Early and systematic integration of palliative care in oncology care

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Conflict of Interest Disclosure
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I have no real or apparent conflicts of interest to report.
• Old Model

• New Model

Early palliative care in oncology
Early palliative care in oncology

Belgium
Patients are standardly offered (free of charge) consultations with:

Nurse specialist
Dietician
Psychologist
Social worker

Palliative care (free of charge) consultations:
   On demand
Referral to specialised palliative care

Timing

- Breast: 29 days
- Respiratory: 20 days
- Hematological: 14 days
Aim

What is the effect of early and systematic integration of palliative care in multidisciplinary oncology care in patients with advanced cancer?
Advanced cancer disease (solid) with a life-expectancy of one year

**Primary objective**
Quality of life (EORTC QLQ C30 – global health/quality of life scale)

**Secondary objectives**
Quality of life (EORTC QLQ C30 – McGill Quality of Life)
Survival
Frequency of consultations by paramedical professionals
Design

Early and systematic palliative care integrated in oncology care

Usual oncology care
Palliative care on demand
Baseline

Randomisation

Early and systematic palliative care integrated in oncology care

Usual oncology care
Palliative care on demand

12 weeks
6 weekly until death
Training

Semi-structured monthly consultations primarily by PC nurses

Symptom assessment (Edmonton Symptom Assessment Scale)

Integration in oncology care
## Patient characteristics

<table>
<thead>
<tr>
<th>Cancer n (%)</th>
<th>Control (n= 94)</th>
<th>Intervention (n=92)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastrointestinal</td>
<td>36 (38)</td>
<td>35 (39)</td>
</tr>
<tr>
<td>Lung</td>
<td>26 (28)</td>
<td>25 (28)</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>6 (6)</td>
<td>9 (10)</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>12 (13)</td>
<td>7 (8)</td>
</tr>
<tr>
<td>Breast</td>
<td>7 (7)</td>
<td>7 (8)</td>
</tr>
<tr>
<td>Melanoma</td>
<td>7 (7)</td>
<td>8 (9)</td>
</tr>
<tr>
<td>Age mean (SD)</td>
<td>63.8 ±9.36</td>
<td>64.3 ±9.39</td>
</tr>
<tr>
<td>Women n (%)</td>
<td>25 (27)</td>
<td>33 (36)</td>
</tr>
</tbody>
</table>
Number of consultations by PC team

![Bar chart showing the number of consultations by PC team for Usual Care and Early and systematic integration. The chart includes categories for 0 consultations, 1 to 5 consultations, 5 to 10 consultations, and 11 or more consultations. The percentages for Usual Care are 56%, 8%, 5%, and 0% respectively, and for Early and systematic integration, they are 39%, 39%, 25%, and 28% respectively.]

Usual Care: Early and systematic integration
Aim

What is the effect of early and systematic integration of palliative care in multidisciplinary oncology care in patients with advanced cancer within 3 months after baseline?
Different components discussed

- Symptom Management: 32%
- Illness Understanding: 29%
- Psychosocial Wellbeing: 16%
- Spiritual Wellbeing: 16%
- Decision-making: 7%
- Other: 1%
## QOL EORTC QLQ C30
### global health status/QOL scale

<table>
<thead>
<tr>
<th></th>
<th>Control Mean score; Baseline adjusted (95% CI)</th>
<th>Intervention Mean score; Baseline adjusted (95% CI)</th>
<th>Change score baseline adjusted (95% CI)</th>
<th>P-value</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>12 weeks (Primary outcome)</strong></td>
<td>54.39 (49.23-59.56)</td>
<td>61.98 (57.02-66-95)</td>
<td>7.60 (0.59-14.60)</td>
<td>0.03</td>
<td>0.4</td>
</tr>
<tr>
<td><strong>18 weeks</strong></td>
<td>54.70 (49.09-60.32)</td>
<td>64.18 (58.78-69.59)</td>
<td>9.48 (2.13-16.82)</td>
<td>0.01</td>
<td>0.5</td>
</tr>
</tbody>
</table>
## McGill QOL Single Item Scale

<table>
<thead>
<tr>
<th></th>
<th>Control Mean score; Baseline adjusted (95% CI)</th>
<th>Intervention Mean score; Baseline adjusted (95% CI)</th>
<th>Change score baseline adjusted (95% CI)</th>
<th>P-value</th>
<th>Effect size</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>12 weeks</strong></td>
<td>5.94 (5.50-6.39)</td>
<td>7.05 (6.59-7.50)</td>
<td>1.11 (0.49-1.73)</td>
<td>&lt; 0.001</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>18 weeks</strong></td>
<td>5.51 (4.96-6.07)</td>
<td>7.00 (6.45-7.55)</td>
<td>1.48 (0.75-2.22)</td>
<td>&lt; 0.001</td>
<td>0.8</td>
</tr>
</tbody>
</table>
Number of consultations by the psychologist of oncology team

- **Usual care**
  - 0 consultations: 78%
  - 1 or 2 consultations: 63%

- **Systematic early integration**
  - 0 consultations: 16%
  - 1 or 2 consultations: 23%
  - 3 or more consultations: 6%
Discussion

Improved overall quality of life after few visits

Nurse led intervention

Psychosocial care is offered in usual care

Systematic versus on demand

Aim

What is the effect of early and systematic integration of palliative care in multidisciplinary oncology care in patients with advanced cancer within at the end-of-life?
QOL at the end-of-life (EORTC QLQ C30 global health status/QOL-Scale)

Diff: 7.6
Positive effect on QOL near the end of life when early integrated PC vs on-demand PC

Patients and PC professionals more time
- to build a relationship
- to focus on coping with the progressive and worsening illness,
- to address decision making in relation to cancer treatment and end-of-life care
- to enhance symptom assessment and management.

Conclusions

Early and systematic integration of palliative care concurrent with oncology care results in:

- a higher quality of life for both patients and informal caregivers
- soon after diagnosis or progression of disease and closer to the patient’s death

Tumor-directed approach AND patient-centered approach
Implications

- Public awareness of palliative care
- How does it work? What is the optimal level of care?
- Sustainability: monthly consultations?
- Is early integration of specialised palliative care beneficial for patients with hematologic cancer?
Physician

- 14%: No specific reason
- 9%: Palliative care is threatening
Patient

33%
Refusal
Patient

16%

PC threatening