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Nicole S Nevadunsky [1*], Zahava Brodt [1], SerifeEti [2], Peter A Selwyn [3], Ann Van Arsdale [1], Bruce Rapkin [4] and Gary L Goldberg [1]

[1]Department of Obstetrics & Gynecology and Women's Health, Division of Gynecologic Oncology, Albert Einstein Cancer Center, Albert Einstein College of Medicine, 0RQWH¿RUH 0HGLFDO &HQWHU 1< 86$

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Abstract

Objective: Recommendations to improve end-of-life cancer care include integration of palliative care into standard FDQFHU FDUH 7KHUH LV OLPLWHG LQIRUPDWLRQ UHJDUGLQJ SDOOLDWLYH FDUH IRU PDOLJQDQFLHV 7KH SXUSRVH RI WKLV VWXG\ ZDV WR GHWHUPLQH WKH LPSDFW R IDFWRUV RQ SDOOLDWLYH PHGLFLQH FRQVXOWDWLRQ

Methods: After IRB approval, patients with gynecologic malignancies who received a palliative medicine FRQVXOWDWLRQ IURP -DQXDU\ XQWLO -XQH ZHUH LGHQWL¿HG $EVWUDF IRU FRQVXOWDWLRQ DQG RXWFRPHV 5HVXOWV ZHUH GHVFULEHG DQG FRPSDULVRQ DQDO\VLV DQG .DSODQ 0HLHU WLPH WR HYHQW DQDO\VLV ZLWK 6366 VRIWZDUH

Results: SDWLHQWV ZHUH UHIHUUHG IRU SDOOLDWLYH PHGLFLQH FRQVXOWDWLRQ :KLWH DQG +LVSDQLF 7KH UHDVRQ V IRU FRQVXOWDWLRQ LQFOXGHG SDL REVWUXFWLRQ G\VSQHD 0HGLDQ QXPEHU RI GD\V IURP WKH LQLWLDO FRQV WR HYHQW DQDO\VLV ZKLFK LV D SUR[\ PHWULF IRU WLPHO\ FRQVXOWDWLRQ ZDV ZHUH OHVV OLNHO\ WR EH '15 S YHUVHV RU UHIHUUHG WR KRVSLF RI FDUH´ ZDV WKH FRQVXOWDWLRQ UHDVRQ LQ RI SDWLHQWV RI PHGLFDO VXE VS S RI SDWLHQWV IURP PHGLFDO VXE VSHFLDOLVWV GLHG LQ WKH KRVSLW UHIHUUHG SDWLHQWV S

Conclusions:

Keywords: Palliative medicine; Gynecologic malignancies; Consultation models

Introduction

Recent attention has focused on innovations to improve end-of-life care for patients with incurable solid tumors while addressing the exponentially increasing costs for cancer and end of life care [1]. It has been predicted that annual direct costs from cancer care will rise from the 2006 cost of $104 billion to $173 billion in 2020 [2]. Integration of palliative care into routine oncology care is one suggested change in attitudes and practices for health care providers managing patients with cancer [3]. In 2012 the American Society of Clinical Oncology put forth a consensus statement that suggested that "combined standard oncology care and palliative care should be considered early in the course of illness for any patient with metastatic cancer and/or high symptom burden" [4]. The consensus opinion cited seven randomized controlled trials (RCT) demonstrating improvement in symptoms, quality-of-life, patient satisfaction, reduced caregiver burden, more appropriate referral and use of hospice, reduced use of futile intensive care and other invasive care and improved survival [5-11]. Additionally there are retrospective reports that timely consultation by palliative medicine experts results in decreased metrics associated with poor end-of-life care, as well as decreased cost [12,13].

Concerns of changing attitudes and practices are real as we do not know how patients, physicians or payers may be affected by these changes. Additionally, negative attitudes and misunderstanding of the role and place of palliative medicine have arisen secondary to references to "death panels" during debate regarding health care legislation. Despite these concerns, no studies to date have described patient/caregiver harm or excessive cost from early palliative care involvement and management [4]. While the evidence from RCTs integrating standard oncology practice and palliative care are promising, the applicability of these trials to general oncology practice is yet to be tested, reproduced or proven. Additionally, the optimal method of integration of palliative medicine into standard oncology care is unknown, and at the present time, less than 1% of National Institute of Health funding is directed at research in palliative medicine [12].

In reviewing the end-of-life care in the last decade in the United States, a significant number of cancer patients who died from cancer received new chemotherapy regimens, had multiple emergency department visits, and hospitalizations including intensive care

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*Corresponding author: Nicole S Nevadunsky, Department of Obstetrics, *\QHFRORJ\ DQG :RPHQ¶V +HDOWK $OEHUW (LQVWHL Medical Center, 3332 Rochambeau Ave Bronx, New York 10467, USA, Tel: 718-920-4794; Fax: 718-920-6313; E-mail: QQHYDGXQ#PRQWH¿RUH RUJ

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pain (45%), bowel obstruction (4%), dyspnea (4%), and nausea/ vomiting (1%) (Table 2). In 46% of the consultations, the palliative care team were asked to address the overall “goals of care”, which includes establishment of a health care proxy, do-not-resuscitate/do-no-intubate orders (DNR/DNI), hospice enrollment, and discussion regarding avoidance of non-meaningful and /or futile invasive interventions. Median number of days from the initial consultation until deathby Kaplan-Meier time to event analysis, which is a proxy metric for timely consultation was 35 days [Range 0-1005 days, 95% CI of medians, 25-49 days] (Figure 1). Median time from consult to discharge was 7 days [Range 0-103 days] (Figure 2).

Hospice referral was made on the first day of consultation for 19 (23%) patients and five patients (6%) were current hospice residents that had been admitted to the hospital. Twenty-two patients (26%) had DNR/DNI consent at the time of admission. During the index hospitalization 60 (71%) of patients were transitioned to DNR/DNI code status. Palliative care consultants recommended medication changes, including addition, removal, change of dose, for 68 (81%) of patients. Pain was reported as uncontrolled by 46 (55%) of the patients, although 67 (80%) of the patients were using opioid narcotics at the time of the initial consultation. Five patients (6%) were noted to be delirious by consultants at the time of the initial consult interview. There was no difference in the consultation rate between older and younger patients (<60 years). However, younger patients were less likely to be DNR (p=0.03, 60% versus 80%) and referred to hospice (p=0.02, 9% versus 33%).

There were differences in consultation reasons and dispositions depending on who referred the patient: gynecologic oncologists or medical sub-specialists (Table 3). Thirty-eight (45%) patients were referred by medical sub-specialists and forty-six (55%) were referred by gynecologic oncologists. “Goals of care” was identified as the initial reason or indication for consultation in 61% of patients from medical sub-specialists (medical oncology and other) vs. 26% from gynecologic oncologists (p=0.003). Twenty-eight percent of the palliative care patients referred from medical sub-specialists died in hospital in compared to 8% of patients of referred by gynecologic oncologists (p=0.02).

Discussion

In this study we have described the current practice of palliative medicine consultation at our institution and for our ethnically/racially diverse patient population. While organizations such as ASCO issue recommendations for earlier initiation and integration of palliative medicine with standard oncology care, there is a paucity of data on which to base guidelines for these referrals. Of note, time from consultation until death in our patient population was about 35 days (0-1005). If we consider that hospice care in the United States is available to patients for the last six months of life, thirty one days between consultation and death appears to be an inadequate length of time for patients to be provided the benefit of palliative medicine resources. From the perspective of the ASCO recommendation for concurrent care at time of diagnosis of metastatic cancer and/or high symptom burden,

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