Where does palliative care fit into pancreatic cancer?

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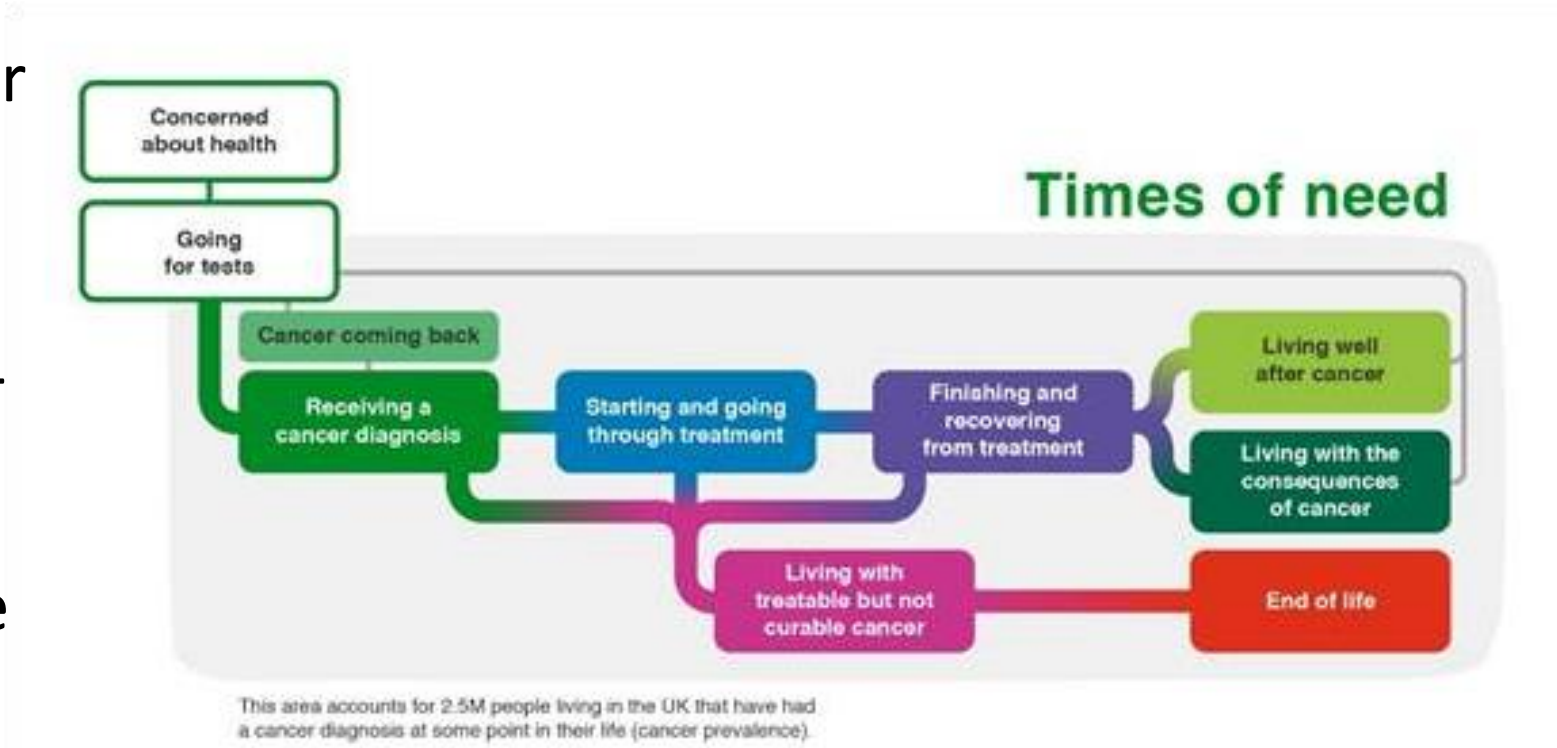
Acute cancer care is often a time of transition

- All acutely unwell cancer patients are at higher risk of death
- Pancreatic cancer often diagnosed later stages – possibly treatable but not curable
- When does this become end of life



Poll

What do you think end of life covers?

1) Last year
2) Last months
3) Last weeks
4) Last hours or days
5) All of the above

- 1 in 3 = last year of life, of which
- 1 in 10 = likely to die during admission

“Starting those difficult conversations about end of life needs and wants is challenging work for family members and for professionals”

- “Do I just send her home with some Oramorph and a prayer?”
- “Lets continue with IVABx for a further 48Hours”
- “Circling the plughole”
- “Is the patient imminently dying?”
- “I fear the situation is terminally grave”
- “Give 2 sensible shocks!”

Acute cancer care – it's a messy business

- Type 1 - diagnosis of cancer as an emergency

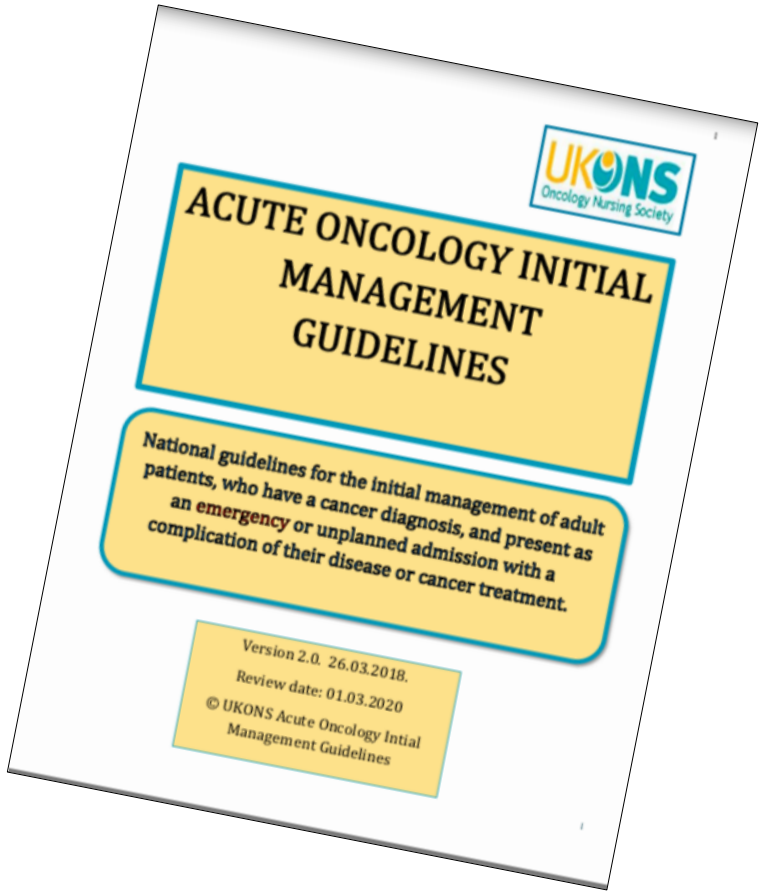
Eg Lung, brain tumours, GI. More likely to have advanced disease and less likely to have anticancer treatment

- Type 2 - complications of anti-cancer treatment

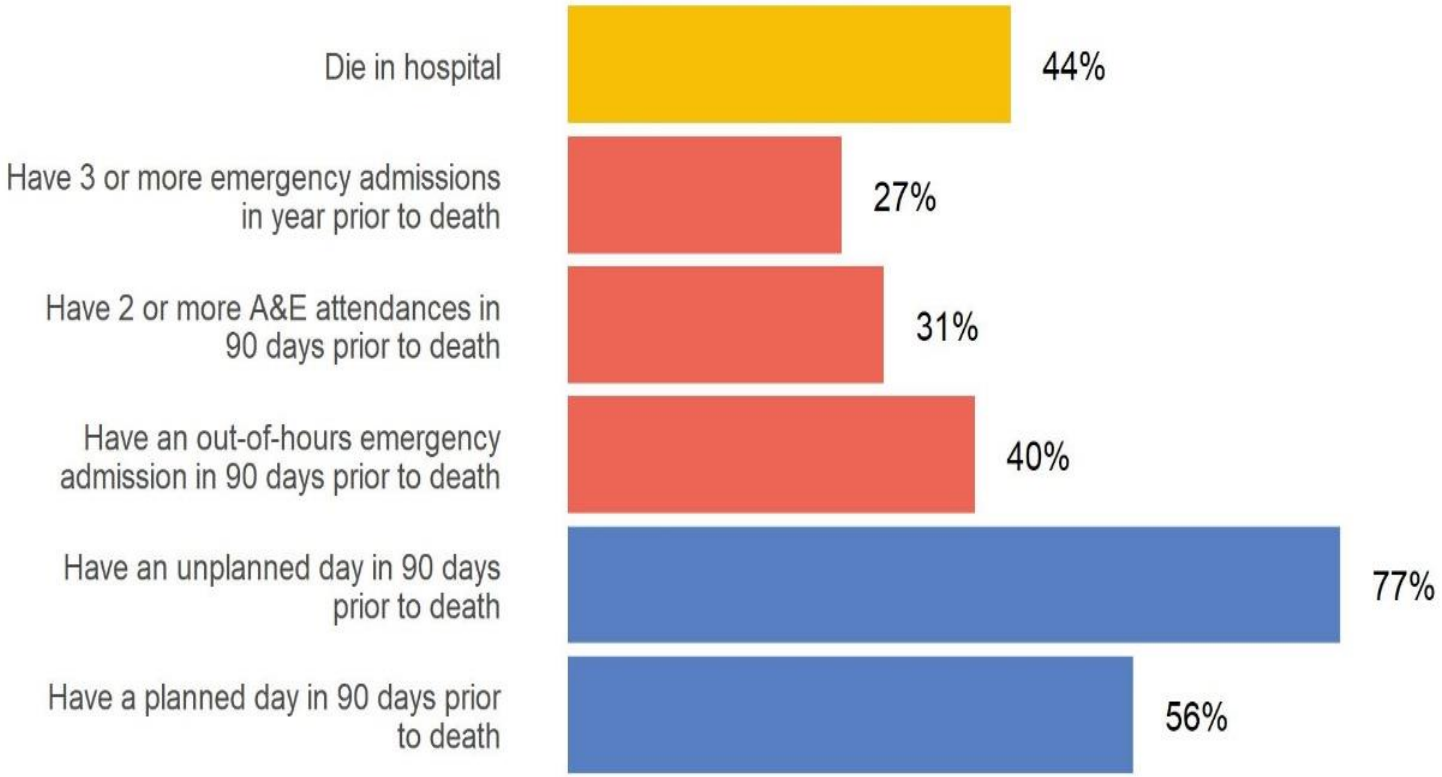
Neutropenic sepsis, complications of novel treatments, chemo issues.

- Type 3 - progression of disease or cancer as a bystander

Nearly 50% of acute cancer admissions, increasing with the age/frailty & co-morbidities of cancer populations



UK wide - presentation with uncontrolled or vague symptoms



Common presentations in acute oncology

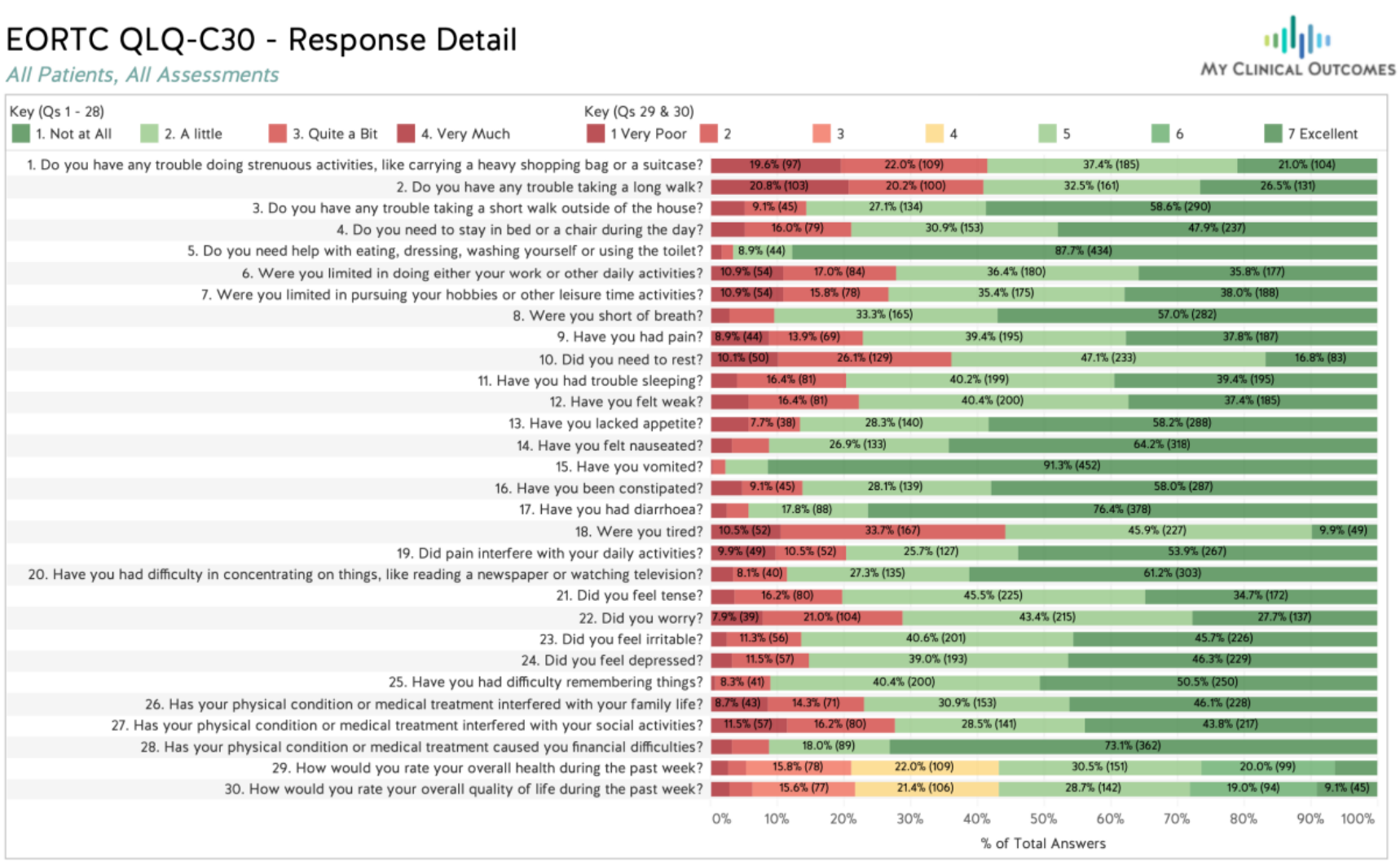
Presentation	Consider
Fatigue/generally unwell	> electrolyte disturbances > adrenal insufficiency* > hyperglycaemia > anaemia > hypothyroidism* *can be ICI/IO related, including hypophysitis
Shortness of breath	> pulmonary embolus > chest infection or sepsis > pneumonitis secondary to IO > cardiac failure including myocarditis > pulmonary spread of cancer
Fever	> febrile neutropenia > immunotherapy-related toxicity > indwelling line > disease related (nodal involvement)
Chest pain	> pulmonary embolus > pleurisy from infection > anaemia worsening angina > chemotherapy-induced coronary spasm
Nausea/vomiting	> chemotherapy related > constipation (may be due to hypercalcaemia) > electrolyte disturbance > low cortisol > bowel obstruction Ensure hydrated and sufficient anti-emetic treatment
Diarrhoea	> chemotherapy or radiotherapy related > ICI-induced colitis Do not give loperamide first line to patients on immunotherapy, as it will mask response
Headaches/new confusion	> brain metastases > hypercalcaemia > electrolyte disturbances > hypophysitis
Pain related to cancer/ metastases	Ensure effective analgesia, treatment of hypercalcaemia and treatment of side effects eg constipation

Poll

What are the most common symptoms in pancreatic cancer in your experience?

1) Pain
2) Vomiting
3) Loss of appetite / weight
4) Diarrhoea
5) Constipation
6) Ascites / +- bowel obstruction
7) Jaundice + – biliary obstruction
8) Symptom cluster of one or more

Symptom burden



Supportive Oncology

MY CLINICAL OUTCOMES

MCO is in use at the UHS oncology service with new pathways being added currently

NHS University Hospitals Sussex NHS Foundation Trust

- 6 hospitals, 51 clinicians, 420 patients, 15,000 PROMs to date
- Earlier supportive and palliative care
  - Intervene sooner and more effectively, reduce unplanned admissions
  - Improve QoL
- £1.20 - £1.40 returned per £1 invested
- Mean savings of £11.2M over 5 years if scaled regionally[7,8]
- RCP FIX IT prize winner 2023[9]

Monetised benefits included:

Unity Insights

- Reduction in non-elective admission rate
- Reduction in non-elective length of stay

Other benefits included:

- Proactive patient management with remote PROMs
- Earlier provision of supportive care for patients at end-of-life

https://www.myclinicaloutcomes.com/case-study/bsuh

"The service reduced length of stay and unplanned readmissions, and had a favourable benefit cost ratio—indicating return on investment…We think this should be a widely adopted service…"

BMJ Support Pall Care, June 2022

7. https://www.sciencedirect.com/science/article/abs/pii/S0936655521004350?dgcid=coauthor
8. https://www.unityinsights.co.uk/our-insights/enhanced-supportive-care
9. https://medicalcare.rcp.ac.uk/content-items/case-study/fix-it-prize-winner-2023-my-clinical-outcomes-mco/

Symptoms specific to pancreatic cancer

- Pain
- Fatigue
- Weight loss
- Diarrhea
- Nausea / vomiting
- Obstructive symptoms
- Biliary tree blockage / Jaundice

Practical tips

- Long-acting opioids – no reason not to start with morphine but be generous
- Low threshold for SC pumps if any question on absorption
- Low threshold to opioid switch
- Low threshold to add in neuropathic agent – my preference pregablin
- Always consider *short course* steroids

Stents from a palliative care perspective

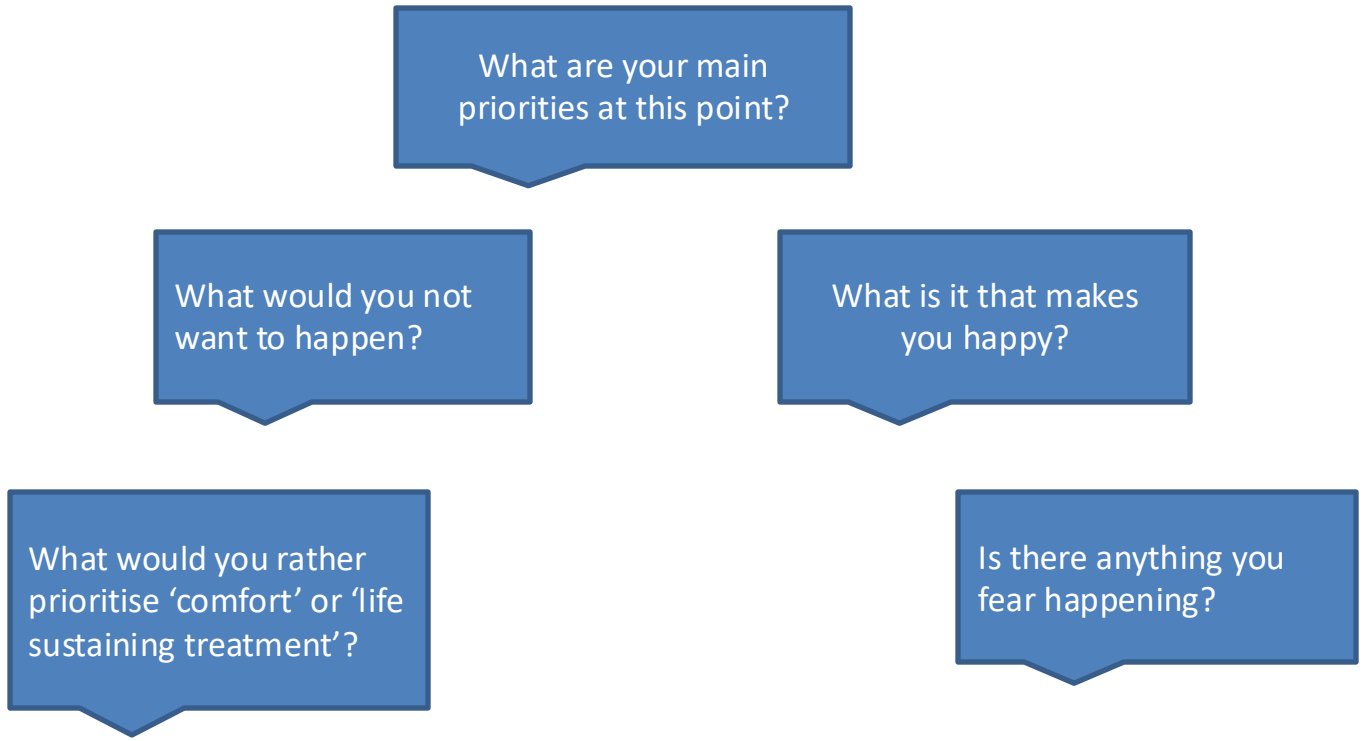
- Anything ERCP – especially if symptom relief + reducing biliary sepsis
- Duodenal stents – yes if fit
- Ascites – aim for an indwelling drain ASAP
- Recurrent ascites / jaundice / infection generally poor prognostic sign
- PTCs – not a fan

Practicalities

- Who best to have these conversations?
- Continuity of care/relationships
- How best to record?
- Fragmented health service
- Time
- Not a priority in outpatients
- Privacy on the ward
- Differing ethnic, religious, spiritual beliefs

‘Creating Conversations’

- **Language Matters:**
- There is no such thing as a “Ceiling of Care”
- Avoid any euphemism for dying



“Sick enough to die”
2nd Conversation

Why aren’t we getting it right?

- Cancer services developed as single disease services but cancer as a single diagnosis is now the exception not the norm and the number of people living with incurable cancer is increasing
- Hoping for the best but not planning for the worst – do novel treatments exacerbate this?
- Reliance on ‘the MDT’ for decision making – is this the right forum for complex decision making?

What happens when we don’t get it right?

- Poor staff and patient experience
- Increased length of stay
- Increased costs - Repeated admissions, excess treatment, multiple specialist interventions
- Poor communication leading to distress, delays
- Lack of prognostication and missed chances for advance care planning
- Loss of continuity of care

MDT working is key – Phone a friend / ask the (expert) audience

Key points

- Cancer patients are high users of urgent and emergency care services
- Presentations may represent symptoms of a new suspected cancer (type I), a complication of cancer treatment (type II) or a complication of a known cancer (type III)
- The majority of cancer presentations requiring an urgent or emergency response are common scenarios to health care professionals and include generally unwell, pain and suspected infection
- Health care professionals need to be aware of the possibility of an uncommon association with recent cancer treatment and should have ready access to local and regional specialist cancer single point of access including cancer treatment and palliative care helplines
- There are a number of readily available published tools and resources to guide cancer patient assessment and initial management
- Cancer patients will benefit from a more integrated offer of community urgent response

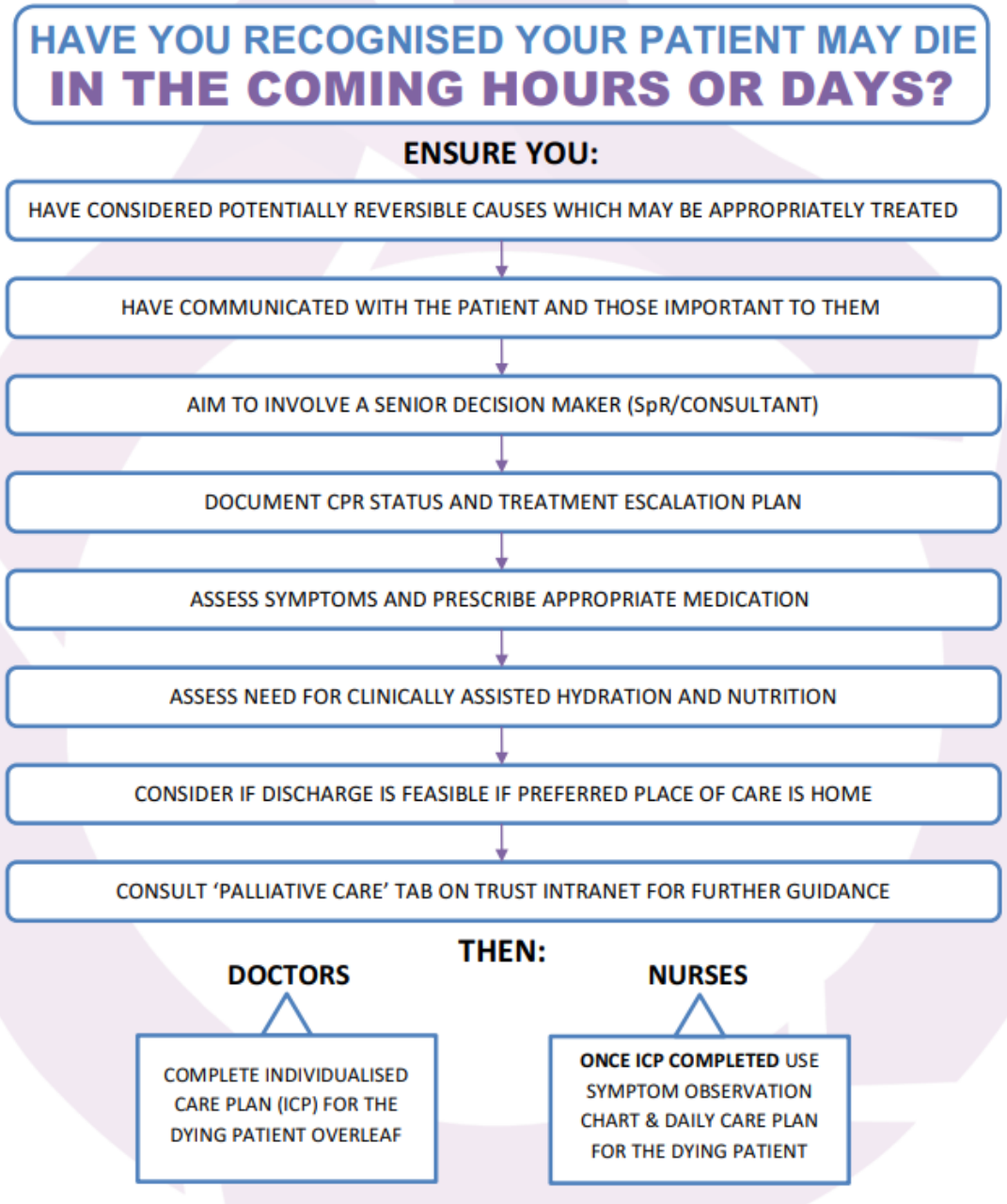
Part 2


JUST ASK
COULD THEY BE
DYING?

If the decision is for end-of-life care

- **Known**
  - Patients dying in hospital have variable access to and input from specialist palliative care (SPC) services.
  - Little is known of the care provided in the absence of such support.
- **Adds**
  - SPC would intervene in the care of more than half of those dying inpatients not referred for their services.
  - End-of-life care plans (EOLCP) appear to be a powerful support to non-specialists in providing end-of-life care in hospital.
- **Policy**
  - Encourage non-specialists in palliative care to consider whether their dying patients may benefit from SPC input.
  - Researching the most effective structure and function of EOLCP should improve the care received by patients managed by non-specialists.

What is the local picture?
(everyone has one)



Date patient was recognised as dying: ___/___/_____

Record observations at least 4 hourly

or affix patient ID sticker here

Month / Year	Date / Time													Date / Time
Pain (reported or observed)	3												3	3
	2												2	2
	1												1	1
	0												0	0
Nausea	3												3	3
	2												2	2
	1												1	1
	0												0	0
Vomiting	3												3	3
	2												2	2
	1												1	1
	0												0	0
Breathless-ness	3												3	3
	2												2	2
	1												1	1
	0												0	0
Respiratory Secretions	3												3	3
	2												2	2
	1												1	1
	0												0	0
Agitation/ Distress	3												3	3
	2												2	2
	1												1	1
	0												0	0
Other, if present (state) _____	3												3	3
	2												2	2
	1												1	1
	0												0	0
Mouthcare - confirm given														
HCA signature														HCA
Registered nurse signature														Reg Nurse
Doctor signature														Doctor

3 = Symptom present, does not resolve with PRN medication	Urgent doctor review of patient and care plan is required for any single symptom score of 3
2 = Symptom present, requires PRN medication to resolve	Care plan continues. If 3 consecutive symptom scores of 2 are present (for any symptom), urgent doctor review of patient and care plan is required
1 = Symptom present	Care plan continues, consider PRN medication
0 = Symptom absent or controlled with CSCI	Care plan continues

Judgement reviews after death

example: end-of-life care

ew Acute Medical Consultant reviews, indicates EOLC. Stops

AH	AI	AJ	AK
Indicates EOLC. Stops antibiotics, all medications now solely for symptom control. 7/1/22 Palliative care review 20mins after Acute Medical WR, who observed patient appeared restless with very laboured breathing. Syringe pump noted to be displaced and unclear if ever sited correctly or administering backround medication ('damp hospital gown') despite regular documented checks of syringe driver. PRN medications given and syringe driver resited and started. Called an updated family who visited. Died at 1600 in the last hours of his life Mick recieved appropriate individualised care for a dying person.	inadequately managed symptoms	several consultant reviews	
At 16:30 she was seen by another specialist registrar, who again assessed her thoroughly. She had responded to BIPAP, but expressed a clear wish to remove the BiPAP mask, even though she understood that this might lead to her death. Again, this SPR discussed the issue with her husband and agreed to keep the BiPAP mask on until he was bale to visit her. After this, BiPAP was removed, the patient was recognised as dying and a symptom observation chart for the dying patient was started. Her symptoms were (twice) recorded as being well controlled. No individualised care plan for a dying person was completed, though most aspects of this were addressed in the medical (and to some extent	dying recognised	no ICPDP	
Delirium occured on the intensive Care unit due to acute illness with congestive cardiac failure and pneumonia. This led to difficulties in managing complex Parkinson's disease at the end of life.	managing chronic conditions at end of life	?was dyign recognised	escalation to ITU ?approp ate
Good care of dying person with symptoms managed with Syringe Pump Clear communication with his friend	CSCI given	communication good	

home eolc, **Tep** consulted and made, **symptom** obs , **transfer** to appropriate setting for eolc **ICP** instituted compassion noted, **person centered approach** noted, cons **review** within 24hrs, putative **diagnosis** made, under section, family discussion **nosocomial infection**, pressure damage, **multiple ward moves**, lack of **documentation** between transfers bed moves need for **recognition** of dementia care needs, **absence of holistic care** **Tep** absent, no **frailty** diagnosis, management plan made, **alliative care input** , senior reviews, , **no recognised palliative care need** is, decision for surgery from decision to operate lack of **gnition of frailty**, management mplications

ime to clerking, pmhx noted, **frailty** completed, **Tep** not completed, seen by cons in 24hrs, **severe frailty** identified , wishes not to be investigated , no **anticipatory** prescribing need for 7/7 pall care input , recognised only as **actively dying** , , **consultant review** , lack of notes re anticipatory prescribing , **deterioration**, **met call** , **itu review**, ?tep , lack of tep notation **diagnosis made** , **severity** not **appreciated** , **absence** of **consultant** handover, unclear handovers , **cardiac arrest**, breach in ED missign senior review , absent TEP , absent DNACPR ,

End of life care

Dying formally recognised

EOLC prescribing

DNACPR completed

TEP adjusted

CPDP

Symptom obs

Family, patient discussions

Wishes

Holistic care?

End of life care

Dying cannot be recognised in all patients, but in those for whom it is clinically appropriate, dying should be recognised and documented. If it is clinically appropriate, a programme of end-of-life care may be started at this time. Specialist palliative care teams may be involved in end-of-life care, or advanced care planning. There are clear NICE quality standards for end-of-life care which inform this guidance.

Theme	Very poor	Poor	Adequate	Good	Excellent
Dying recognised and documented	Dying not recognised, with inappropriate intervention and/or escalation leading to potential or real harm to patient, family and staff. This is particularly important if	Dying not recognised when clinically appropriate, with inappropriate intervention or escalation given clinical status. This has the potential to harm patients, family, and staff.	Dying recognised and documented as appropriate	Dying is recognised and documented, with appropriate interaction with patient and loved ones	Recognition of dying process is clear and clearly documented, is rational and understood by whole team This recognition is breached with patient/family/loved ones as appropriate ACP/EOLC planning is enacted appropriately and quickly
	family, patient or loved ones have recognised dying, and clinical teams do not enact patient-centred care in these situations.				
EOLC prescribing		Absent or inappropriate prescribing at the end of life Prescribing not in accordance with NICE guidance, without clear reason	Prescribing broadly in accordance with NICE guidance: *care of dying adults in last days of life* or local guidance as appropriate	Prescribing is appropriate and patient-centred, with end-of-life needs recognised and managed appropriately	Evidence of judicious use of medication, including (as appropriate) deprescribing, alteration of medication and use of anticipatory medications Prescribing in accordance with NICE guidance: *care of dying adults in last days of life*
DNACPR and TEP	Evidence that advanced care plans are completed	DNACPR or TEP not completed or considered in		Attempts made to consider advanced care	(If appropriate) once dying recognised and felt to be irreversible, evidence of completion or consideration

When a person living with cancer is admitted into hospital as an emergency, this often marks a turning point in their illness. Healthcare professionals should:

See it – recognise an acute admission as a point of transition for many people living with cancer.

Say it – take the opportunity to talk to the person and their family about what matters to them, acknowledge risk of deterioration, their fears, plan ahead to manage common symptoms & reduce future admissions.

Share it – ensure this conversation is the basis of an advance care plan to be shared more widely.

See it, say it, share it

Recognising acute hospital admission as a key milestone in the treatment journey of a person living with cancer

April 2023

In January 2023, Macmillan Cancer Support, the Royal College of Physicians (RCP), the Society for Acute Medicine and the UK Acute Oncology Society organised a multi-professional meeting at The Spine to discuss the impact of acute admission on people living with cancer.

Key call to action: Every person living with cancer admitted into hospital through an urgent or emergency care pathway should be offered a conversation about contingency planning, their prognosis and future care plan by a healthcare professional.

Why is this important?

An acute hospital admission for a person living with cancer can be an important turning point in their illness. **People dying of cancer are at higher risk of acute hospital admission towards the end of their life** and for people with three or more emergency admissions in the last 3 months of life, **more than half have cancer as the underlying cause of death**. An emergency admission is a flag for readmission risk.

MACMILLAN CANCER SUPPORT

Royal College of Physicians

UKAOS UK Acute Oncology Society

sam THE SOCIETY FOR ACUTE MEDICINE

“How people die remains in the memory of those who live on”