早期緩和療護導讀

張正雄
彰濱秀傳紀念醫院

Agenda

- What's early palliative care?
- Why they need early palliative care?
- What is the efficacy?
- Integration of palliative care into standard oncology

What's palliative care ?

Patient-Centred Focus – 安寧

The modern **hospice** movement began in the UK in the 1960s. Cicely Saunders, a 20th century British nurse and social worker, was responsible for the formation of the core tenets applied in hospices around the world through her experiences at St Luke's Home.

The concepts of "total pain", including physical, spiritual, and psychological discomfort; the proper use of opioids for patients with physical pain; attention to the needs of "family members and friends who provide care for the dying",

Patient-Centred Focus – 緩和

The term **palliative care** (in the setting of treatment given with the goal of symptom relief) was probably first coined by the Canadian surgeon Balfour Mount in 1974.

Three main features were developed, namely, multidimensional assessment and management of severe physical and emotional distress; interdisciplinary care by multiple disciplines in addition to physicians and nurses; emphasis on caring not only the patients but also for their families .

Patient-Centred Focus - 支持性

Supportive care emerged as a concept and care approach in the late 1980s, somewhat later than palliative care, but with a similar focus on the individual patient with cancer, the host, not the tumour.

A new medical discipline aiming to provide predominantly cancer patients with support for the management of “treatment-related effects”

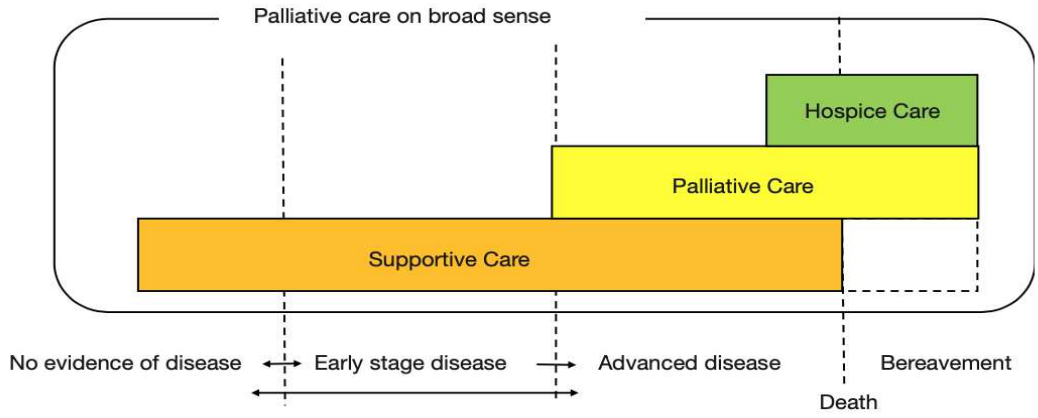
Definition of palliative care in 2002 declared by WHO - 定義

- 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
- 生活品質/ 身心靈

Five Main Ideas

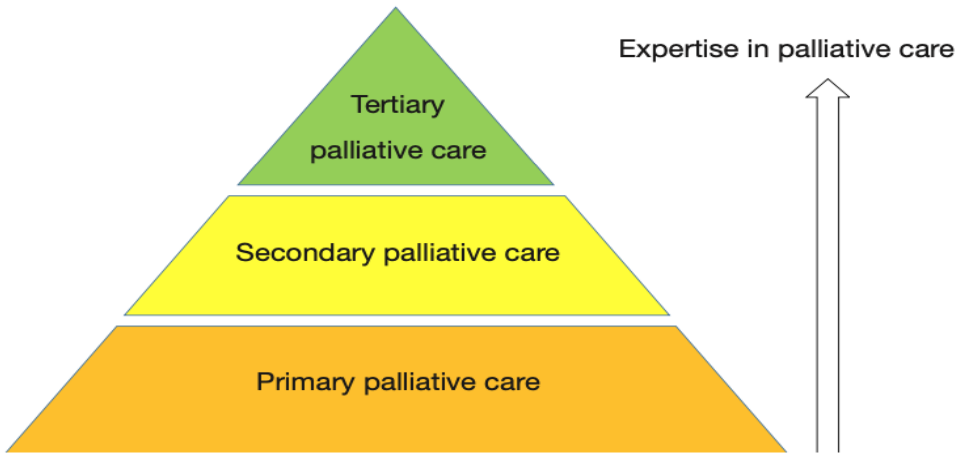
- (I) QOL focused approach - 生活品質
- (II) Whole-human approach - 全人
- (III) Care that encompasses both the patient and those involved with the patient (particularly caregivers) - 全家
- (IV) Respect patient autonomy and choice
- (V) Support people through frank and thoughtful discussions on difficult subjects - 全程

Palliative care classification models – *Time-based model* 時間點模式



Y Saga, et al. Chin Clin Oncol 2018;7(3):32

Provider-based model 服務提供者模式



Y Saga, et al. Chin Clin Oncol 2018;7(3):32

Why they need early palliative care?

Advocacy for early palliative care –
2010, Temel *et al.* announced a clinical trial concerning "early palliative care" in the *NEJM*

The NEW ENGLAND JOURNAL of MEDICINE

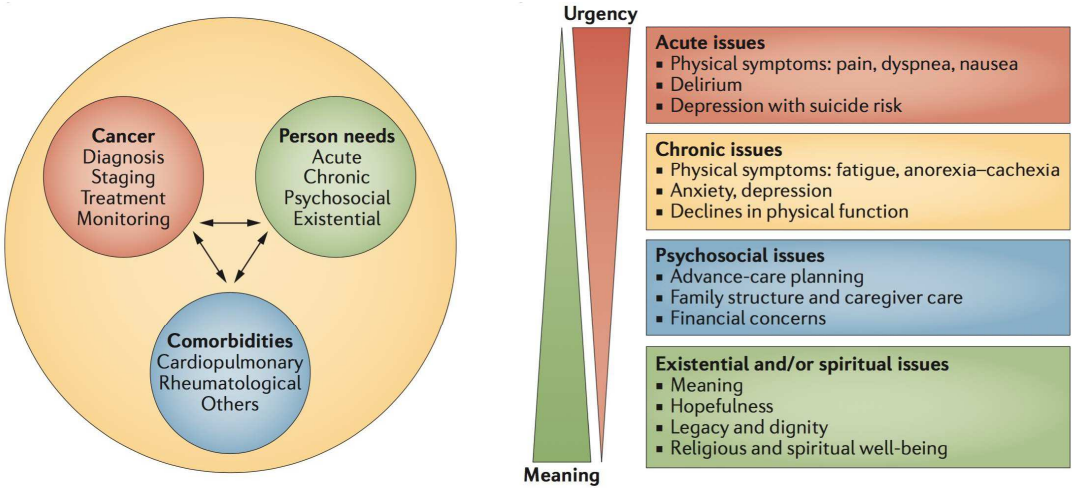
ORIGINAL ARTICLE

Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer

Jennifer S. Temel, M.D., Joseph A. Greer, Ph.D., Alona Muzikansky, M.A., Emily R. Gallagher, R.N., Sonal Admane, M.B., B.S., M.P.H., Vicki A. Jackson, M.D., M.P.H., Constance M. Dahlin, A.P.N., Craig D. Blinderman, M.D., Juliet Jacobsen, M.D., William F. Pirl, M.D., M.P.H., J. Andrew Billings, M.D., and Thomas J. Lynch, M.D.

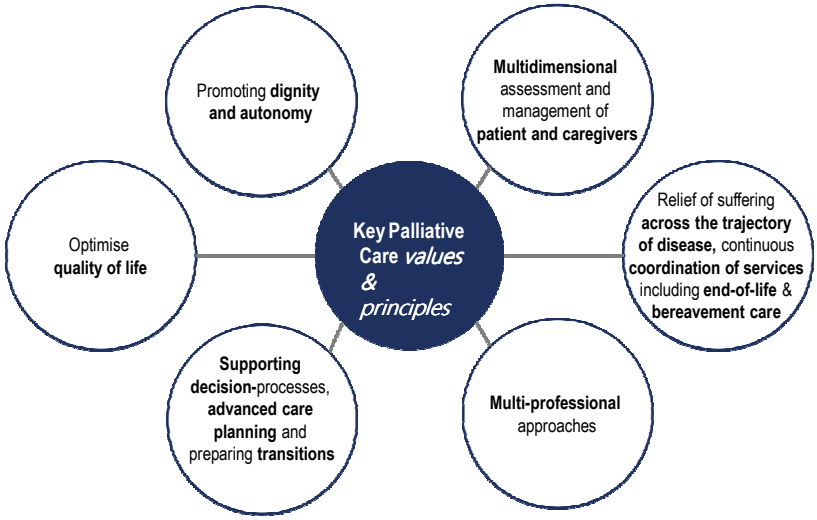
APPROACH TO THE PATIENT WITH INCURABLE CANCER

Palliative care needs in oncology 癌症患者緩和療護的需求



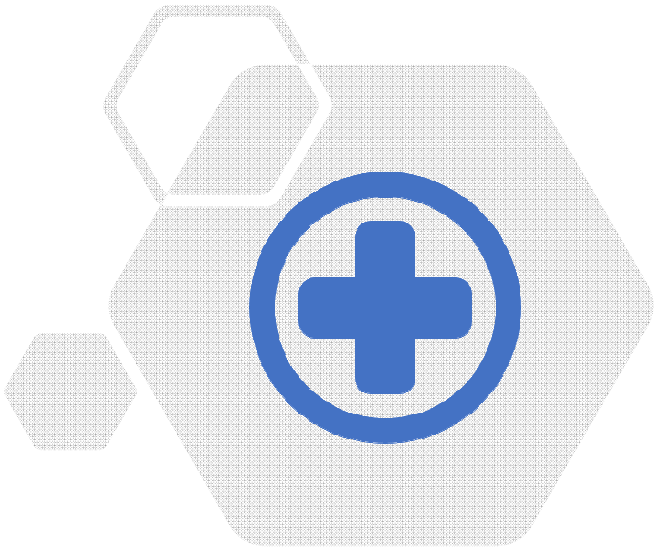
Hui D, and Bruera E, Nat Rev Clin Oncol 2016;13(3):159-171. Reprinted by permission from Mcmillan Publishers Ltd, copyright 2016

CONTENTS AND TIMEFRAME OF PALLIATIVE CARE



Lorenz KA, *et al.,* Ann Int Med 2008;148:147–59; Tieman J, *et al.,* J Clin Oncol 2008;26:56-79

What is the efficacy?



Early, Integrated Palliative Care in Patients with Metastatic Lung Cancer

肺癌照護臨床實證

150 patients with newly diagnosed metastatic NSCLC

- Early palliative care integrated with standard oncology care
- Standard oncology care

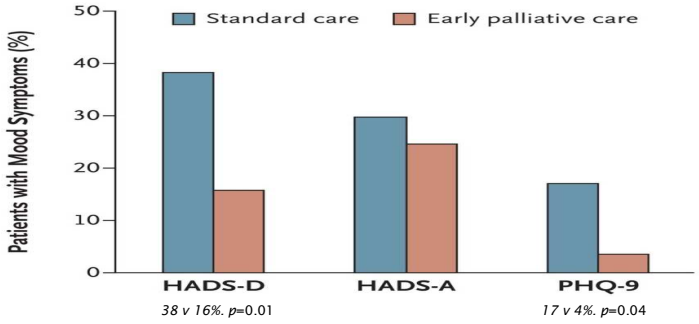
Palliative Care Model

- Palliative care provided by physicians and nurse practitioners
- Visits occurred in the Cancer Center (medical oncology, radiation oncology or chemotherapy visits).
- Oncology and palliative care visits were done in tandem or simultaneously.
- Visits were not scripted or prescribed.
- If patients were admitted to the hospital, they were followed by the palliative care team

Temel NEJM 363 (8) 2010

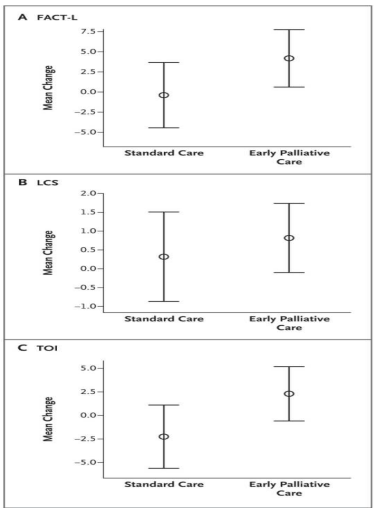
Impact of Early Palliative Care on Patient Reported Measures

Variable	Standard Care (N=47)	Early Palliative Care (N=60)	Difference between Early Care and Standard Care (95% CI)	P Value†	Effect Size‡
FACT-L score	91.5±15.8	98.0±15.1	6.5 (0.5–12.4)	0.03	0.42
LCS score	19.3±4.2	21.0±3.9	1.7 (0.1–3.2)	0.04	0.41
TOI score	53.0±11.5	59.0±11.6	6.0 (1.5–10.4)	0.009	0.52

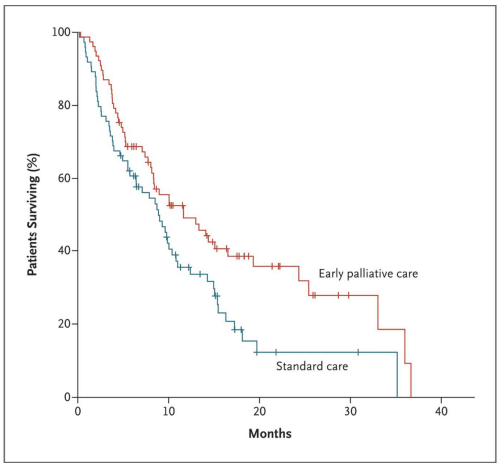


Temel NEJM 363 (8) 2010

Change in QoL and Patient's Survival
生活品質與存活率的差異



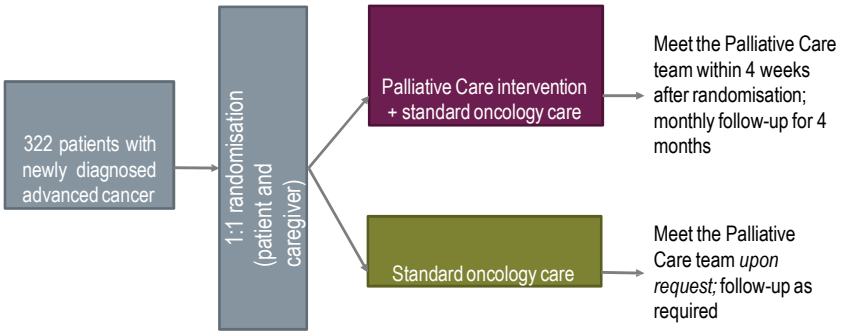
Mean Change in Quality-of-Life Scores from Baseline to 12 Weeks in the Two Study Groups.



Kaplan–Meier Estimates of Survival According to Study Group.

BENEFITS OF EARLY PALLIATIVE CARE

ENABLE II trial 於晚期癌症的效益



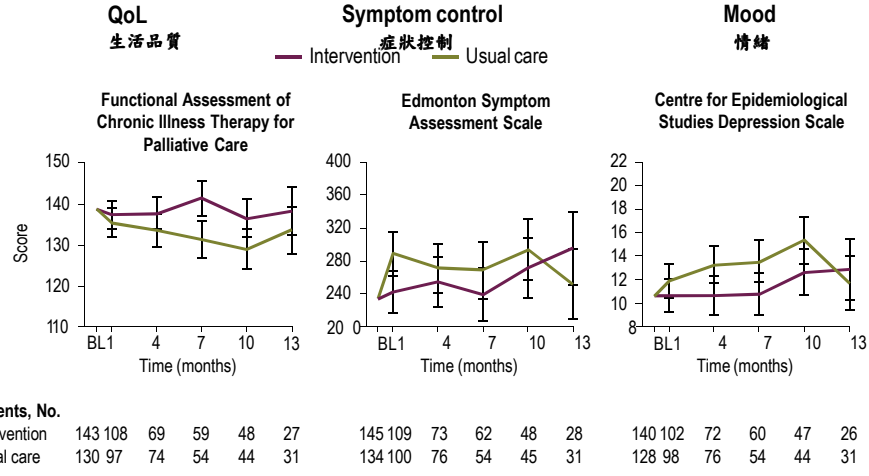
Primary endpoints: patient-reported quality of life (QoL), symptom intensity, and resource use

Secondary endpoint: mood

Bakitas M, *et al.*, JAMA, August 19, 2009; 302 (7): 741-749

BENEFITS OF EARLY PALLIATIVE CARE

Patient outcomes



Patients, No.

Intervention	143	108	69	59	48	27
Usual care	130	97	74	54	44	31
Intervention	145	109	73	62	48	28
Usual care	134	100	76	54	45	31
Intervention	140	102	72	60	47	26
Usual care	128	98	76	54	44	31

Bakitas M, *et al.*, JAMA, August 19, 2009—Vol 302, No. 7

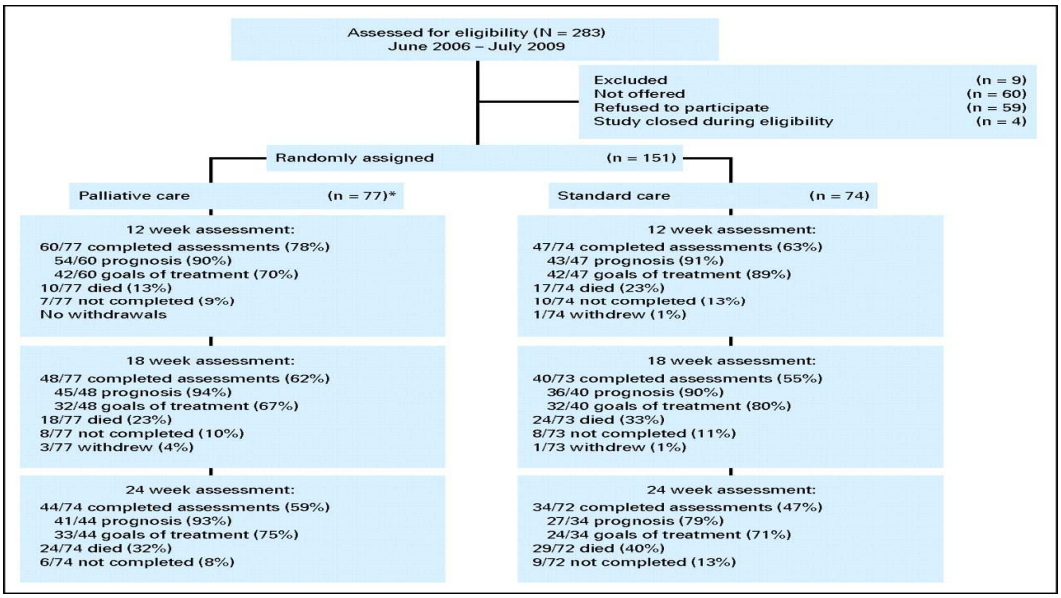


*Fig 1. CONSORT diagram. *One patient randomly assigned to standard care was erroneously assigned to early palliative care at the time of random assignment and therefore is included in the early palliative care study group.*

Published in: Jennifer S. Temel; Joseph A. Greer; Sonal Admane; Emily R. Gallagher; Vicki A. Jackson; Thomas J. Lynch; Inga T. Lennes; Connie M. Dahlin; William F. Pirl; *Journal of Clinical Oncology* 2011 292319-2326.
DOI: 10.1200/JCO.2010.32.4459

Chemotherapy Utilization
化療的利用率

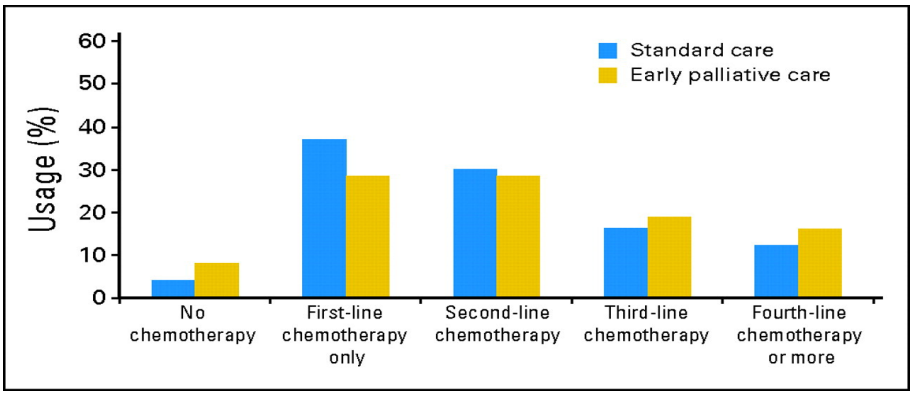


Fig 2. Chemotherapy use between study groups in entire sample (n = 147). Rates of chemotherapy use did not differ significantly between groups for participants who received no chemotherapy (standard care [SC], three of 73 [4.1%] v early palliative care [PC], six of 74 [8.1%]; P = .49); first line only (SC, 27 of 73 [37.0%] v early PC, 21 of 74 [28.4%]; P = .30); second line (SC, 22 of 73 [30.1%] v early PC, 21 of 74 [28.4%]; P = .86); third line (SC, 12 of 73 [16.4%] v early PC, 14 of 74 [18.9%]; P = .83); and fourth line or more (SC, nine of 73 [12.3%] v early PC, 12 of 74 [16.2%]; P = .64). Four participants had missing chemotherapy data because they transferred care to other institutions, reducing sample size from 151 to 147.

Published in: Joseph A. Greer; William F. Pirl; Vicki A. Jackson; Alona Muzikansky; Inga T. Lennes; Rebecca S. Heist; Emily R. Gallagher; Jennifer S. Temel; *Journal of Clinical Oncology* 2012 30394-400.
DOI: 10.1200/JCO.2011.35.7996

Chemotherapy Utilization
化療的利用率

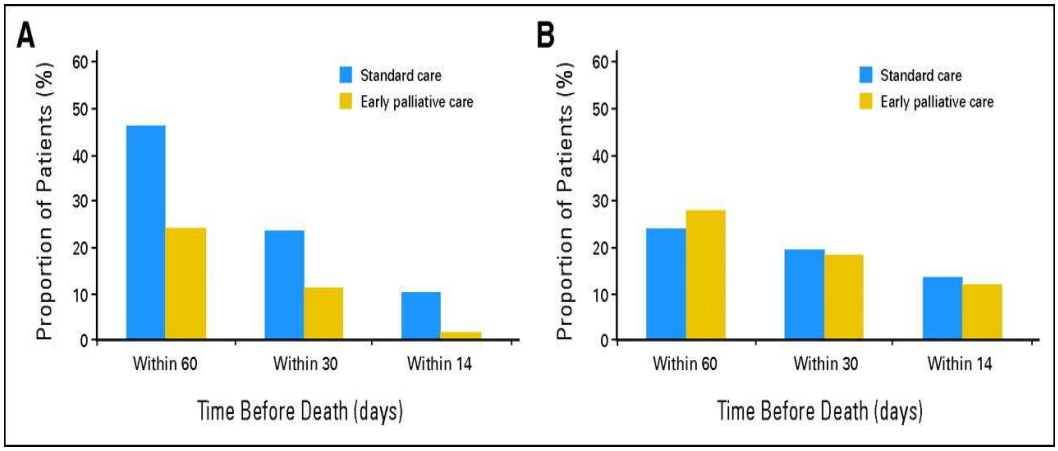


Fig 3. Administration of final regimen of (A) intravenous and (B) oral chemotherapy at end of life (n = 129). Within 60 days of death, a significantly greater percentage of patients were receiving intravenous chemotherapy as final regimen in standard-care (SC) group compared with early palliative care (PC) group (SC, 31 of 67 [46.3%] v early PC, 15 of 62 [24.2%]; P = .01). Finding remained similar within 30 days (SC, 16 of 67 [23.9%] v early PC, seven of 62 [11.3%]; P = .07) and 14 days of death (SC, seven of 67 [10.4%] v early PC, one of 62 [1.6%]; P = .06), although not quite meeting threshold for statistical significance. Percentages of patients receiving oral chemotherapy did not differ significantly between groups within each of three time frames (all P values ranging from .67 to > .99).

Published in: Joseph A. Greer; William F. Pirl; Vicki A. Jackson; Alona Muzikansky; Inga T. Lennes; Rebecca S. Heist; Emily R. Gallagher; Jennifer S. Temel; *Journal of Clinical Oncology* 2012 30394-400.
DOI: 10.1200/JCO.2011.35.7996

Costs at End of Life by Category
生命終期的花費

	Standard Care N=65	Early Palliative Care N=60	Cost Difference
Inpatient Visits			
% of patients	46%	38%	
Mean cost (SD)	$12,665 (20,580)	$9,555 (17,275)	**$3,110**
Outpatient Visits			
% of patients	80%	77%	
Mean cost (SD)	$1,415 (1,649)	$1,683 (2,027)	**$268**
Chemotherapy			
% of patients	42%	28%	
Mean cost (SD)	$1,654 (1,654)	$1,014 (1,913)	**$640**
Hospice Services			
% of patients	65%	70%	
Mean cost (SD)	$1,808 (2,117)	$2,933 (4,011)	**$1,125**

Greer ASCO 2012

Early palliative care might have more beneficial effects on quality of life and intensity of symptoms among patients with advanced cancer than among those given usual or standard cancer care alone. The effects are of clinical relevance for patients at an advanced disease stage with limited prognosis, when further decline in quality of life is the rule.

Early palliative care for adults with advanced cancer (Review)

Haun MW, Estel S, Rücker G, Friederich HC, Villalobos M, Thomas M, Hartmann M

Haun_et_al-2017-Cochrane_Database_of_Systematic_Reviews

Benefits of early Palliative Care
早期療護的整體效益

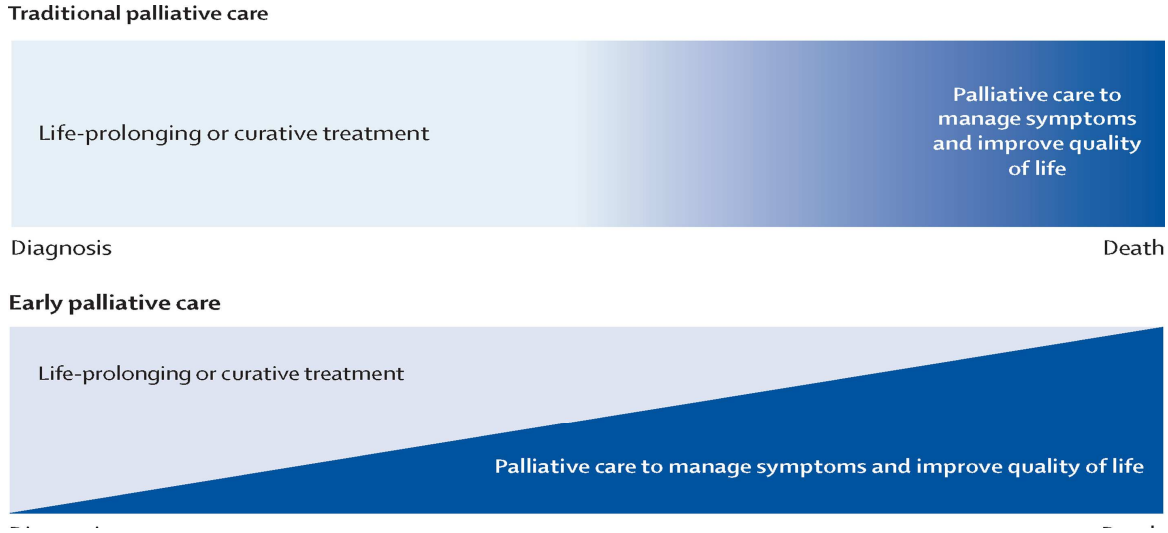
- Improved QOL,
- Quality of end-of-life care,
- Decreased rates of depression,
- Illness understanding,
- Patient satisfaction

Integration of palliative care into standard oncology care

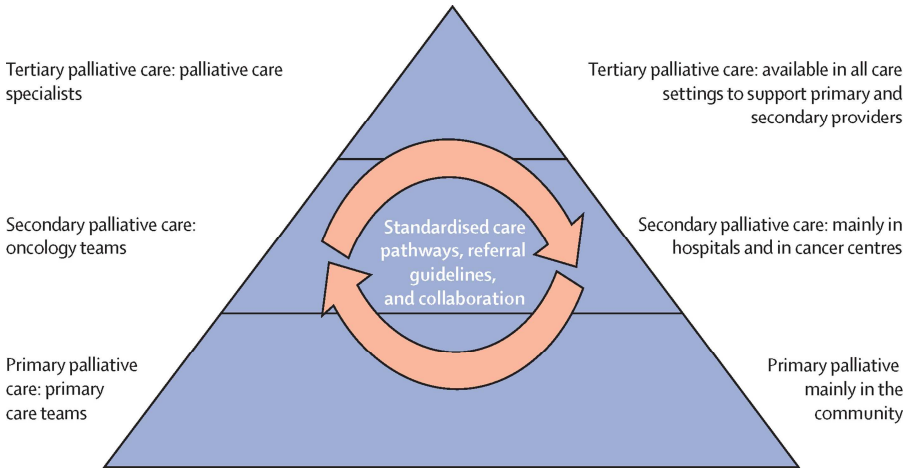
ASCO Guideline

- The guideline states that, "*Inpatients and outpatients with advanced cancer should receive dedicated palliative care services, early in the disease course, concurrent with active treatment*", and
- Strongly recommends "*Integration of palliative care into standard oncology care*".
- 疾病早期與急性治療並存

Traditional versus early palliative care

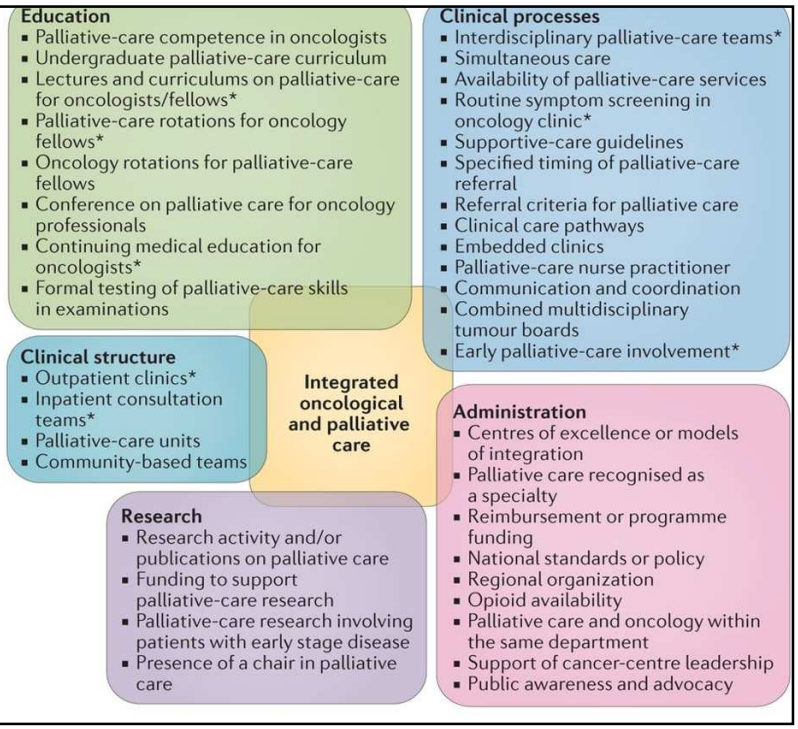


Proposed model of optimal oncology palliative care provision, including integration across providers and settings (全醫療系統整合)



Indicators of successful integration of palliative care into oncology practice

請注意八個打星號的重要指標



ORIGINAL RESEARCH

Early Palliative Care for Oncology Patients: How APRNs Can Take the Lead

HEIDI MASON,[1,2] DNP, ACNP-BC, MARY BETH DERUBEIS,[2] MSN, FNP-BC, and BETH HESSELTINE,[2] MSN, FNP-C

Abstract

Background: Patients with cancer need expert and multidisciplinary care throughout the trajectory of their illness. Palliative care should be instituted early in the course of their disease. Early palliative care enables patients and their families to control physical, psychological, social, and spiritual symptoms of the disease. In our current health-care system, early palliative care is not being integrated due to a lack of education of providers and nurses, an infrastructure that does not support palliative medicine, and poor communication skills among practitioners. **Methods and Results:** The Palliative Care Quiz for Nursing (PCQN) completed by nurse practitioners at a large Midwest cancer center found that those nurse practitioners had a poor understanding of the basic precepts of palliative care. This is consistent with the current literature. **Conclusion:** Advanced practice nurses should be educated on the principles of palliative care, as they are perfectly situated to advance the integration of early palliative care in the oncology setting.

J Adv Pract Oncol 2021;12(5):477–484

Table 3. Criteria for Palliative Care Assessment at Time of Admission[35]

Criterion*
Primary†
Surprise question: You would not be surprised if patient died within 12 months or before adulthood[23-25]
Frequent admissions (eg, > one admission for same condition within several months)[26-30]
Admission prompted by difficult-to-control physical or psychological symptoms (eg, moderate to severe symptom intensity for > 24 to 48 hours)[6,31]
Complex care requirements (eg, functional dependency; complex home support for ventilator, antibiotics, feedings)[6]
Decline in function, feeding intolerance, or unintended decline in weight (eg, failure to thrive)[6,31]
Secondary‡
Admission from long-term care facility or medical foster home§
Elderly patient, cognitively impaired, with acute hip fracture[32,34-36]
Metastatic or locally advanced incurable cancer[37]
Chronic home oxygen use§
Out-of-hospital cardiac arrest[38,39]
Current or past hospice program enrollee§
Limited social support (eg, family stress, chronic mental illness)§
No history of completing advance care planning discussion or document[6,31]

NOTE. Adapted with permission.[35]
*In addition to potentially life-limiting or life-threatening condition.
†Primary criteria are global indicators that represent minimum that hospitals should use to screen patients at risk for unmet palliative care needs.
‡Secondary criteria are more-specific indicators of high likelihood of unmet palliative care needs and should be incorporated into systems-based approa
patient identification if possible.
§These indicators are included based on panel consensus opinion.

Summary of Recommendations

- **CLINICAL QUESTION 3**
- How is palliative care in oncology defined or conceptualized?

- ***Recommendation 3***
- Patients with advanced cancer should receive palliative care services, which may include a referral to a palliative care provider. Essential components of palliative care include:
  - rapport and relationship building with patient and family caregiver(s)
  - symptom, distress, and functional status management (i.e. pain, dyspnea, fatigue, sleep disturbance, mood, nausea, or constipation)
  - exploration of understanding and education about illness and prognosis
  - clarification of treatment goals
  - assessment and support of coping needs (e.g., provision of dignity therapy)
  - assistance with medical decision making
  - coordination with other care providers
  - provision of referrals to other care providers as indicated.
- For newly diagnosed patients with advanced cancer, the Expert Panel suggests early palliative care involvement, starting early in the diagnosis process and ideally within 8 weeks of diagnosis (Type: informal consensus; Evidence quality: intermediate; Strength of recommendation: moderate).

www.asco.org/palliative-care-guideline

目的，原則與目標
（彰濱團隊為例）

目的

減輕痛苦，促進舒適

維護病人自主控制權

原則

針對痛苦和不適症狀提供解除方案

整合病人與家屬心理和靈性層面的照顧

目標

協助病人及其家屬獲得罹病後最佳的生活品質

服務項目

提供緩和照護的團隊服務

提供疾病治療流程與預後的充分資訊

面對死亡威脅的心理輔導與價值觀的再澄清

促進病人與家屬，病家與原治療團隊間之互動與了解

瀕臨死亡前後提供家屬支持及生活模式重建，並轉介安寧團隊的延續照護

緩和照護收案標準

新診斷晚期癌症病人

身體上有較嚴重的疾病症狀或心理、社會及靈性方面的照顧需求

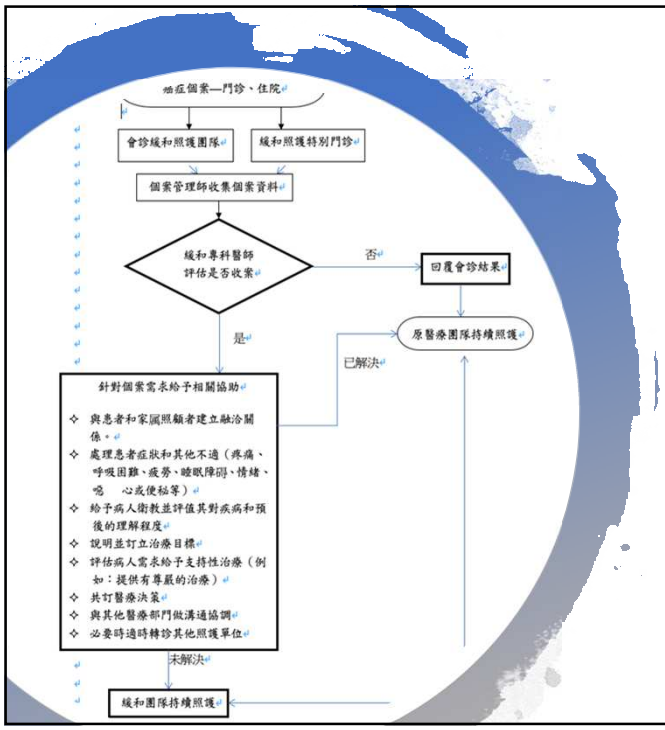
病人與家屬對於疾病，治療目標與預後的認知不足

病人對於治療的選擇與疾病惡化後的處理模式，明顯有下決定上的困難

家屬與病人，病家與原治療團隊間對於治療流程與目標有溝通上的問題

緩和照護團隊之醫療團隊成員

- 癌症緩和專科醫師、藥師、心理師、營養師、社工員、個案管理師等。



收案流程

緩和照護團隊篩選量表

緩和照護團隊篩選量表	這件事對你的生活所造成的影響程度?
1. 得了癌症之後，我每日的活動量是: □ 正常 □ 減少了一點 □ 減少，但每日在床上的時間不會超過一半 □ 大量減少，而且每日有超過一半的時間在床上 □ 嚴重減少，而且一天大部分時間在床上	□ 完全不會 □ 中度影響 □ 嚴重影響
2. 得了癌症之後，我可以做: □ 所有我想做的事 □ 大部分我想做的事 □ 很多我想做的事 □ 部分我想做的事 □ 完全不能做我想做的事	□ 完全不會 □ 中度影響 □ 嚴重影響
3. 得了癌症之後，我經驗到的疼痛程度是: □ 沒有 □ 輕微 □ 中等 □ 嚴重 □ 無法忍受的痛/頻繁地疼痛	□ 完全不會 □ 中度影響 □ 嚴重影響
4. 得了癌症對我家庭造成很大的負擔: □ 完全不會 □ 有時 □ 大部分的日子是如此 □ 每天當中大部分的時間是如此 □ 總是（每天且時時刻刻）	□ 完全不會 □ 中度影響 □ 嚴重影響
5. 得了癌症對我和我的家庭之經濟狀況影響程度: □ 完全不會 □ 輕微 □ 中等 □ 嚴重 □ 非常嚴重	□ 完全不會 □ 中度影響 □ 嚴重影響
6. 得了癌症之後，我還是能夠從事愉快/有興趣的活動: □ 所有時間 □ 大部分日子 □ 部分日子 □ 少數日子 □ 完全沒有	□ 完全不會 □ 中度影響 □ 嚴重影響
7. 得了癌症之後，我感到沮喪、憂鬱、無望: □ 完全不會 □ 部分日子 □ 很常 □ 大部分日子 □ 所有日子	□ 完全不會 □ 中度影響 □ 嚴重影響

其他評估量表或流程

- 疲憊評估
- 疼痛評估
- 心理師收案流程
- 癌症病患營養評估
- 癌症病患營養會診流程
- 癌症資源中心服務流程

Conclusion

- Patients with incurable cancer present palliative care needs throughout the continuum of their disease
- There is increasingly robust level 1 evidence of the benefit of palliative care for patients and caregivers
- The published randomized trials on the subject point to health gains resulting from integration, but what, when, and how to integrate are yet to be established
- Palliative care should be part of national cancer politics and plans

Thank you.

感謝您！