Supportive and Palliative care for patients with Pancreatic Cancer

Dr Holly Taylor
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Aims of this session

• To discuss the principles of supportive and palliative care
• Identification of patients in the last year of life
• Identifying patients approaching end of life
• Basic management of problematic symptoms
• Who, and when to refer to the specialist palliative care team
• Where to get additional support
Palliative care....
However...

- Integrating palliative care earlier into the care of a patient with cancer can improve quality of life, mood and survival
Survival....
Survival in pancreatic cancer

- Median survival following surgical resection 11-20 months
- 5 year survival 7-25 %
- Less than 20% of cases diagnosed in England are stage I or II
- Stage III disease survival 6-11 months
- Stage IV 2-6 months

- Only 1% of all diagnoses survive for 10 years or more

- No improvement in the last 40 years
Supportive care

• Helps the patient to cope with their condition and treatment of it
  – Process of diagnosis, treatment, possible cure, continued illness, deterioration and death
  – Enables patients to live as well as possible with the burdens of their disease
Palliative care

- Palliative care is part of supportive care
  - Holistic care of patients with incurable advanced progressive illness
  - Aim to prevent or treat symptoms as soon as possible
  - Management of pain and other symptoms
  - Includes psychological, social and spiritual support
Palliative care

• Generalist Palliative Care
  – Provided by everyone involved in the care of that patient
  – CNS teams, District nurses, Medical team, GP’s, other members of the MDT

• Specialist Palliative Care
  – Provided by Specialist Palliative Care Teams in the hospital, hospices and community

• Early palliative care input can come from all involved
Specialist palliative care

• Manage more complex patient care problems that cannot be dealt with by generalist services
• Includes Doctors, nurses and allied healthcare professionals
• Hospice care is available for complex symptoms or end of life if needed
What does palliative care involve in your patients?

• Not just physical symptom management...

• Advance care planning
• Social support
• Financial support
• Psychological support
• Continuity
Symptom management

- Mr S, 62 year old man with locally advanced pancreatic cancer was admitted with pain, nausea and jaundice
- How would you manage this patient?
Pain

- Not all patients get pain with advanced cancer
- Multifactorial
- Can be both visceral and neuropathic
- Involvement of gut wall
- Nodal disease around the coeliac plexus
- Metastatic disease in the liver
Management of pain

• Morphine drug of choice in liver failure
• Buprenorphine also safe
• Avoid oxycodone and codeine

• When there is both liver and renal failure, often a choice of which is worse. Should consider discussing these patients with us!

• Dexamethasone 4-6 mg od should be considered if liver capsule pain is thought to be a problem

• Neuropathic agents
• Amitriptyline, gabapentin
Non drug measures

• Interventional analgesia
• Coeliac plexus block
• Endoscopic vs radiologically guided
• Drug used for the procedure

• Radiotherapy

• Consider referral to palliative care early if pain is a problem not responding well to opiates
Nausea

• Cause is important!

• Two common causes in pancreatic cancer
  • Biochemical
  • Delayed gastric emptying
• R had an ERCP and stent, which improved his jaundice
• His nausea resolved with this intervention
• He declined a coeliac plexus block, but pain was under reasonable control with both neuropathic and opiate analgesia
• Unfortunately, his Jaundice recurred and was not stentable
• He became increasingly drowsy and confused

• What symptoms may help us know if he is approaching the end of life?
Identification of dying patients

• Specialist palliative care do not always need to be involved if patients are dying
• Often excellent palliative care can be provided by those that know the patient best
• Prior discussions with patients can guide us when they are not able to make decisions by themselves
ReSPECT

- Recommended
- Summary
- Plan for
- Emergency
- Care and
- Treatment
ReSPECT – who is it for?

• Anyone, with increasing relevance for those:
  ▫ with particular healthcare needs
  ▫ nearing the end of their lives or at risk of cardiac arrest
  ▫ who want to record their preferences for any reason

• A ReSPECT form is best completed when a person is relatively well, so that their preferences and agreed clinical recommendations are known if a crisis occurs

• If an emergency occurs in someone with no ReSPECT form, consider discussing and completing it as soon as possible (before or after hospital admission)
End of life

• 1% of the population die each year
• We are notoriously bad at identifying patients who are approaching the end of their lives
• Increasing the chances that they will receive potentially distressing and unpleasant treatments with no survival benefit

• How can we aim to reduce this?
Gold standards framework
GSF prognostic indicator guidance

• Earlier recognition of patients nearing the end of life
  – Likely to die in the next 12 months

• Triggers
  – Would you be surprised?
  – General indicators of decline
  – Specific clinical indicators
Australia-modified Karnofsky Performance Scale

• Can help with
  – Prognostication
  – Escalation decisions
  – Discharge planning

• We document AKPS weekly in our MDT
<table>
<thead>
<tr>
<th>AKPS Score</th>
<th>Description of performance status</th>
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<tbody>
<tr>
<td>100%</td>
<td>Normal, no complaints, no evidence of disease</td>
</tr>
<tr>
<td>90%</td>
<td>Able to carry on normal activity, minor signs or symptoms of disease</td>
</tr>
<tr>
<td>80%</td>
<td>Normal activity with effort, some signs or symptoms of disease</td>
</tr>
<tr>
<td>70%</td>
<td>Cares for self, but unable to carry on normal activity or to do active work</td>
</tr>
<tr>
<td>60%</td>
<td>Able to care for most needs, but requires occasional assistance</td>
</tr>
<tr>
<td>50%</td>
<td>Considerable assistance and frequent medical care required</td>
</tr>
<tr>
<td>40%</td>
<td>In bed more than 50% of the time</td>
</tr>
<tr>
<td>30%</td>
<td>Almost completely bedfast</td>
</tr>
<tr>
<td>20%</td>
<td>Totally bedfast and requiring extensive nursing care by professionals and/or family</td>
</tr>
<tr>
<td>10%</td>
<td>Comatose or barely arousable, unable to care for self, requires equivalent of institutional or hospital care, disease may be progressing rapidly</td>
</tr>
<tr>
<td>0%</td>
<td>Dead</td>
</tr>
</tbody>
</table>
Other indicators which may help with prognostication

• Albumin
• Rate of decline
• Complications/side effects of disease progression
NICE Guidelines

• NICE – pancreatic cancer in Adults – Feb 2018
  – More focused on diagnosis and treatment pathway
  – Mentions psychological support and pain management

• NICE – Improving Supportive and Palliative Care for adults with cancer – 2004!
Improving supportive and palliative care – NICE 2004

- Co-ordination of care
- User involvement
- Face to face communication
- Information
- Psychological support services
- Social support services
- Spiritual support services
- General palliative care services
- Specialist palliative care services
- Rehabilitation, complementary therapy
- Services for families and carers
Conclusion

• Although pancreatic cancer has a very poor long term prognosis, we should still as an MDT work at supporting people to live well for longer

• This involves early access to support services, and referral to specialist services if appropriate