

Prostate Cancer and Palliative Care

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Overview

- * Palliative Care
- * Earlier Input/Managing Expectations
- * Complete/Impending fractures
- * Spinal Cord Compression
- * Pain
- * Non-pharmacological considerations

Faculty Disclosure

* Relationships with commercial interests: NONE

Background – Prostate Cancer

- * Second leading cause of cancer death in males
- * Second leading cause of metastatic spinal cord compression
- * Significant health care expenditure, with 60% occurring in last 6 months of life
- * Few studies (often sample < 280) on the specific palliative care needs and access of men with metastatic prostate cancer

No More Euphemisms – Early Input

- * “...at that point we’ll transition to palliative”
- * “...they’re not ready for palliative care”
- * “...where’s that palliative patient”
- * “...I made them palliative earlier today”
- * “...well, it doesn’t really matter, they’re palliative”

No More Euphemisms – Early Input

- * “...at that point we’ll transition to **dying**”
- * “...they’re not ready for **dying** care”
- * “...where’s that **dying** patient”
- * “...I made them **dying** earlier today”
- * “...well, it doesn’t really matter, they’re **dying**”

Palliative Care Is...

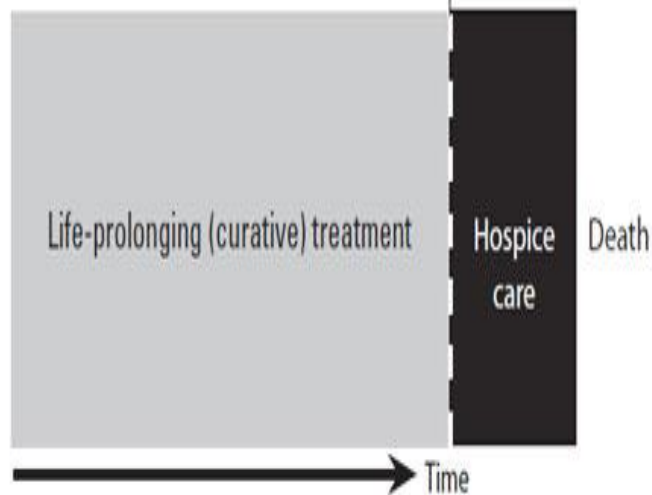
- * A philosophy of care, not a label, not a euphemism for dying
 - * “Is the patient cardiologic”
 - * “Is the patient nephrologic”
- * More than cancer care
- * More than end of life care
- * Interprofessional

Palliative Care Is...

- * “The medical subspecialty focused on providing relief from the symptoms, pain, and stress of serious illness. The goal is to improve quality of life for both the patient and the family.”

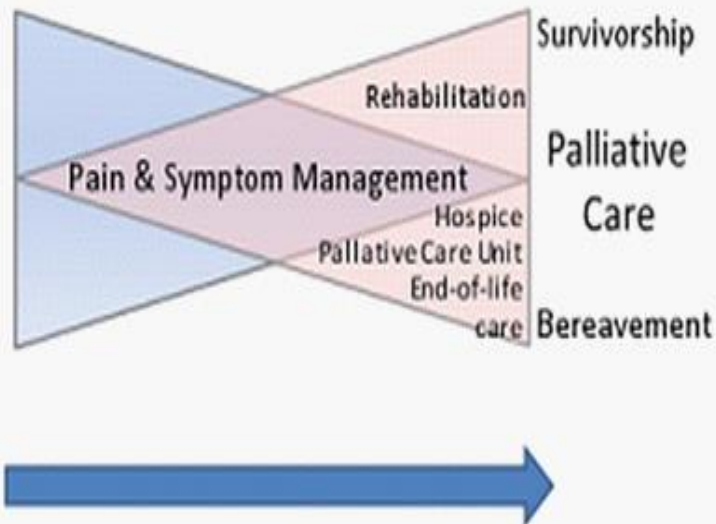
Medicare Hospice Benefit

Diagnosis of Life-Limiting Disease



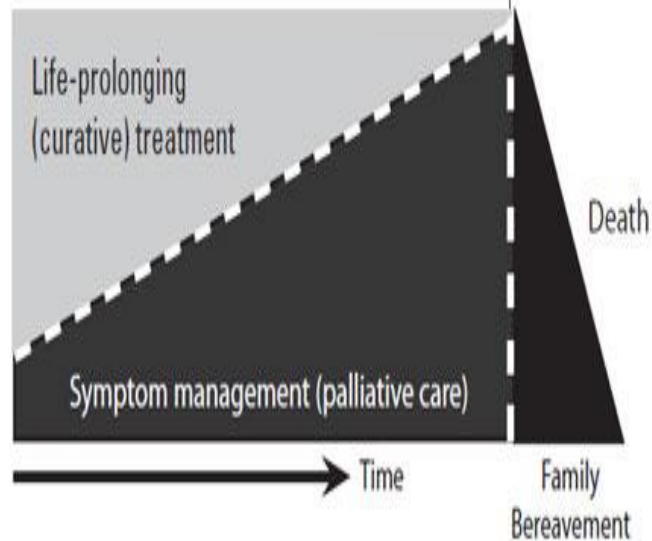
Palliative Care-Enhanced Model

Disease Management



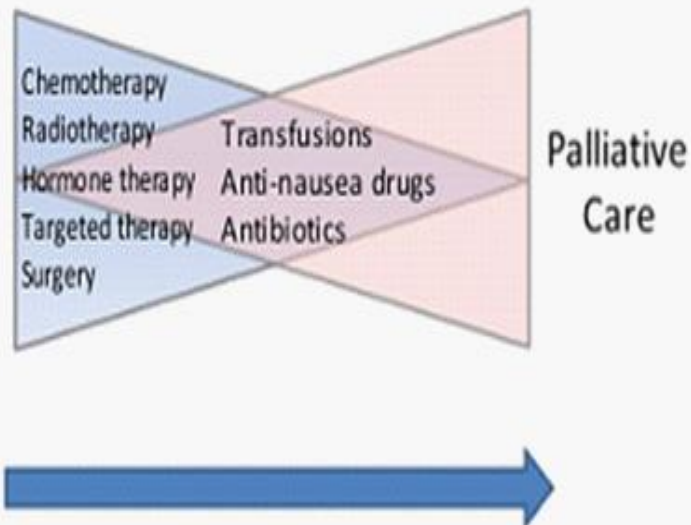
Medicare Hospice Benefit

Diagnosis of Life-Limiting Disease



Disease Management-Enhanced Model

Disease Management



Manage Expectations

- * Xu, J et al. Ann Fam Med 2016 May 14(3)
- * 260 men, 75 or younger, newly Dx LPC
- * Self-administered surveys assessing understanding
- * 33% expected to live < 5 years with no Rx
- * 55% expected to live > 20 years with Rx

Manage Expectations

- * Moses, KA et al. J of Clinical Oncology 2017 Feb
- * 96 men with met prostate CA over a 1.5 year period
- * 33% reported cure likely
- * Positive OR
 - * Better health, higher optimism scores
- * Not associated
 - * Marital status, age

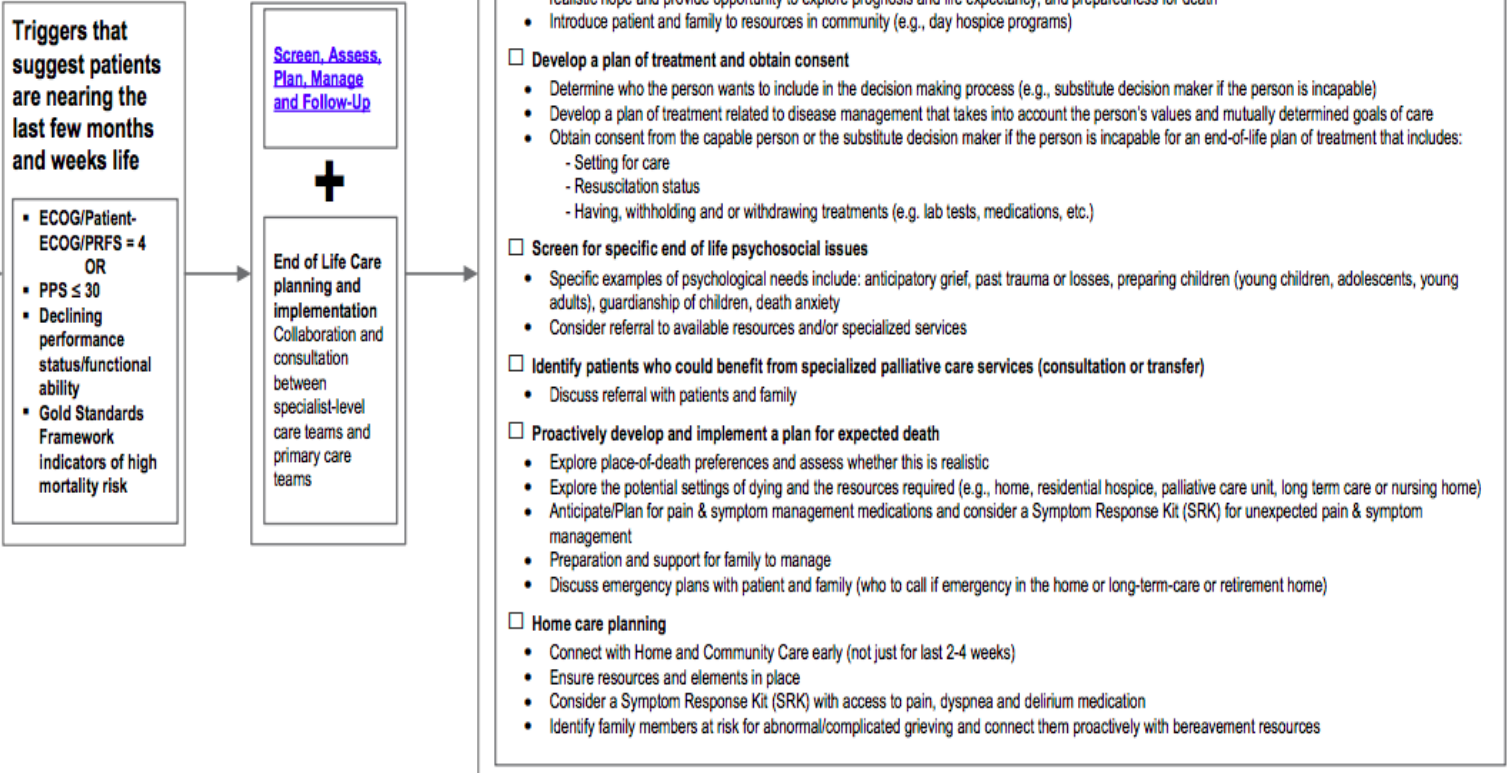
The pathway is intended to be used for informational purposes only. The pathway is not intended to constitute or be a substitute for medical advice and should not be relied upon in any such regard. Further, all pathways are subject to clinical judgment and actual practice patterns may not follow the proposed steps set out in the pathway. In the situation where the reader is not a healthcare provider, the reader should always consult a healthcare provider if he/she has any questions regarding the information set out in the pathway. The information in the pathway does not create a physician-patient relationship between Cancer Care Ontario (CCO) and the reader.

Pathway Map Target Population:

Individuals with cancer approaching end of life, and their families.

While this section of the pathway map is focused on the care delivered at the end of life, the palliative care approach begins much earlier on in the illness trajectory.

Refer to [Screen, Assess & Plan](#) within the Psychosocial & Palliative Care Pathway Map



End of Life Care (refer to [Collaborative Care Plan](#))

- Revisit Advance Care Planning**
 - Ensure the patient has determined who will be their Substitute Decision Maker (SDM)
 - Ensure the patient has communicated to the SDM his/her wishes, values and beliefs to help guide that SDM in future decision making
- Discuss and document goals of care with patient and family**
 - Assess and address patient and family's information needs and understanding of the disease, address gaps between reality and expectation, foster realistic hope and provide opportunity to explore prognosis and life expectancy, and preparedness for death
 - Introduce patient and family to resources in community (e.g., day hospice programs)
- Develop a plan of treatment and obtain consent**
 - Determine who the person wants to include in the decision making process (e.g., substitute decision maker if the person is incapable)
 - Develop a plan of treatment related to disease management that takes into account the person's values and mutually determined goals of care
 - Obtain consent from the capable person or the substitute decision maker if the person is incapable for an end-of-life plan of treatment that includes:
 - Setting for care
 - Resuscitation status
 - Having, withholding and or withdrawing treatments (e.g. lab tests, medications, etc.)
- Screen for specific end of life psychosocial issues**
 - Specific examples of psychological needs include: anticipatory grief, past trauma or losses, preparing children (young children, adolescents, young adults), guardianship of children, death anxiety
 - Consider referral to available resources and/or specialized services
- Identify patients who could benefit from specialized palliative care services (consultation or transfer)**
 - Discuss referral with patients and family
- Proactively develop and implement a plan for expected death**
 - Explore place-of-death preferences and assess whether this is realistic
 - Explore the potential settings of dying and the resources required (e.g., home, residential hospice, palliative care unit, long term care or nursing home)
 - Anticipate/Plan for pain & symptom management medications and consider a Symptom Response Kit (SRK) for unexpected pain & symptom management
 - Preparation and support for family to manage
 - Discuss emergency plans with patient and family (who to call if emergency in the home or long-term-care or retirement home)
- Home care planning**
 - Connect with Home and Community Care early (not just for last 2-4 weeks)
 - Ensure resources and elements in place
 - Consider a Symptom Response Kit (SRK) with access to pain, dyspnea and delirium medication
 - Identify family members at risk for abnormal/complicated grieving and connect them proactively with bereavement resources



Early Palliative Care and Its Role in Oncology: A Qualitative Study



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ABSTRACT

Introduction. Early integration of palliative care alongside oncology is being increasingly recommended, although the strategies and models for integration remain poorly defined. We solicited the opinions of patients and caregivers who participated in a randomized trial of early palliative care versus standard oncology care, regarding the respective roles of their oncologist (both groups) and palliative care physician (early palliative care group).

Materials and Methods. The study was performed at a comprehensive cancer center. Forty-eight patients (26 intervention, 22 control) and 23 caregivers (14 intervention, 9 control) were recruited purposefully at trial end. One-on-one, semistructured qualitative interviews were conducted and analyzed using grounded theory.

Results. The themes resulting from the analysis fell into three categories: the focus of care, the model of care delivery, and the complementarity between teams. The focus of care in oncology was perceived to be disease-centered, with emphasis on controlling

Impact of Oncologists' Attitudes Toward End-of-Life Care on Patients' Access to Palliative Care.

Hui D¹, Cerana MA², Park M³, Hess K³, Bruera E².

- * 182 randomly surveyed oncologists
- * Greater comfort with EOL translated to increased referrals
- * Higher EOL score significantly associated with
 - * Solid tumor oncology
 - * Greater willingness to refer newly diagnosed patients
 - * Greater comfort with symptom management and counselling
- * Not treatment decisions

Manage Expectations – Summary

- * Quality of life
- * Symptom management
- * Acknowledge autonomy

Medical Emergencies – Prostate Cancer

- * Spinal cord compression
- * Fractures/near fractures
- * Bone metastases/pain
- * Malignant hypercalcemia
- * Neutropenic sepsis

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The Role of Surgery - Fractures

- * “Surgical Treatment of Pathological Fractures Occuring at the Proximal Femur”
 - * Yonsei Med. J 2015
- * “Treatment of Pathological Fractures of the Long Bones”
 - * EFFORT Open Rev 2016 May
- * “Surgical Treatment of Pathological Fractures in Patients With Metastatic Tumors”
 - * Coll Antropol 2009 Dec

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 Pain and Functionality Markedly Improved


Radiotherapy, Bisphosphonates and Surgical Stabilization of Complete or Impending Pathologic Fractures in Patients with Metastatic Bone Disease

[Michal J. Wolanczyk](#)^{1,✉}, [Khashayar Fakhrian](#)² and [Irenäus A. Adamietz](#)²

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Abstract

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Purpose: To report the treatment outcomes of patients with metastatic bone disease with complete or impending pathologic fractures, who were treated with postoperative radiotherapy (RT), bisphosphonates or both after orthopedic stabilization.

Material and Methods: We retrospectively evaluated the results of RT, bisphosphonates or both after orthopedic stabilization for complete or impending pathologic fractures in 72 patients with skeletal metastases. After surgery, 32 patients (44%) were treated with RT alone (group 1), 31 patients (43%) were treated with RT and bisphosphonates (group 2) and 9 (13%) patients were treated with bisphosphonates (group 3), respectively. Patients were treated with a median dose of 30Gy (30-40 Gy/2-3Gy per fraction). The local tumor progression, pain progression and need for re-operation or re-radiotherapy were assessed from patients' medical records. Median follow-up time was 9 months.

Results: Median overall survival time was 14 months (95% CI: 12-17). Secondary surgical intervention at the same location was necessary in 1 patient of group 1 (2%), 2 patients of group 2(5%) and 2 patients of group 3 (15%), respectively (p=0.097). Local tumor progress was observed in 3 patients of group 1 (9%), 2 patients of group 2 (7%) and 4 patients in group 3 (44%), respectively (p=0.021). Local pain progress was observed in 19%, 16% and 67% of the same groups (p=0.011).

Conclusion: Our data confirm the efficacy and necessity of postoperative RT after orthopedic stabilization for metastatic bone disease to control the local disease. Bisphosphonates do not obviate the need for RT in the management of bone metastases after surgical stabilization. The combined treatment might lead to a better local tumor and pain control.

Metastatic SCC

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Practice Guideline Series

Treatment of metastatic spinal cord compression: CEPO review and clinical recommendations

Pain

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Cancer. 2013 December 1; 119(23): . doi:10.1002/ncr.28345.

Opioid requirement, opioid receptor expression, and clinical outcomes in patients with advanced prostate cancer

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Abstract

Background—Preclinical studies show that opioids stimulate angiogenesis and tumor progression through the mu opioid receptor (MOR). Although MOR is over-expressed in several human malignancies, the effect of chronic opioid requirement on cancer progression or survival has not been examined in humans.

Methods—We performed a retrospective analysis on 113 patients identified in the Minneapolis VA Tumor Registry (test cohort) and 480 patients from the national VA Central Cancer Registry (validation cohort) diagnosed with stage IV prostate cancer between 1995 and 2010, to examine whether MOR expression or opioid requirement is associated with disease progression and survival. All opioids were converted to oral morphine equivalents (OME) for comparison. Laser scanning confocal microscopy was used to analyze MOR-immunoreactivity in prostate cancer biopsies. The effects of variables on outcomes were analyzed in univariable and multivariable models.

Results—In patients with metastatic prostate cancer, MOR expression and opioid requirement were independently associated with inferior progression-free survival (PFS) (HR 1.65, 1.33–2.07; $p < 0.001$ and HR 1.08, 1.03–1.13; $p < 0.001$, respectively) and overall survival (OS; HR 1.55, 1.20–1.99; $p < 0.001$ and HR 1.05, 1.00–1.10; $p = 0.031$, respectively). The validation cohort confirmed that increasing opioid requirement was associated with worse OS (HR 1.005, 1.002–1.008, $p = 0.001$).

Conclusion—Higher MOR expression and greater opioid requirement are associated with shorter PFS and OS in patients with metastatic prostate cancer. Nevertheless, clinical practice should not be changed until prospective randomized trials show that opioid use is associated with inferior clinical outcomes, and that abrogation of the peripheral activities of opioids ameliorates this effect.

Pain

[Lancet](#). 2014 May 17;383(9930):1721-30. doi: 10.1016/S0140-6736(13)62416-2. Epub 2014 Feb 19.

Early palliative care for patients with advanced cancer: a cluster-randomised controlled trial.

[Zimmermann C](#)¹, [Swami N](#)², [Krzyzanowska M](#)³, [Hannon B](#)⁴, [Leighl N](#)³, [Oza A](#)³, [Moore M](#)³, [Rydall A](#)², [Rodin G](#)⁵, [Tannock I](#)⁶, [Donner A](#)⁷, [Lo C](#)⁸.

- * 76 prostate cancer patients
- * Pain statistically significantly improved
- * Quality of life trended toward improvement

Pain - Interesting Possibilities

- * “Methadone as a Tumor “Theralgesic” against Cancer”
 - * Michalska et al. Front Pharmacol. 2017; 8:733
- * “Impact of Methadone on Cisplatin Treatment of Bladder Cancer Cells”
 - * Michalska et al. Anticancer Research 2018; 38

Pain - Adjuvants

- * Dexamethasone
- * NSAIDS
 - * In particular toradol
- * Lyrica, gabapentin
- * Cymbalta

Non-Pharmacological Considerations

- * Decreased libido
- * Impotence
- * Changes in body habitus
- * Urinary incontinence
- * Caregiver concerns/family support

An Interesting Twist

[Transl Androl Urol](#). 2013 Dec; 2(4): 278–280.

doi: [10.3978/j.issn.2223-4683.2013.09.13](https://doi.org/10.3978/j.issn.2223-4683.2013.09.13)

The argument for palliative care in prostate cancer

[Melissa T. Sanford](#), [Kirsten L. Greene](#), and [Peter R. Carroll](#)

- * ?Name change
- * Dalal 2011 Oncologist – Increased referrals and shorter duration between diagnosis and referral
- * Bruera 2014 – 25% increase in referrals

Summary

- * Earlier Introduction to philosophy of care has impact on quality of life
- * Pain management still follows same structure
- * Interprofessional approach is key
 - * Optimal management of disease
 - * Surgery
 - * Radiation
- * Keep in mind non-pharmacological considerations

Thank You