Effects of Early Integrated Palliative Care in Patients with Lung and GI Cancer: A Randomized Clinical Trial

Presented by: Serena Rix, Pharmacist, January 4th, 2017


ABSTRACT

Purpose: We evaluated the impact of early integrated palliative care (PC) in patients with newly diagnosed lung and GI cancer.

Patients and Methods: We randomly assigned patients with newly diagnosed incurable lung or non-colorectal GI cancer to receive either, early integrated PC and oncology care (n = 175) or usual care (n = 175) between May 2011 and July 2015. Patients who were assigned to the intervention met with a PC clinician at least once per month until death, whereas those who received usual care consulted a PC clinician upon request. The primary end point was change in quality of life (QOL) from baseline to week 12, per scoring by the Functional Assessment of Cancer Therapy-General scale. Secondary end points included change in QOL from baseline to week 24, change in depression per the Patient Health Questionnaire-9, and differences in end-of-life communication.

Results: Intervention patients (v usual care) reported greater improvement in QOL from baseline to week 24 (1.59 v 23.40; P = .010) but not week 12 (0.39 v 21.13; P = .339). Intervention patients also reported lower depression at week 24, controlling for baseline scores (adjusted mean difference, 21.17; 95% CI, 22.33 to 20.01; P = .048). Intervention effects varied by cancer type, such that intervention patients with lung cancer reported improvements in QOL and depression at 12 and 24 weeks, whereas usual care patients with lung cancer reported deterioration. Patients with GI cancers in both study groups reported improvements in QOL and mood by week 12. Intervention patients versus usual care patients were more likely to discuss their wishes with their oncologist if they were dying (30.2% v 14.5%; P = .004).

Conclusion: For patients with newly diagnosed incurable cancers, early integrated PC improved QOL and other salient outcomes, with differential effects by cancer type. Early integrated PC may be most effective if targeted to the specific needs of each patient population.

Strengths of study
Randomized clinical trial with 350 participants, used validated tools (FACT-G, PHQ-9 & HADS depression and anxiety scales) and no conflicts of interest identified.

Weaknesses of study:
The authors identified several limitations to the study. Blinding was impossible. The authors did not anticipate a difference between the lung cancer and GI cancer groups, thus the sub-group analysis is under-powered. The study was conducted at a single center where PC is commonly integrated into usual care, the PC effect may not be as evident as many of the control group received PC. It was also felt that the high intensity of PC at the center for at least 10 years may have enhanced the PC skills of the oncologists, again leading to a possible diminished response in the intervention arm. Having only a single center in the United States participating in this trial may reduce the generalizability of the study especially to other countries, including Canada, with different health-care systems.
The study looked at scores at baseline, 12 weeks and 24 weeks but did not comment on how close to death the patients were at those times. Table 3 provided scores at 2, 4 & 6 months before death, but not the number/percentage of patients in each groups. HADS scores (depression & anxiety) were not reported.

**Relevance to palliative care:**
Lung and GI cancers are common and frequently symptomatic. This study tried to determine if early palliative care improved QOL in both lung and GI cancers. Although the authors determined early PC provided benefit, the lung group appeared to have responded better from the intervention while the effect on the GI group was less conclusive.
While there may be some merit in determining which tumor groups are more likely to benefit from early PC interventions, we need to recognize that any cancer diagnosed at an advanced stage may require prompt attention from the palliative team. We must also be mindful that palliative patients frequently suffer from several issues, varying in intensity, which may be multi-factorial in nature. Therefore, PC must be personalized to patients’ individual needs, in keeping with both their goals of care and their belief systems. Patients should be frequently assessed for symptom burden and adequately educated about the role of PC to ease symptoms at any stage of the disease trajectory as well as providing end-of-life care at the appropriate time, which may be many years away.