When do Pancreatic Cancer Patients need Palliative Care?

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Innovation and excellence in health and care

**Pancreatic Cancer in England**

**Key Statistics:**

- **5th largest cause of cancer death in England** with 7,430 deaths recorded in 2014.
- **Pancreatic cancer has the lowest survival rates of any of the 21 most common cancers**.
- **Deaths within 1 year 80%**.
- **5-year net survival 5.4%**.

- **It is the cause of over 5% of all cancer deaths in England**.
- **11th most common cancer in England** with 7,887 new cases diagnosed in 2013.

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WHO definition of palliative care

• Palliative care is an approach that improves the quality of life of patients and their families facing the problems 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.

• Palliative Care is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life……
2008 National End of Life Strategy

- Everybody deserves ‘a good death’.
- Being treated as an individual, with dignity and respect
- Being without pain and other symptoms
- Being in familiar surroundings
- Being in the company of close family and/or friends
- National coalition – Dying Matters - to support the implementation of the strategy

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End of Life Care Pathway and Tools

CARE IN THE LAST YEAR OF LIFE

Identify and assess
Gold standards framework (GSF)

Plan - communicate
Advance care planning (ACP)

Care in the last days
Care of the Dying Patient
Quality statements

1. Adults with suspected pancreatic cancer have their diagnosis and care agreed by a specialist pancreatic cancer multidisciplinary team (MDT).
2. Staging using FDG-PET/CT
3. Resectional surgery
4. Pancreatic enzyme replacement therapy
5. (placeholder): Effective interventions to address psychological needs

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NICE Nutritional management

- Offer enteric-coated pancreatin for people with unresectable pancreatic cancer.
- For people who have h+-ad pancreatoduodenectomy and who have a functioning gut, offer early enteral nutrition (including oral and tube feeding) rather than parenteral nutrition.

Palliative Care Adds

- Discussion of options
- What happens when nutrition support stops
- Symptom management, vomiting, nausea, early satiety, bloating, bowel obstruction

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NICE Pain Management

- Consider EUS-guided or image-guided percutaneous neurolytic coeliac plexus block to manage pain for people with pancreatic cancer who:
  - have uncontrolled pancreatic pain or .... opioid adverse effects or ..... escalating doses of analgesics.

Palliative Care Adds

- Holistic assessment
- Alternative pain management options
- Alternative drug administration routes
- Psychological support and interplay with pain

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NICE Psychological support

Assess the psychological impact of:

- Fatigue, pain, gastrointestinal symptoms, nutrition, anxiety, depression.
- Provide people and their family members or carers (as appropriate) with information and support service….relevant to persons stage and condition, tailored to their needs.

Palliative Care Adds

- Holistic assessment
- Works with psychological impact on symptoms
- Specialist management e.g. for fatigue

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NICE – Locally advanced pancreatic cancer

• Offer systemic combination chemotherapy ...to people with locally advanced pancreatic cancer (if) well enough to tolerate it.

• Consider gemcitabine for people with locally advanced pancreatic cancer who are not well enough to tolerate combination chemotherapy.

• When using chemoradiotherapy, consider capecitabine as radiosensitiser.

Palliative Care Adds

• Discussion of options, including no treatment
• Enhanced Supportive Care, symptoms due to treatment
• Holistic assessment and advance care planning

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NICE Metastatic pancreatic cancer

- Offer FOLFIRINOX\(^1\) to people with metastatic pancreatic cancer and an ECOG performance status of 0–1.
- **Consider** gemcitabine combination therapy\(^2\) for people who are not well enough to tolerate FOLFIRINOX.
- Paclitaxel as albumin-bound nanoparticles (nab-paclitaxel) with gemcitabine as an option for untreated metastatic adenocarcinoma of the pancreas in adults...
- **Consider** oxaliplatin-based chemotherapy\(^3\) as second-line treatment... if ...not had first-line oxaliplatin.
- **Consider** gemcitabine-based chemotherapy\(^4\) as second-line treatment for people whose cancer has progressed after first-line FOLFIRINOX.

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Early Palliative Care (NEJM, J. Temel 2010)

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Advance Care Planning

• “Without honesty and planning patients may feel isolated, distressed, frightened, impacts on pain and symptoms”
• What do I expect this patient to be doing in 2 weeks time or 2 months time?
• Discuss early, a process not a single conversation
• Relatives/friends and patient plan their priorities

• National CQUIN - Enhanced Supportive Care
• Early palliative care intervention improves quality of life and length of life

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Enhanced supportive care / early palliative care

- Palliative care holistic assessment early
- Patient led agenda
- Allow patient to dip in and out
- Well being/living well
- Difficult conversations, future care planning
- Opportunity to weigh up benefits and burdens of treatments
- An alternative to chemotherapy or active oncological treatments
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<table>
<thead>
<tr>
<th></th>
<th>Control group</th>
<th>ESC group</th>
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</thead>
<tbody>
<tr>
<td>Mortality (%)</td>
<td>28 (56%)</td>
<td>27 (54%)</td>
</tr>
<tr>
<td><strong>Median survival (time from diagnosis to death)</strong></td>
<td><strong>293 days</strong></td>
<td><strong>431 days</strong></td>
</tr>
<tr>
<td>CCC Admissions</td>
<td>34</td>
<td>22</td>
</tr>
<tr>
<td>Admissions to other Trusts</td>
<td>46</td>
<td>18</td>
</tr>
<tr>
<td>Total bed days</td>
<td>316</td>
<td>228</td>
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<tr>
<td>Average bed days</td>
<td>6.3</td>
<td>4.6</td>
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<tr>
<td><strong>30 Day Chemo mortality (%)</strong></td>
<td><strong>8 (16%)</strong></td>
<td><strong>1 (2%)</strong></td>
</tr>
<tr>
<td>Is PPC documented?</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>PPC achieved?</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Missed Appointments</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td><strong>Deferred chemotherapy sessions</strong></td>
<td><strong>51</strong></td>
<td><strong>20</strong></td>
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Triggers for referral – Recognising a patient may be in their last year of life

- The surprise question
- Diagnosis of life limiting disease with no available disease modifying treatment
- Uncertain prognosis, uncertain treatment options
- At the end of options of disease modifying treatment
- Recurrent unplanned/crisis hospital admissions
- Diminishing functional ability/performance status
- Decreasing albumin (<25g/l)
- Staff and family needing support with conversations, coordinating care and advance care planning

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Advance Care Planning

- Parallel planning
- Preferred Priorities for Care (PPC) and preferred place of death (PPOD)
- Urgency due to short prognosis in pancreatic cancer
- Community DNA CPR and Just in case drugs
- Re-admission, if so where?
- Plan for hydration and nutrition?
- Financial and legal planning
- Psychological and spiritual support

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Advance Care Planning: barriers

Healthcare Professional
- Prognostic uncertainty, difficulty in diagnosing dying
- Fear of upsetting patient (and self)
- Desire to maintain hope, motivation
- Limited collaboration and coordination between primary / secondary care
- Lack of time

Patient
- Expectation that professionals will initiate discussion
- Denial, feeling of irrelevance
- Societal and cultural taboos

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Patient examples

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Mr. S

- 38 years old, married no children
- Chronic respiratory disease, life limiting
- New diagnosis of metastatic pancreatic cancer and duodenal obstruction, ‘locally advanced’
- For home parenteral nutrition
- Palliative care not needed??
- ‘He’ll be upset don’t see him yet’

Palliative Care Adds
- Change of focus
- Symptom control
- Advance care plans

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Mr. B

- 59 years old
- Married. Two teenage children, one doing A levels
- New diagnosis pancreatic cancer
- Diagnosed on inpatient stay, under GI surgeons as vomiting and weight loss
- ECOG PS = 1, oncology clinic review
- Couldn’t come to clinic as ‘in too much pain and distress’

Palliative Care Adds

- Symptom control, ESC, option of no treatment
- Psychological support, phoning schools
- Information for children

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Mr P

- 69 years, married, 3 children, Whipples in October
- Gastric outlet obstruction the following February
- Liver metastasis, NG drainage and PN
- ‘I have broken the news to patient and wife, discussed option of palliative chemo closer to home if GI symptoms settle’. Patient states he wants to go home ASAP
- Pyrexia ? cause, disease or infection
- ‘patient appears anxious and low in mood’, ‘will ask us if he wants to talk’
- albumin 17, falling, remains pyrexial, CRP 280 rising

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Mr P

- ‘Discussed lots of surgical options’
- Discussed palliative option ‘treat sepsis, once better and jaundice settling home with NG tube and home PN or ‘No further intervention and best supportive care’
- Patient chooses no surgery, wants NG out and venting PEG, likely to go home with PN
- Referred to palliative care
- Wife concerned ‘he cannot be at home until much better’, ‘how will I check his fluid balance, ‘patient hoped to be ‘built up’ for chemo in future, 'I will be ok when I get home’

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Mr. P

- ‘he is continuing to deteriorate and has unrealistic expectations about the future and treatment. To enable him to go home, we need to have an honest conversation with him and his wife to enable him to plan his remaining time to ensure he does what he wants to do.’
- Palliative care arranged joint visit with HPB surgeon, frank discussion re prognosis of days to weeks, patient wants to die at home.
- He has not discussed dying or his wishes with his family, nor made a will.

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Mr. P

- Fast Track Discharge home, coordinating with hospice and GP
- Continuing HPN, antibiotics, NG drainage, PTC
- Deteriorating fast, risk of dying in ambulance to home
- Transferred and died at home the next day.

Palliative Care Adds

- Facilitated discussion re focus of care
- Agree realistic management plans, (DNA CPR, what is reversible?)
- Specialist liaison to support discharge. Family support

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When do Pancreatic Cancer Patients need Palliative Care?
Managing pancreatic cancer

1. Adult with pancreatic cancer
   - Nutritional management
   - Pain management

4. Psychological support

5. Relieving biliary and duodenal obstruction

6. Cancer treatment options
   - Resectable and borderline resectable pancreatic cancer
   - Unresectable pancreatic cancer
   - Supportive, palliative and end of life care
   - Locally advanced pancreatic cancer
   - Metastatic pancreatic cancer

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Summary - Palliative Care Adds

- Identify and refer patients in their last year of life
- Earlier palliative care leads to better outcomes for patients and families, which may include increased survival
- Palliative care works alongside acute treatments
- Changing focus of care, Holistic assessment, Symptom control
- Psychological support, patient and family
- Facilitating difficult conversations, staff support

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Thank you.

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