   - Yes
   - No

8. **How many times has your patient been hospitalized overnight in the past year?**  
   - 1 time

9. **How does your patient self-rate his or her health?**  
   - Fair

10. **Is your patient dependent in at least one Instrumental Activity of Daily Living (IADL)?**  
    (IADLs include light housework, preparing meals, shopping, taking medication, using the telephone, arranging own travel, and managing money.)  
    - Yes
    - No

11. **Does your patient have difficulty walking ¼ mile (approximately a few city blocks)?**  
    - Yes
    - No

**Total Points:** 15

**Your best guess of five year mortality risk**  
- 35%

[Calculate Risk]
Results Based on Score:

Your total score is 15

**FIVE AND 9 YEAR MORTALITY:**

<table>
<thead>
<tr>
<th>Points</th>
<th>Risk of 5 year mortality (95% CI)</th>
<th>Risk of 9 year mortality (95% CI)</th>
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</thead>
<tbody>
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<td>0 - 1</td>
<td>2% (1-3)</td>
<td>7% (4-13)</td>
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<td>2 - 3</td>
<td>4% (3-5)</td>
<td>8% (6-11)</td>
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<td>4 - 5</td>
<td>6% (5-7)</td>
<td>16% (13-19)</td>
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<tr>
<td>6 - 7</td>
<td>9% (7-10)</td>
<td>26% (23-29)</td>
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<td>8 - 9</td>
<td>13% (12-15)</td>
<td>33% (29-37)</td>
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<tr>
<td>10 - 11</td>
<td>23% (20-25)</td>
<td>52% (48-56)</td>
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<td>12 - 13</td>
<td>35% (32-38)</td>
<td>58% (53-62)</td>
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<tr>
<td>14 - 15</td>
<td><strong>43% (39-47)</strong></td>
<td><strong>75% (69-80)</strong></td>
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<tr>
<td>16 - 17</td>
<td>59% (54-63)</td>
<td>83% (76-88)</td>
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<tr>
<td>≥ 18</td>
<td>69% (63-73)</td>
<td>92% (86-96)</td>
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</tbody>
</table>
WHAT WOULD YOU LIKE TO SCREEN FOR?

- Colorectal Cancer
- Breast Cancer
- Both Cancers
Should I Continue Getting Mammograms after age 75?

This is a tool to help you make this decision. You will need a pen/pencil to complete parts of this tool.
Available DAs

• http://www.psych.usyd.edu.au/cemped/docs/Mammogram_DecisionAid.pdf
• Decision aid on mammography screening for women aged 75 and older
  http://nzbcf.org.nz/BREASTCANCER/BreastAwareness/Woman70-plus/Screen70plus.aspx
• Colon cancer screening DA for adults aged 75 and older (Carmen Lewis, MD, MPH)
• ePrognosis: Cancer screening
Case- Woman

- A 75 year-old woman with a history of arthritis and diabetes
- 16% risk of mortality in 9 years
- Consider mammography/colon cancer screening - use DAs to discuss benefits and risks
- Consider clinical breast exam
- Does not need cervical cancer screening
Case-Man

• 73 yo man has a history of a myocardial infarction and COPD and quit smoking 10 years ago (31 py)

• 58% risk of mortality in 9 years

• Would not recommend prostate or colon cancer screening

• Would consider lung cancer screening:
  – Lung cancer screening tool: 2 out of 1,000 screened avoid death from lung cancer
  – Discuss with pt if he would be willing to undergo surgery for lung cancer if a lesion was found on screening
Thank you!
Caring for the Hospitalized Patient with Cancer

Lisa Diamond, MD, MPH, FACP, Assistant Attending
Hospitalist Service, Memorial Sloan Kettering Cancer Center
Immigrant Health and Cancer Disparities Service
Outline

- Background
- Studies on hospitalized cancer patients
- Role of the hospitalist
- Recommendations
Cancer Patients in US

- 20.1 million noninstitutionalized adults (8.5%) in the U.S. with cancer
- 1.2 million hospital discharges (2010)
- Average LOS 6.3 days
Inpatient Hospitalization of Cancer Patients

• Two studies:
In-hospital Mortality and LOS

• Retrospective cohort study investigated risk factors associated with in-hospital mortality and prolonged length of stay (LOS)
  – n=386,377 hospitalized patients
  – age ≥ 65 years
  – Solid tumors

Results

• Prolonged length of stay in older patients with cancer was strongly associated with mortality
  – Overall mortality=7.3%
  – Twice as many deaths among patients with LOS ≥ 10 days
  – 38% of deceased patients had potentially curable disease
In-hospital Mortality and LOS

Results

• In-hospital mortality was most associated with
  – Primary central nervous system malignancies
  – Esophageal cancer
  – Lung cancer

• Risk factors for prolonged LOS
  – Gastric cancer
  – Infection
  – Venous thromboembolism
  – Red blood cell transfusion
Hospitalization and End-of-Life Care

• U of Wisconsin Hospital Inpatient Oncology
  – Two surveys in 2000 and 2010

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2010</th>
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<tbody>
<tr>
<td>Number of patients</td>
<td>151</td>
<td>119</td>
</tr>
<tr>
<td>Median survival after discharge</td>
<td>4.7 months</td>
<td>3.4 months</td>
</tr>
<tr>
<td>Hospice recommended</td>
<td>23%</td>
<td>24%</td>
</tr>
</tbody>
</table>

– 70% patients were discharged home without additional services
– Unscheduled hospitalization for patients with advanced cancer strongly predicted median survival of fewer than 6 months
– Palliative and end-of-life care is needed
MSKCC Hospitalist Service
MSK Hospitalist Service

• The teams
  – GI Oncology, Lymphoma, Gen Med
  – Attending, Fellow, 2 residents, 4 interns
  – 4/6 attendings also boarded in palliative care

• Cancer diagnoses (GI Onc):
  – Pancreas
  – Colon
  – Gastric

• Admitting diagnoses (GI Onc):
  – Fever
  – Abdominal Pain
  – N/V
MSK GI Oncology Service

- Koo, et al examined outcomes with hospitalist-led vs. oncologist-led house staff teams
- No differences in LOS, 30-day readmissions, new DNR orders, nosocomial pneumonia, UTI, number of radiographic studies/lab tests, and discharge disposition between groups

### GI Oncology

<table>
<thead>
<tr>
<th>Disposition</th>
<th>Hospitalist Led (n = 421)</th>
<th>Oncologist Led (n = 408)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine discharge home</td>
<td>217 (52%)</td>
<td>228 (56%)</td>
<td>.21</td>
</tr>
<tr>
<td>Home with home health care services</td>
<td>101 (24%)</td>
<td>92 (23%)</td>
<td>.62</td>
</tr>
<tr>
<td>Home hospice</td>
<td>46 (11%)</td>
<td>33 (8%)</td>
<td>.16</td>
</tr>
<tr>
<td>Inpatient hospice</td>
<td>25 (6%)</td>
<td>21 (5%)</td>
<td>.62</td>
</tr>
<tr>
<td>Extended skilled nursing facility</td>
<td>0 (0%)</td>
<td>1 (0.2%)</td>
<td>.31</td>
</tr>
<tr>
<td>Rehabilitation center</td>
<td>12 (3%)</td>
<td>8 (2%)</td>
<td>.41</td>
</tr>
</tbody>
</table>
Hospitalists and Palliative Care

• Study on palliative care consults in GI Onc
  – Used NCCN Guidelines for palliative care to screen pts for palliative needs
  – In 30% criteria-triggered consults, palliative care needs were being met by primary teams

Recommendations for Managing Inpatients with Cancer
Recommendations

• Admission is opportunity to evaluate overall situation and consider a shift in course
• Make a determination of prognosis
• Evaluate level of acuity on admission and whether there is time to allow rapport to develop before discussing goals of care
Recommendations (cont.)

- Assemble a multidisciplinary team
  - Case management
    - Prior discharge planning
    - Readmissions – mismatch in expectations btw team and patient/family
  - Nursing
  - Social work
  - Chaplaincy
Recommendations (cont.)

• Assess functional status
  • Formal – using ECOG score
  • Informal – using interview and observation of patient

• Approach patient to determine:
  • Understanding of current cancer treatment
  • Personal goals and expectations
  • The role of the family or other caregivers
Recommendations (cont.)

• Address system-level challenges
  – Hospice care is appropriate for patients but pt is on meds not allowed by hospice
  – Whose pt is it on d/c to home hospice?
  – Services offered vary greatly by region – Manhattan vs. Staten Island vs. NJ vs. LI
  – Few acute care hospitals offer hospice care
Summary
Summary

• Limited evidence suggests hospitalization of cancer patients associated with adverse morbidity and mortality

• Hospitalists can manage inpatient and palliative care needs of cancer patients

• Important to assess goals of care with any hospitalization, particularly readmissions, and involve multidisciplinary team
Key Elements of Cancer Survivorship Care: Treatment Exposures and Guidelines

Emily S. Tonorezos, MD MPH
Adult Long-Term Follow-Up Program
Memorial Sloan Kettering Cancer Center
18 Million Cancer Survivors are Projected in 2022
Survivorship Care: Outline

• Cases with common late effects concerns:
  – Weight gain and fatigue
  – Second malignant neoplasm (SMN)
  – Fertility
  – Cardiovascular toxicity

• Relevant guidelines and recommendations
Sofia: Breast Cancer Survivor

69-year-old woman, diagnosed with stage II breast cancer 4 years ago

L-breast modified radical mastectomy, axillary lymph node dissection
Chemotherapy (doxorubicin, cyclophosphamide, and paclitaxel) + Radiation
Taking anastrozole x 3 years, goal is 5 years total therapy duration

Chief complaints at PCP office:
Weight gain: Pre-cancer BMI=32, now 36
Feels tired
Risk of Ischemic Heart Disease after Radiation for Breast Cancer

Dose to the heart averaged 4.9 Gy.

Majority of women had had mastectomy prior to radiation.

Contemporary breast cancer treatment doses are 1 or 2 Gy.

Methods to protect the heart including breath hold and prone position are now employed at most treatment centers.

Risk of Ischemic Heart Disease after Radiation for Breast Cancer
2-Year Weight Change in Stage I-III Breast Cancer Survivors

Lymphedema and Exercise

Among breast cancer survivors with stable lymphedema of the arm, twice-weekly progressive weight lifting over a one year period resulted in:

- No worsening of limb swelling (as had been taught)
- Reduced hand and arm symptoms
- Increased strength
- Reduction in the incidence of lymphedema exacerbations.

Wearing a compression garment and initiating exercise under supervision are important.

Sofia: Plan

Discuss benefits of physical activity and healthy diet
Monitor glucose, lipids, blood pressure
Schedule annual contralateral mammography

Sources of information:

American Society of Clinical Oncology - www.asco.org
National Comprehensive Cancer Network - www.nccn.org
American Cancer Society - www.acs.org
Louis: Head and Neck Cancer Survivor

67-year-old man presents after moving to the area
History of squamous cell carcinoma (SCC) of the tongue 8 years ago

- Partial glossectomy
- Radiation (6000 cGy) to residual tongue and neck
- Cisplatin, docetaxel, and fluororacil

Louis’ Problem List:

- Poor dentition
- Difficulty with nutrition
- Neck stiffness
- Tinnitus
- Hypothyroidism
Louis: Plan

No long-term follow-up guidelines currently exist

Suggestions for these patients:
- Smoking cessation
- Attention to dentition and nutrition
- Careful examination of the mouth and neck
- Consideration for lung cancer screening
- Consideration for carotid ultrasound
- Annual TSH and free T4 for those with a history of neck irradiation
- Audiology testing and therapy
Jessica: Hodgkin Lymphoma Survivor

36-year-old woman treated at age 16

- 3000 cGy mantle field radiation and chemotherapy doxorubicin, bleomycin, vinblastine, dactinomycin

She has not been back to her oncologist in over 10 years. She asks whether her treatment could impact her fertility.
Mantle Field

Hodgkin lymphoma
2500 – 4500 cGy
Cumulative Incidence of Breast Cancer in Hodgkin Lymphoma Survivors Treated with Chest Radiation

Moskowitz CS. J Clin Oncol, 2014
Children’s Oncology Group

www.survivorshipguidelines.org

Annual mammogram and breast MRI
Starting at the age of 25, or 8 yrs after the radiation therapy
3000 cGy RT to 16-year-old with Hodgkin lymphoma

Courtesy of Constine LS.
Interaction between Chest RT and CVD Risk Factors
Childhood Cancer Survivor Study

Cardiovascular Risk Factor:
- Hypertension
- Type 2 DM
- Dyslipidemia
- Obesity

Jessica: Hodgkin Lymphoma Survivor

36-year-old woman treated at age 16
3000 cGy mantle field radiation and chemotherapy
 doxorubicin, bleomycin, vinblastine, dactinomycin

She has not been back to her oncologist in over 10 years. She asks whether her treatment could impact her fertility.
Impaired Fertility and Early Menopause

• Regular menses does not ensure fertility.
• Ovarian reserve can be assessed with antral follicle count and AMH.
Impaired Fertility and Early Menopause

• Highest risk cancer therapies are radiation to the pelvis, alkylating agents, and hematopoietic cell transplant.

• ABVD, as in Jessica’s case, is a lower-risk treatment.

http://www.myoncofertility.org/
http://www.mskcc.org/
Recommendations for All Survivors

• Address the psychological and social sequelae of the cancer experience.

• Screening for Hepatitis B (if treated before 1972) and Hepatitis C (if treated before 1993).

• Baseline ferritin to screen for acquired hemochromatosis.
Recommendations for All Survivors

• Tobacco avoidance or cessation
• Regular exercise
• Weight loss or weight maintenance
• Healthy diet

Estruch NEJM 2013; 368:1279-1290.
Image.NYTimes.com
Evidence-based Palliative and End-of-Life Care in Cancer

SGIM
April 25, 2015

Jean S. Kutner, MD, MSPH
Professor of Medicine, University of Colorado School of Medicine
Chief Medical Officer, University of Colorado Hospital
A patient -- Mr. K

• 75 year old man who had been doing well until May 2011 - diagnosed with pancreatic cancer.
  – Treated with chemotherapy, with terrible side effects, resulting in a hospitalization in the East

• Moved to Colorado from the East Coast within 1 week of discharge from hospital in the East to be closer to family.

• Comes to see me in my GIM clinic, referred due to my palliative care expertise (no outpatient palliative care available).

• *What should I do / recommend??*
Outline

• Definition: What is palliative care?
• Institute of Medicine reports
  – Delivering High Quality Cancer Care (2013)
  – Dying in America (2014)
• Existing evidence – brief summary
• Recommendations and guidelines
• Current status and opportunities
What is Palliative Care?

• Specialized medical care for people with serious illness and their families
  – Focused on improving quality of life as defined by patients and families.
  – Provided by an interdisciplinary team that works with patients, families, and other healthcare professionals to provide an added layer of support.
  – Appropriate at any age, for any diagnosis, at any stage in a serious illness, and provided together with disease treatments.

Definition from public opinion survey conducted by ACS CAN and CAPC
IOM REPORTS
8 Relevant IOM Reports:

Palliative care is essential to quality
IOM Report: *Delivering High-Quality Cancer Care*

To read the report online: [www.iom.edu/qualitycancercare](http://www.iom.edu/qualitycancercare)
IOM Report: “Dying in America”

iom.edu/endoflife

Released 9/17/14
Key Areas for Findings and Recommendations

• Delivery of person-centered, family-oriented care
• Clinician-patient communication and advance care planning
• Professional education and development
• Policies and payment systems
• Public education and engagement
Palliative Care = Quality Care

Research shows that palliative care:

- Relieves pain and distressing symptoms
- Clarifies goals of care and supports decision-making
- Improves quality of life
- Increases patient and family satisfaction with care
- Eases burden on providers and caregivers
- Helps patients complete life prolonging treatments
- Enhances the value of health care

Concurrent palliative care

Randomized trial: simultaneous standard cancer care with palliative care co-management from diagnosis vs standard cancer care only:

- **Improved quality of life**
- **Reduced major depression**
- **Reduced ‘aggressiveness’** (less chemo < 14d before death, more likely to get hospice, less likely to be hospitalized in last month)
- **Improved survival** (11.6 mos. vs. 8.9 mos., p<0.02)

Early Versus Delayed Initiation of Concurrent Palliative Oncology Care: Patient Outcomes in the ENABLE III Randomized Controlled Trial

Marie A. Bakitas, Tor D. Tosteson, Zhigang Li, Kathleen D. Lyons, Jay G. Hull, Zhongze Li, J. Nicholas Dionne-Odom, Jennifer Frost, Konstantin H. Dragnev, Mark T. Hegel, Andres Azuero, and Tim A. Ahles

Four well-designed randomized interventions as well as a growing body of nonrandomized studies indicate that outpatient palliative care services can:

1) improve patient satisfaction
2) improve symptom control and quality of life
3) reduce health care utilization, and
4) lengthen survival in a population of lung cancer patients.
Palliative Care Lowers Costs

• Community / Academic:
  • ↓ direct costs $4908/admit;
  • ↓ direct costs $374/day

• VA: ↓ direct costs $464/day

• Kaiser: ↓ direct costs $4855 / 6 month

• NO difference in survival

The Care Span

By R. Sean Morrison, Jessica Dietrich, Susan Ladwig, Timothy Quill, Joseph Sacco, John Tangeman, and Diane E. Meier

The Care Span

Palliative Care Consultation Teams Cut Hospital Costs For Medicaid Beneficiaries

Health Affairs

At the Intersection of Health, Health Care and Policy
Palliative Care Improves Value

Quality improves
– Symptoms
– Quality of life
– Length of life
– Family satisfaction
– Family bereavement outcomes
– MD satisfaction

Costs reduced
– Hospital cost/day
– Use of hospital, ICU, ED
– 30 day readmissions
– Hospitality mortality
– Labs, imaging, pharmaceuticals
RECOMMENDATIONS AND GUIDELINES
American Society of Clinical Oncology Provisional Clinical Opinion: The Integration of Palliative Care Into Standard Oncology Care

Thomas J. Smith, Sarah Temin, Erin R. Alesi, Amy P. Abernethy, Tracy A. Balboni, Ethan M. Basch, Betty R. Ferrell, Matt Loscalzo, Diane E. Meier, Judith A. Paice, Jeffrey M. Peppercorn, Mark Somerfield, Ellen Stovall, and Jamie H. Von Roenn
What can ASCO members do today?

- Consider early referral to palliative care
- Establish working relationships with local hospice and palliative care providers.
- Monitor important Quality Oncology Practice Initiative (QOPI) metrics
  - Their own referrals and length of patient stay in hospice
  - How many patients get chemotherapy within 2 weeks of death
  - Evaluation of pain by the second visit
- Consider a “hospice information visit” 3-6 months before the patient is expected to die, to ease the transition later
What can ASCO members do today?

- Discuss, early in the course of illness, rather than when there is no more chemotherapy to give:
  - Prognosis, with the most likely outcome
  - Medically appropriate goals (risks and benefits)
- Establish
  - Advance medical directives
  - Durable Power of Medical Attorney
  - Involvement of hospice as the best way of taking care of people at the end of life, when prognosis warrants
- Present palliative care as an added layer of support for patients and families
NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

Palliative Care

Version 1.2015
NCCN.org
STANDARD 2.4 Palliative Care Services Palliative care services are available to patients either on-site or by referral.
CURRENT STATUS AND OPPORTUNITIES
2011 Report Card on Access to Palliative Care at Our Nation’s Hospitals

% of Hospitals > 50 beds with a Palliative Care Program

- National
- Colorado
- Vermont
- Nebraska
- Oregon
- California
- New York
- New Mexico
- Wyoming
- Kansas
- Texas
- Mississippi

Center to Advance Palliative Care/ National Palliative Care Research Center (www.capc.org)
Palliative Care Growth in the U.S.

► In 2012, hospital programs were serving over 6MM patients each year.

► Palliative care prevalence and # of patients served has nearly tripled since 2000.

► 100% of the U.S. News 2014 – 2015 Honor Roll Hospitals Have a Palliative Care Team.

► 100% of the U.S. News 2014 – 2015 Honor Roll Children’s Hospitals Have Palliative Care Teams.
Palliative Care is Present at:

- 100% of the top 20 NIH-funded medical schools
- 97% of the Council of Teaching Hospitals member organizations
- 87% of the National Cancer Institute’s designated comprehensive cancer centers
MR. K
Mr. K

• First meeting included patient, wife, daughter, son-in-law and granddaughter
  – Primary concern: how he could feel better
  – On multiple medications, very fatigued and weak

• Assessed:
  – Understanding of illness and treatment
  – Symptoms
  – Quality of life
  – Sources of support (social and spiritual)
  – Coping
  – Goals
Patient Perspective

• Parallel goals:
  – to feel better, gain back function, have a better quality of life; AND
  – live as long as possible with the best quality of life possible
  – Did not want to pursue further pancreatic cancer treatment if it would mean that he would feel as poorly as he currently felt
Recommendations

• Referred to pancreatic cancer specialists
  – to explore potential for additional treatments that
    would be better tolerated in the hopes that
    pancreatic cancer progression could be slowed
• Adjusted medications to address bothersome symptoms
• Connected with community-based palliative care
• Addressed advance directives
Outcome

• 22 months after initial encounter
  – Received chemotherapy and then radiation therapy
  – Had initial shrinkage of his tumors
  – Improvement in symptoms and quality of life
    • Nutrition support
    • Physical Therapy
    • Integrative Medicine
    • Psychological support
  – Did well for many months, then recurred and received more chemotherapy

• 24 months after initial encounter:
  – Died at home with hospice care
Outcome

• Palliative care enabled Mr. K to achieve his dual goals of having a better quality of life while pursuing treatment for his pancreatic cancer.
• He and his family were realistic about the future, were prepared for the eventual progression of his disease and enjoyed his last 2 years of life together.
• *How do we achieve this for ALL patients with advanced cancer?*
More than a quarter of all adults have given little or no thought to their end-of-life wishes. Have you?

Learn more: iom.edu/endoflife

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES
Treating the person beyond the disease.

Atul Gawande

Being Mortal

Medicine and What Matters in the End
Palliative care is for people of any age, and at any stage in illness, whether that illness is curable, chronic, or life threatening.

_Palliative care_ focuses on improving a patient's quality of life by managing pain and other distressing symptoms of a serious illness. Palliative care should be provided along with other medical treatments.

_Hospice_ is palliative care for patient in their last year of life. Hospice care can be provided in patients’ homes, hospice centers, hospitals, long-term care facilities, or wherever a patient resides.

We had peace of mind knowing we were only a phone call away
Right now an estimated 6,000,000 people in the US need palliative care.
Resources for Teen and Young Adults

http://agingwithdignity.org/voicing-my-choices.php
Thank you!

• Questions and comments?