Understanding the Hospice Cancer Patient

The Challenges of Providing Effective End of Life Care in a Culture That Views Death as Failure

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Objectives

- Identify 3 common cancer types and treatments as they relate to overall prognosis and survival
- Appreciate the view from the other side of the stethoscope (the oncologist’s point of view)
- Identify ways to be part of the same team

Lung Cancer

Leading Cause of Cancer Deaths Among Men and Women

STAGING

NSCLC
Stage I: Confined to lung
Stage II-III Confined to chest
Stage IV Mets to liver, bone, brain, adrenals, soft tissue, muscular tissue

SCLC
Limited Stage: Chest
Extensive Stage: Mets to liver, bone, brain, adrenals, soft tissue, muscular tissue
Non Small Cell Lung Cancer

Stage IV Non Small Cell Lung Cancer

In this patient: hilar, supra-clavicular, and left femoral mets.

Possible Metastatic sites in lung cancers:
- Brain, pleura, lung, bones, liver, lymph adrenal, pelvic, cutaneous

Case Study

JB is a 68 year old male admitted with AMS, ataxia, shortness of breath, and cough.
- CT head done in ED notable for multiple brain lesions with vasogenic edema.
- Chest X-ray done in ED notable for large area of central adenopathy.
- PET CT showed extensive mediastinal adenopathy with compression of superior vena cava and proximal airways as well as trachea narrowing.
• MRI brain notable for multiple brain lesions.
• Bronchoscopy completed and pathology consistent with small cell lung cancer
• This patient is symptomatic from both the brain and lung mets. He has SVC and will need urgent radiation therapy to his chest to preserve his airway.
• He is not a surgical candidate.
• He will have radiation to his brain and chest prior to treatment.
Case Study

JB begins radiation to both his brain and chest.
He completes all 10 treatments while in the hospital.
His performance status remains poor after treatment, and he is unable to tolerate chemotherapy.
He is recommended for best supportive care 4 months after diagnosis.

• Some cancers are diagnosed at early stages, allowing more treatment options, & time to treat, with months and even years of cancer free survival.
• Others are diagnosed at late stage, with few, or even no treatment options.

Chemo: Love and Hate

Lung Cancer Therapies
• Taxol
• Carboplatin
• Cisplatin
• Avastin
• Tarceva
• New Immunotherapies

Side Effects
• Anaphylaxis, cytopenias
• Nephrotoxicity, cytopenias
• Bleeding / Hemorrhage
• Acneform rash
• Diarrhea, rash, pneumonitis
Case Study

The Before

- Metastatic Lesion:
- Note the blood supply.
- This lesion was present as a small, flesh colored bump on the day of surgery, and grew into this from April-October.

The After

Surgery in April.
(Left lower lobe resection)
* June: Taxol and Cisplatin x1
  (and a trip to urgent care for antibiotics for arm)
* July: Taxotere and Cisplatin
  (and a trip to urgent care for antibiotics)
* August: Gemzar
  (and a trip to the ED for SOB and 2 units of blood)
* September: Gemzar
  (and a trip to the ED for SOB and 2 units of blood)
* October: Surgery to remove arm growth
* November: Stereotactic Radiation Therapy to brain.
(4 days and no follow up later, s/p fall, back to ED. He remained in the hospital 2 weeks, then to VA in Columbia where he stayed until he died.)
* February: He died 10 months after diagnosis.
Breast Cancer

• Most diagnosed cancer in women.
• Staging is based on:
  - Tumor type
  - Tumor size
  - Tumor location
  - Degree of invasion of surrounding tissue and metastases.

  • Metastatic Sites
    - Chest wall, fat under arm
    - Lymph nodes
    - Soft tissue
    - Bones
    - Brain
    - Lung, pleural spaces
    - Liver
    - Other sites are possible (peritoneum)

Case Study

55 year old with metastatic Breast Cancer diagnosed at age 42, now with bone, pleural, liver, and peritoneal mets, and malignant pleural effusion.

S/P:
- Neoadjuvant chemotherapy
- Surgery
- Chemotherapy
- Radiation Therapy
- Multiple lines of chemotherapy and hormonal therapy
- Pleurex Catheter Placement
Prior Therapy:
• Taxol, Adriamycin, Carboplatin, Herceptin
• Taxotere, Carboplatin
• Abraxane, Carboplatin
• Herceptin
• Gemzar
• Xeloda
• Zometa
• Multiple radiation therapy treatments to bony mets.

Case Study
• Her performance status has declined in the past few months, with increasing debility, bony and abdominal pain, and poor po intake.
• She and her physician have had multiple discussions in the past year regarding goals of care, her progression despite ongoing and multiple prior lines of treatment, and her ability to tolerate more therapy.
• She asks about a clinical trial- but there are none she would qualify for.
• She goes to seek a second opinion, and best supportive care with hospice was recommended.

GI Cancers
• Colon Cancer
  - Curable depending on stage. Can be years between recurrences.
• Pancreatic Cancer
  - Often diagnosed at late stage.
• Gastric Cancer
  - Prognosis depends on type and stage
• Liver Cancer
  - Hep C is a risk factor
  - Often diagnosed at late stage
GI Cancer Treatments

• Treatment for GI cancers are varied, and surgical appropriateness, performance status, and liver/renal function are factors.
• Radiation therapies are possibilities
• Patients and families tend to grasp at any treatment possibility.
• It is very easy to judge this when it is not your or your family member’s treatment decision

GRADE ECOG PERFORMANCE STATUS
0 Fully active, able to carry on all pre-disease performance without restriction
1 Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work
2 Ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours
3 Capable of only limited self-care; confined to bed or chair more than 50% of waking hours
4 Completely disabled; cannot carry on any self-care; totally confined to bed or chair
5 Dead

The Other Side of the Stethoscope

Case Study
• 18 y/o non smoker diagnosed with Stage IV lung cancer with bulky and diffuse lung disease, with widespread bone and liver mets.
• ECOG performance status is 4.
• Incurable.
• Patient has debilitating back pain and shortness of breath.
• Patient and family are told the facts. Not curable but treatable. The goal? To shrink the cancer and provide symptom management to hopefully prolong life.

• Patient refuses to believe diagnosis. Does not make eye contact, and chants repeatedly that there is no cancer.

• Palliative medicine is consulted for pain management and support

• Patient eventually discharged to complete radiation at home and follow up with palliative medicine and a medical oncologist.

• Patient hospitalized again for pain before radiation was completed.

• At follow up: Performance status was 4. Patient did not walk. Flat affect. QOL was poor. The oncologist stated he would only treat the patient if the PS was improved. He did recommend hospice at that visit, which the patient and family declined.

• Patient returned to clinic (walking in) one month later, and was treated with one cycle of chemotherapy per patient/family request.

• Patient was hospitalized twice afterwards for pain, and had other areas radiated.

• Performance status continued to decline. Patient wasn’t eating or drinking much.

• Patient continued to follow with palliative medicine, and with each visit, goals of care and hospice were discussed.
• Patient was again admitted with intractable pain, and multiple conversations were had with patient and family regarding further treatment, and goals of care.
• Patient was discharged to a hospice house, and died the next day. (Less than one year after diagnosis)

Discussion

Case Study
• 68 y/o previously independent grandmother admitted with acute failure to thrive and abdominal pain.
• Diagnosis: Stage IV Gastric Cancer with peritoneal mets and small bowel obstruction.
• Obstruction resolved without surgery
• Patient and family interested in treatment which is systemic chemotherapy- she is not a surgical candidate.

• Patient’s performance status is poor due to recent illness.
• Best supportive care vs. treatment are discussed.
• She is requesting treatment. Family agrees.
• She is treated with DCF.
  (Docetaxel, cisplatin, Fluorouracil, leucovorin)
• Her admission is complicated by persistent nausea, with diarrhea, and she is therefore not eating or drinking much.
• She became febrile and neutropenic, requiring IV antibiotics and growth factors.
• She recovers from the neutropenia, but due to declining performance status and continued diarrhea, she remains hospitalized.
• We held cycle two due to continued hospitalization with debility.
• She passed away 4 ½ weeks after diagnosis.

Discussion

Case Study
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• 72 y/o male admitted from OSH with AMS.
• Patient with a remote (>10 year h/o treated colon cancer.)
• MRI Brain: single brain lesion.
• PET/CT: lung mets (seen on CT scan done 8 years prior)
• CT guided lung biopsy: non diagnostic
• Brain lesion resected: pathology consistent with colon cancer.

• Patient recovers well after resection, and is discharged home to follow with medical oncology nearer to his home.
• He is unsure he will pursue systemic therapy due to his prior experience and his current age.
• He understands that his cancer has grown slowly, and may be more comfortable living his life well for as long as he can live it.

Discussion
Case Study

19 y/o male admitted with shortness of breath and chest pain. CT scan notable for large lung masses and bulky lymph disease in chest, as well as left testicular mass obstructing his left ureter.

He has urgent left orchiectomy: pathology consistent with testicular cancer: stage IV.

Discussion

“Lines of Therapy” Whaatt???

• Cancer treatments are “approved” and standardized across the country. They do get adjusted as needed according to each patient’s individual needs.

• Each “line of therapy” is used as long as it works. If there is progression, and the patient wants to continue and can tolerate it, the next line is introduced.

Lines of Treatment

• Cancer treatment is evolving

• Immunotherapies are being approved for lung, breast, and other cancers, as well as melanoma.

• Targeted therapies are being used in patients with certain gene mutations in lung, gastric, breast, colon, and other cancers.

• These advances are allowing for longer survival (and treatment lines!)
Fight the Good Fight
Quitters are weak. And other words...

• FIGHT LIKE A GIRL
• SAVE THE TA TA’S
• KEEP ON POUNDING
• CANCER SUCKS
• NO ONE FIGHTS ALONE
• JOIN THE FIGHT – ONE STEP AT A TIME
• YOU NEED TO TRY… NO NEED TO DIE

Conclusion

• Some cancers are diagnosed at early stages, allowing more treatment options & time to treat, with months and even years of cancer free survival.
• Some people never have a recurrence
• Others are diagnosed at late stage, with few, or even no treatment options.

Conclusion

• Most patients are told their prognosis with and without treatment.
• Most patients only hear the word “treatment” and how long they can live with it.
• Most do not “hear” the side effects..
• Some physicians will not offer treatment to end stage cancer patients they feel will not tolerate it, while some physicians will.
Conclusion

• Some patients do not want treatment and prefer to “go home” and “live the life they have.”
• Some patients will never - EVER- choose best supportive care, preferring to “fight” till the end.
• Some physicians do not want to suggest best supportive care if there are treatment options they feel the patient can tolerate.

Conclusion

• Most physicians are grateful to have palliative medicine and hospice available to their patients, and are not opposed to this choice if the patient does not want to pursue or continue treatment.
• Many physicians offer best supportive care and hospice up front in late stage cancer diagnosis, and discuss EOL with late stage patients.

Questions
References

• American Cancer Society (acs.org)
• Eastern Cooperative Oncology Group: ECOG
  http://ecog-acrin.org/resources/ecog-performance-status
• National Comprehensive Cancer Network
  (nccn.org)
• Other references noted on individual slides.