推動癌症早期緩和療護的困境與突破

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主題

- What’s early palliative care?
- Why they need early palliative care?
- What is the efficacy?
- Integration of palliative care into standard oncology
- Advances in early palliative care in Taiwan
- Barriers to early palliative care

What’s palliative care ?

Hospice care – 安寧療護

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",

Palliative care – 緩和療護

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 .

Comparing Palliative Care and Hospice Care

Palliative Care	Hospice Care
Physical and psychosocial relief	Physical and psychosocial relief
Focus on quality of life	Focus on quality of life
Multidisciplinary Team Approach	Multidisciplinary Team Approach
Any stage of disease	*Prognosis 6 months or less*
May be concurrent with curative treatment	*Excludes curative treatment*

VS

https://www.nhpco.org/wp-content/uploads/2019/04/PalliativeCare_VS_Hospice.pdf

Supportive care - 支持性照護

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”

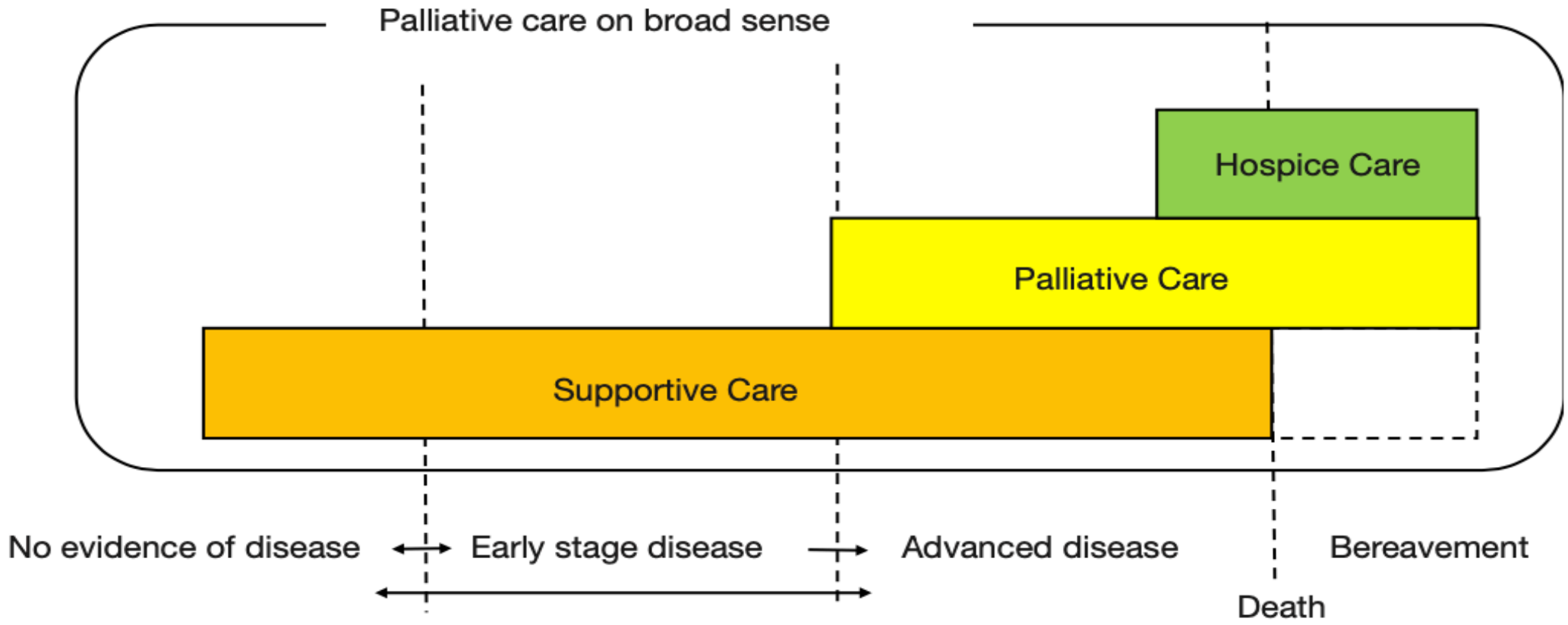
Definition of palliative care in 2002 declared by WHO - 定義

- 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
- 促進生活品質/ 身心靈

Five Main Ideas
五個主要重點

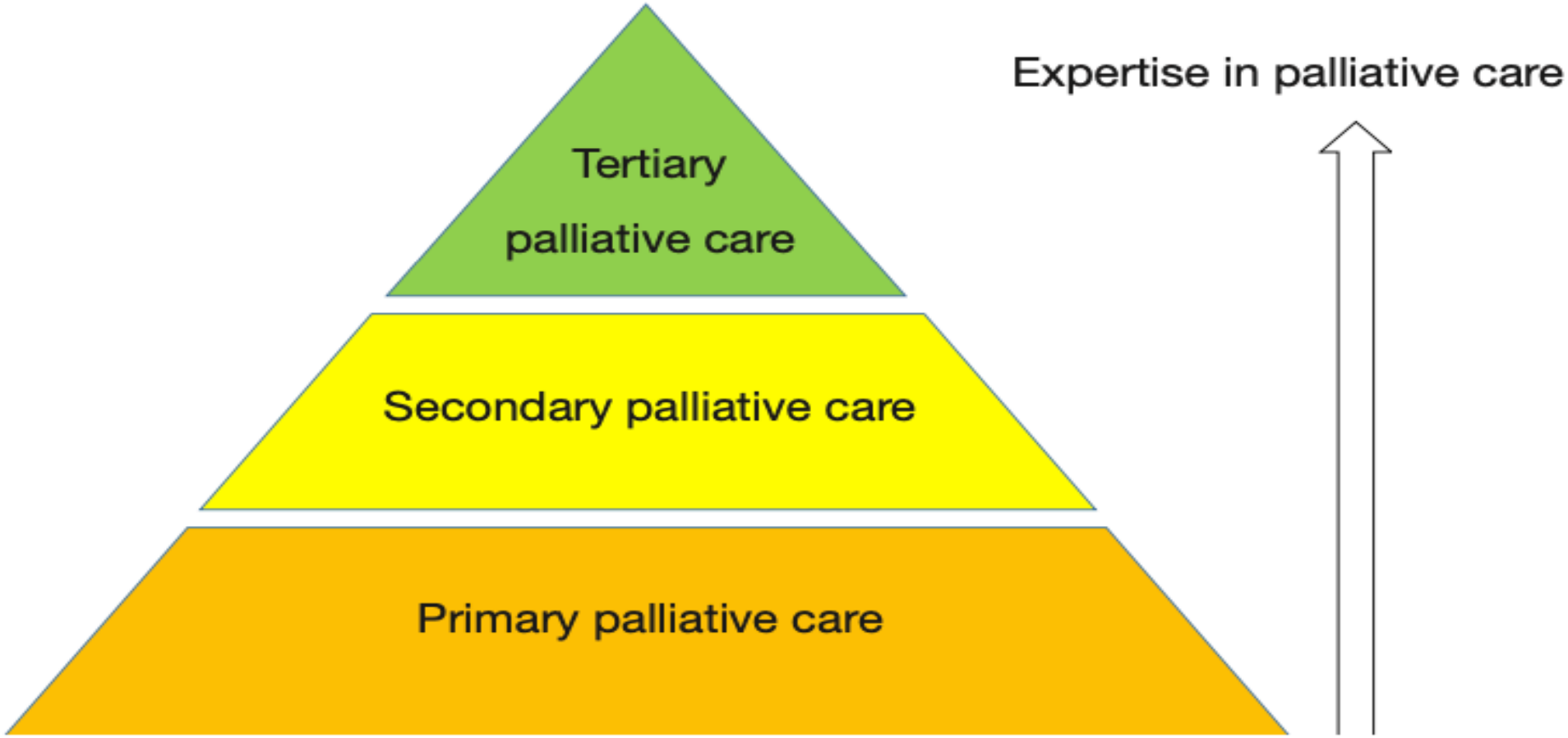
- (I) QOL focused approach - 生活品質
- (II) Whole-human approach - 全人
- (III) Care that encompasses both the patient and those involved with the patient (particularly caregivers) - 全家
- (IV) Respect patient autonomy and choice- 自主選擇
- (V) Support people through frank and thoughtful discussions on difficult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

Palliative care classification models – *Time-based model 時程模式*



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

Palliative Care: YOU Are a Bridge

https://www.youtube.com/watch?v=IDHhg76tMHc

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

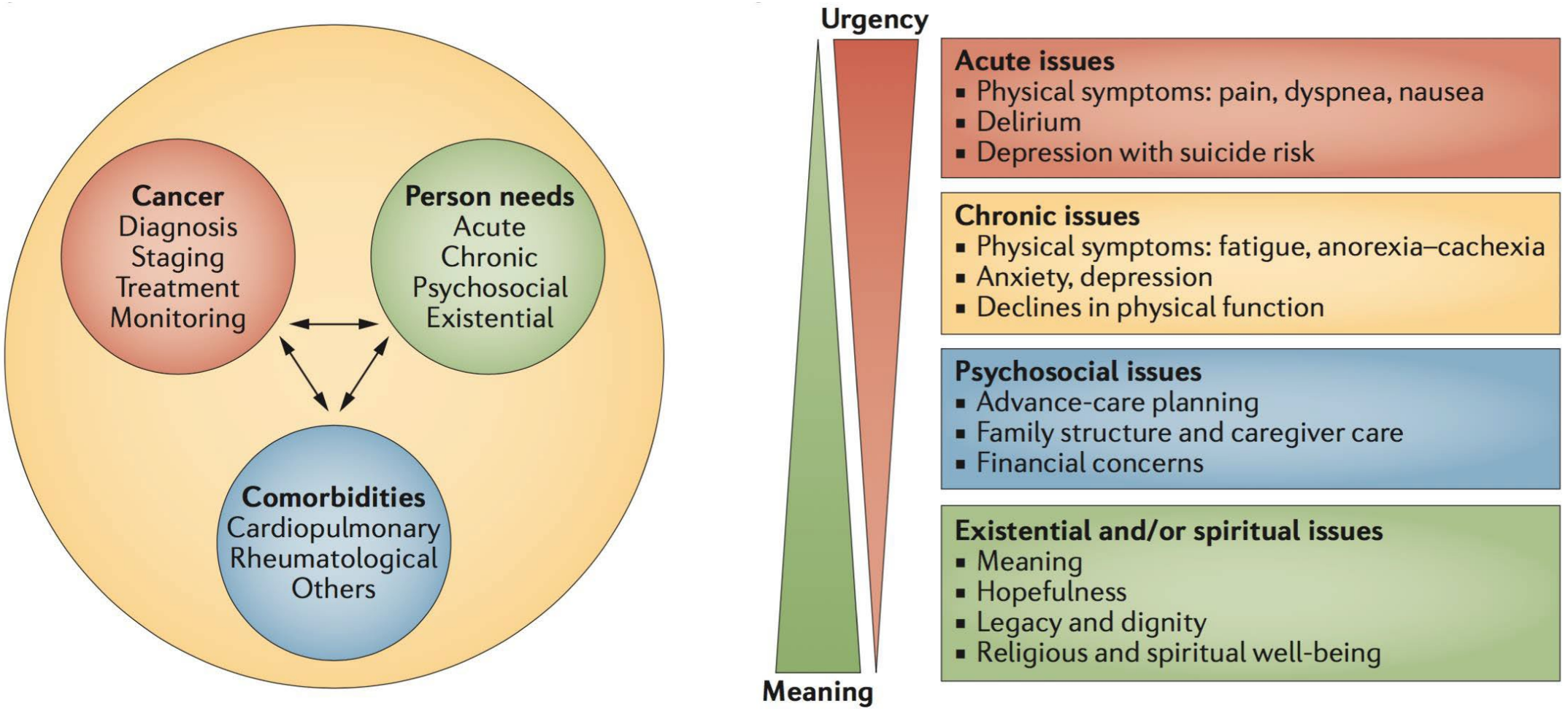
ORIGINAL ARTICLE

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.

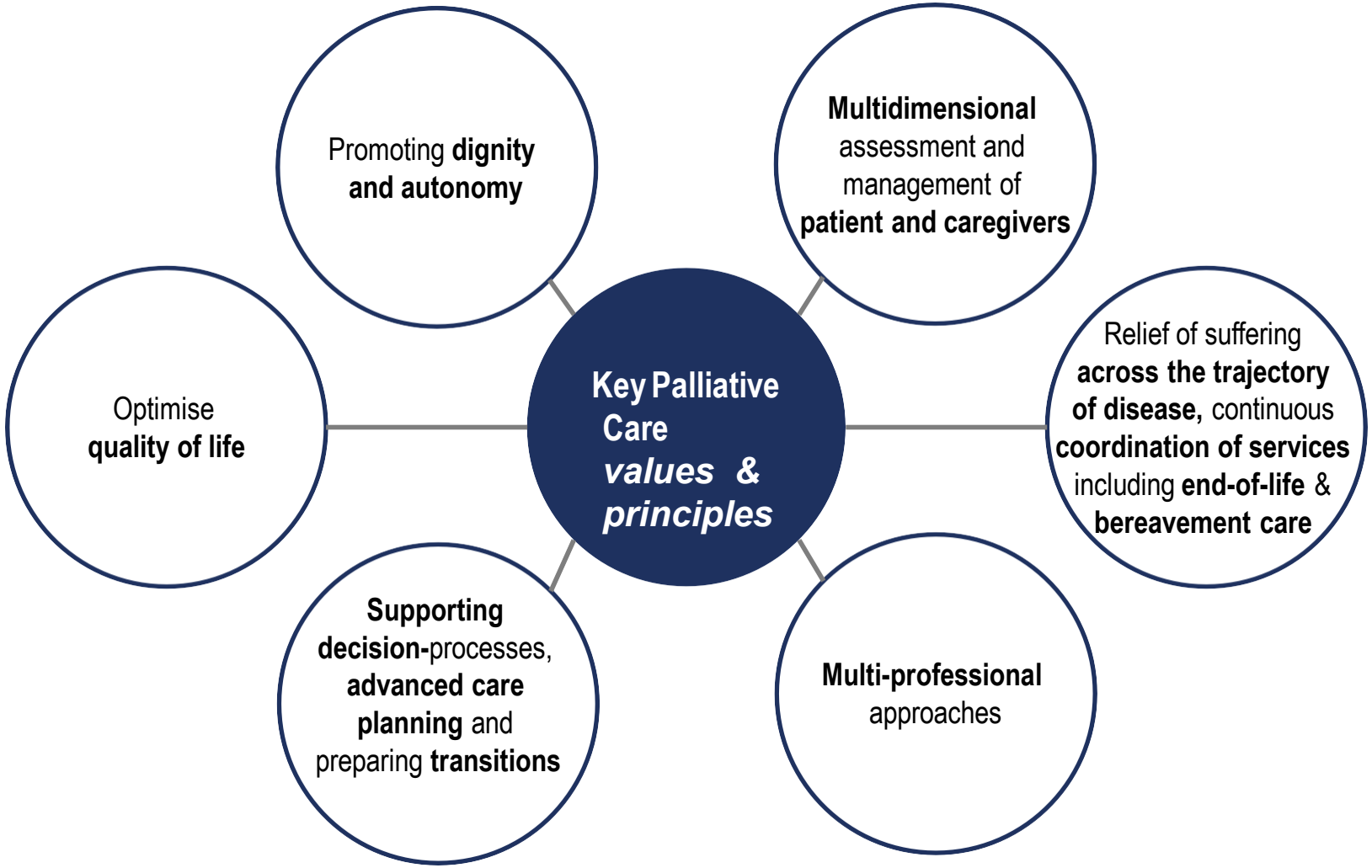
APPROACH TO THE PATIENT WITH INCURABLE CANCER

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

緩和療護的內容和時間表



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 轉移性肺癌臨床試驗

150 patients with newly diagnosed metastatic NSCLC

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

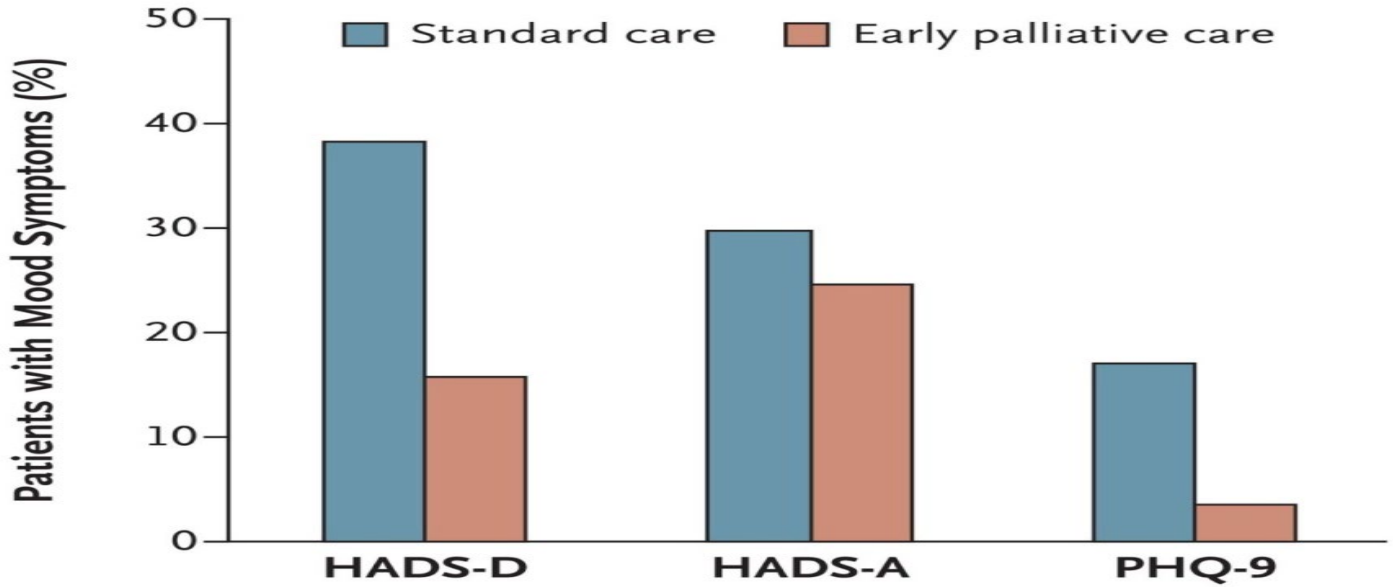
Palliative Care Model

- 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

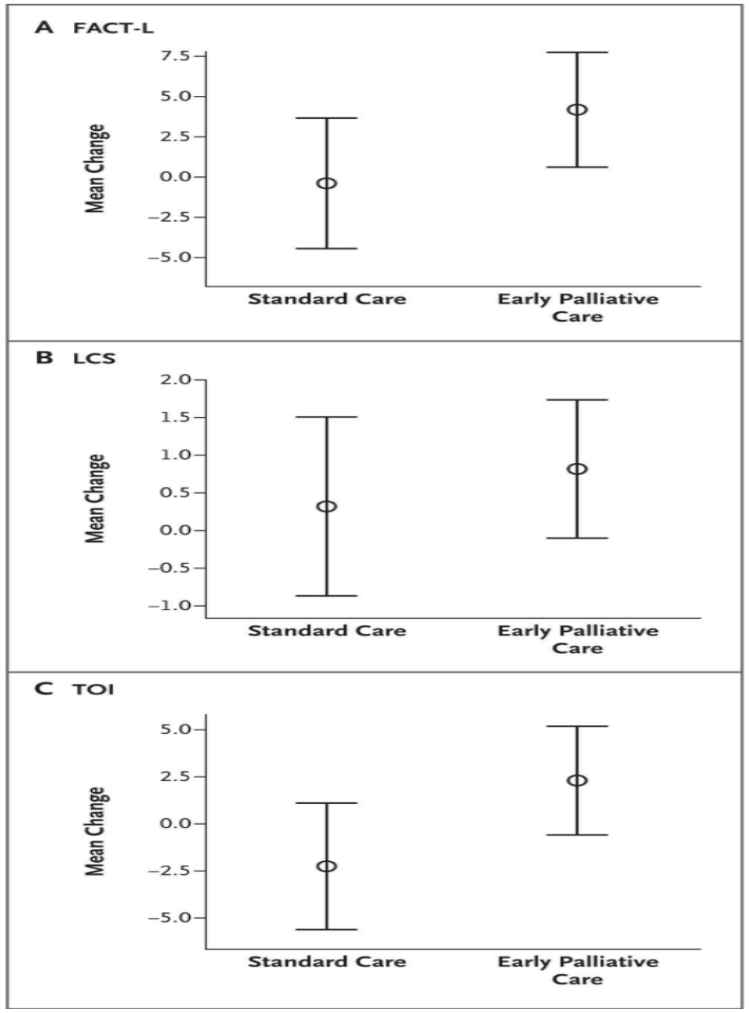
早期緩和治療對患者報告指標的影響

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

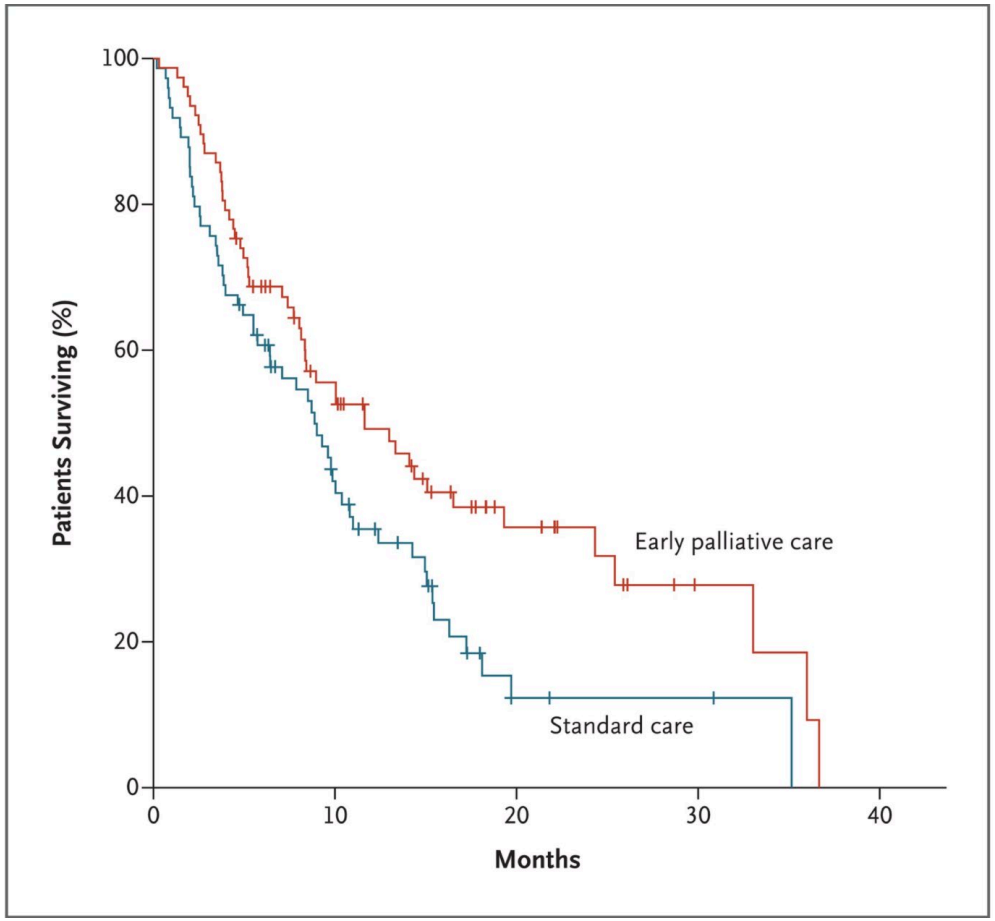


Temel NEJM 363 (8) 2010

病人存活率與生活品質的改變

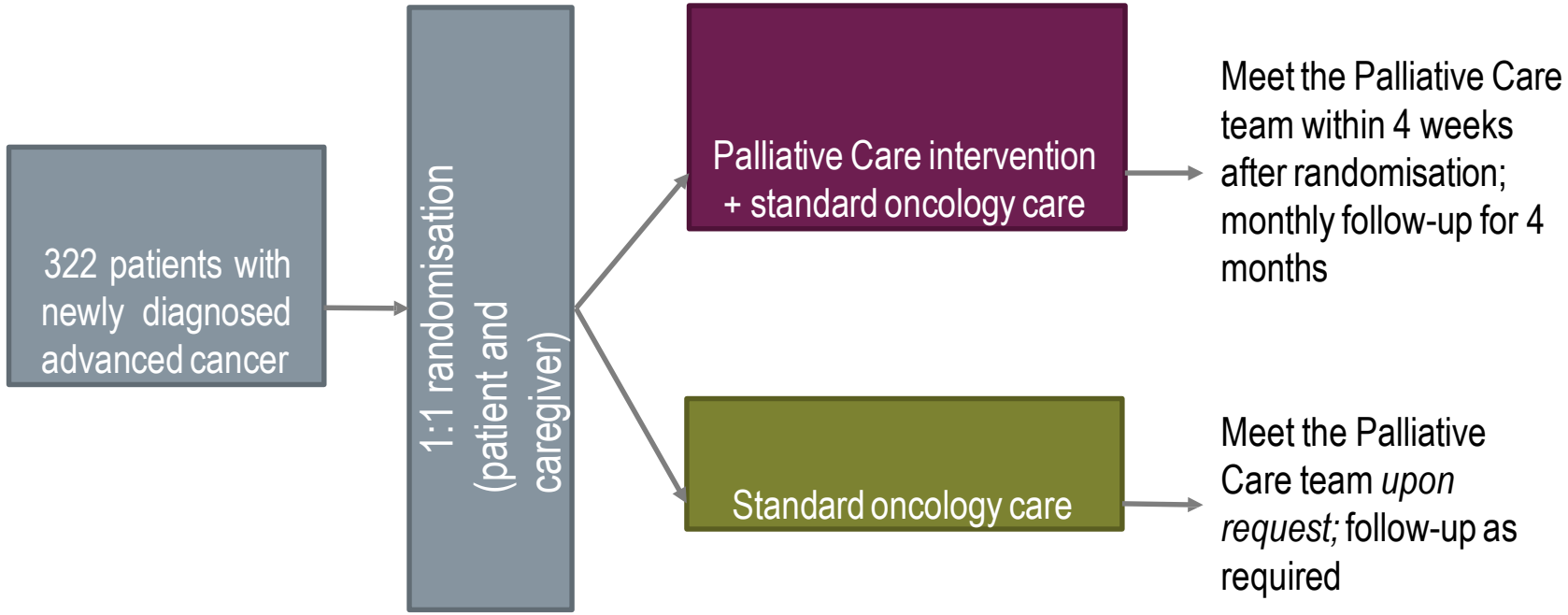


Mean Change in Quality-of-Life Scores from Baseline to 12 Weeks in the Two Study Groups.



Kaplan–Meier Estimates of Survival According to Study Group.

早期緩和治療的好處 —— ENABLE II trial



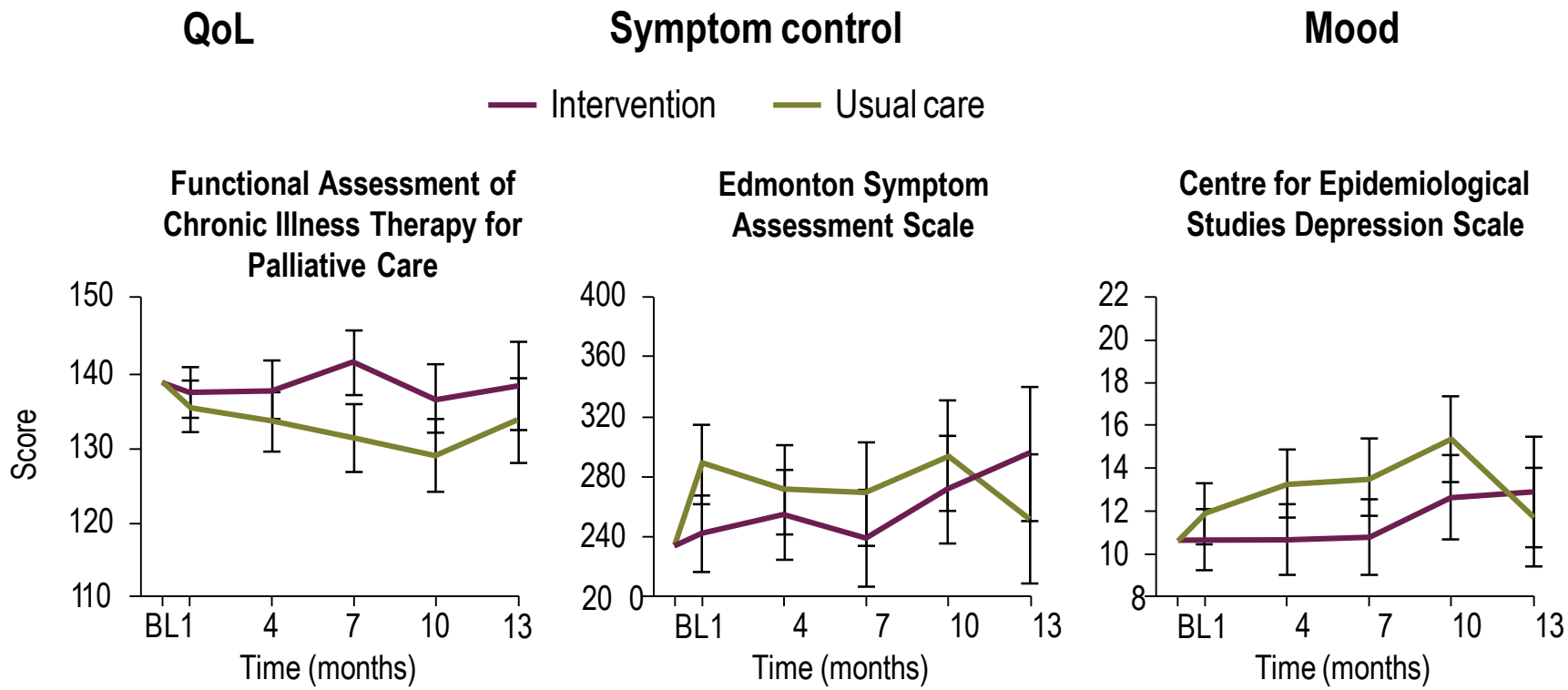
Primary endpoints: patient-reported quality of life (QoL), symptom intensity, and resource use

Secondary endpoint: mood

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

早期緩和治療的好處

Patient outcomes



Patients, No.

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

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

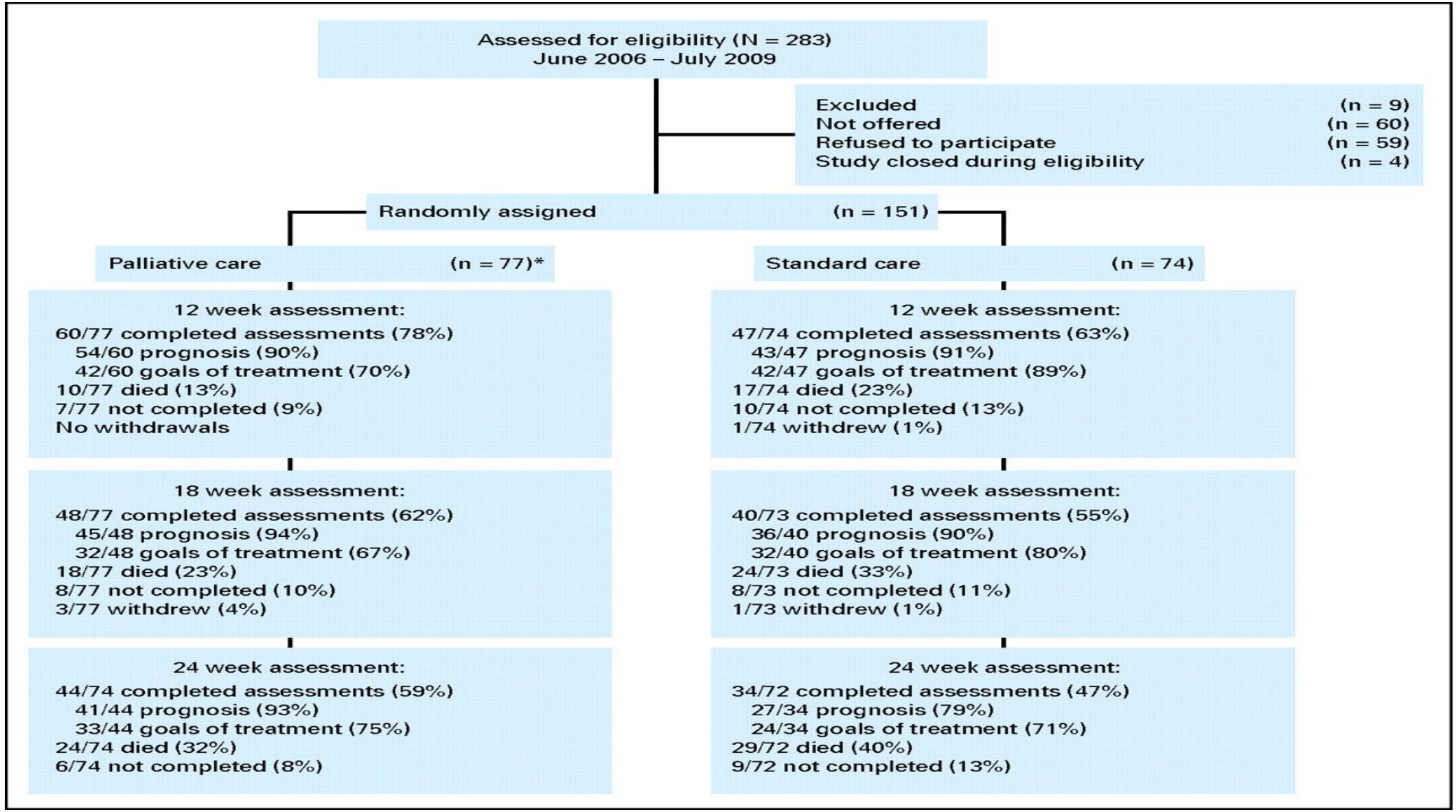


*Fig 1. CONSORT diagram. *One patient randomly assigned to standard care was erroneously assigned to early palliative care at the time of random assignment and therefore is included in the early palliative care study group.*

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

化學治療利用率

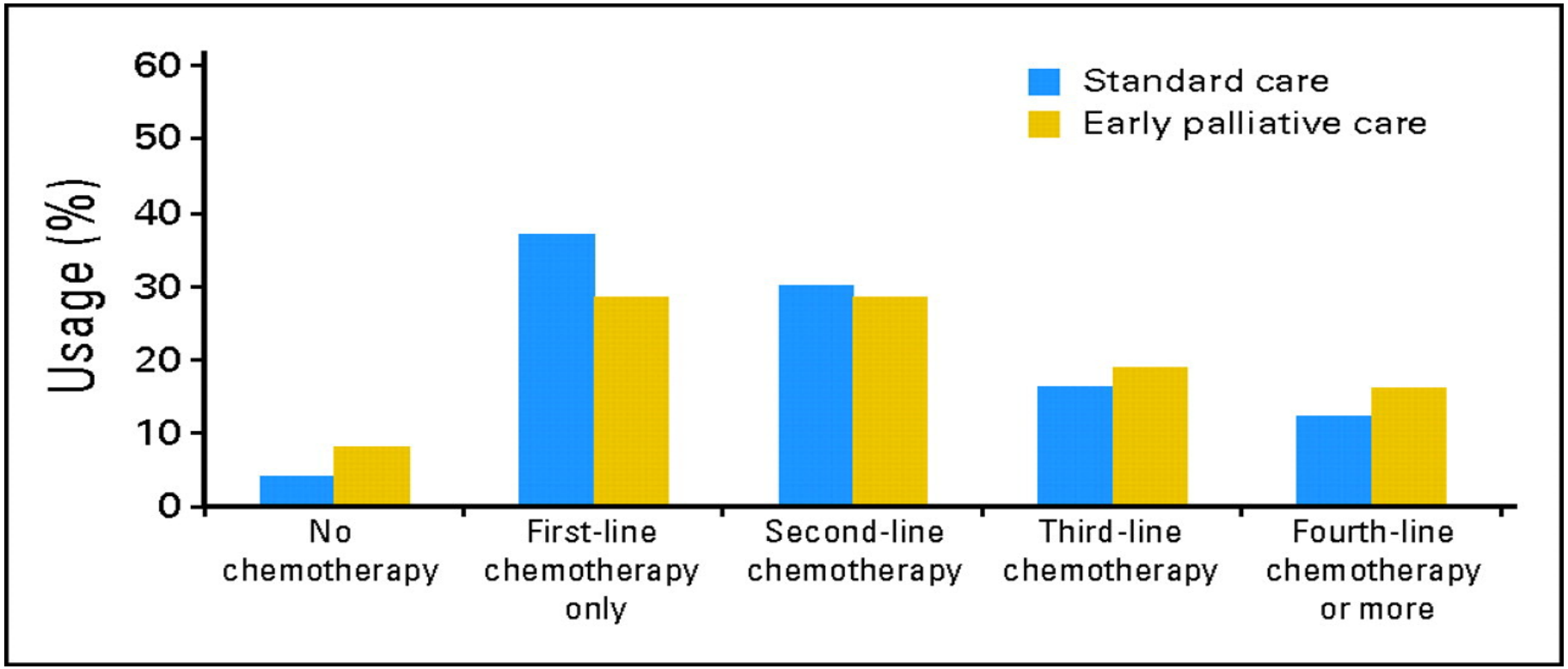


Fig 2. Chemotherapy use between study groups in entire sample (n = 147). Rates of chemotherapy use did not differ significantly between groups for participants who received no chemotherapy (standard care [SC], three of 73 [4.1%] v early palliative care [PC], six of 74 [8.1%]; P = .49); first line only (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

化學治療利用率

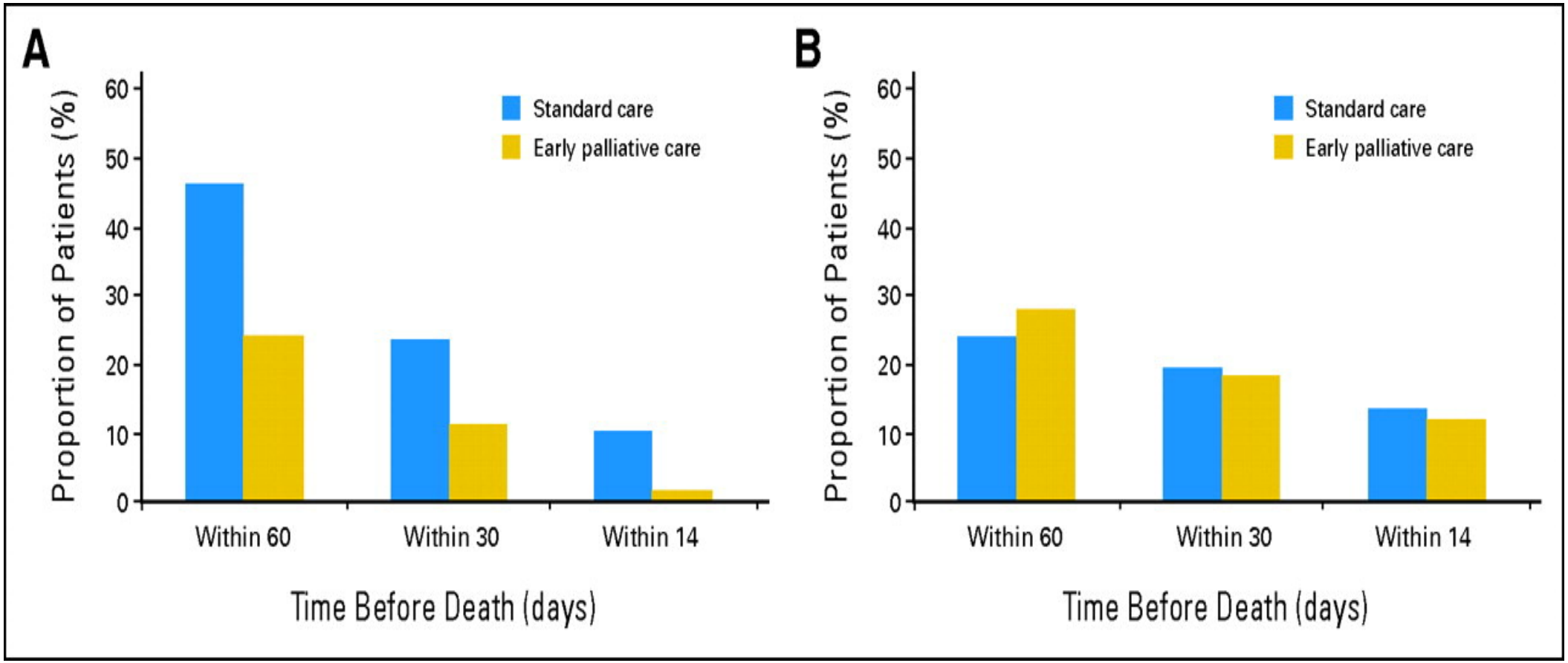


Fig 3. Administration of final regimen of (A) intravenous and (B) oral chemotherapy at end of life (n = 129). Within 60 days of death, a significantly greater percentage of patients were receiving intravenous chemotherapy as final regimen in standard-care (SC) group compared with early palliative care (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

按類別劃分的生命末期成本

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

Greer ASCO 2012

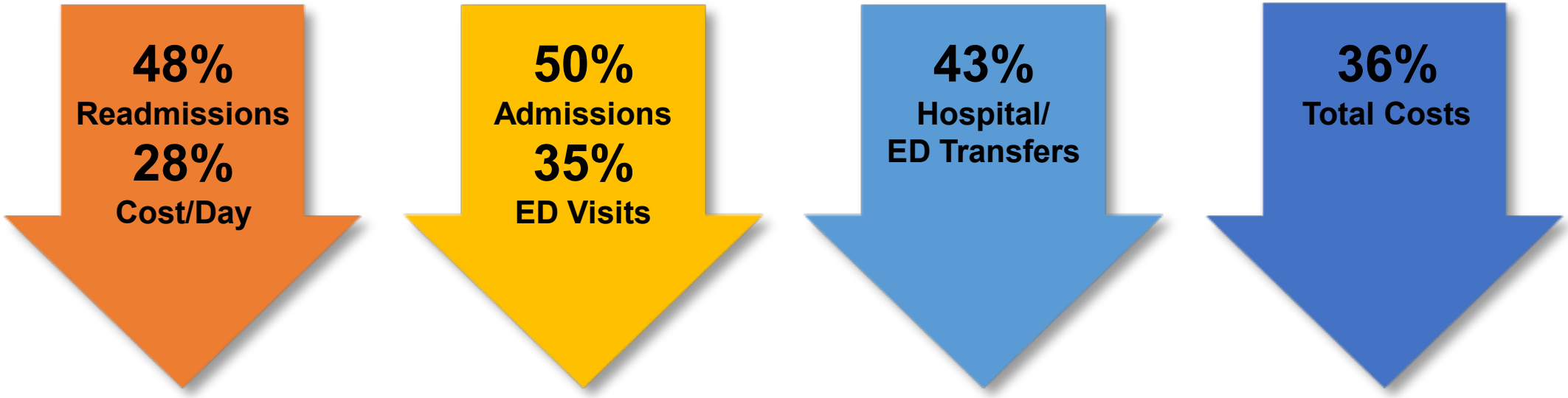
Early palliative care might have more beneficial effects on quality of life and intensity of symptoms among patients with advanced cancer than among those given usual or standard cancer care alone. The effects are of clinical relevance for patients at an advanced disease stage with limited prognosis,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

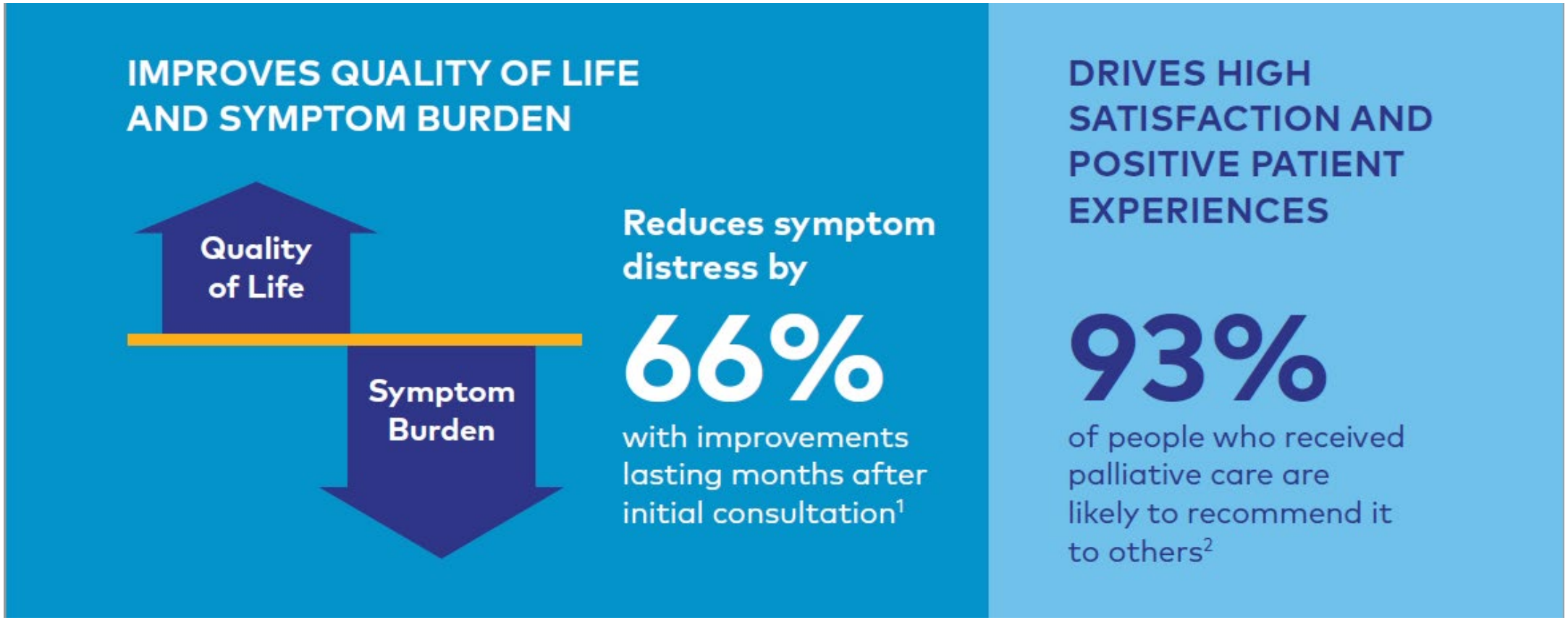
Haun_et_al-2017-Cochrane_Database_of_Systematic_Reviews

Palliative Care Reduces Avoidable Spending and Utilization in All Settings



Source Centers to Advance Palliative Care

Palliative Care Improves Quality of Life



Center to Advance Palliative Care, 2018 Retrieved from https://www.capc.org/tools-for-making-the-case/downloadable-tools/

早期緩和治療的好處

Improved QOL,

Quality of end-of-life care,

Decreased rates of depression,

Illness understanding,

Patient satisfaction

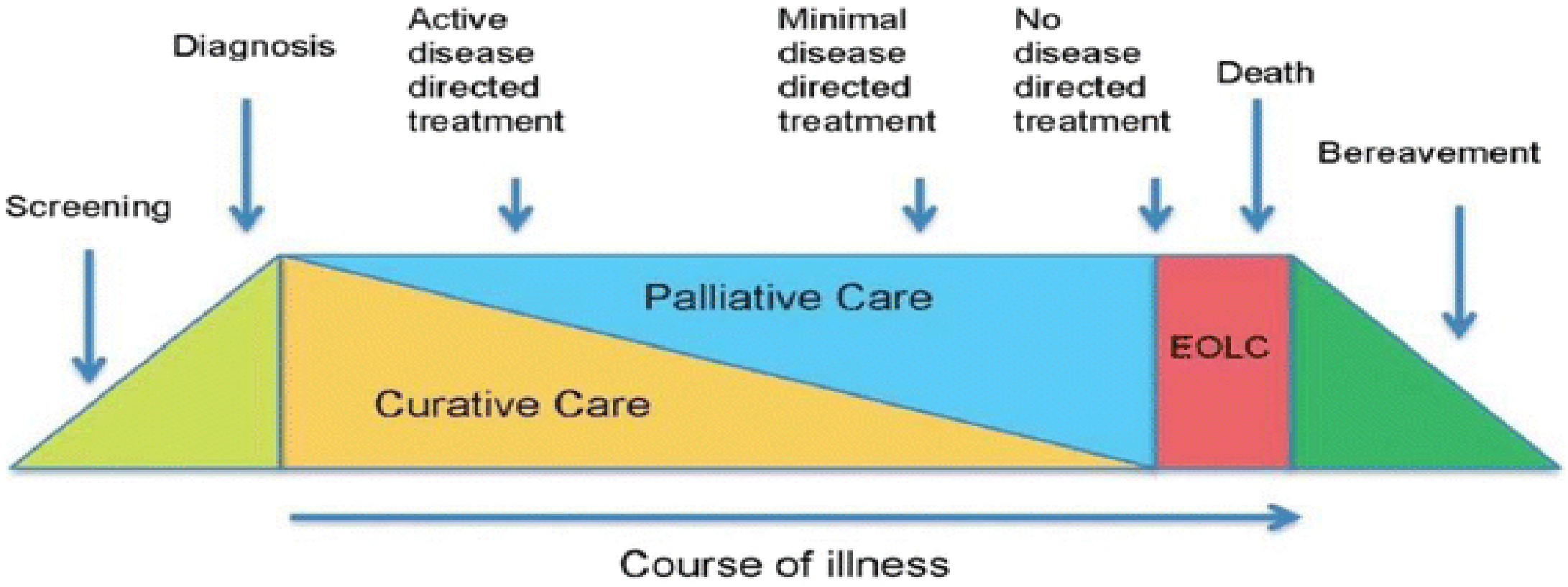
Integration of palliative care into standard oncology care

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*".

Palliative Care vs Hospice Care

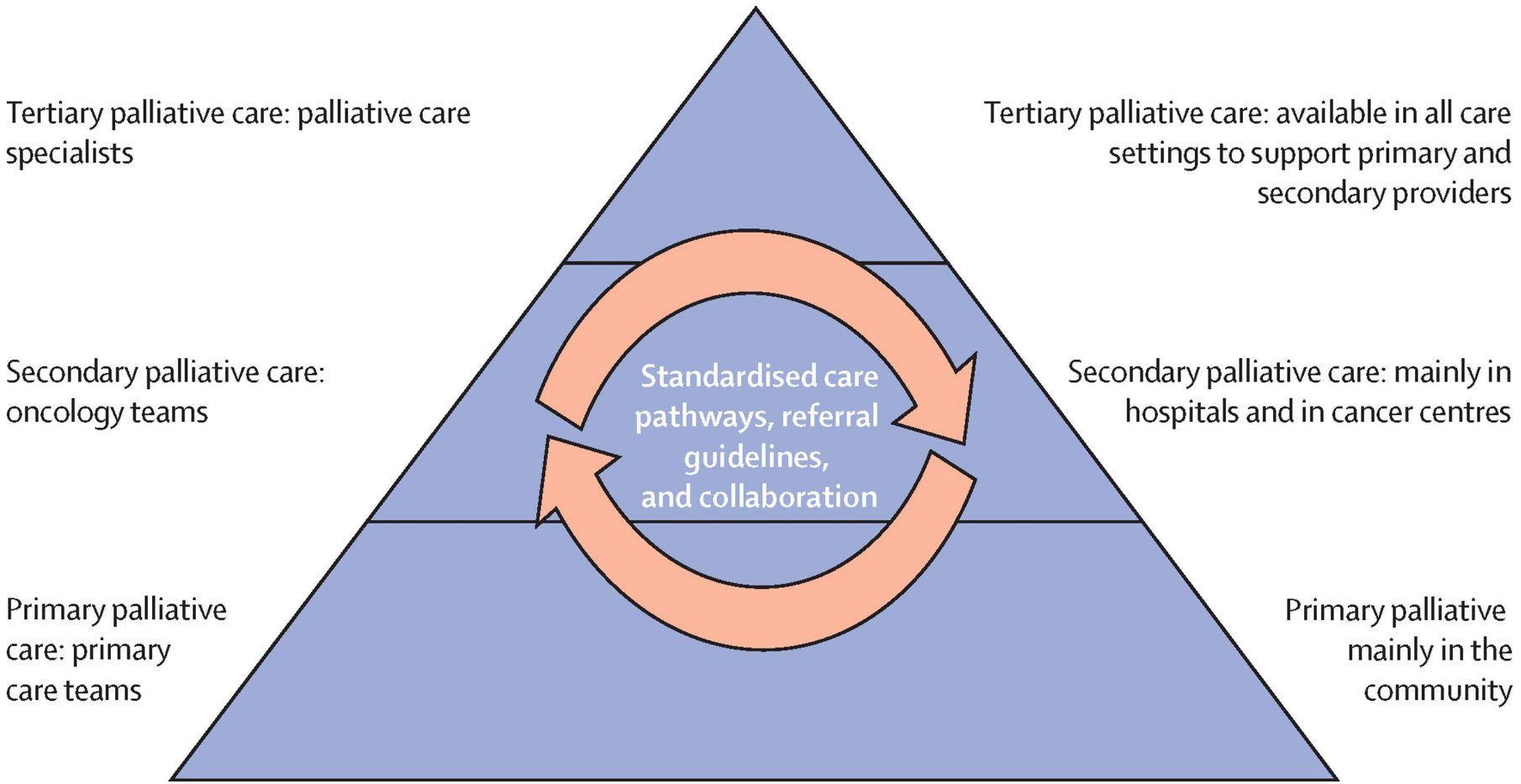
"Would I be surprised if this patient died within 12 months?"



https://media.springernature.com/full/springer-static/image/art%3A10.1186%2Fs12904-017-0221-0/MediaObjects/12904_2017_221_Fig2_HTML.gif

Jennings, Marks, & Lum, 2022

Proposed model of optimal oncology palliative care provision, including integration across providers and settings



緩和療護成功融入腫瘤臨床實務的指標

Components of integration from seven randomised trials

	Jordhøy et al (2000)[47]	Temel et al (2010)[3]	Zimmermann et al (2014)[5]	Bakitas et al (2015)[48]	Maltoni et al (2016)[49]	Temel et al (2017)[50]	Grønvold et al (2017)[51]
Clinical structure							
Palliative care inpatient consultation team	Y	Y	Y	Y	..	Y	Y
Palliative care outpatient clinic	Y	Y	Y	Y	Y	Y	Y
Community-based care or home palliative care	Y	..	Y	..	..	..	..
Clinical processes							
Multidisciplinary specialised palliative care team	Y	Y	Y	Y	Y	Y	Y
Routine symptom screening in the outpatient oncology clinic	..	..	..	..	..	..	..
Administration of systemic cancer therapy (eg, chemotherapy and targeted agents) possible in patients admitted to palliative care service	Y	Y	Y	Y	Y	Y	Y
Follow prespecified palliative care guidelines	Y	Y	..	..	Y	Y	Y
Early referral to palliative care	Y	Y	Y	Y	Y	Y	Y
Availability of clinical care pathways (automatic triggers) for palliative care referral	..	..	..	..	..	..	..
Palliative care team routinely involved in multidisciplinary tumour conference for patient case discussions	..	Y	..	..	..	..	..
Communication, cooperation, and coordination between palliative and oncology service	Y	Y	..	..	Y	..	..
Routine discussion of prognosis, advance care planning with goals of care	Y	Y	Y	Y	Y	Y	Y

Y=presence of component in trial. Table adapted from Hui and colleagues.[44,52]

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

台灣早期緩和療護的進展

The fourth phase of the national cancer prevention program (2019-23)-- Health Promotion Administration

- **6 Strategies:**
- **5 (2)** The importance of hospice and palliative care:
- Since 2018, the HPA promoted that cancer prevention and treatment institutions should establish early care standards and procedures for providing early palliative care for patients with advanced cancer.

癌症診療品質認證

“Accreditation standard 3.3 (since 2019)

Cancer prevention and treatment institutions should establish palliative care standards and procedures for patients with advanced cancer.

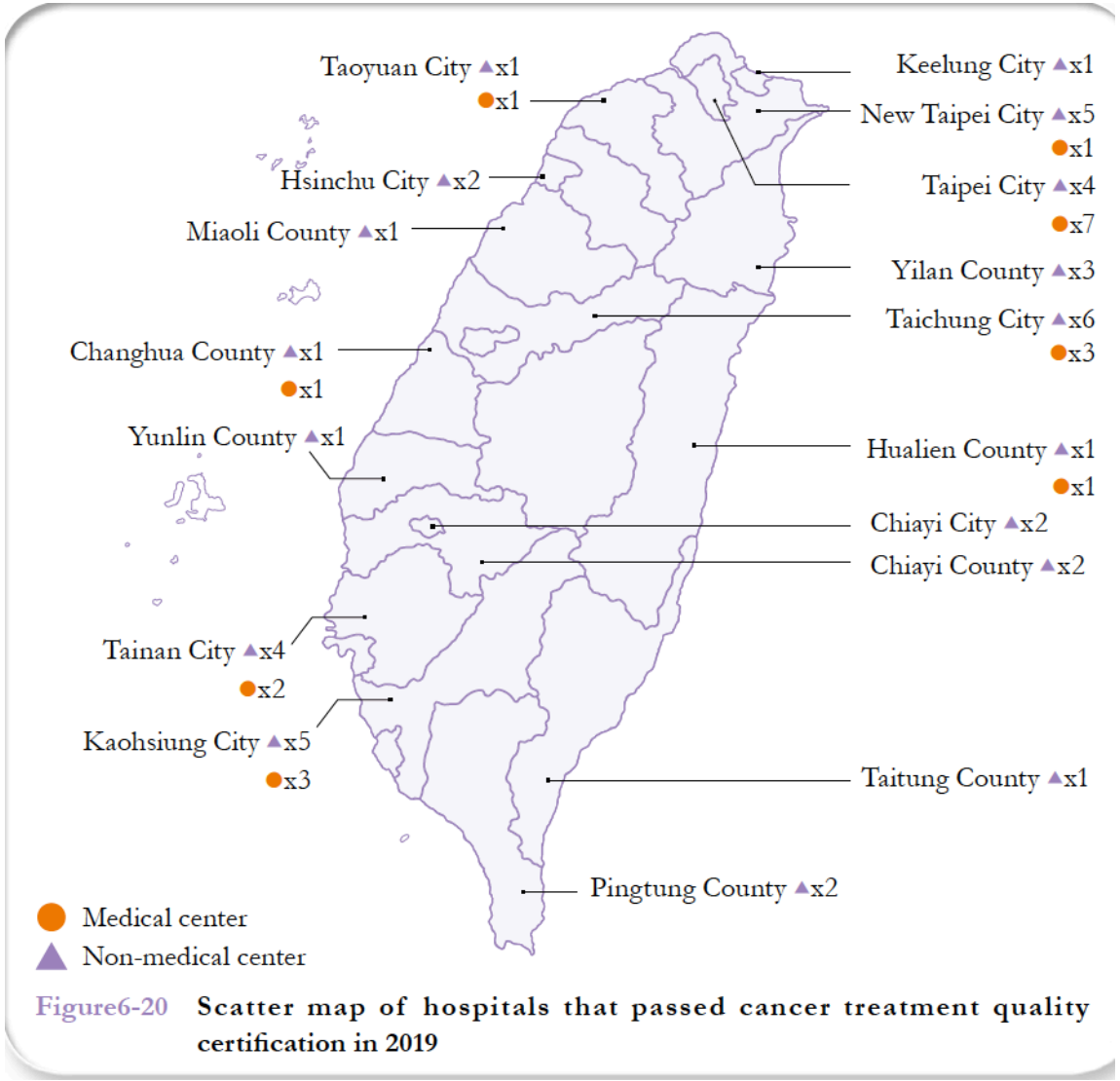


Figure6-20 Scatter map of hospitals that passed cancer treatment quality certification in 2019

秀傳彰濱緩和照護團隊

目的，原則與目標

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。

緩和照護收案原則

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

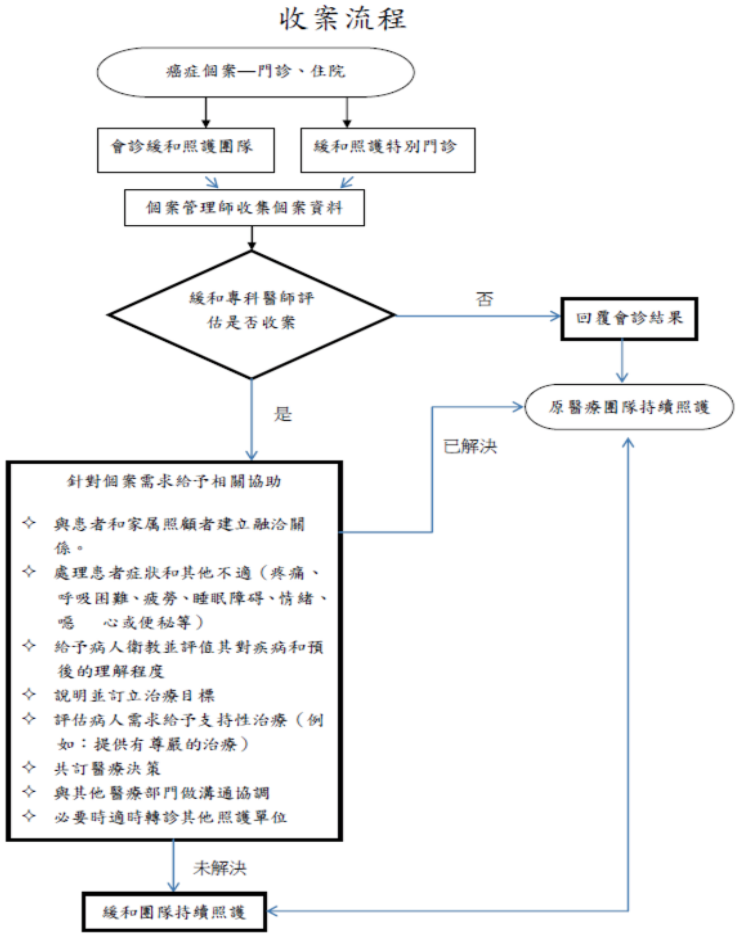
病人對於治療的選擇與疾病惡化後的處理模式，明顯有下決定上的困難

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。

收案流程與篩選量表



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?	結果
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	由心理師進行： 疲憊評估_____分 因疲憊進行收案： ☐ 是 ☐ 否
2 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	簡式健康量表評估_____ 分，因心理評估後進行收案 ☐ 是 ☐ 否
3. 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	由營養師評估 進行營養評估_____分 因營養問題進行收案： ☐ 是 ☐ 否
4. 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	由醫師或癌症個案管理師評估： 進行疼痛評估_____分， 因疼痛進行收案： ☐ 是 ☐ 否
5. 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	由社工師進行評估 進行經濟評估，因經濟進行收案： ☐ 是 ☐ 否
6. 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	

Estimated adjusted mean change in FAMCARE-P16 and CARES-MIS total scores in high and low baseline symptom subgroups at 4 months

- 症狀學的評估可以提高效益

	Intervention		Control			
	n	Observed change from baseline	*n*	Observed change from baseline	Adjusted difference in change scores between study arms (95% CI)	*p*
		Mean (SD)		Mean (SD)		
FAMCARE-P16 total score						0.13[a,c]
High baseline symptoms	64	4.3 (8.2)	57	−3.3 (8.3)	6.9 (3.8 to 9.9)[b]	0.001
Low baseline symptoms	57	3.1 (9.0)	96	−1.9 (8.4)	3.4 (−0.5 to 7.4)[b]	0.08
CARES-MIS total score						0.06[a]
High baseline symptoms	64	−0.8 (4.7)	58	1.0 (4.3)	−1.7 (−3.4 to −0.1)[d]	0.04
Low baseline symptoms	59	0.1 (4.0)	96	0.4 (3.1)	0.2 (−1.3 to 1.7)[e]	0.77

Barriers to Early Palliative Care

了解腫瘤專科醫師對緩和療護的看法以及阻礙其使用的障礙

Patient referrals: About two-thirds of participating oncologists said they refer selected patients to palliative care based on symptoms and life expectancy, but nearly half said better data is needed for making referral decisions.

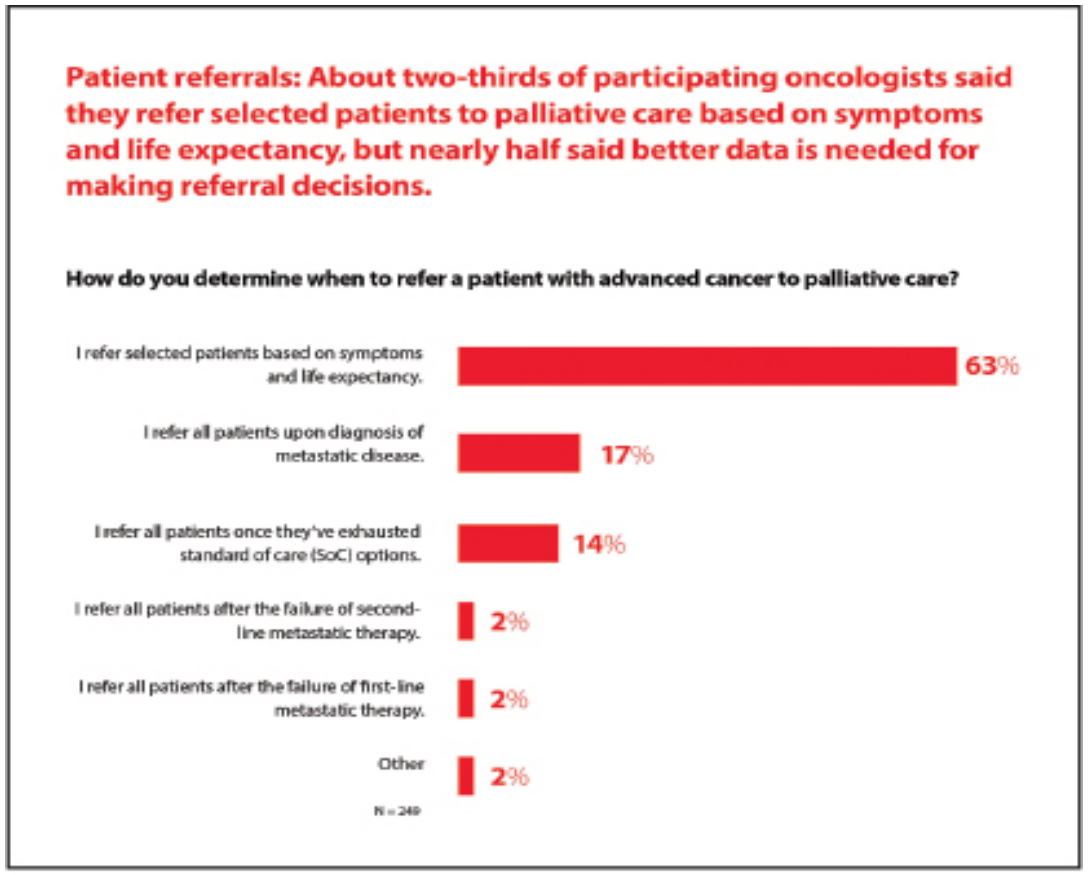


FIGURE 1: Patient referrals to palliative care. Chart courtesy of Cardinal Health Specialty Solutions.

Early introduction of palliative care: About two-thirds of participating oncologists said earlier introduction of palliative care leads to better outcomes.

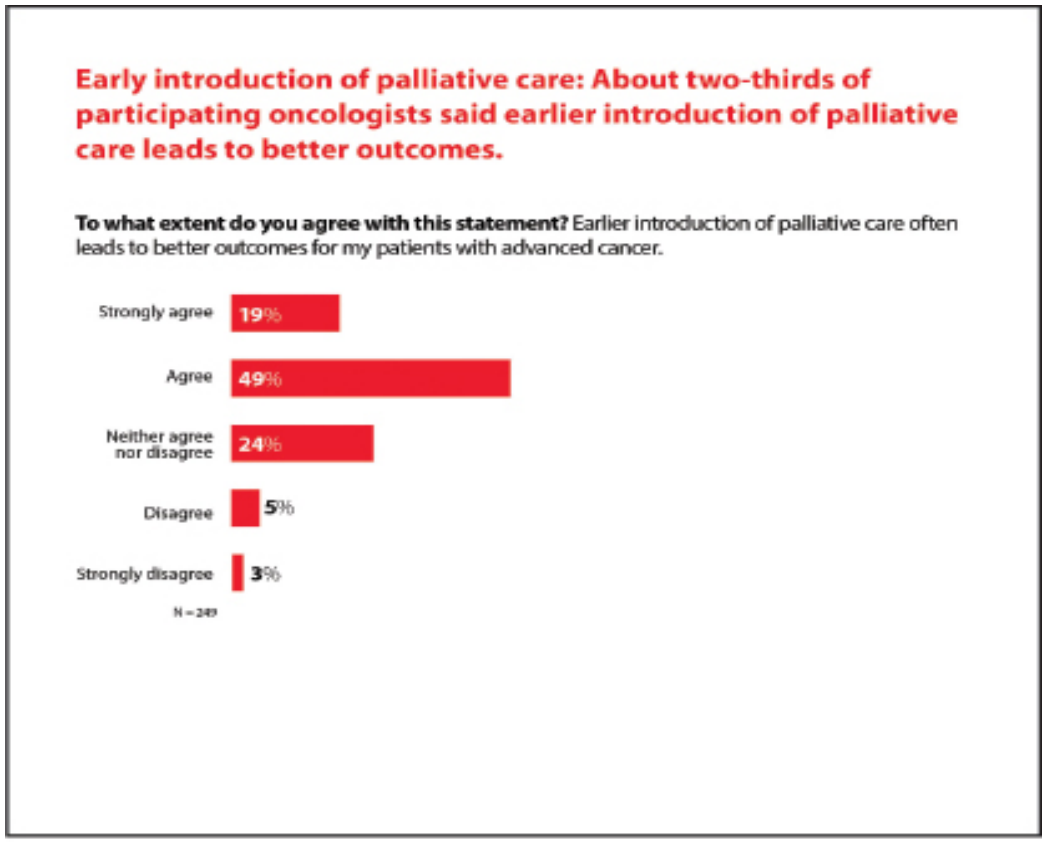


FIGURE 2: Early introduction of palliative care. Chart courtesy of Cardinal Health Specialty Solutions.

A Conversation With Ajeet Gajra, MD, MBBS, FACP

Understanding Oncologists' Perceptions About Palliative Care and the Barriers Preventing Its Use

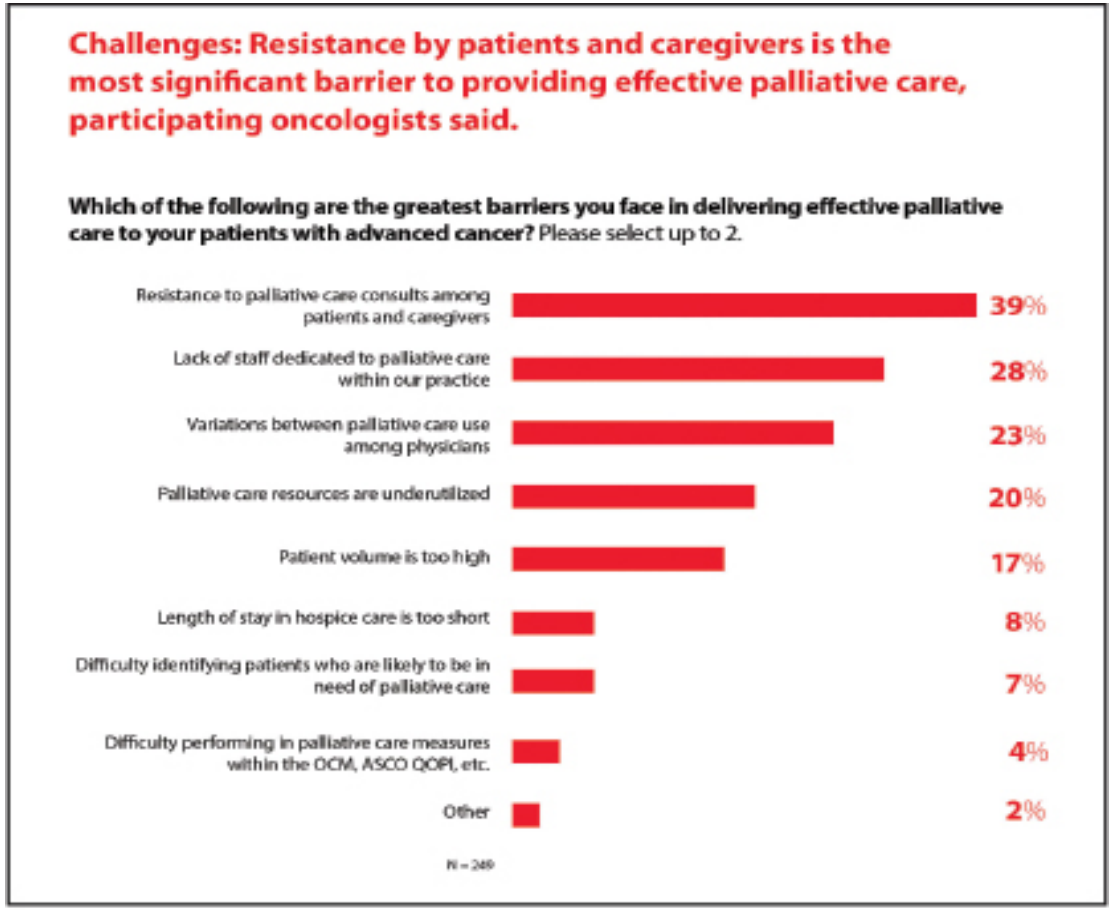


FIGURE 3: Challenges to delivering effective palliative care. Chart courtesy of Cardinal Health Specialty Solutions.

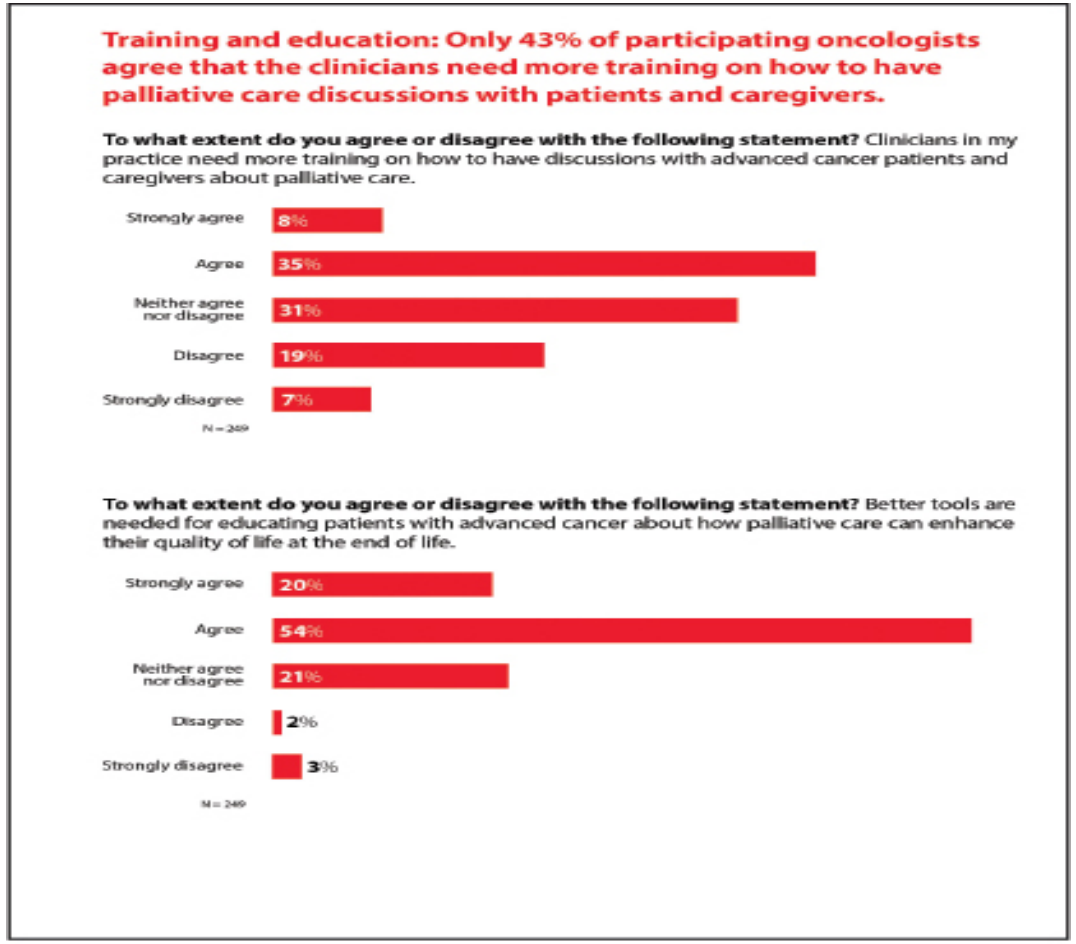
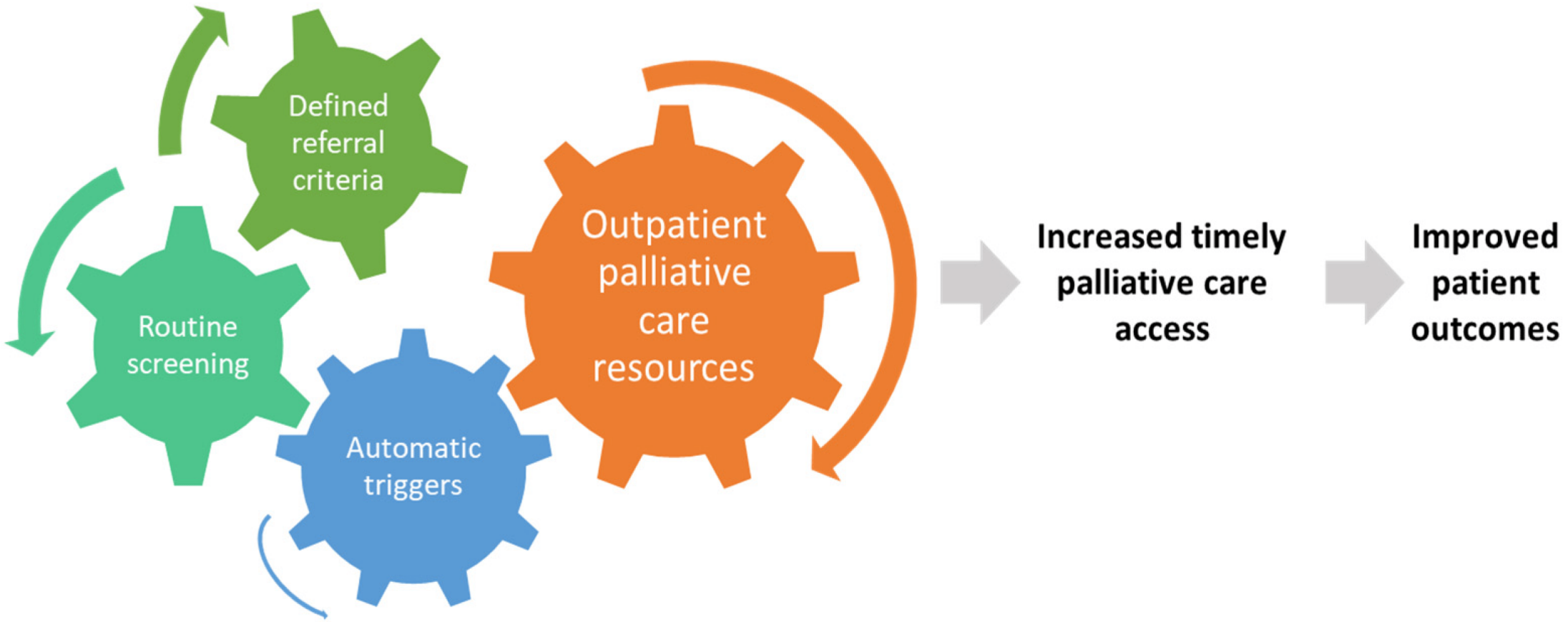


FIGURE 4: Training and education about palliative care. Chart courtesy of Cardinal Health Specialty Solutions.

Conceptual model for timely palliative care



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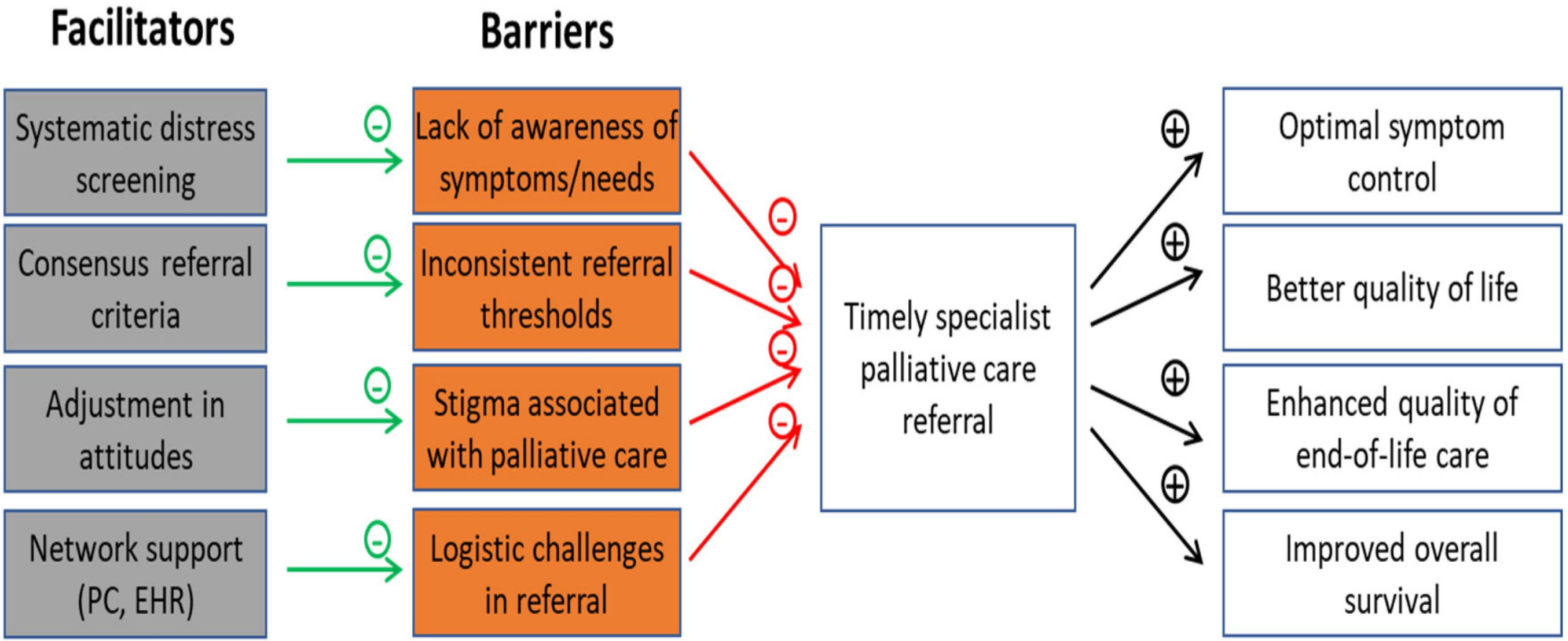
及時轉診緩和療護的障礙和促進因素



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Top 10 Communication Skills
十個溝通技巧應用

Listening	Nonverbal Communication	Clarity and Concision	Friendliness	Confidence
Empathy	Open-Mindedness	Respect	Feedback	Picking the Right Medium

結論

- 患有無法治癒癌症的患者，在整個疾病過程中都需要緩和療護
- 越來越多強有力的 1 級證據，顯示緩和治療對患者和負責照顧家屬的益處
- 已發表關於該主題的隨機試驗，顯示跟主要治療整合可以帶來病人健康上的益處，但整合的內容、時間和方式尚未完全確定
- 緩和療護已成為國家癌症防治計劃的一部分

Q&A