Symptom Management and the Incorporation of Palliative Care Techniques into the Routine Care of Ovarian Cancer Patients

Gynecological Cancer Symposium: Striving for a Healthier Tomorrow Today
November 19, 2015
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What Does Palliative Care Mean to You?

• End of life care
• Symptom management
• Getting optimal treatment of the underlying medical condition
• Giving up
• Hospice
• Assures that all medical needs are recognized and addressed
Palliative Care (World Health Organization)

• Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.
Goals of Palliative Care
American Academy of Hospice and Palliative Medicine www.ahpm.org

• Provides relief from pain and other uncomfortable symptoms.
• Assists the patient and family in making difficult medical decisions.
• Coordinates care with other healthcare providers enabling navigation of an often complex health care system.
• Guides the patient in making a plan for living well, based on their needs, concerns and goals of care.
• Provides the patient and family emotional and spiritual support and guidance.
Benefits of Palliative Care
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• Palliative care helps achieve quality of life as the patient defines it.
• The palliative doctor and team explain the pros and cons of treatment options to facilitate informed decisions about management of the illness and symptoms, enabling the patient to live their life.
  – Controls pain
  – Controls common symptoms of serious illness such as fatigue, anxiety, shortness of breath, nausea, depression and constipation
  – Improves quality of life
SPECTRUM OF PALLIATIVE CARE

PALLIATIVE CARE

HOSPICE

CURATIVE AND LIFE-PROLONGING TREATMENTS

PAIN MANAGEMENT

COMFORT CARE

INFUSIONS
Early Palliative Care for Patients with Lung Cancer

Patients with metastatic non-small lung cancer were randomized to either standard oncologic care or early palliative care integrated with standard oncologic care

- Met with palliative care team in addition to their oncologist
  - Assessing physical and psychosocial symptoms
  - Establishing goals of care
  - Assisting with decision making regarding treatment
  - Coordinating care on the basis of the individual needs of the patient

- Quality of life, depression and survival were analyzed for both groups
  - Dimensions assessed included physical, functional, emotional and social well-being.
Patients assigned to palliative care had a better quality of life and fewer depressive symptoms.

Duration of hospice care was 11 days for the palliative care group and 4 days in the standard of care group.

Fewer patients in the early palliative care group received aggressive end of life care.

Median survival was longer for patients receiving palliative care 11.6 versus 8.9 months.
Evolving Model of Palliative Care

“Active Treatment”  Palliative Care

Cure/Life-prolonging Intent  Palliative/Comfort Intent  Bereavement
Which patients benefit from a palliative approach?

- Patients for whom care needs are extensive and complicated
  - Frequent hospitalizations for recurrent illness or symptoms
  - Difficult to control physical or emotional symptoms related to serious medical illness
  - Limited social support and a serious illness (e.g. homeless, chronic mental illness)
  - Patient, family or physician uncertainty regarding goals of care/prognosis
  - Patient, family or physician request for information regarding hospice appropriateness
Survival in Ovarian Cancer Obs Gyn 2012;

• Median survival optimally cytoreduced patients is 62 months
• Ovarian cancer is now considered a chronic disease and therefore patients are likely living with disease recurrence
• 10-year survival estimates provide prognostic information
• SEER Registry shows for all stages 36% 10 year survival

• Relative survival rates

<table>
<thead>
<tr>
<th></th>
<th>Stage I</th>
<th>Stage II</th>
<th>Stage III</th>
<th>Stage IV</th>
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<tbody>
<tr>
<td>5 years</td>
<td>89%</td>
<td>70%</td>
<td>36%</td>
<td>17%</td>
</tr>
<tr>
<td>10 years</td>
<td>84%</td>
<td>59%</td>
<td>23%</td>
<td>8%</td>
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</table>
Ovarian Cancer is a Chronic Disease

- Patients are coping with the side effects of their prior therapies
- Patterns of disease recurrence are changing
- Patients are developing second malignancies
- Develop treatment strategies that maximize benefit and take into account the “long haul”.
- Incorporation of participation on Clinical Trials into treatment plan.
Developing a Strategy For Treatment in the Setting of Disease Recurrence

- Participation on Clinical Trials
- Minimizing treatment related side effects
- Maintaining Quality of Life

- Goals of Care
  - Remission
  - Partial Response
  - Disease Stabilization
  - Alleviation of Symptoms
Quality of Life in Ovarian Cancer Clinical Trials

- 2005 GOG looked at HRQOL changes with interval secondary cytoreduction for patients who were initially suboptimally cytoreduced
  - No appreciable differences in QOL between the groups
  - This was due to improved overall survival among all patients
- 2007 GOG 172 QOL measurements intraperitoneal vs. intravenous chemotherapy
  - OS improved by 16 months in the intraperitoneal arm
  - HRQOL significantly worse during active treatment due to toxicity
  - Neurotoxicity remained significantly greater for intraperitoneal patients 12 months post-treatment
Quality of Life in Ovarian Cancer Clinical Trials

• 2010 Vergote Neoadjuvant chemotherapy trial versus upfront debulking followed by chemotherapy
  – Similar survival outcomes in two group with both perioperative and postoperative morbidity higher in the upfront surgery group
  – QOL global health scores were not significantly different between the two groups
  – HRQOL measurement did not seem to correlate with the toxicity demonstrated upfront

• Treating recurrent ovarian cancer tumor control without compromising HRQOL should be the goal of therapy
  – No Phase III trial reported by the GOG that involves QOL assessments for recurrent ovarian cancer
  – Even international data HRQOL data recurrent setting deficient in terms of detailed descriptions of QOL disruptions and numbers of studies including QOL measurements
Symptoms Contributing to QOL Changes Ovarian Cancer

- Fatigue (asthenia)
- Bloating
- Pain
- Peripheral Neuropathy
- Sexual Dysfunction
**Fatigue**

- Cancer related fatigue is fatigue not relieved by rest or sleep
- Affect women across all stages and influences other factors involved in general QOL such as social or functional well-being
- Holzner examined the prevalence of fatigue in ovarian cancer survivors
  - Hgb > 10 g/dl
  - 32.7% women were suffering from fatigue
  - Fatigue scores correlate with lower QOL, less spirituality increased fear of recurrence and lower emotional well being
- Need to treat underlying anemia or depression
- Weinrub looked at alterations in cortisol levels and found that higher nocturnal cortisol and lower cortisol variability were significantly associated with fatigue.
Causes of Cancer Related Fatigue

- Anemia
- Chronic Infection
- Sleep disturbances
- Fluid and electrolyte disturbances
- Drugs
- Direct tumor effects
- Paraneoplastic syndromes
- Humoral and hormonal influences
- Over-exertion due to too many doctor appointments
Management of Cancer Related Fatigue

- **Steroids**
  - Dexamethasone 4-8 mg PO daily
  - Prednisone 10 mg PO BID with food
- **Methylphenidate morning and noon**
  - Side effects
    - Tremulousness
    - Anorexia
    - Tachycardia
    - Insomnia
    - Myocardial ischemia
- **Increase physical activity and participate in Yoga**
- **Acupuncture**
Bloating

• Gastrointestinal dysfunction or ascites
• Husain looked at symptoms in women with ascites referred for paracentesis
  – At pre and post paracentesis there were two clusters of symptoms depression/anxiety and fatigue/appetite/wellbeing
  – Paracentesis improves single symptoms such as distention and dyspnea with a decline in the cognitive domain of QOL

• Treatment of symptomatic ascites
  – Paracentesis provides immediate symptom palliation
  – Improvement in dyspnea and appetite loss
  – Marked deterioration in cognitive and emotional scales such as anxiety and fatigue

• There is no data in women requiring multiple paracentesis
  – Pleurex catheters or in a subset of patients Bevacizumab
Pain

• In ovarian cancer patients with lowest QOL scores pain contributes significantly

• Pain is linked to fatigue and also affects depression

• Stewart et al surveyed 200 women without evidence of active disease for 2 years
  – 53.5% reported current pain or discomfort
  – 21% pain as severe and 21% reported that the pain affected their life.
Barriers to Pain Management: The Patient’s Perspective

• Reluctance to reporting pain
  – Good patient
  – Inevitability of pain
  – Keep the doctor focused
  – Fear of implications

• Reluctance to taking opioids
  – Fear of addiction
  – Side effects
  – Development of tolerance

• Physician reluctance to prescribe opioids
  – Concern of iatrogenic addiction
  – Suspicion of abuse
  – Concern of regulatory control
  – Inability to control side effects
  – Development of tolerance
Assessment of Pain

Circle a number from 0-10 that best describes how much pain you are having now.

For a child or non-English speaking adult, use Wong-Baker FACES Pain Rating Scale. Ask the patient to circle the face that best describes how he/she feels:
# Types of Pain

<table>
<thead>
<tr>
<th>Origin</th>
<th>Characteristics</th>
<th>Treatment</th>
</tr>
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<tbody>
<tr>
<td>Somatic</td>
<td>Skin, joints, muscle, bone</td>
<td>Aching sharp throbbing, worse with movement, constant or intermittent</td>
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<tr>
<td>Visceral</td>
<td>Organs such as bladder, bowel, pancreas, uterus</td>
<td>Diffuse or poorly localized, intermittent or crampy, may change with bladder or bowel function</td>
</tr>
<tr>
<td>Neuropathic</td>
<td>Nerve tissue</td>
<td>Shooting, stabbing, burning</td>
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</table>

- **Somatic** typically affects skin, joints, muscle, and bone, characterized by achy, sharp, throbbing pain that may worsen with movement and can be constant or intermittent. Treatment options include NSAIDS with or without opioids.
- **Visceral** pain involves organs such as bladder, bowel, pancreas, and uterus, presenting as diffuse or poorly localized pain that can be intermittent, crampy, or change with bladder or bowel function. Non-opioid and opioid treatments are effective.
- **Neuropathic** pain originates from nerve tissue, manifesting as sharp, stabbing, or burning sensations that follow nerve or dermatome distribution. Treatment avoids NSAIDS and uses non-opioid and opioid medications, such as Neurontin, Lyrica, or amitriptyline.
Principles of Pain Management

- Use oral agents whenever possible
- Match analgesia to degree of pain
- Administer medications scheduled basis for chronic pain
  - Use long-acting analgesia for chronic pain (not prn)
  - Use appropriate breakthrough doses (10% 24-hr dose)
- Maximize dose and schedule before adding/changing drugs
- Anticipate and address adverse effects
- Evaluate frequently and titrate dose
- Use appropriate adjuvant agents
- Consultation with pain medicine specialists when necessary
Peripheral Neuropathy

- SEER 2010 incidence in ovarian cancer patients was 21.5/1000 person years higher than either breast or lung cancer patients
- 25% of patients receiving cisplatin or taxane based regimens are at risk for developing peripheral neuropathy
  - 23% of patients may suffer for up to 48 months after treatment and therefore these agents cannot be used in the setting of recurrent disease
- Does not respond well to opioids
- Treat with antidepressants or anticonvulsants
- Vitamin B6 has been shown to decrease chemotherapy induced neuropathy
- Gabapentin (Neurontin or Lyrica)
Sexual Dysfunction

- Sexual health described by 4 different levels of dysfunction
  - Body image
  - Gender Role (femininity identity)
  - Sexual functioning
  - Reproductive ability

- Sexual dysfunction is multifactorial
  - Affected by fear/anxiety, lack of desire, aches/pains, shortening of the vagina and decrease in the ability to obtain orgasm

- Literature limited sexual dysfunction specific to ovarian cancer
- Surgical menopause significantly poorer sexual functioning
- Stewart’s survey 57% reported negative effect of cancer and cancer treatment on sexuality
  - Half women expressed fear of the effects of treatment on sexual relationships and physical symptoms during sexual activity.
When asked about treatments or therapies how would you respond?

- I would want to receive treatment even if I know I will not benefit from treatment.
- I would want to receive treatment even if I know I will only gain an extra week or two.
- I would want to receive treatment if there is a reasonable chance of my having at least several extra months.
- I would want to receive treatment only if I knew that I would be cured.
Trajectory of Ovarian Cancer

Cancer 2008;112(10):2221-2227
Aggressiveness of Care and Survival
Cancer 2008;112(10):2221-2227

• Admissions for bowel obstruction, pleural effusions and ascites increases during the final stages of disease

• Aggressiveness of care
  – Start new chemotherapy regimen within 30 days of death
  – Last chemotherapy within 14 days of death
  – More than 1 ER visit within last month
  – More than 1 hospital admission within 1 month
  – Admission to ICU within the last month
  – Hospice admission less than 3 days

• Most aggressive treatment did not lead to longest survival

• Patients with shorter survival
  – Trend toward more chemotherapy within last 3 months of life
  – Received more aggressive care
Aggressive Treatment

- Patients with a shorter survival time received more chemotherapy during the last 30 days of life and more aggressive care
- Administration of a new chemotherapy regimen resulted in more hospitalizations
- Patients with a short trajectory of disease appeared to have the same clinical events as what would be characteristic of what is normally seen
- In the presence of rapidly progressive disease aggressive care measures are not associated with a survival benefit.

- Use of chemotherapy to decrease symptoms and improve quality of life
- Evaluated using Minimal Clinically Important Difference (MCID)
  - Smallest difference that patient perceives as beneficial and would change management
  - Change in score .5 (7%) on a 7 point scale
- 27 patients participated
- After 2 cycles of therapy an improvement seen in 20% patients
- Quality of life improved 33% (Range 8.3 – 75%)
  - Greatest improvement in emotional function
- Discrepancy between expectations and outcomes significant predictor for quality of life
- 42% patients had moderate to high expectation cure
Why stop chemotherapy?

• Disease progression
• Unable to tolerate chemotherapy due to medical problems
• Intolerable side effects
• Patient desires
Goals of Surgery

• Benefits of palliative surgery should always focus on quality of life, symptom control and symptom prevention
  – Secondary benefit is survival.

• Measures for success are unclear
  – Outcome measures related to QOL are not clearly defined

• Goals of Palliative Procedures
  – Pain and symptom relief
  – Maintaining independence and function
  – Fewer and shorter hospitalizations
  – Preemptive palliative procedures should be considered in settings where tumor related morbidity can be anticipated.

• Need to consider surgical risks
  – Potential complications including infections, wound healing, lymphatic leaks
  – Nutritional compromise
Relative Contraindications to Surgery

- Poor PS
- Patient > 65 with cachexia
- Albumin level < 2.5
- Metastatic cancer with poor symptom control
- Palpable Mass
- Diffuse Carcinomatosis
- Preoperative weight loss of > 9 kg
- Prior RT to the abdomen or pelvis
- Extensive prior chemotherapy or radiation therapy
- Small Bowel Obstruction at multiple sites
Absolute Contraindications to Surgery

- Patient refusal to undergo surgery
- Carcinomatosis
- Diffuse palpable intra-abdominal masses
- Massive ascites which recurs rapidly after drainage (3 liters)
- High obstruction involving proximal stomach
- Obstruction at multiple sites
- Pre-operative weight loss greater than 9kg
Hydration and Nutrition

- **Role of parenteral nutrition**
  - Ability to demonstrate genuine benefit for the patients
  - Improves quality of life without merely lengthening survival
  - Is the bowel obstruction temporary and can it spontaneously resolve.
- **TPN should be considered if the patient is going to die of starvation rather than disease**
- **Correction of dehydration does not have an effect on dry mouth and thirst and a high level of hydration may result in more bowel secretions**
- **Intensity of nausea significantly lower in patients treated with moderate amounts of water (>500 ml/day)**
- **Prevents metabolic derangement and reduces stimulation of chemoreceptor trigger zone.**
- **Administration of 1-1.5 liters/day containing electrolytes and glucose may be useful in preventing symptoms due to metabolic derangement.**
Nutrition Recommendations

http://www.cancer.gov/cancertopics/pdq/supportivecare/lasthours/healthprofessional/page1/AllPages/Print#Section_52

• “American Academy of Hospice and Palliative Medicine (AAHPM) recommends that individual clinical situations be assessed using clinical judgment and skill to determine when artificial nutrition is appropriate. Recognizing that the primary intention of nutrition is to benefit the patient, AAHPM concludes that withholding artificial nutrition near the end of life may be appropriate medical care if the risks outweigh the possible benefit to the patient.”
# Palliative Care and Hospice: Similarities and Differences

<table>
<thead>
<tr>
<th>Purpose/Definition</th>
<th>Palliative Care</th>
<th>Hospice</th>
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<tbody>
<tr>
<td></td>
<td>Improves the quality of life of patients and families facing life-threatening illness</td>
<td>Provides care for patients no longer seeking curative treatment</td>
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<thead>
<tr>
<th>Timing</th>
<th>Begins early</th>
<th>Begins later</th>
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<table>
<thead>
<tr>
<th>Duration</th>
<th>Throughout the treatment process</th>
<th>Life expectancy of less than six months</th>
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<table>
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<tr>
<th>Care Strategies</th>
<th>Palliative Care</th>
<th>Hospice</th>
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<tbody>
<tr>
<td></td>
<td>Pain control</td>
<td>Includes similar strategies with emphasis on pain control</td>
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<tr>
<td></td>
<td>Symptom relief</td>
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<td></td>
<td>Spiritual support</td>
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<td></td>
<td>Psychosocial support</td>
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<td></td>
<td>Bereavement support</td>
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<tr>
<th>Location</th>
<th>Palliative Care</th>
<th>Hospice</th>
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<tbody>
<tr>
<td></td>
<td>Hospital</td>
<td>Patient’s home</td>
</tr>
<tr>
<td></td>
<td>Outpatient</td>
<td>Family member’s home</td>
</tr>
<tr>
<td></td>
<td>Home</td>
<td>Nursing home</td>
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Hospice Care
American Academy of Hospice and Palliative Medicine www.aahpm.org

• Efforts to cure or slow an illness are not working and can be harmful, rather than helpful.
• Hospice is a form of palliative care.
• Ensure final months of life are as good and fulfilling as they can be for patients and loved ones.
• Hospice is not about giving up. It's about giving comfort, control, dignity and quality of life.
• When to request hospice care is a personal decision,
  – At a certain point, doing "everything possible" may no longer be helping
• Sometimes burdens of a treatment outweigh the benefits.
  – An aggressive treatment might give another month of life, but make the patient feel too ill to enjoy that time.
Place of Care and Death of Medicare Beneficiaries at End-of-Life

- Percent of Deaths in Hospice
- Percent Using ICU Services in Last Month of Life
- Percent of Deaths in Acute Care Hospitals

Source: Dr. Joan Teno, et al., “Change in End-of-Life Care for Medicare Beneficiaries,” Journal of the American Medical Association, February 2013
What is “Bad News”?

• Any news that drastically and negatively alters the patient’s view of his or her future

• The “badness” of the news depends on what the patient already understands or expects

• Physicians must therefore first determine the patient’s viewpoint
Barriers to Communication

Clinician:

• Lack of training or strategy
• Fear of upsetting patient
• Fear of failure
• Time constraints

Patient:

– Gender/Cultural issues
– Denial or unreasonable expectations
– Information processing style differs patient to patient
SPIKES

- **S**etting
- **P**erception
- **I**nvitation
- **K**nowledge
- **E**mpathy and exploration
- **S**trategy and Summary
Setting

• Physical Setting
  – Privacy
  – No interruptions
  – **Sit down**, nearby

• Accommodate patient preferences

• Include significant others

• Maintain Eye contact

• Introduce yourself and if there are new members of family, ascertain their names and relationships

• Be aware of your and their body language
Preparation

• Preparation
• Rehearse a dialogue
• Anticipate
• Plan emotional support
• Consider the outcome you want
Perception

• Before you tell, ask
  – “What do you understand about your medical condition?”
    • Allows clinician to learn how patient perceives problem; opportunity to start “on the same page”

• Ask open-ended questions
• Listen to what is and is not said
• Don’t interrupt
• Repeat what they say, in your own words
Invitation

“How would you like me to give you the information about the test results. Would you like all the details or have me just describe what they mean? Is there anyone else we should include in these discussions?”

Includes patient and family as players
Knowledge

• Provide the medical facts, at the patient’s level
  • Must be in language patient can understand
    Example: MD: “The biopsy is positive”
    Patient: “Oh what a relief”

• Forecast the news
  • “I’m afraid I have some bad news”
  • Don’t over protect the patient as it damages trust later

• Give news in small chunks and verify understanding

• Avoid excessive bluntness.
  • If prognosis is poor, suggest goals such as symptom relief and spiritual support.
  • Never say there is nothing we can do for you.
Empathy and Exploration

• Respond empathetically to all emotions
  – “I know this is not good news”.. “I can tell you were not expecting this” “I too was hoping for a better result”

• Ask when you are unclear as to the patients thoughts and feelings
  – “tell me more”… “How do you mean”.. “Could you tell me what worries you most”

• Validate the patient’s emotional concerns
  • “This must be a shock to you”. “I understand why you would feel this way”… “Many other people would have the same feelings”..” You’ve thought this through very well.” (reduces patients isolation, expresses solidarity)

• Wait as needed before further discussions
Answering Tough Questions

• Does this mean I’m going to die?
• How long do I have?
• Is there any hope for me?
• Will I be in pain?

Best advice: Don’t duck the questions, but try to focus on the positive things that can be done.
Strategy and Summary

- Collaborate
- Prepare treatment plan
- Describe options and consequences; uncertainties and decision points
- Make recommendations, but also
  - Decide next steps together
    - Shared decisions help patient “buy-in”
- Elicit concerns
- Include family or significant others
The End of Her Journey

• “Before I could write all this—I’ve been working on it for days—I had to make peace with the news. To be perfectly honest, I am ready to be done with chemo, with doctor appointments, and with nausea, fatigue, and uncertainty. As any cancer patient will tell you, chemo wears you down. Cancer is awfully quiet, too quiet. It doesn’t even hurt most of the time. But Western medicine’s treatment regimen—and it is, indeed, a regimen because there is nothing easy about it—is exhausting, often painful, physically and emotionally scarring, and, at best, a big fat roll of the medical dice. Surgery, chemo, and radiation work well for some people and for some cancers. Not everyone gets lucky. After two-and-a-half years of fighting for my life, I’m sick and tired of being sick and tired. I am ready to rest.” JM Caring Bridge Entry